Cambridgeshire County Council

City and South Cambridgeshire Learning Disability Partnership

Inspection report

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

Ratings

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

Summary of findings

Overall summary

- There was no risk assessment of the providers premises, and no fixed alarm points in any of the interview rooms.
- Staff did not routinely hold staff alarms to keep them safe.
- At the time of inspection, the service had high vacancy rates.
- Staff did not complete risk assessments for three people.
- Staff did not receive regular supervision and appraisals.
- Managers did not receive sufficient up to date information to have oversight of specific performance areas.
- We observed a planned session with one person that was not carried out by staff in a respectful and supportive way.
- The service did not meet the target time of 18 weeks for seeing people from referral to assessment and assessment to treatment. The South team referral to assessment waiting time was 45 weeks. In the City team referral to assessment waiting time was 21 weeks
- The information management system was burdensome to front line staff. Staff used a mix of electronic systems, with improvements due to take place from August 2022.

However:

- People were protected from abuse.
- People received kind and compassionate care from most staff who protected and respected their privacy and dignity and understood each person's individual needs. People had their communication needs met and information was shared in a way that could be understood.
- People were involved in managing their own risks whenever possible. Staff developed positive behaviour support plans with people who used the service so that they were aware of any risks they posed to themselves, others or their environment.
- People made choices and took part in activities which were part of their planned care and support. Staff supported them to achieve their goals.
- We observed a multidisciplinary meeting where staff demonstrated strong links with adult social care services and others to meet people's social care, housing, employment and education needs.
- People and those close to them were active partners in their care. Staff empowered people who use the service to have a voice and to realise their potential. They showed determination and creativity to overcome obstacles to delivering care.
- People were empowered to feedback on their care and support. We saw examples where staff had encouraged feedback using an easy read "we welcome your feedback" form. We also saw an easy read version of "our learning disability vision, making a better future together" that had been co-produced and set out agreed next steps for enabling people to live happy, safe and healthy lives, and to have the same life opportunities as anyone else.
- Staff understood their roles and responsibilities under the Human Rights Act 1998, Equality Act 2010, Mental Health Act 1983 and the Mental Capacity Act 2005.
- Staff supported people through recognised models of care and treatment for people with a learning disability or autistic people. Leadership was good, and governance processes helped the service to keep people safe, protect their human rights and provide good care, support and treatment.
- Staff worked with social care providers to ensure care was line with best practice and national guidance. For example, quality standard 101, behaviour that challenges National Institute for Heath and Care Excellence (NICE).

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Community mental health services for people with a learning disability or autism	Requires Improvement 	• There was no risk assessment of the providers premises, and no fixed alarm points in any of the interview rooms. • Staff did not routinely hold staff alarms to keep them safe. • At the time of inspection, the service had high vacancy rates. • Staff did not complete risk assessments for three people. • Staff did not receive regular supervision and appraisals. • We observed a planned session with one person that was not carried out by staff in a respectful and supportive way. • The service did not meet the target time of 18 weeks for seeing people from referral to assessment and assessment to treatment. The South team referral to assessment waiting time was 45 weeks. In the City team referral to assessment waiting time was 21 weeks • The information management system was burdensome to front line staff. Staff used a mix of electronic systems, with improvements due to take place from August 2022. However: • People were protected from abuse. • People received kind and compassionate care from most staff who protected and respected their privacy and dignity and understood each person's individual needs. People had their communication needs met and information was shared in a way that could be understood. • People were involved in managing their own risks whenever possible. Staff developed positive behaviour support plans with people who used the service so that they were aware of any risks they posed to themselves, others or their environment.

Summary of findings

- People made choices and took part in activities which were part of their planned care and support. Staff supported them to achieve their goals.
- We observed a multidisciplinary meeting where staff demonstrated strong links with adult social care services and others to meet people's social care, housing, employment and education needs.
- People and those close to them were active partners in their care. Staff empowered people who use the service to have a voice and to realise their potential. They showed determination and creativity to overcome obstacles to delivering care.
- People were empowered to feedback on their care and support. We saw examples where staff had encouraged feedback using an easy read "we welcome your feedback" form. We also saw an easy read version of "our learning disability vision, making a better future together" that had been co-produced and set out agreed next steps for enabling people to live happy, safe and healthy lives, and to have the same life opportunities as anyone else.
- Staff understood their roles and responsibilities under the Human Rights Act 1998, Equality Act 2010, Mental Health Act 1983 and the Mental Capacity Act 2005.
- Staff supported people through recognised models of care and treatment for people with a learning disability or autistic people. Leadership was good, and governance processes helped the service to keep people safe, protect their human rights and provide good care, support and treatment.
- Staff worked with social care providers to ensure care was line with best practice and national guidance. For example, quality standard 101, behaviour that challenges National Institute for Heath and Care Excellence (NICE).

Summary of findings

Contents

Summary of this inspection

Background to City and South Cambridgeshire Learning Disability Partnership

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

The LDP is responsible for commissioning and providing these services on behalf of Cambridgeshire and Peterborough Integrated Care Board and Cambridgeshire County Council as part of a Section 75 Agreement. Social Care staff are employed by the County Council, and health staff are employed by Cambridgeshire and Peterborough Foundation Trust. There is a Formal Management Agreement between both organisations for the Integrated service and all staff are part of the LDP.

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

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

Cambridgeshire Learning Disability Partnership has not been inspected by the Care Quality Commission.

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

What people who use the service say

We spoke with three people using the service and reviewed comments and feedback from surveys, speak out forums and local partnership board.

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

One person told us their named worker supported them when they are contemplating suicide, and advice and guidance helped and redirected him. The person felt strongly the staff member had saved their life.

Summary of this inspection

Two people told us they had the mobile phone numbers of named workers to contact. When they had messaged or telephoned, staff responded quickly. They felt well supported and staff understood their needs. They could ask for a meeting and this would be arranged quickly.

One person said the psychiatrist helped reassure them and feel better about their health condition. The psychiatrist visited them at home and were easy to talk with.

How we carried out this inspection

Our inspection team was led by an inspector.

The team included one inspector and one specialist advisor on site.

To get to the heart of people who use services' experience of care, we always ask the following five questions of every service and provider:

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

Before the inspection visit, we reviewed information we held about the location.

During the inspection visit, the inspection team:

- spoke with three people using the service;
- spoke with the lead service manager, and one team manager;
- spoke with eight other staff members including; one nurse, two health care assistants, one occupational therapist, one assistant occupational therapist, one speech and language therapist, one assistant speech and language therapist and one adult worker;
- attended and observed one multidisciplinary meeting;
- observed three sessions where staff supported people in the community;
- reviewed six care plan and positive behaviour support plans of people;
- reviewed a range of policies, procedures and other documents relating to the running of the service.

You can find information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspectio

Areas for improvement

Action the service MUST take to improve:

- The service must ensure staff check people are offered physical health checks and annual health checks. Regulation 12. Safe Care and Treatment

Summary of this inspection

- The service must ensure all appropriate staff receive regular supervision and annual appraisal in accordance with their own policy. Regulation 18 Staffing
- The service must ensure fixed alarm points in interview rooms. Regulation 12 safe care and treatment
- The provider must ensure that staff were able to access the environmental risk assessment for the building. Regulation 12 safe care and treatment
- The service must ensure that there is a plan to reduce waiting times to within the 18-week target. Regulation 17 Good Governance
- The service must ensure managers receive sufficient up to date information to have oversight of specific performance areas. Regulation 17 Good Governance

Action the service SHOULD take to improve:

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

Our findings

Overview of ratings

Our ratings for this location are:

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

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

Requires Improvement

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

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

Requires Improvement

Safe and clean care environments

Staff told us that people would attend appointments for example to see the psychologist for planned sessions. The location had an entrance and a layout that takes account of people's mobility needs and minimises the risk of slips, trips and falls. All areas were clean, well maintained and well furnished.

Managers confirmed there were no risk assessments of the environment. We saw four interview rooms and there were no fixed alarm points. The meeting room areas were at the far end of the building away from the main staff area. If staff needed to summon help, they may not be heard from a distance and through the security doors. However, there had been no incidents of harm reported. Staff told us they did not routinely hold personal alarms. The service had a lone working policy with no reference made to staff carrying personal alarms. A manager said one staff member held a number of personal alarms and they would be made available to staff if required. Limited information was available about the number and type of personal alarms and how they were maintained. Staff told us where a person was risk rated as high risk then two staff would see the person together.

Safe Staffing

At the time of inspection, the South Cambridgeshire and City Team had high vacancy levels.

At the time of the inspection, for the City team there were seven vacancies equating to 2.81 full time equivalent posts. For the South team there were 13 vacancies equating to 3.5 full time equivalent posts. Managers were aware and had an active recruitment plan in place and had ensured locum staff were in place in the interim. There was no evidence of impact on patient safety or experience.

The Learning Disability Partnership consultant lead psychologist had stepped down with a new post holder due in September 2022. There was an interim plan in place to cover the lead responsibilities and ensure continuity of a safe and effective Psychology service within the learning disability partnership.

Managers had active staff recruitment plans in place, with staffing regularly reviewed at Learning Disability Partnership managers and governance meetings.

Managers did not regularly use bank and agency staff. One agency social worker worked long term at the South Cambridgeshire and City team.

Managers made arrangements within the team to cover staff sickness and absence. This sometime involved staff covering across other teams at learning disability partnership.

Managers supported staff who needed time off for ill health, staff were supported to access occupation health services. Sickness levels across the Learning Disability Partnership teams were 6%. Data provided by Learning Disability Partnership for sickness percentages were total sickness days for the City team staff from 19 July 2021 to 17 July 2022 were 394 days (49%). The total sickness days for the South team from 19 July 2021 to 17 July 2022 were 162 days (18%). However, local team managers knew their staff and managed absences with individual staff.

Medical staff

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

Mandatory training

Staff had completed and kept up to date with their mandatory training. Mandatory compliance rates across Learning Disability Partnership teams were at 96%, this was not broken down to team level, however managers kept local records. The mandatory training programme was comprehensive and met the needs of people and staff and included; treating people with respect, safeguarding adults' level two and children level three, infection prevention, good governance and control and working safely.

The partnership had identified that Oliver McGowan training was now a legal requirement within the Health and Social Care Act 2022 and had begun to scope how this would be rolled out in 2023.

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

Assessing and Managing Risk

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

Assessment of risk

We reviewed six care records. We found three people had risk assessments. however, one was robust and the other two risk assessments included only basic information. The remaining three care records had no risk assessments, with people's care needs risk rated as green, low risk. The service used a colour coded risk rating system for people with high risk rated red, medium risk amber and green low risk.

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

Requires Improvement

The team supported staff looking after people living in supported housing to update and manage risks. Staff used the care programme approach risk assessment tool. They also used risk assessment tools withing the integrated care record with adult services.

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

Management of risk

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

The service had a lone working policy dated 13 May 2019.Staff told us about lone working where a person was identified as high risk then staff would visit the person in pairs. We saw mitigation and evidence of staff working in pairs recorded in care plans, multidisciplinary and team meeting notes.

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

Staff identified and responded to any changes in risks to, or posed by, people using the service. Staff attended daily safety huddle meetings where those people known to be currently posing the most risk were discussed, and mitigation implemented where appropriate.

Safeguarding

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

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

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

Staff access to essential information

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

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

Requires Improvement

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

Each locality team has read only access to the NHS SystemOne. Staff we spoke with said the local authority system was difficult to navigate and had limited functionality with regard to mental and physical health and wellbeing.

During the inspection we saw care record systems went offline, staff told us this was a frequent occurrence and caused disruption and additional work. Staff told us they adapted the system to ensure there was a location for this information. Improvements to the IT platforms were due to take place in August 2022 and be completed by April 2023.

Records were stored securely.

Medicines management

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

Track record on safety

The service had a good track record on safety.

Reporting incidents and learning from when things go wrong

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

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

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

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

One learning outcome from an incident meant staff across the Learning Disability Partnership were asked to undertake epilepsy training.

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

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

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

Requires Improvement

Staff at Learning Disability Partnership held monthly complex case huddle meetings which is a multidisciplinary panel to review and guide complex learning disability and/or autism cases.

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

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

Requires Improvement

Assessment of needs and planning of care

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

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

Out of six care records we reviewed, one care record included evidence of physical health checks and annual health checks. The person had physical and sensory needs and their health checks were an integral part of the care plan. The remaining five care records did not include information about annual health checks or physical health checks. We were told the responsibility for offering physical health checks and Annual Health Checks is the responsibility of the individuals GP. The LDP are reliant on this information being provided by the individual, the people who support them or the GP Surgery. Practitioners within the team ask about physical and annual health checks at the time of assessment and where known, this is recorded within the individual's social care documentation.

The six care records were personalised, recorded the persons voice and were strengths-based.

We saw six positive behaviour support plans. The plans ensured people with behaviour that challenges had a proactive positive behaviour support plan which were reviewed regularly. Positive behaviour support plans were developed following a comprehensive assessment, plans focused on people's quality of life outcomes and met best practice.

Best practice in treatment and care

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

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

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

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

Requires Improvement

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

Practitioners within the team ask about physical and annual health checks at the time of assessment and where known, this is recorded within the individual's social care documentation.

Some staff provided training to GP practices. The training included communication, reasonable adjustments and health inequalities for people with learning disabilities.

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

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

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

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

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

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

Skilled staff to deliver care

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

The South Cambridgeshire and City team had high vacancy rates. Manager told us that recruitment plans were ongoing for a team leader, social workers and adult support workers. Managers were aware and had an active recruitment plan in place and had ensured locum staff were in place in the interim.

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

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

Requires Improvement

Managers said they were looking to create a physical health nurse post and were devising the job description with funding from Cambridge and Peterborough Clinical Commissioning Group.

One occupational therapist told us the Learning Disability Partnership had funded them and other therapists, for sensory integration distance learning at Sheffield Hallam University. With the new training staff were starting to undertake sensory assessments which takes account of the sensory issues often experienced by people with autism.

Staff told us dysphagia eLearning was being piloted with staff before a launch. Dysphagia is the medical term for swallowing difficulties. Some people with dysphagia have problems swallowing certain foods or liquids.

Managers gave each new member of staff a full induction to the service before they started work. Managers told us they had secured approval from Learning Disability Partnership to provide as part of the induction programme, a video about the social history of Ida Darwin. The film showed the Ida Darwin hospital site in Cambridgeshire through the memories of ex residents and staff along with historical footage and photographs. This was in part recognition of Ida Darwin's pioneering work in mental health.

Managers had not ensured staff received an annual appraisal, the appraisal across the countywide Learning Disability Partnership was 49%, managers did not routinely receive a specific breakdown of appraisals for their team, however, this information was available upon request. However, there was an organisation agreement that appraisals be suspended during the pandemic. There was a lack of local team oversight.

Managers had not ensured that supervision across the partnership was regularly received. The figures month on month had dropped from 68% in April, 54% in May to 38% in June 2022. However, staff told us they received regular supervision and appraisals. Managers had an action plan in place to address this issue.

We spoke with eight staff they all told us if they needed an urgent clinical supervision with a senior or manager this was always facilitated. Staff felt well supported.

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

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

Multi-disciplinary and interagency teamwork

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

Staff held regular multidisciplinary meetings to discuss people who used the service and improve their care. We observed a City multidisciplinary meeting where staff demonstrated strong links with adult social care services and others to meet people's social care, housing, employment and education needs.

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

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

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

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

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

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

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

Good practice in applying the Mental Capacity Act

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

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

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

We examined one person's mental capacity assessment completed by a social worker 30 June 2022. We saw the assessment was comprehensive and the social worker had taken steps to explain decisions that needed to be made in a way the person could understand, using their preferred communication method.

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

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

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

Requires Improvement

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

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

Good

Kindness, privacy, dignity, respect, compassion and support

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

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

We observed staff working in the community, we saw during our observations that in the main, staff were kind, compassionate, listened and responded appropriately with meaningful discussions, we also observed staff talking rapidly, didn't allow time for the person to respond.

Clinical records demonstrated that people's individual preferences and needs were always reflected in how care was delivered. Staff recognised that people needed to have access to, and links with, their advocacy and support networks in the community and they supported people to do this. They ensured that people's communication needs were understood and promoted the wider health and social care to access communication aids if required.

Involvement in care

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

Staff informed and involved families and carers appropriately.

Involvement of people

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

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

Requires Improvement

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

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

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

Staff made sure people could access advocacy services.

Involvement of families and carers

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

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

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

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

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

Requires Improvement

Access and waiting times

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

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

The service did not meet target time of 18 weeks for seeing people from referral to assessment and assessment to treatment. The South Cambridgeshire and City team had different timescales. In the South team the referral to assessment waiting time was 45 weeks. The waiting time for referral to treatment was 49 weeks. There were 30 people on the waiting list with none rated as a high priority.

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

Requires Improvement

In the City team referral to assessment waiting time was 21 weeks. The waiting time for referral to treatment was 25 weeks. There were 29 people on waiting list with none rated as a high priority.

The service used systems to help them monitor waiting lists and support people. We observed one weekly multidisciplinary meeting which reviewed risks and changes in circumstances of people on the waiting list.

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

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

Staff supported people when they were referred, transferred between services, or needed physical health care. We saw evidence that a person had been supported by the team as they had diabetes with visit at home ensuring the person received the most appropriate support.

The organisation had some commissioning responsibilities to identify appropriate support and accommodation to people who used the service. Where an appropriate placement could not be found, this would then be escalated to the national team for their action.

The service followed national standards for transfer.

The facilities promote comfort, dignity and privacy

The design, layout, and furnishings of treatment rooms supported People' treatment, privacy and dignity.

The service had a separate accessible entrance and four interview rooms to support treatment and care. Interview rooms in the service had sound proofing to protect privacy and confidentiality.

The service had considered and responded to the needs of people with autism in the environment

Peoples' engagement with the wider community

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

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

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

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

Requires Improvement

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

Meeting the needs of all people who use the service

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

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

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

Listening to and learning from concerns and complaints

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

The service had received two complaints both partially upheld, both related to information not being given in a timely manner.

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

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

Requires Improvement

Leadership

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

Vision and strategy

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

Requires Improvement

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

Culture

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

Managers told us they actively worked alongside staff, with some managers carrying a small workload. Staff were aware of the values of the service, knowing how to advocate for people, raised the profile of reporting concerns, ensuring senior management staff had a presence in the service and ensuring staff had sufficient training and supervision to support them in their roles. One adult worker told us staff training opportunities and support were good. They had been offered opportunities to study for national vocational qualifications and a social work degree

Staff were very motivated by and proud of the service. We saw two examples of constructive engagement with people through face to face meetings, however one staff member did not show empathy or respect for the person they were engaging with. Managers had developed their leadership skills and those of others, to ensure they were empowered to make positive changes.

Governance

The arrangements for governance and performance management did not always operate effectively. Managers had limited oversight of performance that were team specific unless requested. Reports were produced for sickness and staff supervision and appraisals; however, these were service wide and not location specific. Managers did not receive sufficient up to date information to have oversight of specific performance areas.

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

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

Management of risk, issues and performance

Managers had not managed some risks and issues appropriately. There were no risk assessment of the provider's premises and no fixed alarm points in any of the interview rooms. Staff did not routinely hold staff alarms however there were mitigation in place. The service did not have enough staff although managers had recruitment plans in place to address this.

Out of six care records we reviewed, one did not include a risk assessment and five care records did not include a physical health checks and annual health check. However, the organisation had been greatly impacted during the COVID-19 pandemic, and as part of contingency planning had paused appraisals. The service had business continuity plans for emergencies for example, adverse weather or a flu outbreak.

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

Requires Improvement

The service did not meet the target time of 18 weeks for seeing people from referral to assessment and assessment to treatment. The South team referral to assessment waiting time was 45 weeks. In the City team referral to assessment waiting time was 21 weeks.

Under the formal management agreement for the delivery of the Integrated Service, the sole and primary case management electronic recording system is Mosaic, which is hosted via the Adult Social Care system. All staff have access and have been fully trained to use this electronic system for the recording of service user information. Staff we spoke with said the local authority system was difficult to navigate and had limited functionality with regard to mental and physical health and wellbeing. Staff were required at times to input information across both systems to ensure the information was consistent. Managers told us information management system improvements were on the risk register and improvements would start in August 2022.

Staff notified and shared information with external organisations, for example the local authority and clinical commissioning groups. People we spoke with said they liked staff and felt supported.

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

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

Staff made notifications to external bodies as needed.

Engagement

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

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

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

Learning, continuous improvement and innovation

The learning disability partnership produced a virtual exhibition to display the art and music inspired during the first national COVID-19 lockdown.

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

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The service did not ensure fixed alarm points in interview rooms. The service did not have an up to date environmental risk assessment for the building. Regulation 12. (1) (2) (a) (b)

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The service did not meet target time of 18 weeks for seeing people from referral to assessment and assessment to treatment. Managers did not receive sufficient up to date information to have oversight of specific performance areas. Regulation 17 (1) (2) (a)(b)

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing The service must ensure all appropriate staff receive regular supervision and annual appraisal in accordance with their own policy. Regulation 18 (1) (2) (a)