Derbyshire Healthcare NHS Foundation Trust

Community mental health services for people with learning disabilities or autism

Quality Report

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Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RXM	Kingsway Hospital, Trust Headquarters, Bramble House	Derby City Community Learning Disabilities Team, Council House	DE1 2FS
RXM	Kingsway Hospital, Trust Headquarters, Bramble House	Assessment and Treatment Support Services (ATSS), St Andrews House	DE1 2SX

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

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

- In June 2016, we inspected the core service as requires improvement for effective. We identified that across all teams, not all patients had a care plan in place, care plans did not represent patient views, strengths, goals, and some patients were not given a copy of their care plan.Staff did not always carry out an assessment of capacity to consent in a consistent way.
- In February 2017, we inspected the community mental health services for people with learning disabilities and autism rated as requires improvement for effective. During this inspection, we looked at patient electronic records, clinical audits and spoke with staff.
- When we inspected this service in February 2017, we found the trust had made some improvements in this area. The trust was in the process of scanning all patients' paper records onto electronic patient records. Policies on Health Records and Mental Capacity were updated and three audits were completed to assess how staff applied the updated policies.
- Out of the 20 patient records selected from across the teams we looked at, we found six electronic patient records did not have a completed care plan, eight records had no care plan review date, seven records had no evidence of patient involvement in developing their care plan and 12 patients had not received a copy of their plan. Twelve out of 20 records we saw recorded of a patient's mental capacity on a specific decision and three mental capacity assessments were incomplete and did not follow the five guiding principles.

We did not change the rating, it remains as requires improvement.

Summary of findings

Information about the service

The community learning disabilities teams provides a specialist mental health service for people with a learning disability or autism living in Derbyshire. The teams operate between 9am and 5pm weekdays only. The teams consists of nurses, physiotherapists, occupational therapists, speech and language therapists, doctors and assistant practitioners that supported people to understand their health needs and get the treatment they needed.

The community learning disabilities teams were in four areas; Derby City team based at the Council House, Derby, Amber Valley team based in Belper, Dales South team based in Ashbourne. The assessment and treatment support service, based at St Andrew's House in Derby City, covered the Derby City and South Derbyshire areas. The team provided assessment and treatment support services, to avoid unnecessary admission to impatient services. The team supports people with challenging behaviour or mental health needs to be assessed and treated at home wherever possible.

Our inspection team

Our inspection team was led by Judy Davies. The team included three CQC inspectors and an assistant inspector.

Why we carried out this inspection

We undertook this inspection to find out whether Derbyshire Healthcare NHS Foundation Trust had made improvements to their community based mental health services for people with learning disabilities or autism. We rated the trust as requires improvement at the last comprehensive inspection of the trust that we undertook in June 2016.

Following the June 2016 inspection, we told the trust it must make the following actions to improve community mental health services for people with learning disabilities or autism:

- The trust must ensure that all patients have care plans in place that contain patients' views, strengths and goals. Care plans must have agreed dates of review.
- The trust must ensure all patients had copies of their care plan.
- The trust must ensure that staff demonstrate and apply good practice in the Mental Capacity Act.

We issued the trust with two requirement notices that affected this core service. These related to the following regulations under the Health and Social Care Act (Regulated Activities) Regulations 2014:

- Regulation 9 Person Centred Care
- Regulation 11 Need for Consent

How we carried out this inspection

To fully understand the experience of people who use services, we asked the following question of this service and provider:

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

Summary of findings

• Is it well led?

Before visiting, we reviewed a range of information we held about Derbyshire Healthcare NHS Foundation Trust. We carried out a short-noticed announced visit on the 13 February 2017.

We looked at information provided to us on site and requested additional information from the Trust during the inspection. This information suggested that the rating of requires improvement for effective that we made following our June 2016 inspection, was still valid. Therefore, during this inspection, we focused on issues that we had received information about, which were related to the effective domain.

We also made a number of recommendations at the last inspection where we think the Trust should take actions to improve services.

During the inspection visit, the inspection team:

- visited the community learning disabilities team at Derby City Council House and St Andrew's House and spoke to the management team
- looked at 20 randomly selected electronic patient records from across all team bases.

What people who use the provider's services say

We did not speak with patients during this inspection, as the focus was on particular concerns identified during the comprehensive inspection for community mental health services for people with learning disabilities or autism. This inspection took place in June 2016.

Areas for improvement

Action the provider MUST take to improve

- The trust must ensure all patients have care plans in place that contain patients' views, strengths and goals. The care plans must have agreed review dates.
- The trust must ensure that staff demonstrate and apply good practice in using the Mental Capacity Act.

Action the provider SHOULD take to improve

- The trust should ensure staff consistently record the next review dates on all risk assessments.

Derbyshire Healthcare NHS Foundation Trust

Community mental health services for people with learning disabilities or autism

Detailed findings

Are services effective?

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

Our findings

Assessment of needs and planning of care

- At our previous inspection in June 2016, we identified across all teams, not all patients had a care plan in place given a copy of their care plan and care plans did not represent patient views, strengths and goals. Staff did not complete review dates on care plans and consistently record next review dates on all risk assessments.

During this inspection, we found the trust had made some improvements in this area.

- The trust was in the process of scanning patients' paper records onto patient electronic records. They transferred patient records dated September 2016 onto electronic patient records. Management staff we spoke with told us said the trust developed a plan to upload all patient paper records onto the electronic patient record system; however, staff did not know the completion date for the transfer of patient paper to electronic records.

  The trust revised their health records policy and completed an audit to assess the use of this policy. The trust reviewed their policy on Minimum and Accessible Information Standards for Health Records and updated it to include electronic patient records. They completed an audit in November 2016, which focussed on service user and carer involvement in care planning and risk assessments. This audit looked at 50 sets of patient notes from four community learning disabilities team and found 72% of patient notes showed evidence patients were involved in their care plan and showed evidence of patients/carers views, perceptions and wants.

- The trust established a learning disability audit group that took on the role of auditing care and treatment records. This group developed a self-audit tool, used by nursing staff to audit two care and treatment records from their caseload. The audit identified an action plan with a time scale on how to manage the issues raised from this audit.

- We read the summary of findings from the learning disability audit group dated 10 February 2017. The audit found out of 20 patient electronic records, 19 files had an up to date care plan, 10 files had a review date, 17 files had evidence of patient involvement in developing their care plan, and six patients received a copy of their plan.

- However, during this inspection, out of the 20 patient notes we looked at, we saw six electronic patient files did not have a completed care plan, eight files did not have a care plan review date, seven files had no evidence of patient involvement in developing their care plan and 12 patients did not receive a copy of their plan.

- Patients who had more than one professional involved with their care had more than one care plan. We saw seven patient care plans had one main care plan and specialist professional care plans linked to the main care plan. These care plans gave a clear overview of the patient's care and the role of involved professionals. Staff said the trust made a request for an overarching care plan but this was not possible to include on the electronic patient records.

- Not all patients' files we saw had a completed risk assessment. Staff completed the Functional Analysis of Care Environment risk assessment tool, which is a group of risk assessment designed for use in adult mental health services. We saw 18 patient electronic records had completed Functional Analysis of Care Environment risk assessment tools. Of these 18 files, five risk assessment tools were not updated and did not have a review date

Good practice in applying the Mental Capacity Act

- At our previous inspection in June 2016, staff did not always carry out assessment of capacity to consent in a consistent way in all teams. Some records where staff identified patients as lacking capacity had no associated documentation in place and advanced decisions recorded where appropriate.

During this inspection, we found the trust had made some improvements in this area.

- The trust updated the Mental Capacity policy in November 2016. This policy included appendices on recording of mental capacity and best interest decisions. Management staff said they used the central capacity preparation sheet found within the policy, which helped them to think clearly about the Mental Capacity Act during their role with patients.

Are services effective?

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

- The learning disabilities audit group completed an audit on patient care and treatment files on mental capacity. This audit dated February 2017, found that out of 20 audited files, 12 files had a record of a patient's capacity to consent to treatment and one file where a patient lacked mental capacity had a best interest decision recorded. The trust said all staff within the community learning disabilities team had received training and briefings on the Mental Capacity Act.
- We looked at 20 electronic patient records. Twelve out of 20 records we saw recorded a patient's mental capacity on a specific decision. Eight of the records showed staff reported a comprehensive assessment of patients' mental capacity. However, three mental capacity assessments were incomplete and did not follow the functional test of capacity. The functional test of capacity looked how the patient understood the information that is relevant to the decision they wanted to make, retain the information long enough to be able to make the decision, weigh up the information available to make the decision and communicated their decision by any possible means.
- We saw four electronic patients' records with best interest decisions assessments. One best interest decision assessment provided comprehensive information relating to the decisions made; however, three patients' files best interest decision assessments were incomplete.
- We saw no advanced decisions in the patient's files we looked at. Management staff said staff wrote information about advanced decisions in electronic patient notes and reviewed advanced decisions when needed.

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
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care Out of the 20 patient records we looked at, six electronic patient records did not have a completed care plan, eight records had no care plan review date, seven records had no evidence of patient involvement in developing their care plan and 12 patients did not receive a copy of their plan. This was a breach of Regulation 9(3)(a)(b)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent Staff did not always consistently carry out assessment of capacity to consent in a consistent way across all teams. Out of the 20 patients, records we looked at, three mental capacity assessments were incomplete and three best interest decision assessments were incomplete. This is a breach of Regulation 11 (1) (3)