CareQuality Commission

Good ●

Cornwall Partnership NHS Foundation Trust

Community mental health services for people with learning disabilities or autism

Quality Report

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Date of inspection visit: 14 - 17 April 2015
Date of publication: 09/09/2015

Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RJ8X7	Trust Headquarters	West Cornwall Adults with Learning Disabilities Team	TR15 2SP
RJ8X7	Trust Headquarters	East Cornwall Adults with Learning Disabilities Team	PL31 1AH
RJ8X7	Trust Headquarters	Intensive Support Team	TR4 9LD

This report describes our judgement of the quality of care provided within this core service by Cornwall Partnership 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 Cornwall Partnership NHS Foundation Trust and these are brought together to inform our overall judgement of Cornwall Partnership NHS Foundation Trust.

Summary of findings

Ratings

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

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

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

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

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

Summary of findings

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Summary of findings

Overall summary

We rated community based services for adults with learning disabilities as good because:

The trust had a system of governance in place, which team managers, and the service manager, used to identify and monitor risks in the services they provided. There was a clear system in place to report incidents. Staff were able to learn from incidents occurring within their locality and were given time to discuss issues in either supervision or team meetings. The teams were well resourced with experienced, skilled and competent staff.

The service had developed clear, evidence based clinical pathways to support effective assessment, treatment and management of varied clinical needs. The teams implemented best practice guidance within their clinical practice. We observed appropriate sharing of information to ensure continuity and safety of care across teams, including involvement of external agencies.

We saw numerous examples of care and service development which reflected the determination and creativity of staff to maximise opportunities for service users. These reflected innovative and person centred best practice.

People using services told us they were treated with kindness, dignity and respect. Clinicians' knowledge and skills within the teams were highly regarded by all carers and patients we spoke with.

We observed a number of home visits and clinic appointments. We saw staff members were caring and respectful in all their interactions. The staff we met clearly placed the people who use the service at the centre of what they did. The records we reviewed showed evidence of people deciding how they wanted to be supported, and involvement of carers in best interest decisions.

The service had a system in place which ensured all new referrals were made through a single point of triage. The teams worked flexibly to meet individuals needs and promoted social inclusion and community involvement. Services received few complaints from patients and carers, but when they did, we saw examples which reflected that they had responded promptly and implemented learning from complaints.

Staff told us that a service redesign was underway, and this had been a very difficult process and there had been a significant, negative impact on staff morale. Staff were concerned that this was affecting relationships between the professional groups within teams. Some staff did not feel that senior trust management consulted with them, and most staff felt that communication and management of the process had been poor. Some staff felt unable to raise concerns above their team managers, and were not confident that they would be listened to.

Summary of findings

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

Are services safe?

We rated safe as **good** because:

• The trust policies and procedures enabled team managers and the service manager to identify and monitor risks in the services they provided.

• There was a clear system in place to report incidents. Staff were able to learn from incidents occurring within their locality and were given time to discuss issues in either supervision or team meetings.

• Staff had received mandatory training on safeguarding, and knew how and where to report safeguarding issues.

• Staff felt confident in raising concerns and knew how to escalate them if necessary.

• The teams were well resourced with experienced, skilled and competent staff.

However:

• The trust were unable to provide any service specific data on safeguarding referrals made by the teams. There was an internal safeguarding form that should be completed alongside the external local authority referral form, we were told this was not always completed.

• The community team buildings were not fit for purpose and the East resource centre was in poor condition.

Good ●

Are services effective?

We rated effective as **good** because:

• The service had developed clear, evidence based clinical pathways to support effective assessment, treatment and management of varied clinical needs. The teams implemented best practice guidance within their clinical practice.

• We observed appropriate sharing of information to ensure continuity and safety of care across teams, including involvement of external agencies.

• Staff were supported to access additional training and conferences to keep up to date with best practice and national strategies.

However:

• Consent to treatment and information sharing was not consistently recorded. The trust had identified areas for improvement in relation to quality of care records.

Good ●

Summary of findings

Are services caring?

Outstanding ☆

We rated caring as **outstanding** because:

• We observed a number of visits and clinic appointments and saw staff were caring and respectful in all their interactions. We saw numerous examples of care and service development which reflected the determination and creativity of staff to maximise opportunities for service users. These reflected innovative and person centred best practice.

• People using services told us they were treated with kindness, dignity and respect. Carers and patients spoke of the positive and exceptional input that they received, and the difference it made to their lives.

• Clinicians' knowledge and skills within the teams were highly regarded by all individuals who use the service, carers and other professionals we spoke with.

Are services responsive to people's needs?

Good ●

We rated responsive as **good** because:

• The service had system in place which ensured all new referrals were made through a single point of triage. The teams worked flexibly to meet individuals needs and promoted social inclusion and community involvement. Services received few complaints from patients and carers, but when they did, we saw examples which reflected that they had responded promptly and implemented learning from complaints.

• The teams all worked within the targets agreed by the trust and there were systems in place to monitor compliance with waiting and response times.

• Pressures on social care services affected services provided by the trust, such as closure of respite beds and variation in the quality of care from some providers. There was a lack of clarity regarding funding and commissioning requirements. The adults learning disabilities service was undergoing service re-design and the trust was engaging with external stakeholders, including commissioners, to try and develop an effective model of care.

However:

• The service was not commissioned to provide out of hours support. Adults with learning disabilities, who experience mental health crises outside of office hours had very limited support available.

Summary of findings

• There was not always a specialist learning disabilities professional available out of hours for advice. For example, if a person was detained under a section of the Mental Health Act, by the police, they may be reviewed by a general adult psychiatrist.

Are services well-led?

We rated well led as **good** because:

• We saw good examples of local leadership from the all of the team managers we met.

• We saw a wide range of audits to inform and improve service development. Some of these were being used to inform the redesign.

• The service has undertaken a comprehensive review of assurance processes and reviewed local team performance monitoring and management structures, as part of the service re-design. These were still becoming embedded within the teams, however we saw that the systems were being used effectively to identify risks and monitor team performance.

However:

• Staff told us that a service redesign was underway, and this had been a very difficult process and there had been a significant, negative impact on staff morale.

• Staff were concerned that this was affecting relationships between the professional groups within teams.

• Some staff did not feel that senior trust management consulted with them, and most staff felt that communication and management of the process had been poor.

• Some staff felt unable to raise concerns above their team managers, and were not confident that they would be listened to.

Good ●

Summary of findings

Information about the service

The adult learning disability community service is part of Cornwall Partnership Foundation NHS Trust. The service works alongside other statutory health and social care providers, voluntary and private organisations, to support adults with health needs associated with learning disabilities. There are three multi-disciplinary community teams providing this service. The East Cornwall team, the West Cornwall team and the countywide intensive support team. The community teams provide specialist health assessments and interventions for people with learning disabilities. They provide specific areas of clinical assessment, diagnosis and evidence based interventions in relation to epilepsy, mental health, autism, dementia, behaviours that challenge and sensory integration. The focus is on individuals with complex needs whose requirements cannot be met by mainstream services.

Our inspection team

Chair: Michael Hutt, Independent consultant

Head of Inspection: Pauline Carpenter, Head of Hospital Inspection CQC

Team Leader: Serena Allen, Inspection Manager CQC

The team was led by a CQC inspector and three specialist advisors experienced in learning disabilities provision. The specialist advisors included a social worker, a nurse and a psychologist.

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 all three community locality teams, that provide a service for adults with learning disabilities.

- Reviewed trust information relating to the whole service, as well as specific to these localities.

- Spoke with nineteen carers, and met with thirteen people that use the service

- Spoke with the managers for each of the teams

- Spoke with thirty five staff, from a range of disciplines, including service managers, consultants, administrative support staff, clinicians and allied health professionals.

- Interviewed the service manager and professional lead, with responsibility for these services

- Spoke with other professionals who work with the service, for example, commissioners, advocates and care managers.

- Reviewed 24 staff supervision

- Reviewed information and records used to manage the service and 25 patient care records.

- Attended a training session run by the service for other health and social care providers

- Undertook 11 home visits and clinic appointments with staff.

Summary of findings

What people who use the provider's services say

Clinicians' caring, knowledge and skills within the teams were highly regarded by all carers, individuals who use the service, and other professionals we spoke with.

The teams were consistently identified as being an invaluable support. Carers and patients spoke of the positive and exceptional input that they received.

Good practice

Staff members have been proactive and successful in obtaining resources to improve the quality of the services that individuals have access to. For example, applying for lottery funding to access rebound therapy, and use of an external occupational therapy space for sensory integration clinics.

The Communication Charter – Public engagement work by the teams, for example, communications training offered to people working in community settings like pubs and cafes. There are currently 160 community leads identified and trained throughout Cornwall and the identification of `safe places` throughout the community.

Pro-active training and support to a range of health and social care providers, including voluntary and private organisations. This had ensured that people with learning disabilities get the right support at the right time.

The teams had developed a range of communication passports; my health plan, hospital passports, police passports, to assist in communicating individual`s needs within their support setting and when accessing other services.

The teams actively engaged in development work to use technology to assist with communication, using I-Pad communication tools, they had developed `Appy Talk`.

The specialist learning disabilities epilepsy team had developed a website e-learning tool in relation to safe, medication targeting seizures. A specialist epilepsy care plan and monitoring of outcomes with epilepsy radar. The team had also worked to reduce Sudden Unexpected Death in Epilepsy (SUDEP), including following up patients after discharge and implementing the SUDEP checklist to ensure that safe and robust practice is in place.

The national `Green light` Policy was well embedded within local services. This policy ensured learning disabilities liaison nurses in primary care, acute care and secondary mental health care, work with the learning disabilities teams to link a wide range of mainstream health services, with the aim of supporting individuals with learning disabilities to access these services.

Areas for improvement

Action the provider SHOULD take to improve
Ensure that all staff and team managers have access to well-structured and effective support and supervision through the re-design process, with a clear plan to monitor and undertake impact assessments on staff health and wellbeing.

Establish clear plans for assessing and monitoring current buildings and facilities, in particular the East resource centre, which has been identified as unfit for purpose.

Continue to improve working relationships with the adult social care service in order to further develop the model of care in line with current and projected population changes, and discuss with commissioners out of hours provision.

Continue monitoring improvement to care records, in particular that mental capacity assessments, consent to treatment and information sharing is clearly and consistently recorded.

Cornwall Partnership NHS Foundation Trust

Community mental health services for people with learning disabilities or autism

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Community-based services for adults with learning disabilities	Cornwall Partnership NHS Foundation Trust

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.

• We did not have a Mental Health Act reviewer as part of our team, however, the Mental Health Act documentation reviewed within the care records was completed in line with the Code of Practice.

• We reviewed staff mandatory training records and these showed that the teams had a 95% - 100% compliance rate on staff completing their Mental Health Act training.

Mental Capacity Act and Deprivation of Liberty Safeguards

• Staff were up to date with training around the Mental Capacity Act. Staff from all disciplines were able to explain about consent and capacity, and how this is integrated in their daily practice. When we reviewed care records, overall we saw evidence of good practice documented throughout the daily progress notes and clinic letters. However, we found two capacity assessments which were not clearly documented.

Detailed findings

• Documentation showed that mental capacity was routinely discussed during routine visits, clinical reviews, MDT meetings and complex case reviews.

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

Summary of findings

Please see summary at beginning of report.

Our findings

Safe and clean environment

• All three bases for the community teams had limited appropriate clinic space and facilities. The East ALD team based at the East resource centre was a particular cause of concern, due to its age and poor condition. This had adversely affected service provision when the boiler room flooded and also when a ceiling had collapsed. We saw this had been identified on the corporate and local risk register. The service manager informed us that an alternative location was being looked for, although there was not a clear plan for this. There was no current action plan to monitor and address the issues with the building.

• The community bases were clean. The teams had the same cleaner across the services, who was supervised by the lead administrator. We were advised that the trust maintenance team responded quickly to requests. The overall décor and internal fabric of the buildings looked worn. We saw the March 2015 environment & clinical practice audit report for the ALD service. This reported that the most common causes of non-compliance were: "….minor signs of wear and tear to the general environment."

Safe staffing

• In all three teams we inspected, staffing levels met the establishment set by the Trust. The teams were well resourced with experienced, skilled and competent staff. A review of staffing levels and skill mix formed part of the service redesign, we saw that proposals indicated that safe staffing levels would be maintained.

• We saw training records for all the teams, these showed that overall teams had 90% - 95% completed required mandatory training. The mandatory training was a mixture of E-learning and face to face training.

• Staff told us their case loads were manageable, weighted by individual need and the most appropriate clinician to meet those needs. We saw caseload figures assigned to clinicians, the highest caseload was thirty four people.

• Caseload audit and review had been undertaken as part of the service redesign. Whilst there was a clear rationale to implement discharge plans for individuals who no longer required a secondary learning disabilities service, some staff found it challenging to review their caseloads in line with the service redesign. Some staff were concerned about the options for individuals who would no longer fit in the service model, for example, individuals with mild learning disabilities.

• The service had processes in place to manage any foreseeable risks to continued service provision, such as adverse weather or staff holiday and sickness. The teams were able to get appropriately skilled, interim bank staff to cover absences.

Assessing and managing risk to patients and staff

• All staff we spoke with demonstrated a good knowledge on how and where to report safeguarding issues. We saw safeguarding concerns were discussed during the multidisciplinary team meetings. There was a variety of current safeguarding issues at the time of inspection within the teams we inspected, and these were being managed appropriately and documented clearly in the care records.

• The teams did not have an overall log of safeguarding referrals, which would allow them to monitor actions and potentially identify trends across the teams, for example, if the same care provider was involved in several concerns. The trust was unable to provide any data on safeguarding referrals made by the service. They advised that this was held with the local authority. Although there was an internal safeguarding form that should be completed alongside the external local authority referral form, we were told this was not always completed.

• There was a 'lone working' policy which, ensured that there was a consistent system to ensure whereabouts of staff and how to raise alarm in case of emergency. Staff advised that initial assessments, or visits where risks were clearly identified, were undertaken with two members of staff.

Are services safe?

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

• None of the teams stored or prescribed medication. However, all teams worked with other health and social care providers to ensure best practice in prescribing. For example, the epilepsy team had established an on-line tool to support safe prescribing in managing seizures.

• We reviewed a sample of twenty five care records across the three teams. These showed needs and risks were assessed and clearly documented. Risk assessments we reviewed were up to date and reflected current individual risks and relevant historical risk information. We saw that actions taken in progress notes were linked to the risk assessments.

• Each team held weekly multi-disciplinary meetings (MDT). We reviewed meeting minutes for all the teams. These showed a range of risk issues, such as safeguarding, staff safety and clinical risks, were regularly discussed within the MDT. Complex case meetings were also held by the teams. Teams also worked closely with other teams within the trust, for example, the forensic service, to undertake assessments where indicated. Staff told us that they felt well supported in discussing and managing risks.

Track record on safety

• There had been no serious untoward incidents, which had resulted in serious harm to an individual, within the last 12 months.

Reporting incidents and learning from when things go wrong

• The team managers showed us how they used the trust`s management information system and risk registers to identify and monitor risks. This included systems to report and record safety incidents, concerns and near misses. All incidents were reviewed by the managers and then via the risk management team for the trust, who would then monitor them for trends.

• Staff we spoke with described their role in the reporting process and told us they felt supported by their team managers following any incidents. They told us that they could access effective support from within each team. Staff were able to learn from incidents occurring within their locality and were given time to discuss this in supervision and team meetings.

• We reviewed a sample of incident reports for each team, these reflected that staff reported incidents appropriately. We were given examples of how learning had changed practice within their teams.

• We saw the service `quality and assurance group` monthly meeting minutes. These reflected that a range of risk information, including incidents, were reviewed and discussed by the area management teams. The minutes outlined the impact to the local service, and any agreed actions for improvements to safety. There were also weekly meetings with the team managers and the service manager to review a range of service issues.

• Incidents and any learning was also reported in the monthly adults with learning disability service staff newsletter, `The Voice`.

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.

Summary of findings

Please see summary at beginning of report.

Our findings

Assessment of needs and planning of care

• We reviewed twenty five care records, spoke with staff and patients and carers. We found that staff assessed and planned care in line with the needs of the individual, under the framework of the care programme approach .

• We found that while care plans and risk assessments varied in detail and quality, overall they reflected holistic, person centred care. They incorporated positive behavioural support plans where appropriate. We saw examples of detailed, clear plans to meet complex behavioural and physical needs. The epilepsy team had developed specialist epilepsy care plans.

• Staff demonstrated a pro-active, creative and collaborative approach to ensure that people are effectively supported to get physical health needs met in the least distressing and intrusive way possible. For example, by arranging for various health professionals to be available at the same appointment to reduce the number of visits an individual had to make to the hospital.

• The service was developing a range communication passports, My Health Plan, hospital passports, police passports, to assist in communicating individual`s needs within their support setting and when accessing other services. The service user learning disability advisory group contributed to this work.

• Staff did not consistently record consent to treatment and information sharing. We found that overall the quality and detail in mental capacity assessments and outcomes of best interest meetings was good. We found two where there was limited specific mental capacity assessment information documented, however, the daily progress notes contained comprehensive detail about capacity, care that was being provided and plans agreed with people using the service.

• The trust had identified areas for improvement in relation to quality of care records. We saw that the trust had developed an audit tool and training to support staff and improve the quality of records. We saw evidence in supervision records that this was implemented within the teams through individual supervision.

Best practice in treatment and care

• In line with NICE clinical guidelines and the Department of Health learning disability strategy, the trust provided early assessment, treatment and management for adults with a moderate to severe learning disability.

• NICE Quality standards and current national guidance, relevant to adults with learning disabilities, were reviewed every six months by the service clinical psychology lead. The purpose was to ensure that best practice and current national guidance were incorporated into the service.

• The teams offered a range of pharmacological, psychosocial, functional and psychological approaches to individuals with a wide range of learning disabilities, behaviours that challenge and associated complex physical conditions. The teams worked effectively and flexibly with a range of professionals to meet individuals' physical needs.

• The occupational therapy department have developed the sensory clinic pathway, running twice weekly sensory clinics and also provide sensory training and support for carers. The physiotherapy team facilitate rebound therapy – using local gymnastic and trampoline facilities to provide specialist assessment and therapeutic intervention.

• A number of recognised multi-disciplinary assessment tools were used to plan and monitor care needs. Health of the nation outcome scales for learning disabilities (HONOS-LD) was the agreed clinical outcome measurement used. The teams had all been trained in using the health equality framework, and this outcome measurement was being implemented. The epilepsy team used epilepsy radar to monitor epilepsy outcomes and responses to complex needs.

Skilled staff to deliver care

• We saw the teams were well resourced with experienced and skilled staff. The teams included a full range of specialist allied health professionals to provide effective assessment and treatment. This included physiotherapists, speech and language therapists and occupational therapists.

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.

• Each team had access to a consultant psychiatrist and access to an approved mental health professional when required. Medical and nursing staff worked well with other specialities and therapy services to provide good multidisciplinary care.

• Staff confirmed that they were able to access additional and external training when appropriate, if they were up to date with all the mandatory training. We met a number of staff who had been supported to undertake degrees and additional vocational qualifications. Staff told us that they felt the trust invested in staff training and development.

• The nursing staff group had felt less supported in accessing external training and conferences. This had been identified by the senior management team, and as part of the re-design, continuing professional development (CPD) budgets would be centrally managed, to ensure that training funds were accessible equally to all professional groups.

• Professionals attended CPD groups. For example, there was a monthly nurses meeting. Professionals also attended national conferences and regional events.

• We found that frontline staff had access to regular management and performance supervision. We reviewed a sample of supervision records in each team, a total of 24 across the service. Although these varied in quality and detail, although showed that clinicians were supported with caseload management and other work related issues. A supervision audit had been undertaken to review and monitor the effectiveness of supervision. Plans were in place to increase the time given to clinical supervision. Staff confirmed that they had regular supervision.

• We saw examples of how staff performance issues, or additional staff support requirements, had been addressed effectively by team managers.

Multi-disciplinary and inter-agency team work

• We saw the teams worked effectively and collaboratively to plan and develop appropriate interventions with other health and social care providers. The service used the trust electronic records system. Access to these records was secure and password protected.

• We saw the teams made good use of specialist support for complex care planning, for example, the legal team, court of protection, multi-agency public protection

arrangements. There were regular meetings with the commissioners and local authority, which team managers attended and felt were useful to contribute to effective, collaborative working.

• Local authority colleagues were currently co-located with the adults with learning disabilities teams, as the original re-design plan was for an integrated model of care between health and social care. No-one was able to identify why this proposed model had broken down. The adults with learning disabilities teams and the local authority staff told us that being located together had contributed to effective, collaborative working. Some staff raised concern that this may not be maintained as effectively once local authority staff are moved to another location.

• Each team had administrative support. Administrative staff told us that they felt integrated within the teams. We saw there were effective administrative processes in place. The administrative staff had attended training on learning disabilities and felt confident on their interactions with individuals who use the service and carers.

• The teams held weekly multi disciplinary team (MDT) meetings to discuss a range of locality service delivery issues, as well as specific patients. The community teams also met once a month with the intensive support team to discuss shared care.

• Staff reported good relationships with other teams within the trust, such as supporting transition from children`s services, the mental health home treatment team and in-patient teams; the teams provided support and managed discharge plans if any individuals who used the adult learning disabilities service were admitted to the mental health wards.

• As part of the `green light` policy, learning disabilities liaison nurses in primary care, acute care and secondary mental health care, worked with the learning disabilities teams to link a wide range of mainstream health services, with the aim of supporting individuals with learning disabilities to access these services.

• The teams have developed a range of training sessions for colleagues within the trust, carers and other professionals. Autism training and key signs (for sign language) are run annually and form part of the overall trust staff training package. Teams have also been providing education and support to local care providers, as well as bespoke individual treatment plans. Care providers we spoke with

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.

confirmed that the training, advice and support provided by the teams was excellent. An example of training we observed was introducing meaningful activity into daily living.

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

• We did not have a Mental Health Act reviewer as part of our team, however, the Mental Health Act documentation reviewed within the care records was completed in line with the Code of Practice.

• We reviewed staff mandatory training records and these showed that the teams had a 95% - 100% compliance rate on staff completing their Mental Health Act training.

Good practice in applying the Mental Capacity Act

• Staff were up to date with training around the Mental Capacity Act. Staff from all disciplines were able to explain about consent and capacity, and how this is integrated in their daily practice. When we reviewed care records, overall we saw evidence of good practice documented throughout the daily progress notes and clinic letters. However, we found two capacity assessments which were not clearly documented.

• Documentation showed that mental capacity was routinely discussed during routine visits, clinical reviews, MDT meetings and complex case reviews.

Are services caring?

Outstanding ☆

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

Summary of findings

Please see summary at beginning of report.

Our findings

Kindness, dignity, respect and support

• People using services told us they were treated with kindness, dignity and respect. We observed outstanding levels of care and respect for the people receiving their services.

We saw numerous examples of care and service development which reflected the determination and creativity of staff to maximise opportunities for service users. This reflected innovative and person centred best practice.

• Clinicians' knowledge and skills within the teams were highly regarded by all individuals who use the service, carers and other professionals we spoke with. Carers told us that the positivity and dedication of individual staff had made a significant difference to their families.

• Staff we met were all professional, caring and committed to providing the best service and care they could, within their current resources and commissioning agreements.

The involvement of people in the care that they receive

• Within daily progress notes and in initial assessments we could see that involvement of people was promoted and their wishes integrated into care, where possible. Patients and carers we spoke with confirmed that they were well informed and involved in their care.

• Care plans provided were in a format that patients could understand, for example, in pictorial format if they had poor literacy skills.

• The trust had a Learning Disabilities Advisory group and forum members were involved in various local and national events. They were engaged with the service to help inform and develop service delivery. For example, they had helped develop various easy read documents and undertook staff interviews.

• There was evidence that carers were involved where possible. The teams also referred carers for carers assessments with the local authority. Carers we spoke with confirmed that they received excellent information, care and support from the teams.

• Staff, advocates, carers and individuals who used the service confirmed that they were supported to access advocacy services when required.

• The service was in the process of initiating the Friends and Family Test; however, the adult learning disability service had two surveys they used to collect feedback; one for carers and one for patients. These were available in easy read format. These were accessible online, on the I-Pad or on paper versions. The results of these were also published in the adult learning disabilities service newsletter. The trust also used `you said, we did`, to reflect how they had responded to feedback.

• The service circulates a monthly communication letter to people who use the service, carers and other members of the community.

• The service promoted social inclusion and was committed to developing a "capable community". The communication charter was initiated by the speech and language service lead and launched in 2013 and now has 160 community leads identified and trained by the service throughout Cornwall. The main function of the charter was to help local businesses and organisations to communicate with people who have a learning disability or a communication difficulty.

Are services responsive to people's needs?

Good ●

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

Summary of findings

Please see summary at beginning of report.

Our findings

Access and discharge

• Cornwall Foundation Partnership Trust had been working with a number of other organisations and key stakeholders to transform the way adult learning disabilities services were delivered. The service was in the process of re-design and change. The anticipated benefits of the re-design were: streamlined clinical pathways, improved patient experience and partnership working with other stakeholders.

• On average the service was receiving approximately seven new referrals per week. The teams had systems and capacity to respond to routine and urgent referrals. The service had a system in place which ensured all new referrals were made through a single point of triage. The team managers then triaged the referrals together to agree the most appropriate action. We were shown the referral tracker which contained information about all referrals received, including referrals not accepted by the service. This provided clear data for service development and improvement.

• Quality assurance information provided by the trust reflected that the teams were keeping within the assessment and treatment timescales agreed with local commissioners, the average wait from referral to assessment was twenty days. The teams were able to respond effectively to changing needs. For example, if a referral for an individual became more urgent and needed to be seen earlier than arranged.

• In line with the national guidance, we saw evidence that the teams worked with mainstream services to ensure reasonable adjustments were made, to support access where patients were identified as clinically appropriate for these services. For example, primary care mental health, physiotherapy or GP services.

• The service was not commissioned to provide out of hours support. Adults with learning disabilities, who experience mental health crises outside of office hours, could access the home treatment team (HTT) which the trust provided for adults of working age, or the police. The trust did not keep data about the number of people using the adults learning disability service who made contact out of hours, with the HTT or who were detained under Section 136 of the Mental Health Act, used by the police.

• The trust does not provide any in-patient facilities for adults with learning disabilities. The staff told us this was rarely required and they worked hard to ensure individuals were supported at home. On the occasions a bed has been needed, they used the trust mental health units. The learning disabilities liaison mental health nurse and the learning disabilities community staff provided support to the units to ensure the right care was given. The mental health ward staff confirmed this happened and was effective. The trust provided information which showed there had been no admissions to trust mental health units from any of the community adults with learning disabilities teams in the past 12 months. One patient had been recalled during the past 12 months on a Community Treatment Order.

• There was limited access to respite beds or appropriate facilities for short assessment admissions. The intensive support team had an allocated staff member who managed all the service out of area placements. We spoke with a commissioner who reported this arrangement was excellent. There had been no out of county placements in the past 12 months by the intensive support team.

The facilities promote recovery, comfort, dignity and confidentiality

• Some of the community team locations were hard for people to access due to distance and transport difficulties. Where this was identified all the teams would undertake home visits, or wherever it was identified the individual would prefer to be seen.

• The poor quality of buildings and facilities had an impact on accessibility and availability of services. For example, occupational therapists and physiotherapists did not have access to trust facilities to support physical therapy and sensory integration clinics. Provision of these services were reliant on individual staff being creative and accessing resources themselves. The West ALD community team could not see individuals at their base, as the ALD community team building was not suitable.

Are services responsive to people's needs?

Good ●

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

• None of the bases were equipped with clinic rooms which contained necessary equipment to carry out physical examinations. People who use the service were well supported by teams to access the appropriate healthcare facilities and services to meet their medical and physical needs.

• Staff had a good understanding of confidentiality, although it was not always clearly documented who they were able to share information with.

Meeting the needs of all people who use the service

• Staff worked with a variety of statutory and non-statutory providers to meet the needs of people.

• The trust had access to interpreting services and patient information in a variety of languages. The service had developed a wide range of easy read information about a range of health needs and services. The speech and language therapists developed effective communication packages for individuals, including training in signing.

• The service was developing a range of communication passports with the Learning Disability Advisory forum, these included my health plan, hospital passports, police passports, . This would assist in communicating individual`s needs within their support setting and when accessing other services.

• The service launched the `communication charter` in 2013 and the identification of "safe places" throughout the community meant that people who use the service knew where they could go if they needed help. This led to public engagement work by the teams. For example, communications training was offered to people working in community settings like pubs and cafes.

Listening to and learning from concerns and complaints

• There was a complaints procedure, although in the first instance people were encouraged to speak with a member of staff involved in providing the care. Information on the patient advice and liaison service (PALS) was provided to people. Easy read complaints information had been developed. Patients and carers told us that they felt able to raise concern or make a complaint.

• We saw the trust`s complaints records which showed that there had been seven complaints across the three teams, between January 2014 and February 2015. Of these complaints, four had been upheld and none had been referred to the ombudsman. We saw examples of how complaints had been responded to.

• We saw that formal complaints were discussed in monthly quality and assurance group meetings. This demonstrated that there was senior overview about complaints relating to the individual localities, in order to identify themes and share learning points across all services.

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.

Summary of findings

Please see summary at beginning of report.

Our findings

Vision and values

• Staff were aware of the organisation's values. However, they did not feel connected to the rest of the trust. Most staff we talked to did not think that the executive team had a good understanding of the learning disabilities service.

Good governance

• The ALD service has undertaken a comprehensive review of assurance processes and reviewed local team performance monitoring and management structures, as part of the service re-design. These were still becoming embedded within the teams. However we saw that the systems were being used effectively to identify risks and monitor team performance. We saw that there were a number of well structured management meetings, all attended by the service manager, to discuss performance and service issues.

• The trust business information report (PIMMS) was generated for each team to monitor overall performance, for example, training and referral waiting times. The administrative team supported this process with team managers in each team. We saw that the PIMMS was circulated throughout the service.

• The ALD service line staff newsletter "The Voice" contained a range of trust and specific ALD service governance information. For example, staff news, audit updates and team performance indicators.

• There were a number of local service led audits which have led to development, improvement and evaluation in service provision. Some of these have been used to inform the service re-design, for example, the caseload needs audit.

Leadership, morale and staff engagement

• Staff told us that a service redesign was underway, and this had been a very difficult process that had a significant impact on staff morale. Some staff felt de-valued. Some staff did not always feel that senior trust management

consulted with them and there was a varied understanding about what the redesign plans were. Staff did not feel the senior management team had listened to their concerns about the impact of redesign on service users.

• A consultation meeting with staff had taken place in January 2015, and there had been an additional nurses meeting. Information about the consultation was documented in the monthly newsletter, distributed to all staff within the adult learning disabilities service.

• The current redesign plans had been developed following a failed health and social care integration redesign approximately 15 months earlier, which had also had an impact on the teams. No-one at frontline or management level was able to explain why the previous redesign for an integrated health and social care model had broken down. This added to staff concerns about trust management of change and communication.

• We spoke with thirty five members of staff. Nearly all staff, from across all disciplines, told us that the management of change had been unsupportive and that there was poor communication from the executive and senior management team. We were told that there were divisions developing between the different professional staff groups, for example, nursing staff and allied health staff. The divisions were due to different staff groups feeling more affected by the redesign than other colleagues due to changing roles. Staff were concerned that there would be permanent damage to team relationships. We were told however, that the team managers had been very open and supportive throughout this difficult process.

• We asked for information around the plans to support staff and monitor the impact of this process on staff health and wellbeing. We were informed that this was largely the responsibility of the team managers to oversee. We found that the team managers were new in post, although well known to the teams and had worked within the community teams for a number of years. This could make it potentially difficult for them managing the degree of impact from the redesign and people being moved into different roles or teams. We reviewed a sample of managers' supervision files (including allied health managers and team managers). We found that there was little evidence of individual regular, structured supervision from the senior management team, or additional leadership training, to

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effectively support them in managing this change. However, the team managers did have a weekly meeting with the service manager to review a range of service issues.

• The senior management team informed us that they were tracking staff health and wellbeing through the staff surveys. 32 staff had completed surveys in November 2014. This represented 32% of the whole workforce. In February 2015, the return rate had decreased to 22 staff who had completed surveys, this represented 22% of the workforce; of the 22, 7 staff stated that they felt bullied. Several staff we spoke with told us that they did not feel confident that the surveys were anonymous and therefore were not completing them. Some staff told us that they did not feel able to raise concerns with the executive or senior management team.

• The senior management team had not identified an additional strategy to monitor impact on staff, as a result of the small sample and decrease in uptake of the survey. We were concerned that this was not an effective staff monitoring and engagement strategy, because 78% of staff were not represented. We were concerned that the senior management team and executive board did not have a good understanding of the extent of staff distress, the impact on team relationships and the potential impact this could have on the service overall.

• We requested copies of the monthly project meeting minutes, which we were informed were held in order to monitor and evaluate the redesign process. We were advised that minutes were not kept for these meetings. We were concerned that there was not an overarching, contemporaneous log of actions, discussions and outcomes of the redesign process.

Commitment to quality improvement and innovation

• We saw numerous examples which reflected the determination and creativity of staff to maximise opportunities for service users. These reflected innovative and person centred best practice. We have given examples at the beginning of this report. In addition to this, the service was committed to quality improvement through audit and innovation.

• The ALD research and audit committee meet quarterly and at the time of inspection there were eleven live clinical

audits, including participation in national audits. We saw easy read information about getting involved with research. We saw a wide range of audits to inform and improve service development.

• The service was currently accredited by the National Autistic Society, and staff were working on a programme to achieve re-accreditation in 2016.

• The epilepsy team had developed a SUDEP checklist, to ensure robust and clinical best practice is followed. The epilepsy team used epilepsy radar to monitor epilepsy outcomes and specific care plan for effective responses to complex needs. The epilepsy team had developed a website e-learning tool via the Cornwall County Council website, on safe medications in managing seizures.

• There was work underway, focussing on developing a checklist for primary care providers to monitor use of anti-psychotic medications for adults with learning disabilities. This was in response to the outcome of an audit into annual health checks of adults with learning disabilities taking anti-psychotics undertaken in December 2014.

• The communication charter was launched in 2013 and now has 160 community leads identified and trained throughout Cornwall. The main function of the charter is to help local businesses and organisations to communicate with people who have a learning disability or a communication difficulty.

• The service has a commitment to developing capable communities, to promote social inclusion and ensure individuals with a learning disability are supported by the right services in their local community. They undertake a number of training sessions and hold public engagement events to promote understanding, for example, the silent coffee morning to demonstrate how it may feel to not be heard.

• The teams were pro-actively involved in the development and use of technology to engage and communicate with people, for example, the development of "Appy Talk", using I-pads to communicate.

• The Green Light policy was developed to ensure that an ALD nurse identifies key staff working with ALD patients in mainstream services, to ensure staff in those services understand good practice around responding to patient needs.

Are services well-led?

Good 🟢

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• The physiotherapy team had been recognised by the trust for their innovative work in rebound therapy.

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.