

Pennine Care 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)
RT210	Heathfield House	Heywood, Middleton and Rochdale community team for learning disabilities	OL16 2AU
RT210	Heathfield House	Oldham adult learning disability team	OL4 1DE
RT210	Heathfield House	Stockport integrated community learning disability team	SK1 3XE

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

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

Summary of findings

Where applicable, we have reported on each core service provided by Pennine Care NHS Foundation Trust and these are brought together to inform our overall judgement of Pennine Care 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?

Requires improvement 

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 Pennine Care NHS Foundation Trust community mental health services for people with learning disabilities as good because:

- A range of high quality, person-centred therapeutic interventions were being delivered to patients to support them to achieve improved independence and wellbeing.
- Interactions between staff and patients demonstrated personalised, collaborative, recovery-oriented care planning.
- Patients who had been assessed as being at risk of crisis had clear crisis plans.
- All staff had a good understanding of the principles and application of the Mental Capacity Act
- Staff attitudes and behaviours were responsive, respectful and caring.
- Staff were using innovative methods to involve patients in their own care.
- Services routinely supported patients to get involved in staff recruitment. This was underpinned by a detailed trust policy.
- The Oldham service was facilitating a supported internship for a person with a learning disability.
- Teams had made efforts to engage people from minority ethnic communities. The team in Oldham had developed a set of easy-read pictures and symbols for patients from a South Asian background.
- Teams had a strong identity and were committed to helping people with a learning disability achieve improved independence and wellbeing.
- Managers attended directorate governance meetings, and received regular feedback on their teams' performance.

- Two of the teams had audited themselves against the National Learning Disability Professional Senate specification for learning disability teams.
- The learning disability directorate participated in the Greater Manchester plan to transform care for people with learning disabilities.
- Teams had been able to raise their concerns about confidentiality in the bases to their senior managers.

However,

- Seven of 32 case records checked did not include a risk assessment, and 15 others did not include a full risk assessment.
- In two of the locations, patients and carers needed to walk through or past staff desks to get to the interview rooms. This made it difficult to protect confidentiality.
- Interview rooms were not soundproofed.
- The joint protocol between mental health and learning disability services in Stockport did not cover the home treatment team and on-call psychiatrist. This meant that patients may need to go to accident and emergency to access a mental health crisis service.
- Learning disability, psychiatry and mental health teams kept separate care records. This meant that staff did not have easy access to all of the information they needed to be able to deliver safe and effective care.
- An audit of antipsychotic prescribing in people with a learning disability identified that there was no documented evidence of side-effect monitoring in around half of care records.
- Two of the teams did not employ the full range of professional disciplines recommended by the national specification for community learning disability teams.

Summary of findings

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

Are services safe?

We rated safe as requires improvement because:

- Seven of 32 case records checked did not include a risk assessment, and 15 others did not include a full risk assessment.
- None of the interview rooms were soundproofed, and conversations in some areas were audible in adjacent rooms.
- In two of the locations, patients and carers needed to walk through or past staff desks to get to the interview rooms. This made it difficult to protect confidentiality.
- In Oldham, staff from a private health service in the same building could access the office and filing area.
- The joint protocol between mental health and learning disability services in Stockport did not clearly identify arrangements with the home treatment team and on-call psychiatrist. This meant that patients may need to go to accident and emergency to access a mental health crisis service.
- Compliance rates for two trust mandatory training topics in Stockport were well below 75%.
- The lone working procedures in the Stockport integrated team did not fully ensure staff safety.

However,

- People who had been assessed as being at risk of crisis had clear crisis plans.
- One of the services had developed a person-centred, accessible risk assessment tool.
- Managers had apologised to patients when things had gone wrong.
- There were enough staff in each team to meet the needs of the local population.
- Referrals and waiting lists were discussed at every team meeting.
- Teams were reporting incidents and learning when things had gone wrong.
- Community bases were clean and well maintained.

Requires improvement



Are services effective?

We rated effective as good because:

- Interactions between staff and patients demonstrated personalised, collaborative, recovery-oriented care planning.

Good



Summary of findings

- Community learning disability teams had good relationships with psychiatrists and attended psychiatry reviews where possible. They updated each other by email.
- The directorate had developed a number of evidence-based care pathways.
- There was a comprehensive trust policy for positive behaviour support and physical intervention.
- Services monitored outcomes using the health equalities framework.
- Staff had access to specialist training.
- Supervision and appraisal records were up to date.
- The trust employed a clinical nurse specialist in learning disability in Oldham, who liaised between the community learning disability team and generic mental health services.
- All staff had a good understanding of the principles and application of the Mental Capacity Act.

However,

- Most of the care plans we viewed focused on one specific problem rather than the holistic needs of the individual.
- Learning disability, psychiatry and mental health teams kept separate care records. This meant that staff did not have easy access to all of the information they needed to be able to deliver safe and effective care.
- An audit of antipsychotic prescribing in people with a learning disability identified that there was no documented evidence of side-effect monitoring in around half of care records. There was no clear action plan from the audit.
- Two of the teams did not employ the full range of professional disciplines recommended by the national specification for community learning disability teams.

Are services caring?

We rated caring as good because:

- Staff attitudes and behaviours were responsive, respectful and caring.
- People and carers spoke very highly of staff.
- Staff were using innovative methods to involve patients in their own care.
- Services routinely supported people with a learning disability to get involved in staff recruitment. This was underpinned by a detailed trust policy.
- Patients had been involved in delivering training.
- The Oldham service was facilitating a supported internship for a person with a learning disability.

Good



Summary of findings

Are services responsive to people's needs?

We rated responsive as good because:

- The teams accepted referrals from patients and carers as well as from professionals.
- Patients and carers told us that it was easy to contact the teams.
- Teams had systems that allowed them to respond quickly to urgent referrals.
- Accessible information about advocacy and complaints was displayed in the team bases.
- We saw many examples of creative, adaptive communication to help patients make decisions about their lives.
- Teams had made efforts to engage people from minority ethnic communities.
- Incidents and complaints were standard agenda items at team meetings.

Good



Are services well-led?

We rated well-led as good because:

- The learning disability directorate had developed their own vision, based on the overall trust vision.
- Teams had a strong identity and were committed to helping people with a learning disability achieve improved independence and wellbeing.
- Managers attended directorate governance meetings, and received regular feedback on their teams' performance.
- Staff spoke positively about opportunities for development and support provided by managers.
- Staff felt able to express their opinion and ideas in their teams.
- Managers had opportunities to develop their leadership skills.
- Two of the teams had audited themselves against the National Learning Disability Professional Senate specification for learning disability teams.
- The learning disability directorate participated in the Greater Manchester plan to transform care for people with learning disabilities.
- Teams had been able to raise their concerns about confidentiality in the bases to their senior managers.

However,

- Staff worried that integration with the local authority would compromise their focus on health.

Good



Summary of findings

Information about the service

Pennine Care NHS Foundation Trust provides community learning disability services across Bury, Heywood, Middleton, Rochdale, Oldham and Stockport. These teams enable people with a learning disability to access a full range of community health and social care services through the management of complex physical, emotional and psychological needs. The trust also provides psychological therapies and a dementia pathway for people with learning disabilities in Tameside.

We inspected a sample of three of the five community learning disability services. They were based in Heywood, Middleton and Rochdale, in Oldham and in Stockport.

Heywood, Middleton and Rochdale and Oldham community learning disability team were commissioned

by the local clinical commissioning group. Stockport community learning disability team were integrated with the local authority social care team for adults with a learning disability. All of the staff except for the clinical psychologists were commissioned and hosted by Stockport Metropolitan Borough Council under a section 75 (NHS Act 2006) agreement. Clinical psychology was commissioned by the local clinical commissioning group.

Psychiatric services for people with learning disabilities were commissioned as above but based in local mental health hospitals alongside psychiatry colleagues.

CQC has not previously inspected community learning disability services at this trust.

Our inspection team

Our inspection team was led by:

Chair: Aidan Thomas, Chief Executive of Cambridgeshire and Peterborough NHS Foundation Trust

Head of Inspection: Nicholas Smith, Care Quality Commission

Team Leaders: Sharron Haworth, Inspection Manager, Care Quality Commission; and Julie Hughes, Inspection Manager, Care Quality Commission

The team that inspected community teams for people with a learning disability comprised an inspection manager and two specialist advisors. One of the specialist advisors was a speech and language therapist and the other was the chief executive of two autism and learning disability charities.

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?

During the inspection visit, the inspection team:

- visited three of the six community learning disability services provided by the trust

Summary of findings

- visited one of the learning disability psychiatry services
- visited the clinical nurse specialist in learning disability at the community mental health team
- spoke with eight patients
- spoke with 10 patients' carers
- spoke with team managers, service managers and the acting directorate manager
- spoke with 33 other staff members, including nurses, clinical psychologists, speech and language therapists, physiotherapists, an administrator and a psychiatrist
- attended and observed one multidisciplinary meeting
- attended and observed two care reviews, one group session and seven individual sessions for patients
- looked at 32 care 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

We spoke with eight patients and 10 carers or relatives. Patients told us that staff listened to them and did not

judge them. They enjoyed group activities. They said that care plans and easy-read letters helped them understand what was happening. Carers said that they felt supported by the teams, and that it was easy to contact staff.

Good practice

The Oldham adult learning disability service was providing a supported internship to a person with a learning disability, in partnership with a local college and third sector organisation. Supported internships are a Department for Education initiative. They help young people with additional educational needs gain work experience in preparation for paid employment. The intern in Oldham had been working as part of the physiotherapy team. She helped to set up equipment and spoke to patients who were unsure about coming to 'rebound therapy' to provide reassurance.

Communication development workers in Oldham (employed by the local authority but supervised by the team's speech and language therapists) had created a range of easy-read text, pictures and symbols specifically for people from a South Asian background.

In Oldham, there was a clinical nurse specialist in mental health and learning disability employed in the community mental health team. The clinical nurse specialist linked in with teams to ensure that patients with mental health problems and learning disabilities received a safe and effective service at all times.

Areas for improvement

Action the provider **MUST** take to improve

The trust must improve all three office environments to ensure patients' confidentiality is protected when they visit the buildings.

The trust must ensure that all care records contain comprehensive risk assessments, as outlined in the trust policy on clinical risk assessment.

Action the provider **SHOULD** take to improve

The trust should review the joint protocol between mental health and learning disability services in Stockport, to clarify whether the home treatment team and on-call psychiatry should be providing a service to people with a learning disability.

Summary of findings

The trust should ensure that information sharing between community teams and psychiatric services is effective, so that staff have easy access to all the information that they need to be able to deliver safe and effective care.

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Pennine Care 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)

Heywood, Middleton and Rochdale community team for learning disabilities
Oldham adult learning disability service
Stockport integrated community learning disability team

Name of CQC registered location

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.

None of the patients being cared for by the community learning disability teams were detained under the Mental Health Act. Staff knowledge and understanding of the Mental Health Act was variable, but all knew where they could access further advice or support.

We reviewed one care record for a person with a learning disability subject to a community treatment order. This person was being cared for by the community mental health team. All of the Mental Health Act documentation within this care record was completed in line with the Code of Practice.

Mental Capacity Act and Deprivation of Liberty Safeguards

Staff demonstrated a high level of understanding of the Mental Capacity Act. They took practicable steps to enable

Detailed findings

patients to make decisions about their care and treatment by using a variety of communication methods. Staff could describe the process they needed to follow if they needed to assess, or participate in an assessment of, a patient's capacity to consent.

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

The team bases were clean and well maintained. Cleaning records were up to date and demonstrated that the environment was cleaned at least once every two days.

The trust policy stated that ligature point risk assessments should only be done in community services when the reception area had toilet facilities that were accessible to patients and not under constant observation. The team bases were therefore exempt from ligature point risk assessments. A ligature point is anything which could be used to attach a cord, rope or other material for the purpose of hanging or strangulation.

Health and safety checks, including fire equipment, fire evacuation procedure, first aid equipment and office furniture were up to date in Heywood, Middleton and Rochdale and in Oldham. Health and safety checks in the Stockport base were undertaken by the local authority.

None of the interview rooms in the three locations had an integrated personal alarm system. Alarm call points in interview rooms mean that staff can access help quickly in an emergency. Staff did however carry personal alarms. In Heywood, Rochdale and Middleton there was also a personal alarm attached to the wall halfway down the long corridor between the entrance and the staff area. In Oldham and in Heywood, Rochdale and Middleton the interview room was next to the staff office, and had a glass panel in the door or wall. This meant that other staff would be able to unobtrusively check that people were safe if there were any reasons to be concerned. In Stockport, the interview rooms were separated from the staff areas by a short corridor. Staff told us that they would book one of the other interview rooms (downstairs in the same building) if they thought that the people they were seeing might pose any risk. These 'downstairs' interview rooms did contain integrated alarm points, and some had two exits.

There were no clinic rooms and no clinical equipment in any of the locations. Staff would support patients to access clinical services (for example weight management, blood pressure monitoring) in their local community health centres. The trust told us that they did not complete formal

environmental and infection control audits at community learning disabilities premises. This was because the teams did not deliver clinical practices and procedures at these locations.

In the Heywood, Middleton and Rochdale base, patients had to walk past staff desks and the care record filing cabinets to get to the interview or group rooms. This was managed by making staff aware of when patients were due to come in so that they could ensure that patient identifiable information was not visible on desks or computer screens. We also saw a set of mobile boards, which could be moved to block off the windows between the meeting room or interview room and the office. Staff acknowledged that it could be difficult to manage telephone calls. It would be possible for them to receive a call regarding one patient while another patient was walking past.

The Oldham base was shared with several other NHS and private health services. There was a reception area staffed by a community learning disabilities administrative worker. Similarly to Heywood, Middleton and Rochdale, there was a central large office space with a rolling rack for care records and several rooms leading off. Staff from a private health service in the building could freely access the central office and care record area, and patients would need to walk past the care record area to get to interview rooms. We raised concerns that this did not guarantee the confidentiality of the care records. Managers responded by contacting the trust information governance department, who advised them to keep the rolling rack locked at all times.

None of the interview rooms in any of the locations were soundproofed. We were able to hear parts of staff conversations in adjacent rooms while we were completing our interviews on inspection. This meant that confidential discussions with patients could potentially be overheard by other members of staff, or in Stockport where there was more than one interview room, by other patients. Stockport staff were aware of this problem and told us that they would book a room at the end of the corridor or use the more private rooms on the ground floor.

Are services safe?

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

None of the services had reported any incidents or complaints in relation to breaches of confidentiality at their bases. The risks at Heywood, Middleton and Rochdale had previously been raised with senior managers.

The Heywood, Middleton and Rochdale service was located in a business park alongside other offices and light industrial units. There were no separate walkways for pedestrians within the business park. This meant that people travelling in on public transport would have to walk down a road that was also used by cars and light commercial vehicles. The Heywood, Middleton and Rochdale team managed this potential risk by seeing the majority of patients at home or in the community. Staff told us that they would go out to meet patients at the local bus stop and walk back to the office with them if it was their first visit. There had been no incidents or near misses involving traffic on the business park.

Safe staffing

Pennine Care NHS Foundation Trust establishment levels for each community learning disability team are listed below, with whole time equivalent numbers for each role.

Heywood, Middleton and Rochdale community learning disability team:

- Clinical team managers 1.0
- Nurses: 8.2
- Clinical psychologists: 1.0
- Speech and language therapists: 1.0
- Assistant practitioners: 0.5
- Administrators: 0.8

According to Public Health England there are likely to be 4088 people with a learning disability living in Rochdale. Nine hundred and thirty-seven will probably be known to services. The trust employed 11.2 qualified practitioners (including managers) and 0.5 assistant practitioners to support this population.

Heywood, Middleton and Rochdale had one nursing vacancy at the time of inspection. There was a sickness rate of 5.3%, which was better than trust average.

Oldham community learning disability team:

- Clinical team managers: 1.0
- Dieticians: 0.4

- Drama therapists: 1.2
- Nurses: 7.0
- Physiotherapists: 1.8
- Clinical psychologists: 0.8
- Speech and language therapists: 2.3
- Assistant practitioners: 4.1
- Administrators: 1.6

According to Public Health England there are likely to be 4334 people with a learning disability living in Oldham. Nine hundred and ninety-nine will probably be known to services. Pennine Care NHS Foundation Trust employed 14.3 qualified practitioners (including managers) and 4.1 assistant practitioners to support this population.

Oldham had no vacancies at the time of inspection. There was a sickness rate of 4.6%, which was better than trust average.

There were also three communication development workers (1.8 whole time equivalent) in the Oldham team. The communication development workers were employed by the local authority, not by Pennine Care NHS Foundation Trust.

Stockport community learning disability team:

- Clinical team managers: 1.0
- Assistant team managers: 0.8
- Nurses: 6.2
- Clinical psychologists: 1.4
- Physiotherapists: 1.8
- Speech and language therapists: 1.0
- Occupational therapists: 1.0
- Assistant practitioners: 4.8

According to Public Health England there are likely to be 5677 people with a learning disability living in Stockport. One thousand, two hundred and eighty-one will probably be known to services. The trust employed 13.2 qualified practitioners (including managers) and 4.8 assistant practitioners to support this population.

Are services safe?

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

Stockport had one nursing vacancy at the time of inspection. The sickness rate for the service was 6.4%, which was worse than trust average.

The Stockport integrated team also included the following staff, all of whom were employed by the local authority: 1 whole time equivalent service manager, 1 team manager, 1.3 assistant team managers, 9.6 social workers and 2 transition workers.

Managers of all three services told us that they had some flexibility in being able to remodel the service when posts became vacant. Any changes in staffing would need to be negotiated with commissioners so that contracts could be amended. For example, when a full-time assistant psychologist resigned their post in Stockport they were replaced by a part-time qualified clinical psychologist. Managers explained how they would use national specifications, local performance information and consultation with staff to identify how best to meet local need. The Heywood, Middleton and Rochdale service had recognised a deficit in occupational therapy and physiotherapy, and hoped to be able to use any future vacancies to address this.

Caseloads ranged between 20 and 30 patients for full-time members of staff. Staff told us that other commitments (for example consultation, joint working, training) and complexity of cases were taken into account when decisions were made about how many patients they were able to support at any one time. We saw evidence of this in supervision records and team meeting minutes. Staff told us that they were busy, but felt able to manage their caseloads.

There were appropriate cover arrangements in place for staff who were absent and posts that were vacant. Oldham and Stockport operated a 'nurse cover' and duty system respectively, which meant that a designated member of staff handled patients' telephone calls when their usual worker was not available. Heywood, Middleton and Rochdale staff gave patients their direct telephone numbers. Patients and carers could contact a central office number or text phone answered by an administrator if their worker was unavailable. Managers across the three teams told us that they could access bank staff to cover long-term vacancies. Absent staff members' cases were monitored

and re-allocated through team meetings. However, we did find one set of case notes in Oldham that showed a person had not been contacted for over eight weeks after their worker had left the service.

On the day of inspection there were 30 patients waiting to be allocated to a member of staff in Heywood, Rochdale and Middleton; 45 in Oldham and 32 in Stockport (health only).

Each of the three services also had access to a 0.5 whole time equivalent consultant psychiatrist. Psychiatrists were located with and managed by the wider psychiatry team in Pennine Care NHS Foundation Trust. The psychiatrists kept separate clinical notes and did not routinely copy letters to the community learning disabilities teams. However they did regularly share information by email.

All staff at Heywood, Middleton and Rochdale and at Oldham had received and were up to date with 100% of mandatory training.

In Stockport, compliance with two of mandatory training topics were very low: conflict resolution level 1 (9%) and equality and diversity (18%). Compliance with the trust adult safeguarding level 1 was 12% and trust information governance was 9%, but staff had completed separate adult safeguarding and information governance training provided by the local authority. Staff told us that they could not always access the trust electronic learning system from their local authority laptops. The Stockport base was not directly connected to the trust network. Managers had tried to resolve this by requesting paper copies of the training. When the paper copies were sent some of the modules were missing.

Assessing and managing risk to patients and staff

Pennine Care NHS Foundation Trust's clinical risk assessment management policy applied to all mental health, substance misuse and learning disability service users. It stated that risk assessment must be incorporated into initial screening and assessment and reviewed at regular intervals and/or following a significant change in the service user's circumstances. The policy also stated that the trust approved risk assessment tool should be used for all service users; this tool consisted of four risk domains (risk to self, risk to others, self-neglect and exploitation and vulnerability).

Are services safe?

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

We reviewed 32 care records across the three teams. The Heywood, Middleton and Rochdale and the Oldham service both used paper records. The Stockport integrated service, which was hosted by the local authority, used the local authority electronic care record system.

All eight of the care records that we looked at in Heywood, Rochdale and Middleton contained a comprehensive risk assessment, although one had not been updated within the last twelve months. Staff used a risk screening tool at initial assessment, and then completed the trust approved risk assessment if there was any evidence of risk under any of the four domains.

In Oldham, 10 of the 12 care records we looked at contained a risk assessment. Nine of the 10 risk assessments had been updated in the last year. None of the risk assessments were recorded on the trust approved risk assessment tool, and only one considered risk under all four of the trust approved risk domains. The remaining nine were specific to the piece of work that was being provided by the team. For example, one care record contained an assessment of the risk of the patient attending rebound therapy (which was a physiotherapy intervention), and another contained a risk assessment for home visiting. Another contained a comprehensive positive behaviour support plan. We saw elsewhere in the care record that the patient was also experiencing dysphagia, which put them at risk of choking. This had not been documented in the behaviour-focused risk assessment.

In Stockport, three of the 12 care records we looked at contained a discrete risk assessment. These risk assessments were recorded on the local authority template. They included information on physical health, mental health, carers' health, substance misuse, harm to others, medication and uninhibited behaviour. Four of the remaining nine care records included a completed 'goals, capacity and risk assessment'. This was a social care tool designed to inform decision-making about personal budgets and support needs. However it did include some consideration of risks around vulnerability, neglect and harm.

This meant that, out of the 32 care records we reviewed, seven patients did not have a risk assessment and of the remaining 25, 13 did not fully consider risk under the multiple domains specified by the trust policy. Staff had not provided evidence that they were certain of all of patients' risks, or that management plans were in place to

address them. When we could not find a risk assessment, we asked staff to check for us. Staff told us that they were in the process of ensuring that all files contained risk assessments, following a directive from senior managers. Managers agreed to ensure that risk assessments were in place for those seven patients who did not have one immediately following our inspection.

Staff in the Stockport team had developed a person-centred, accessible risk assessment tool, which could be completed and uploaded into an electronic document management system linked to the electronic care record. We saw two paper examples of these risk assessments, however they had not yet been uploaded and were therefore not accessible to the rest of the team.

There was however evidence across the three locations that patients who had been assessed as being at risk of presenting in crisis had clear crisis plans. We saw three positive behaviour support plans, which were tailored to the individual and included comprehensive advice for carers.

In Stockport, a patient with learning disability and mental health needs had not been able to access a mental health crisis service from either the trust home treatment team or on-call psychiatry. This was despite the fact that the community learning disability team had attempted to refer them as they posed a high risk of harm to self and others. Staff appeared to be unsure about whether the patient was eligible for a crisis service. The joint protocol between mental health and learning disability services in Stockport did not cover any arrangements for access to the trust's home treatment team and on-call psychiatry.

Minutes of team meetings showed that patients on the waiting list for allocation were discussed regularly. When we observed a team meeting, it was clear that staff had gathered further information about specific patients since referral. This helped the team decide how quickly someone needed to be seen. However, services did not routinely monitor all of the patients on the waiting list to detect increases in level of risk.

Teams sent out standard letters to referrers to let them know that patients had been added to the waiting list. Oldham sent a copy of this letter to patients. The Heywood, Middleton and Rochdale service and the Stockport service sent patients an additional letter letting them know that they had been referred and that they could telephone the

Are services safe?

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

team if they needed to speak to someone. None of the services' letters clearly stated that patients and carers should contact the service if their health or situation deteriorated.

Staff in Heywood, Middleton and Rochdale and staff in Oldham were fully compliant with mandatory training in safeguarding adults and safeguarding children level one. Staff in Stockport were fully compliant with safeguarding children level one but only nine per cent had completed safeguarding adults level one. Stockport staff received additional training and supervision in safeguarding from the local authority. This was essential to band six and band seven nurse roles, which included acting as investigating officers and case managers. Some of the staff in Stockport were trained as appropriate adults, which provided a safeguard when patients in vulnerable circumstances were arrested by the police. Staff in each service were able to tell us how they would make a safeguarding alert. Care records contained evidence that safeguarding concerns had been referred to the local authority. We also saw that safeguarding was considered during discussions between staff, patients, carers and care workers.

Teams in Heywood, Middleton and Rochdale and in Oldham followed the trust lone working policy. All clinical staff carried personal alarms and work mobile telephones. Staff understood their responsibilities to update the board with their whereabouts and telephone the office after home visits. They knew what to do if a colleague did not ring in, and how to access colleagues' personal contact details and car registration. The Heywood, Middleton and Rochdale team had a file that contained the trust lone working policy, local procedures, staff contact information and the name of the person allocated to monitor staff members' whereabouts each day. This file was checked and signed by the team manager at least once every six months. All trust-supplied mobile phones were programmed with an application that allowed staff to record their location prior to a visit. If they felt at risk during the visit, they could press a button on the phone that would then replay the recorded information to an alarm receiving centre. One member of staff mentioned this application when we asked about lone working.

We were told that the Stockport team followed a separate lone working procedure to reflect their status as mobile workers. Staff described a 'buddy system' for out of hours working, whereby staff would contact a designated

colleague to confirm that they were safe after a late visit. Staff were also expected to update their electronic diary, which was visible to the rest of the team. Part of the duty worker's responsibility was to check electronic diaries, but they would not routinely make contact with colleagues to monitor their safety during working hours. There was no formal, written policy endorsed by the trust and local authority. However there had not been any incidents of harm occurring to staff.

None of the three teams stored or administered medication.

Track record on safety

None of the three teams had reported a serious incident requiring investigation over the twelve months leading up to the inspection.

Reporting incidents and learning from when things go wrong

All staff were able to give examples of incidents that would need to be reported (for example accidents, assaults, safeguarding, self-harm and slips trips and falls). They told us that they would report through their manager, governance meetings and electronic systems.

The learning disability directorate governance panel reviewed all of the incidents that were raised in the teams. Eighteen incidents had been reported across the directorate (including services that had not been inspected by CQC on this occasion) in April 2016. Each incident was graded for severity on a scale of one to five. The governance team decided whether incidents needed to be formally reviewed. One incident, an adult safeguarding issue in Oldham, was being reviewed at the time of inspection.

Staff described being given feedback about past incidents, and how this had changed the team's practice. For example a past serious case review in Stockport had identified that a patient had been bullied in the community. This had not been picked up by services. Staff told us that they were reminded to think about risks for patients living on their own.

We also saw that the trust had reviewed their response to 19 deaths across the learning disability directorate. This was prompted by the December 2015 publication of the Independent review of deaths of people with a Learning Disability or Mental Health problem in contact with Southern Health NHS Foundation Trust April 2011 to March

Are services safe?

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

2015. Copies of the trust report were available to staff, and had been discussed in at least one team. The report indicated that the trust had reviewed, but not changed, their response to the 19 deaths.

Duty of candour

Staff understood the principles of duty of candour. They told us that there was a standard question on the trust incident reporting form about whether duty of candour may apply. Some of the staff could name the duty of candour lead for the trust.

We reviewed an incident report regarding the loss of a patient's confidential and identifiable care plan in the community. The team manager had met with the patient and their carer to tell them what had happened and to apologise. The apology was also provided in writing

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

The eight care records we reviewed in Heywood, Middleton and Rochdale contained a comprehensive assessment and up-to-date care plan. Four of the eight care plans were holistic (meaning that they focused on the whole person and covered their entire well-being – physical, emotional, spiritual, mental, social and environmental).

In Oldham, all twelve care records contained an assessment and care plan. All except one had been reviewed within the last twelve months. However, the assessment and care plan tended to be discipline-specific and driven by the reason for referral. For example, a patient referred with anxiety was assessed as suitable for drama therapy; a patient referred with behaviour that challenges received a positive behaviour support plan. Some of the care plans did consider wider needs; however none of them were fully holistic.

In Stockport, seven of the 12 records contained a goal, capacity and risk assessment completed within the last 12 months. This included information on physical health, mental health, social circumstances and environment. The electronic care record system did not provide a template for a single holistic care plan. There was however evidence of multidisciplinary support planning for patients with complex needs. It was difficult to ascertain how many of the 12 people we reviewed had care plans or assessments in other formats, as the information was stored in multiple locations across two different systems. The members of staff who went through the care records with us were not able to easily access a summary of patients' needs.

In all three of the locations, we observed interactions between staff and patients that demonstrated personalised, collaborative, recovery-oriented care planning. All of the patients and carers that we spoke to had a good knowledge of what the service was providing to them. The staff themselves showed a detailed understanding of patients' individual needs. We felt that the quality of staff's work was not being demonstrated in the care record, possibly because the trust and local authority templates were not fully tailored to health intervention for people with a learning disability. The

Stockport service had recently designed a 'consent, care plan, risk assessment and review toolkit for use with service users' which, if completed, would resolve many of the shortfalls in care recording described above.

Staff within all three of the teams told us that they were easily able to access the information that they needed to be able to deliver care. In Heywood, Middleton and Rochdale and in Oldham the paper care records were stored in lockable cabinets in the staff office area. Stockport staff could access electronic records both on and off-site from their local authority provided secure laptops. Although information was not always easy to find (as described above), the integrated nature of the team meant that clinicians could see the work that their social work colleagues had been doing within the same care record. When we reviewed care records for patients who had transitioned from children's services, we saw that a summary of key information had been provided.

The three psychiatrists providing services for people with a learning disability were based in separate buildings, alongside psychiatry colleagues from other directorates. Psychiatrists kept their own separate care records. Staff told us that they found it easy to share information with psychiatric services, however we observed that documents (for example, risk assessments from the community team and correspondence from the psychiatrist) were not routinely copied over. This meant that staff did not have easy access to all the information they needed to be able to deliver safe and effective care. We did see evidence that staff provided updates to the psychiatrists by email. In Heywood, Middleton and Rochdale, there were also regular case discussion meetings. Staff also attended patients' psychiatry reviews where possible and documented the outcomes in the community team record.

Best practice in treatment and care

The trust learning disability directorate had developed evidence-based pathways for communication, dementia, dysphagia, end of life care, parenting support, physical health, positive behaviour support and supporting people into hospital. We saw evidence from care records that these pathways had been followed for patients presenting with difficulties in communication and behaviour.

Positive behaviour support was underpinned by a comprehensive trust standard operating procedure. The procedure made clear references to National Institute for Clinical and Health Excellence guidance NG11: challenging

Are services effective?

Good 

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behaviour and learning disabilities: prevention and interventions for people with learning disabilities whose behaviour challenges. It also included a person-centred values base, and legal and policy frameworks.

Services monitored their outcomes using the health equalities framework, which was a tool provided by the National Development Team for Inclusion. Services were also monitoring and meeting post-Winterbourne fast-track discharge targets.

Psychological therapies for adults (including those with learning disabilities) were provided by the trust's Healthy Minds service. The lead clinical psychologist for the learning disability directorate was working with Healthy Minds to make psychological therapy services more accessible.

The community learning disabilities teams were able to provide a range of psychological therapies for patients who were unable to access generic services. Models used included cognitive behaviour therapy, cognitive analytic therapy and drama therapy. All of these models have some evidence base for use in people with a learning disability. There were also a range of groups available across the teams, including groups for social understanding, managing difficult feelings, healthy hearts, men and ladies.

The trust had completed an audit of antipsychotic prescribing in people with a learning disability in July 2015. The audit sampled 47 care records for patients accessing community and inpatient services for adults and for people with a learning disability. The audit showed that the rationale for prescription of antipsychotics had been documented and reviewed in all of the relevant records. However, only half or less of the records held documented evidence of at least some side-effect monitoring. This is not compliant with trust or national standards. The audit recommended that the findings be discussed in local teams, but did not propose any specific changes to practice. None of the patients whose care records we reviewed were being prescribed antipsychotics so we could not determine whether side-effect monitoring was taking place. We did however speak to one of the psychiatrists, who told us that he would involve general practitioners, rather than community teams, in prescribing and monitoring of antipsychotics.

Skilled staff to deliver care

The national specification for community learning disability teams recommends that, at minimum, sufficient numbers of registered and assistant practitioners should be employed from the following professional groups: clinical psychologists, learning disability nurses, occupational therapists, physiotherapists, psychiatrists and speech and language therapists. The Stockport team included all of these disciplines. The Oldham team did not have occupational therapy. The Heywood, Middleton and Rochdale team did not have occupational therapy or physiotherapy. People in these areas had to access these via referral to generic services. Managers were aware of the deficits within their teams and told us that they planned to use future vacancies to recruit from these professional groups.

Stockport also had social workers (employed by the local authority). Oldham had communication development workers (employed by the local authority) and drama therapists. Heywood, Rochdale and Middleton had a hospital liaison nurse. As described above, psychiatrists were located in a separate psychiatry team.

We saw evidence from personnel files that staff had the appropriate qualifications and experience to be able to carry out their roles. We also saw that staff had undergone a trust and a local induction, which covered topics including health and safety, lone working, fire evacuation, information governance and core skills. A member of staff who had recently started with the trust described her induction as thorough.

The supervision and appraisal records that we checked were up to date. Staff received line management supervision once every six to eight weeks. Records were comprehensive, including case discussion, safeguarding, personal development and a case file audit checklist. Staff could also access clinical supervision in various formats. Most of the allied health professionals had at least two-monthly supervision from senior staff from the same discipline. Staff could also attend reflective practice and peer supervision. A small number of staff could not access discipline-specific clinical supervision from a senior colleague, as they were the most senior in that role across the directorate. Ninety-two per cent of staff in Heywood,

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Middleton and Rochdale, 97% of staff in Oldham and 85% of staff in Stockport had received an appraisal in the last 12 months. There was a good level of staff attendance at team meetings.

Staff were able to request specialist training through the individual performance and development review yearly appraisal process. Managers told us that budgets were tight, but that staff could still access additional training if it was linked to their role. Individual members of staff in each of the services were studying towards recognised qualifications in subjects including epilepsy, dysphagia and positive behaviour support. We also saw evidence that staff had been released to attend conferences and special interest groups, and that staff cascaded training internally (for example, on gender differences in autism spectrum conditions). Some staff did tell us that it could be difficult to access continuing professional development.

Multi-disciplinary and inter-agency team work

We observed one multidisciplinary team meeting and reviewed minutes of 12 multidisciplinary team meetings across the three services. When we attended the meeting, we saw that staff spoke to each other in a respectful way and that each member of the team had the opportunity to make a contribution. Minutes evidenced regular discussion of new referrals, waiting lists, risks, safeguarding, complaints and lessons learned.

The effectiveness of teams' communication with and handover to crisis services was variable. In Stockport, a patient using the service presented with high risk of harm to self and others during the period of inspection. Staff had attempted to refer to the trust mental health home treatment team and on-call psychiatrist. The care record documented that the referral had not been accepted because home treatment team staff did not feel qualified to support someone with autism and learning disability. This meant that the patient had to go to the accident and emergency department to receive an urgent mental health assessment.

In Oldham, a clinical nurse specialist in mental health and learning disability was employed to sit within the community mental health team. The clinical nurse specialist offered support to staff in adult mental health services. Staff in Oldham did not report any problems in referring to the home treatment team when patients presented in crisis.

The learning disability directorate had worked closely with the local acute hospital trusts to develop reasonable adjustment care plans and accessible information for people with a learning disability. We saw evidence from CQC colleagues inspecting the trust's community health services that these tools were in use. For example, the 'hospital passport' was a detailed but accessible document including information about a patient's risks, eating and drinking needs, and likes and dislikes. Community learning disability teams had also delivered training on reasonable adjustments to local general practitioners.

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

Training in the Mental Health Act was not a standard trust requirement for staff in the community learning disabilities teams.

Several of the staff at Heywood, Middleton and Rochdale and at Oldham had recently attended a Mental Health Act Code of Practice 'train the trainers' event commissioned by the trust. There were plans in place to disseminate this training to the rest of the team. Staff at Stockport had not received any specific training in the Mental Health Act.

Staff's knowledge and understanding of the Mental Health Act was variable. Staff in Heywood, Middleton and Rochdale told us that they would contact the trust Mental Health Act administrator if they needed advice; staff in Stockport said they would go to the approved mental health professional in the mental health access team.

None of the patients currently open to the three teams were subject to a community treatment order.

We did however look at the care record in one of the community mental health team for a patient who had a learning disability and was subject to a community treatment order. This patient was not open to the community learning disability team. The notes showed that the patient's rights under the Mental Health Act had been explained to them in an accessible way. Paperwork concerning the community treatment order and responsibilities for aftercare under section 117 was all in order.

Good practice in applying the Mental Capacity Act

All of the staff that we spoke to were able to talk about the principles of the Mental Capacity Act, and give examples of

Are services effective?

Good 

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how they had considered capacity in their practice. Some of the social workers in the Stockport team were also best interest assessors, which meant that staff had easy access to colleagues who could advise on capacity.

There was evidence in patients' files that capacity to consent had been assessed and recorded appropriately. Family, carers and independent advocates had been involved in best interest meetings where appropriate. Best interest decisions took account of patients' wishes, feelings, culture and history.

There were examples in patients' care records of best interest meetings being used to support care planning. We observed staff giving patients support to manage their own medication and decide who to inform about the results of an assessment. Staff checked patients' understanding using varied and flexible means of communication. For example, a patient drew circles around stick figures to show who they wanted to be involved in their care.

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

The Heywood, Middleton and Rochdale service had received three formal compliments between April 2015 and March 2016. The Stockport service had received one. The most recent compliment to the Heywood, Middleton and Rochdale service thanked the team for the support provided to a patient who had undergone a procedure at a local hospital. Staff had arranged for the patient's familiar music to be playing to help calm them prior to surgery.

We observed 11 direct contacts with patients and/or carers across the three services. Staff attitudes and behaviours were compassionate, sensitive, respectful and caring. Staff also showed a good understanding of patients' individual needs. Staff were attentive towards non-verbal patients in a group, and seemed to quickly pick up on signals that they were uncomfortable. We also saw that staff took patients' concerns seriously, and liaised with other agencies on their behalf.

Patients spoke very highly of staff. They said 'staff don't judge you', 'they're easy to get on with', 'they don't mind explaining things' and 'they listen to me and sort it for me when I need support'. Some patients told us that they had enjoyed group activities. Others said that they liked it when staff phoned 'to see how I'm doing'.

The involvement of people in the care that they receive

We observed staff working hard to involve patients in decisions about their care. For example, patients were supported to decide who would have access to their information, supported to engage in rebound therapy at their own pace and supported to contribute towards their own care reviews. Staff used technology such as iPads, pictures and humour to help patients communicate. Some patients told us that they liked their care plan because it helped them 'know what's happening'. One patient said

that the easy-read letters were good because 'they put pictures and broke it down so I could understand it'. Two patients said that they would like more appointments or group activities.

Carers told us that they felt supported by the teams. They said that it was easy to contact staff. Some carers said that staff had helped them to understand their family member, and others valued the consistent input over a period of time.

Pennine Care NHS Foundation Trust's recruitment policy advocated the involvement of people who use services. The learning disability directorate had a separate, detailed recruitment policy to ensure that people with a learning disability were involved and supported. Patients had recently helped to recruit several members of staff.

Managers from each of the services attended local learning disability partnership board meetings. A learning disability partnership board is a group made up of people with a learning disability, carers, and agencies including local authorities, colleges and voluntary sector services as well as the NHS. Minutes of the meetings showed that issues important to local people had been discussed. For example, in Oldham the partnership board had plans to help people be healthy, live well and keep safe.

Services also linked in with local advocacy and service user and carer forums. Heywood, Middleton and Rochdale staff told us that they would ask a group of local people with a learning disability for their help in making the team leaflet more accessible.

The trust hosted a conference on emotional wellbeing and learning disability in March 2015. People with a learning disability and staff delivered a presentation at the conference. The slides included 'what it feels like to have a learning disability', 'what we need from other people' and 'how services can help us'. There were also examples of patients' poetry and artwork at the conference.

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

Services operated an open referral system. This meant that they accepted referrals from anyone, including people with a learning disability, carers, care workers and general practitioners. In Heywood, Middleton and Rochdale and in Oldham, referrals came straight through to the teams. The Stockport service's referrals went to the local authority contact centre, which would screen for suitability before forwarding them to the team.

People could access the Heywood, Middleton and Rochdale and the Oldham services if they were aged 18 or over, had a learning disability or suspected learning disability and were registered with a general practitioner in that area. The referral criteria for Stockport were different because it was an integrated team. People could access the Stockport service if they were aged 18 or over, lived in Stockport and either had a learning disability/suspected learning disability or were eligible under the Care Act 2014. Care Act eligibility is about the impact that an impairment or illness has on the patient, for example preventing him or her achieving at least two outcomes in their day-to-day life.

In Heywood, Middleton and Rochdale and in Oldham, referrals were checked by an administrator (for eligibility) and by a qualified member of staff (for eligibility and urgency) within 24 hours. If the patient referred was in crisis or at risk of placement breakdown due to behavioural issues then the team would arrange to visit within 48 hours. Referrals for dysphagia (difficulty swallowing) were allocated to a member of staff straight away, to be contacted and then seen within two weeks. Other referrals could be offered a screening assessment or placed on a waiting list for allocation to the member of staff thought to have the right skills to be able to meet the patient's needs. Senior members of the multidisciplinary team decided whether the referral was graded priority or routine. The status of the referrals on the waiting list was reviewed at every team meeting.

In Stockport, referrals were screened immediately by one of two designated duty officers, in line with the local authority safeguarding responsibilities. Nursing and social work staff rotated duty work. The duty officer was able to see urgent referrals on the same day if necessary. Non-urgent referrals were added to a waiting list for allocation and discussed at team meetings as in the other two teams.

The trust set an 18-week target for the length of time between referral and allocation to a member of staff. Eighteen weeks is the maximum waiting time for the start of non-emergency treatment set out in the NHS constitution for physical healthcare (there are not yet any compulsory standards for mental health care). The services monitored and recorded waiting times through spreadsheets and team meeting minutes. Heywood, Middleton and Rochdale had not breached the 18-week target over the twelve months leading up to inspection. Oldham reported five breaches for psychology. Staff said that this was because of high demand and because there had been no assistant psychologist in post until recently. Managers told us that Stockport was exempt from the trust's 18-week target because the team was fulfilling a care as well as a health role.

The electronic recording systems in the services did not allow staff to monitor the period between referral and assessment and assessment to treatment. Teams kept track of their waiting lists at team meetings, as described above, but recorded the wait for date of allocation to a practitioner rather than the wait for date of first appointment. However, of the 32 care records we checked, only one patient had not been assessed within 18 weeks of referral. This patient was referred in February 2015 and contacted for the first time in July 2015.

Oldham and Stockport both designated a member of staff to respond to urgent telephone calls. In Heywood, Middleton and Rochdale, patients were given the direct telephone number for their allocated worker. All of the patients and carers that we spoke to said that they found it easy to contact the community learning disability teams.

Staff told us that they would try to engage patients who did not attend appointments by repeating visits, liaising with advocacy and considering evidence for a best interests decision. Support workers had been allocated to spend time building up relationships with patients who seemed reluctant to use the service.

Staff told us that appointments would only be cancelled on rare occasions, for example in emergencies and during unanticipated staff sickness. We did not find any evidence of frequent appointment cancellations in care records. None of the patients that we spoke to said that their

Are services responsive to people's needs?

Good 

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

appointments had run late. One patient told us that on one occasion, a group had been cancelled. This was due to none of the other patients being able to attend. This patient had received an apology from staff.

The facilities promote recovery, comfort, dignity and confidentiality

Staff at each of the three locations told us that they would see the majority of patients in the community. This allowed them to build relationships with patients in a place that was comfortable and familiar. It also meant that staff could gain a better understanding of a patient's needs by seeing them in their usual environment and speaking to carers and care workers. Some of the patients were however seen at the team bases. Staff told us that they used the bases for individual therapy if no other private space could be found, if any risks of home visiting had been identified and (in Heywood, Middleton and Rochdale) for groups. Accessible information was pinned on the walls around all three locations and in Oldham on the table in the reception area. This included posters and leaflets about how to make a complaint, CQC's visit, advocacy and other local services.

The Heywood, Middleton and Rochdale base consisted of an unstaffed entrance with an intercom, a long corridor with toilets leading off and then a large office space with access to a meeting room, kitchen and two smaller rooms. One of the small rooms and the large meeting room were available for seeing patients. Each room had a sign on it, for example 'toilet', printed on yellow paper and with symbols and pictures to help patients understand. Print on yellow rather than white paper is easier for people with dementia to read. The small room contained three mismatched office chairs, several locked filing cabinets, a computer, a table and various boxes and books. It was an adequate, but not the most welcoming and comfortable, therapeutic space.

Only one room at the Oldham base was available for seeing patients. It was large enough for six or seven people, with comfortable chairs and brightly-coloured decoration. Staff told us that they struggled to find locations to deliver groups or training.

The Stockport team were based on the fourth floor of a large local authority building in Stockport town centre. There was a reception area on the ground floor, which was shared by a number of other services. Visitors were expected to sign in on a computer screen. There were however a number of local authority staff in the reception area available to help anyone who did not know how to use

the technology. The team area itself was large, consisting of three open-plan office spaces and a number of interview rooms and meeting rooms. The team could also access interview rooms on the ground floor. All of the interview rooms were bright and comfortable. Patients visiting the service did not have to walk through the office areas.

Meeting the needs of all people who use the service

All of the locations were fully accessible to wheelchair users. We saw many examples of information in easy-read format for people with learning disabilities. These included person-centred risk assessments, health checks and fire evacuation procedures. Signs around the building in Heywood, Middleton and Rochdale were accessible to people with dementia. Communication development workers in Oldham showed us visual resources they had created, including a pictorial food guide for a patient with diabetes and a set of photographs of professionals for a patient about to transfer to a different team. Staff in Stockport had designed a toolkit for gaining consent, assessing risk and planning care. It contained person-centred prompts (for example, 'what needs to happen to keep me safe') and traffic-light style pictures to indicate degrees of risk. We were shown a high-quality easy-read waiting list letter in Heywood, Middleton and Rochdale but it was not yet in use.

The electronic systems did not allow services to record or monitor the ethnicity of their open cases. The trust did not know whether the proportion of patients from a minority ethnic background was reflective of the local population. However, each service had made efforts to engage with people from minority ethnic groups. Services were linking in with local communities to raise their profile. Some of the staff talked to us about how their own ethnic background and fluency in different languages had helped them engage families. These staff had also supported colleagues to understand the reasons that people from minority ethnic communities might find it difficult to access services.

Staff told us that it was easy to access interpretation services through the trust (or in Stockport, from the trust or local authority). Verbal translation was used when needed. However, leaflets were not routinely made available in other languages and services only rarely used written

Are services responsive to people's needs?

Good 

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

translation. We observed a care review meeting for a patient with visual impairment. The patient told us that he would have liked to receive information in Braille, but that staff had never offered this.

One of the communication development workers in Oldham had been specifically recruited to support the local minority ethnic community. They were fluent in Bangla and, although employed by the council, worked under supervision of the speech and language therapist. They had written easy-read documents in Bangla and designed a bespoke set of symbols and pictures for people from a South Asian background. They had recently attended a best interest meeting, and used these symbols to help the patient understand and communicate. The work was stored in a shared drive, which meant that all of the staff in Oldham could access it from their computers.

Listening to and learning from concerns and complaints

The Oldham service and the Stockport service had each received one complaint over the past six months. Neither of

the complaints were referred on to the health and parliamentary ombudsman. Heywood, Middleton and Rochdale had not received any complaints over the past six months.

We viewed records for complaints at Stockport and Oldham. There was evidence of internal investigation and learning outcomes. We saw records of complaints being reviewed within the learning disability directorate governance meetings.

Some of the patients and carers we spoke to were confident in how to make complaints; some were not. Most of those who were not told us that they had never thought about complaining because they were happy with the service. Some said that they could not remember if they had been told how to complain.

Staff understood the procedure for handling complaints. There were separate procedures for complaints about health and complaints about social care staff in Stockport. Staff knew that patient experience forms went back to trust headquarters, and that they received regular feedback by email. Incidents and learning were standard agenda items at team meetings.

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

Pennine Care NHS Foundation Trust's vision was 'to deliver the best possible care to patients, people and families in our local communities by working effectively with partners, to help people to live well'. The vision included five strategic goals: put local people and communities first, strive for excellence, use resources wisely and be a great place to work.

The learning disability quality strategy described what the trust vision meant to the learning disability directorate:

"We will deliver person centred, specialist healthcare support in partnership with learning disabled children and adults, their parents and carers. We will promote evidence based practice that will result in the reduction in the health inequalities experienced by learning disabled people"

Staff told us that they received weekly updates about the trust vision and goals from an email called 'Pennine Care Connected'. Individual performance development reviews were clearly linked to the trust objectives and principles of care. We also observed a strong service identity and commitment to working with people with a learning disability. There were clear team objectives that linked to the vision, for example the reduction of health inequalities, keeping people safe from harm, improved health outcomes, improved choice and control, and partnership working. Many staff spoke about the importance of empowerment, independence and wellbeing.

Staff described their team managers, service managers and directorate managers as approachable and supportive. All of these senior managers were present throughout the inspection to support the teams. Staff also knew the director of specialist services (who oversaw the directorate managers) by name.

Good governance

Governance systems were effective in ensuring that staff were regularly appraised and supervised, that incidents were reported, and that any learning from incidents was fed back to staff. Safeguarding and Mental Capacity Act procedures were followed.

Governance systems in Heywood, Middleton and Rochdale and in Oldham were effective in ensuring that staff received mandatory training. However, in Stockport, training rates were below 75% in three areas.

Team managers attended monthly learning disability directorate governance meetings. These meetings included discussion of key themes reports. Key themes reports summarised team performance across a number of different areas including safety indicators, compliments and complaints, and incidents.

Teams routinely audited care records. They did a comprehensive audit once a year, and looked at two care records in every line management supervision session. However, these audits had not resolved some of the issues that we found with care plans and risk assessments. We also saw that there had not been a clear action plan following the audit of prescription of antipsychotics.

Team managers were respected and that they had sufficient authority. Staff were able to submit items to the trust risk register through the team managers, who would take the information to the directorate governance meeting. However, the risks that we identified on inspection (namely, potential breaches of confidentiality at the team bases, inaccessibility of information across psychiatry and community teams and inaccessibility of mental health crisis services in Stockport) had not been reported to the trust risk register. The learning disability directorate and teams did not have a local risk register.

The directorate had a business continuity plan, which outlined the resources needed to maintain critical activities to an acceptable level.

Leadership, morale and staff engagement

Sickness rates were 5.4% across the three teams, which was slightly higher than the 4.4% average for the NHS. There had not been any cases of bullying or harassment in any of the services.

Staff were aware of the whistleblowing policy. They told us that they would feel confident to raise concerns about poor practice without being worried that they would be treated differently as a result.

Staff also said that they were able to express their opinions in the teams. They told us that their caseloads were monitored through supervision, and that they were able to talk to their managers if they felt overwhelmed. Most staff

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 happy with opportunities for development. We heard that staff enjoyed coming to work and that they were proud of the patients they worked with. The students and junior members of staff told us that they felt supported and welcomed by the team. However, some of the staff in Stockport told us that they were 'not doing enough nursing' because their time was being taken up by social care work. Some of the staff in Oldham described low morale. The Oldham service had undergone a restructure in October 2015, and one of the posts had been disestablished. Staff in Oldham were also anxious about future plans for their team to be co-located or integrated with the local authority. They worried that their professional identities and focus on health could become compromised because of the pressures the local authority was under.

Several staff mentioned 'perform at your peak' training. This had been provided by the trust, and considered ways of promoting staff health and wellbeing.

Team managers in Heywood, Middleton and Rochdale and in Oldham told us that the trust had provided them with

leadership training. We saw plans for further development (for example, 360 degree feedback) in their personal development reviews. Team managers in all three locations felt supported by senior managers.

Commitment to quality improvement and innovation

Heywood, Middleton and Rochdale and Oldham had both completed audits against the National Learning Disability Professional Senate specification for learning disability teams in April and June 2015 respectively. These audits showed evidence of good practice and areas for development under five 'essential functions'. The teams were working on some of the areas identified for improvement, for example including service users and carers in training. Services also monitored their compliance with the 'green light' service improvement toolkit. The toolkit outlines good practice in reasonable adjustments for people with a learning disability and mental health problems.

The learning disability directorate participated in the Greater Manchester plan to transform care for people with learning disabilities. This was a set of mental health and learning disability priority programmes linked to the NHS England document, 5 Year Forward View.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity

Treatment of disease, disorder or injury

Regulation

Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect

Service users must be treated with dignity and respect.

How the regulation was not met:

Office environments in all three locations did not always ensure the confidentiality of patients. Visitors had to walk through or past staff desks to get to interview rooms. Conversations held in interview rooms were audible in adjacent rooms.

This is a breach of regulation 10(2)(a)

Regulated activity

Treatment of disease, disorder or injury

Regulation

Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

Care and treatment must be provided in a safe way for service users.

How the regulation was not met:

Staff did not routinely carry out risk assessments of all patients.

Out of 32 care records we reviewed, seven patients did not have any risk assessment.

This was a breach of regulation 12 (2) (b)