

Lancashire Care NHS Foundation Trust

Community mental health services for people with learning disabilities or autism

Quality Report

Sceptre Point
Sceptre Way
Walton Summit
Preston
PR5 6AW

Tel: 01772 695300

Website: www.lancashirecare.nhs.uk

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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)
RW5	Trust Headquarters	Integrated health team for adults with learning disabilities or autism - Preston	PR1 1LD
RW5	Trust Headquarters	Integrated health team for adults with learning disabilities or autism – Burnley, Pendle and Rossendale	BB11 5ST
RW5	Trust Headquarters	Integrated health team for adults with learning disabilities or autism - Lancaster	LA1 4XQ

Summary of findings

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

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

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

Summary of findings

Ratings

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

Overall rating for the service

Good 

Are services safe?

Good 

Are services effective?

Good 

Are services caring?

Good 

Are services responsive?

Good 

Are services well-led?

Good 

Mental Health Act responsibilities and Mental Capacity Act / Deprivation of Liberty Safeguards

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

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

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

Summary of findings

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Summary of findings

Overall summary

We rated the community based services for people with learning disability or autism as 'Good' because:

- The services had reliable systems, processes and practices in place to keep patients safe and safeguard patients from abuse. There was an openness and transparency about safety. Staff understood their roles and responsibilities to raise concerns and report incidents and near misses.
- Individual and environmental risks were monitored and managed appropriately. In most teams comprehensive risk assessments were carried out by staff for patients who used the service; risk management plans were developed in line with national guidance.
- There was a holistic approach to assessing, planning and delivering care and treatment to patients. Patient's individual care and treatment was planned using best practice guidance. Outcomes were monitored to ensure changes were identified and reflected to meet patient's needs.
- Consent practices and records were monitored and reviewed to improve how patients were involved in making decisions about their care. Staff requested patient's consent to care and treatment in line with the Mental Capacity Act.
- Staff had the skills, knowledge and experience to deliver effective care and treatment. Staff were supported by means of supervision and appraisal processes, to identify additional training requirements and manage performance.
- Feedback from patients who used the services was positive, regarding how staff treated patients and their

families. Patients were treated with dignity, respect and compassion whilst receiving care and treatment. Patients and the ones who were close to them were involved in their care decisions.

- Planning and delivery of service took patient's individual needs and circumstances into consideration. Access to care and treatment was timely. Waiting times, delays and cancellations were minimal and managed appropriately.
- The services managed complaints and concerns effectively; they listened to patient's concerns with a view to improve the services being provided.
- The services had good structures, processes, and systems in place to manage current and future performance and ensure quality to drive improvements. The information used in reporting, performance management and delivering quality care was timely and relevant. Performance issues were escalated to the relevant monitoring committee and the board through clear structures and processes.

However in the Lancaster team, risk information was not consolidated into a single overarching risk assessment and management plan for individual patients. We found that there were variations in the multi-disciplinary make up of teams in different teams; some teams did not have good access to psychiatrists, occupational therapists, or speech and language therapists. The recording of patient information did not optimise the sharing of patient data between staff of differing services and teams. GPs were not given regular updates regarding any plans specific to patient care such as treatment interventions or information about patients being discharged from the teams.

Summary of findings

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

Are services safe?

We rated the community based services for people with learning disability or autism as **'Good'** for safe because:

- The three community based services we visited all had safe environments which were suitable for delivering care to patients with learning disability or autism. Buildings were clean and interview rooms were equipped with alarm systems.
- There were good staffing levels and skill mix was planned and reviewed to ensure patients received safe care and treatment.
- Staff managed and responded to changes in identified risks to patients.
- Staff we spoke with had safeguarding training and understood their responsibilities in raising concerns or alerts to keep patients safe. Staff knew the procedure to escalate and report concerns.
- The service had good systems in place for reporting incidents and ensuring investigation into incidents. Staff we spoke with understood their responsibilities in reporting incidents and were updated with lessons learnt feedback following investigation.
- There was a lone worker policy in place to keep staff safe and staff had personal alarms.

However in the Lancaster team, risk information was not consolidated into a single overarching risk assessment and management plan for individual patients. The trust was not meeting its completion target rate on staff attending some mandatory training courses across the community based services for people with learning disability or autism.

Good



Are services effective?

We rated the community based services for people with learning disability or autism as **'Good'** for responsive because:

- Patients had their needs assessed, care planned and delivered in line with best practice.
- Patient outcomes of care and treatment were routinely monitored.
- Staff had appropriate skills, knowledge, and experience to deliver care and treatment.

Good



Summary of findings

- Arrangements were in place to support staff by means of clinical and management supervision, appraisal, handovers and team meetings.
- Care records contained up to date, individualised, holistic, recovery oriented care plans.
- Teams managed the referral process, assessments, ongoing treatment and care by discussing the best treatment and pathway options for individuals.
- Care plans were developed collaboratively with patients.

However we found that there were variations in the multi-disciplinary make up of teams in different areas as some teams had limited access to psychiatrists, speech and language therapists and occupational therapists. The recording of patient information did not optimise the sharing of patient data between staff of differing services and teams. GPs were not given regular updates regarding any plans specific to patient care such as treatment interventions or information about patients being discharged from the teams.

Are services caring?

We rated the community based services for people with learning disability or autism as **'Good'** for caring because:

- Patients and carers told us that staff engaged with them in a caring, compassionate and respectful manner. This was also observed by the inspection team during staff and service user interactions.
- Patients, carers and family members spoke positively about the support of regular appointments with the service.
- Patients, carers and family members told us they felt involved in the decisions about the care and treatment planned.
- Patients were supported to manage their own health and independence where possible by staff from the learning disability team.
- Teams provided leaflets to carers that explained specific information regarding learning disability services in further detail.

Good



Are services responsive to people's needs?

We rated the community based services for people with learning disability or autism as **'GOOD'** for responsive because:

Good



Summary of findings

- Services were planned and delivered to meet patient's needs through an individualised approach. This took into consideration their cultural and complex needs.
- Patients had access to care and treatment in a timely manner.
- Concerns and complaints were listened and responded to appropriately. Lessons were learnt to improve the future quality of care and treatment.

Are services well-led?

We rated the community based services for people with learning disability or autism as '**GOOD**' for well-led because:

- There were clear team objectives which reflected the provider's values and strategy.
- Staff knew who the executive and senior management team were as they were visible within the organisation.
- There were good meeting structures in place to escalate and cascade information through all levels of staff. This included management, review and improvements of risks, incidents and performance monitoring.
- Staff understood their roles and responsibilities. Staff felt respected, valued and supported by the management team and their peers.
- Patients' views and experience were gathered to drive performance.

Good



Summary of findings

Information about the service

Lancashire Care NHS Trust provided integrated community health team for adults with learning disabilities or autism. Teams worked primarily with people with learning disabilities who were over 18 years of age. They also worked with 16 year olds if they had left full time education, and 16-18 year olds who were in transition to adult services. The service aimed to meet the health needs of people with a learning disability and to work with people who presented with challenging behaviours or where they presented a risk.

We visited three out of seven community health teams for adults with learning disability teams provided by Lancashire Care NHS Trust. The teams we visited were:

- Integrated health team for adults with learning disabilities or autism – Preston
- Integrated health team for adults with learning disabilities or autism – Burnley, Pendle and Rossendale
- Integrated health team for adults with learning disabilities or autism – Lancaster

Our inspection team

Our inspection team was led by:

Chair: Peter Molyneux, Chair, South West London and St George's Mental Health NHS Trust

Head of Inspection: Jenny Wilkes, Head of Inspection, Care Quality Commission

Team Leader: Sharon Marston, Inspection Manager (mental health), Care Quality Commission

The inspection team for this core service was composed of three CQC inspectors and two specialist advisers - a consultant psychologist and a lead learning disability nurse.

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

The inspection took place across a range of the community based services for people with learning disability or autism. The sample size inspected was a third of the services based within the community across three locational areas.

Before visiting the service, we reviewed a range of information we held about the core service and asked other organisations to share what they knew. We carried out an announced visit on 28 to 30 April 2015.

During this inspection we

- spoke with 12 patients who used the service and four carers.
- looked at 18 patient care records.

- observed three clinical sessions between staff and patients.
- spoke with 29 members of staff from a range of disciplines and roles; these included service manager, team managers, support workers, learning disability nurses, psychologists, occupational therapists, psychiatrists, speech and language therapists and administration staff.
- held focus groups for patients and staff of differing disciplines and grades.
- We attended a team "huddle" meeting and a screening & intake meeting.
- We also attended a health action cycling group for patients and observed the react service user group in Preston.

Summary of findings

To get to the heart of the experiences of people who use services, we 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?

What people who use the provider's services say

During this inspection we spoke with 12 patients and four carers.

Patients who used the service told us the service had a positive impact on their lives and staff genuinely endeavoured to help them improve their lives. Patients and their carers told us staff treated them with dignity, respect and compassion. They felt involved in the decisions about their care and treatment.

Patients and their carers told us that access to the service was good and support was given when needed in a crisis situation.

The four carers we spoke with were all very complimentary about the service and they all told us they really appreciated the support provided by the service.

Good practice

There was a dementia intervention service being piloted in the East Lancashire district and developed by the Hyndburn, Ribble Valley, Burnley, Pendle and Rossendale Team. The service screened patients with learning disability or down's syndrome for dementia and offered

treatment to patients and support to carers with multidisciplinary input from psychologists, learning disability nurses, psychiatrists, and speech and language therapists.

Areas for improvement

Action the provider SHOULD take to improve

- The trust should ensure that risk information was consolidated into a single overarching risk assessment and management plan for each individual patient at the Lancaster team. The trust should ensure across other teams that risk assessments contain key patient information such as the date when risks were assessed or reviewed and who completed the risk assessment.
- The trust should review the recording of patient information to optimise the sharing of patient data between staff of differing services and teams.

- The trust should ensure that GPs are up dated with plans specific to patient care including any interventions being delivered and goals achieved and information on patients being discharges from the service.
- The trust should continue to work with commissioners on the development of the service provision to meet the needs of the local population and prevent variations of service provision in different areas. At present some teams have limited access to psychiatrists, speech and language therapists and occupational therapists.

The trust should improve attendance at mandatory training to meet its own target of 85% completion target across all ten mandatory training courses.

Lancashire Care NHS Foundation Trust

Community mental health services for people with learning disabilities or autism

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Integrated health team for adults with learning disabilities or autism - Preston	Trust Headquarters
Integrated health team for adults with learning disabilities or autism – Burnley, Pendle and Rossendale	Trust Headquarters
Integrated health team for adults with learning disabilities or autism - Lancaster	Trust Headquarters

Mental Health Act responsibilities

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

Overall we found that there was very little use of the Mental Health Act (MHA) within the service. Staff demonstrated a good understanding of how to initiate a MHA assessment

and the implications of this where people with learning disability were presenting with seriously irresponsible or abnormally aggressive behaviour requiring compulsory admission.

We found that patients were offered information about their treatment and care and that consent to medication and side effects were discussed. This helped to ensure people received appropriate treatment in the community without recourse to the MHA.

Detailed findings

Mental Capacity Act and Deprivation of Liberty Safeguards

Overall we found the services complied with the requirements of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguarding (DOLs). There was a record and monitoring of capacity and consent with regular review of capacity assessments and evidence of best interest meetings and agreed decisions.

Staff had a clear understanding of their responsibilities in undertaking capacity assessments. Patients were continuously monitored to ensure health decisions were based on consent or in the best interest of the person. Staff were provided with clear guidelines and a checklist to ensure capacity assessments and processes were followed correctly.

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

We rated the community based services for people with learning disability or autism as 'Good' for safe because:

- The three community based services we visited all had safe environments which were suitable for delivering care to patients with learning disability or autism. Buildings were clean and interview rooms were equipped with alarm systems.
- There were good staffing levels and skill mix was planned and reviewed to ensure patients received safe care and treatment.
- Staff managed and responded to changes in identified risks to patients.
- Staff we spoke with had safeguarding training and understood their responsibilities in raising concerns or alerts to keep patients safe. Staff knew the procedure to escalate and report concerns.
- The service had good systems in place for reporting incidents and ensuring investigation into incidents. Staff we spoke with understood their responsibilities in reporting incidents and were updated with lessons learnt feedback following investigation.
- There was a lone worker policy in place to keep staff safe and staff had personal alarms.

However in the Lancaster team, risk information was not consolidated into a single overarching risk assessment and management plan for individual patients. The trust was not meeting its completion target rate on staff attending some mandatory training courses across the community based services for people with learning disability or autism.

Our findings

Safe and clean environment

The team locations we visited were clean and generally well maintained with a safe environment for delivering care.

The Preston service had clean and bright patient areas and rooms. There was an alarm system in place to address any issues of risk. Both the Lancaster and Burnley teams had similar safe and clean building environments.

None of the services we visited carried out physical examinations as patients would be referred to their GP for physical health issues.

We observed that equipment was checked regularly and stored safely and that this was clearly documented. There were suitable lone worker policies and practices in place throughout all three of the teams we visited. These included a "safe to visit checklist" highlighting known information for the area being visited, previous history of violence from the patient or anyone living with them. The service also had a mobile phone sign in and out procedure. When visits occurred after hours or out of the area a "buddy system" was also in place to check on staff safety. This included an escalation process if there had been no contact made with the staff member who had attended the visit.

Safe staffing

The key staffing Indicators within the teams were as follows:

Preston Team

Establishment levels – qualified nurses (WTE): 6

Establishment levels – nursing assistant staff (WTE): 0

Number of vacancies: qualified nurse (WTE): 0.1

Number of vacancies: nursing assistants: 12.9

Staff sickness rate (%) in last 12 month period: 6%

Staff turnover rate (%) in last 12 month period: 1%

Burnley, Pendle and Rossendale Team

Establishment levels – qualified nurses (WTE): 4

Establishment levels – nursing assistant staff (WTE): 1

Number of vacancies: qualified nurse (WTE): 0

Number of vacancies: nursing assistants: 0

Staff sickness rate (%) in last 12 month period: 6%

Are services safe?

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

Staff turnover rate (%) in last 12 month period: 35%

Lancaster Team

Establishment levels – qualified nurses (WTE): 4.8

Establishment levels – nursing assistant staff (WTE): 4

Number of vacancies: qualified nurse (WTE): 1.5

Number of vacancies: nursing assistants: 0

Staff sickness rate (%) in last 12 month period: 8%

Staff turnover rate (%) in last 12 month period: 0%

Staffing levels within the teams had not been reviewed for some time in light of current demand or population weighting. This had led to some disparities within the teams. Managers were aware of the disparities and had plans to meet with commissioners to make the staffing levels more equitable and reflect the demographics of the areas.

Staff turnover within the learning disability and autism community based services across all community based teams was nine leavers within the last 12 months.

Caseload indicators

Preston Team: Average caseload 16

Burnley, Pendle and Rossendale: Average caseload 22.7

Lancaster Team: Average caseload 22.3

Staff we spoke to confirmed they had regular caseload supervision and that cases were allocated by considering the assessed need of the person and the skill mix of staff.

Staffing levels and skill mix were planned, implemented and reviewed to keep patients safe at all times. Skill mix within teams varied due to disparities within different commissioning groups. Any staff shortages were acknowledged by team managers; however staff reported that the process to recruit was often delayed due to lengthy recruitment processes. Staff also told us that roles within the teams were undergoing restructuring which was also presenting a challenge to staff.

The service had low levels of usage of bank staff with the highest team use being only 248 hours for the period of 1 March – 31 May 2015. This was within the Fylde and Wyre and Chorley South Ribble teams. For the teams we visited during the inspection the use of bank staff was as follows; Preston Team had 1 administrator at 18 hours per week a

total of 234 hours, Blackburn, Pendle and Rossendale had no temporary staff usage and Lancaster team had 1 physiotherapist who was part time. There was no use of agency staff across the service for that same period.

There was a core programme for mandatory training which included equality and diversity, fire, infection control, safeguarding children, safeguarding adults, health and safety, moving and handling, basic life support and conflict resolution.

Staff within teams were meeting the trust's target of 85% staff completion rate for the following training programmes

- equality and diversity
- safeguarding children
- moving and handling
- health and safety
- infection control

However, the services were failing to meet the 85% target on the following training programmes,

- fire safety - 72%
- basic life support - 75%
- conflict resolution - 83%
- safeguarding adults - 83%

We found no evidence of any immediate negative impact on patients who use the service regarding mandatory training rates.

Assessing and managing risk to patients and staff

In total we examined 18 sets of care records within the three services that we visited.

We found that staff undertook risk assessments of patients at initial referral and triaged referrals by asking for any risk information within the referral form. Staff members also completed a "safe to visit" checklist prior to any first home visits. Individual risk mitigation profiles were used to assess risks associated with individual patients. Assessment tools were used to objectively assess risk and help build positive behavioural support plans including O'Neil functional behavioural assessments and the questions about behavioural function assessment scale. If any risks were identified as changing significantly then this would trigger a full review and case discussion within the MDT.

Are services safe?

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

However, not all care records reflected good practice with regards to risk assessments. We found that across the teams we visited, some risk assessments did not contain key patient information, did not include a date of when the risks were assessed or reviewed or who completed the risk assessment. In the Lancaster and Morecambe team, four out of five paper care records did not have separate risk assessments contained within them. Risks were recorded in other documents but risk information was not consolidated into a single overarching risk assessment and management plan.

Staff took a proactive approach to safeguarding and focused on early identification. There was adapted information about abuse given to patients as a picture bank leaflet within the introduction pack given on the initial visits. Staff took steps to prevent abuse from occurring, responded appropriately to any signs or allegations of abuse and worked effectively with others to implement protection plans. Safeguarding champions were identified within the teams and there was a trust policy and procedure in place. Safeguarding alerts were recorded on the trust's incident management system known as Datix and any local alerts were discussed at the team meetings or multi-disciplinary meetings.

There was active and appropriate engagement in local safeguarding procedures and effective work with other relevant organisations.

There were no serious incidents reported by the service in the last 12 months.

Reporting incidents and learning from when things go wrong

Staff understood and fulfilled their responsibilities to raise concerns and report incidents. Staff were aware of the process for reporting incidents using the Datix system.

During the last 12 months, the Lancaster and Preston teams both reported 6 incidents each via Datix and Burnley, Pendle and Rossendale reported 12 incidents.

The integrated service lead explained how the learning from incidents was shared throughout the organisation. There was a standard form entitled "Sharing the Learning" which was circulated to services and teams to outline the brief details of the incident; it listed the Datix number it related to, the nature of the incident, description of lessons learnt, description of any good practice identified, along with a conclusion and recommendations for the local teams to contribute towards future improvements. There was a category assigned on the form which identified if it was a complaint, serious untoward incident or other incident. We saw five examples of the "sharing the learning" form which has been circulated prior to our visit. This shared learning was discussed and implemented during weekly team "huddles" with management and staff. During these meetings staff had the opportunity to contribute to feedback.

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

We rated the community based services for people with learning disability or autism as 'Good' for responsive because:

- Patients had their needs assessed, care planned and delivered in line with best practice.
- Patient outcomes of care and treatment were routinely monitored.
- Staff had appropriate qualifications, skills, knowledge, and experience to deliver care and treatment.
- Arrangements were in place to support staff by means of clinical and management supervision, appraisal, handovers and team meetings.
- Care records contained up to date, individualised, holistic, recovery oriented care plans.
- Teams managed the referral process, assessments, ongoing treatment and care by discussing the best treatment and pathway options for individuals.
- Care plans were developed collaboratively with patients.

However we found that there were variations in the multi-disciplinary make up of teams in different areas as some teams had limited access to psychiatrists, speech and language therapists and occupational therapists. The recording of patient information in electronic records and management of paper files did not optimise the sharing of patient data between staff of differing services and teams. GPs were not given regular updates regarding any plans specific to patient care such as treatment interventions with information about patients being discharged from the teams.

Our findings

Assessment of needs and planning of care

There were effective weekly allocation or intake meetings involving relevant professionals and also weekly "huddle" meetings for a general sharing of information

Referrals were allocated on a weekly basis to individual practitioners. Each referral was discussed and prioritised at the multi-disciplinary team (MDT) meeting which took place each week.

Initial assessments were used to form care plans and treatment interventions. Teams used the Mini PAS-ADD tools which were a set of assessment tools for undertaking mental health assessments with patients with learning disabilities.

Care plans contained up to date, personalised, holistic, recovery focused information to support the treatment pathway. We found care plans to be "easy read" and that patients contributed where possible. Goals were clearly identified and ongoing interventions were highlighted.

Information was stored securely and available to practitioners when needed. Information was held on a paper based system and each professional discipline had a separate patient file. Staff informed us that they did not have access to mental health team electronic records. This led to problems at times with joint working and sharing of information.

Best practice in treatment and care

The services followed relevant best practice which were based on National Institute for Health and Care Excellence (NICE) guidance and the Winterbourne View report, Transforming Care, (2012) This was evident within care plans which frequently referenced evidenced based practice.

Psychological therapies were available at all three service locations we visited.

Staff spoke passionately about being able to support patients to attend mainstream activities and employment. The Preston team supported the react service, which was a patient led group involved in advocacy and learning disability awareness training. The group now employed a number of learning disability service users who were also instrumental in the recruitment process and overall running of the service.

There was a system in place for sharing best practice and implementing this within teams. The clinical practice teacher had implemented a system of monitoring best practice guidelines and logging it onto a spreadsheet. The clinical practice teacher circulated outline guidance to

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.

team managers and asked them to complete an action plan on how they would meet that best practice which included timescales. This was then discussed at the business manager's meeting with the team managers.

Both staff and patients spoke highly of the "hospital passport" scheme which was a document available to health professionals and included important information regarding individual health needs.

Staff informed us that they worked closely with GP surgeries to ensure that annual health checks were carried out. However GPs were not given regular updates regarding any plans specific to patient care such as treatment interventions or information about patients being discharged from the teams. One service user felt that the learning disability team had "saved their life", when referring to the support he had received in relation to a physical health condition.

During our inspection process we observed good practice and innovative working in relation to a dementia pathway which was developed by the Burnley, Pendle and Rossendale Team. This was based around national guidelines from the Department of Health's national dementia strategy. From this initiative, three patients had been diagnosed with dementia and treatment was being offered. The team offered support to carers and providers around communication, information and health. The team also provided person centred training in relation to dementia and learning disability to local care providers.

All services used an electronic outcome measures tools called quality SEEL, team information boards, integrated quality reports and quality improvement frameworks. The quality SEEL consisted of data collected from various sources and measured 18 quality outcomes.

Outcomes were also measured within the services by using a service user evaluation tool. This consisted of patients being interviewed following discharge from the service in order to give feedback on their experience. Once analysed, this information was then shared with senior managers and governance leads, as well as individual team managers. From this information, actions were identified and cascaded back to the relevant staff.

Skilled staff to deliver care

Teams had access to a range of learning disability disciplines which included consultant psychiatrists, speech

and language therapists, psychologists, occupational therapists, support workers, medical secretaries and administration support. However, the availability of occupational therapists and speech and language therapists, in particular, varied due to differences in commissioning structures throughout the trust area.

If patients required input from a social worker, staff routinely made referrals to the social work department of the local authority.

Many of the staff members within the services had a high degree of experience, and were qualified appropriately. There was additional training in place to support the development of staff and quality of care. Additional training included a wide selection of courses from basic awareness of relevant interventions to master's degree level courses. Specialised training was accessible to staff who were then required to cascade this information to the wider teams. For example staff at Lancaster had received positive behaviours training, autism training and dementia training which had been developed in house.

A member of the psychology department had also been trained in autism diagnostic observation schedule which was an observation assessment of autistic spectrum disorder (ASD). It presented various activities that elicit behaviours directly related to a diagnosis of ASD. By observing and coding these behaviours information was obtained that informed diagnosis, treatment planning and educational placement of people with ASD.

There was a supervision policy in place to ensure the appropriate clinical and management supervision programme was effective. Supervision took place on a monthly basis, with weekly "huddle" meetings to share any other information.

Multi-disciplinary and inter-agency team work

Services worked together to plan ongoing care and treatment in a timely way through the MDT meetings and handover structures which were in place. Care was co-ordinated between teams and services from referral through to discharge or transition to another service.

Multi-disciplinary team (MDT) meetings were used to collaboratively manage referrals, risks, treatment and appropriate care pathways options.

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.

The learning disability teams linked in with the inpatient services for patients who have been admitted to psychiatric inpatient units. Staff had good working relationships with mental health teams for adults and children, social work teams and other third sector organisations.

Access to psychiatry services we found to be varied due to service locations being commissioned by different clinical commissioning groups. The service commissioned one day a month from another NHS provider for a learning disability psychiatrist. However, if an urgent mental health problem occurred, psychiatry support could be accessed via crisis resolution home treatment teams. There was no provision for out of hours support for patients with learning disability or autism.

Adherence to the MHA and the MHA Code of Practice

Overall we found that there was very little use of the Mental Health Act (MHA) within the service. Staff demonstrated a good understanding of how to initiate a MHA assessment and the implications of this where people with learning disability were presenting with seriously irresponsible or abnormally aggressive behaviour requiring compulsory admission.

We found that patients were offered information about their treatment and care and that consent to medication and side effects were discussed. This helped to ensure people received appropriate treatment in the community without recourse to the MHA.

Good practice in applying the MCA

Overall we found the services were compliant with the requirements of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguarding (DOLs). There was a record and monitoring of patient's capacity and consent which was regularly reviewed where appropriate. For example there was a very thorough capacity assessment for one patient being considered for a temporary change of accommodation.

Staff we met with had a clear understanding of their responsibilities in undertaking capacity assessments and continuous monitoring to ensure health decisions were made based on mental capacity or the best interest of the person. Patients told us that staff discussed information about medication and the side effects with them to seek informed consent. This meant that consent to treatment and capacity requirements were adhered to.

We saw evidence of good practice in the case notes which reflected appropriate use of the Mental Capacity Act and outcomes following best interest decisions.

Are services caring?

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

Summary of findings

We rated the community based services for people with learning disability or autism as 'Good' for caring because:

- Patients and carers told us that staff engaged with them in a caring, compassionate and respectful manner. This was also observed by the inspection team during staff and service user interactions.
- Patients, carers and family members spoke positively about the support of regular appointments with the service.
- Patients, carers and family members told us they felt involved in the decisions about the care and treatment planned.
- Patients were supported to manage their own health and independence where possible by staff from the learning disability team.
- Teams provided leaflets to carers that explained specific information regarding learning disability services in further detail.

Our findings

Kindness, dignity, respect and support

Feedback from patients who used the service and their carers or family members was positive about the way staff treated them. Patients told us they were treated with dignity, respect and kindness during all interactions with staff.

Patients told us staff understood their needs and respected their privacy and confidentiality.

We observed interactions between patients, carers and staff and found all the interactions we observed to be respectful and supportive. We spoke separately to patients and carers who described the service as “excellent”, “can’t fault them” and that they have “helped me more than anyone else”.

We observed staff showing understanding of individual patients by acknowledging when patients were feeling distressed and offering to end the session. This was also reflected in individualised care plans in patient records.

The involvement of people in the care they receive

Patients were involved and encouraged to be part of their care and treatment decisions with support when it was needed. Patients were actively encouraged to be as independent as possible.

Team managers told us that patients were involved in the interview process for the recruitment of staff. Patients also supported the delivery of training to staff by sharing their stories during training sessions which helped staff to understand the individual impact of care and treatment delivered to patients. One team manager told us about a particular patient who created a video to share their story with the support from the team and how this has aided her recovery.

Staff helped patients and those close to them to cope emotionally with their care and treatment. Patients were supported to maintain and develop their relationships with people close to them, their social networks and their community. Teams provided leaflets to carers that explained specific information regarding learning disability services in further detail.

Patients were provided with copies of their care plans and it was recorded in the care records when a copy had been declined by the person with an explanation. Patients told us about how they could access advocate services if they wanted assistance.

On discharge from the service, patients were interviewed in order to give feedback on their experience of the service. There were also patient groups which met on a monthly basis with the speech and language therapist to provide input into the service and provide feedback regarding their views of the service.

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

We rated the community based services for people with learning disability or autism as 'GOOD' for responsive because:

- Services were planned and delivered to meet patient's needs through an individualised approach. This took into consideration their cultural and complex needs.
- Patients had access to care and treatment in a timely manner.
- Concerns and complaints were listened and responded to appropriately. Lessons were learnt to improve the future quality of care and treatment.

Our findings

Access and discharge

People were accepted into teams if they had a significant impairment of intellectual functioning combined with an impairment in social functioning which was evident during developmental years before adulthood and their needs could not be met by mainstream health services without the support of specialist services. Teams also worked with people placed out of area in specialist hospital beds.

The number of referral to treatment cases which exceeded over 18 weeks or more wait as at April 2015 was as follows:

Waiting time from referral to treatment

Number of Referrals

Community Adult LD	14
Lancaster & Morecombe	11
Fylde & Wyre	9
Chorley & South Ribble	6
Adult Learning Disability	2
Multi-Disciplinary team	1
East Lancashire	1
Preston	0
West Lancashire	0

In April 2015, the community based services for people with learning disabilities or autism had 92 referrals in total within their waiting system. Lancaster & Morecombe had the most referrals in total with 35, of which 18 referrals had been waiting 0-10 weeks and 17 referrals had been waiting 10-18 weeks or more.

Referral cases were discussed at the weekly intake meetings to ensure the best care pathway and treatment options were assigned to meet the individual's needs. Prior to these meeting, referrals were screened to obtain further information to support any decision making. If cases could not be allocated immediately, staff would contact either the individual, the carer of the referrer to assess if they required urgent support which would be offered if appropriate.

Patients and carers described having very good phone support and that they were responded to quickly. This was also observed by the inspection team.

Staff responded quickly with regards to patients' physical health needs and worked well with GPs and hospital staff. This was demonstrated with the use of the hospital passport where physical health needs were identified and information was shared regarding the persons' needs. Staff informed us that they often acted as advocates and would support patients to attend GP surgeries or other clinics. Staff also highlighted a physical health checklist which they complete collaboratively with patients.

Teams demonstrated good examples of working with patients who were difficult to engage. For example, the Lancaster team in particular had engaged well with a person who had previously been in secure placements and was now working towards living independently in the community.

The facilities promote recovery, comfort, dignity and confidentiality

Most contact with patients occurred in their own homes. However, patients attended team premises for psychology sessions, appointments with consultant psychiatrists or in an emergency. We found that all rooms used to see patients in the team offices were appropriate to meet the needs of patients

Leaflets were available including information about patient rights, relevant help-lines and other local services. The building had been made accessible for wheelchair users

Are services responsive to people's needs?

Good 

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

with a ramp outside and a downstairs disabled toilet. We observed that signage around the building was in easy to read format such as the entrance to the building, the waiting rooms and the toilet

Staff routinely gave patients information regarding confidentiality during the first appointment with the service. Records were kept safely and securely to ensure that confidentiality was maintained.

Meeting the needs of all people who use the service

Teams utilised different communication tools to meet the needs of all patients who used the services. This included providing written information in easy read formats and communicating in Makaton and sign along which were forms of sign language adapted for people with learning disabilities. Teams also utilised tools to aid communication such as boardmaker and lightwriter. Some patients who used the services required interpreters which were arranged. Information on local services and treatments were available in the waiting areas and were available in other languages on request.

Listening to and learning from concerns and complaints

Total number of complaints in last 12 months **8**

Total number of complaints upheld/partially upheld **3**

Total number of complaints referred to Ombudsman in last 12 months **zero**.

Total number of complaints upheld by ombudsman in last 12 months **zero**.

Patients and carers described feeling confident to raise any complaint with staff directly. Information regarding the complaints procedure was given to patients at their first appointment.

Complaints were usually addressed at a local level to attempt a resolution. If a local attempt this failed to address the complaint, then it was escalated through the trust's formal complaints process and contact made with the trust's patient advisory liaison service (PALs).

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

We rated the community based services for people with learning disability or autism as 'GOOD' for well-led because:

- There were clear team objectives which reflected the provider's values and strategy.
- Staff knew who the executive and senior management team were as they were visible within the organisation.
- There were good meeting structures in place to escalate and cascade information through all levels of staff. This included management, review and improvements of risks, incidents and performance monitoring.
- Staff understood their roles and responsibilities. Staff felt respected, valued and supported by the management team and their peers.
- Patients' views and experience were gathered to drive performance.

Our findings

Vision and values

The trust's vision was to provide high quality care with wellbeing at its heart. The trust had the following values:

- Teamwork – share it
- Compassion – offer it
- Integrity – show it
- Respect – earn it
- Excellence – reach for it
- Accountability – accept it

It was clear from speaking to patients, carers and staff; observing care and looking at records that these values were evident within the community teams for people with learning disability. Staff were committed to providing compassionate and respectful care which evidenced best practice. The teams all described working well together and being able to assist each other when necessary.

There were clear team objectives which reflected the provider's values and strategy. Managers were promoting 'thinking space', which allowed staff time to reflect on the trust's values and how this interacted with their own practice.

Staff knew who the senior managers were in the trust and that they felt their own service level management team were approachable and listened to them.

Good governance

There was an effective governance framework in place to support the delivery of the strategy and quality assurance to drive performance improvement. The service used a quality monitoring system to ensure service were safe and meeting the needs of patients. This process included patient, carer and staff feedback. This information was reviewed by trust staff external to the teams. Action plans were then devised to support any quality improvements that were required. We saw samples of actions plans with updates on completion or dates due to be completed.

There was a training matrix in place to monitor levels of mandatory training used by the team manager and at the trust's corporate services.

Staff we spoke with confirmed they had regular supervision on a monthly basis. This was monitored by team managers who reported on a monthly basis on supervision rates.

The service had a system for sharing information from both executive levels to team level. Each locality had a weekly "huddle" meeting to share any information; any relevant information from these were shared on a twice monthly basis with business managers who reported to the executive team. This system also incorporates information regarding feedback from patients, shared learning from incidents, safeguarding issues and complaints. Information was passed from executive team down to teams using these meetings.

Each team also has an electronic 'score card' to monitor performance with regards to number of referrals that were new, accepted, rejected, and discharged, waiting times and number of contacts with patients. This information was used to develop action plans if a problematic theme was evident. This system created a live dashboard which highlighted waiting times and potential breaches and could identify data at patient level.

Leadership, morale and staff engagement

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.

There was a strong culture of openness and honesty with effective mechanisms in place to disseminate lessons learnt. Staff spoke of feeling valued and supported by the management and their peers. Sickness and absence rates across the service was an average of 5.2 %

Staff members told us they felt very well supported and that morale was generally good. Staff also informed us they felt satisfied in their work and empowered to deliver good practice. Staff we spoke to commented that they felt confident to raise any concerns with their management team and that there was no fear of victimisation.

There had been one complaint of bullying and harassment in relation to one team. A third sector agency raised concerns regarding the treatment of a service user. Staff from the agency alleged that they were subsequently bullied and harassed by a staff member from this team. This complaint was partially upheld with the advice that communication with the service user and care agency required improvement.

Staff survey results had positive responses in all six categories which were vision, values and behaviour; belonging and teamwork; self-esteem; quality and innovation; relationship with line manager and service user experience. Results from the staff survey were used to identify themes and drive improvements.

Leadership development was supported by various managerial courses being available for staff in management roles.

We observed staff being open and transparent with patients and carers regarding the service and limitations and difficulties the service was experiencing.

Commitment to quality, improvement and innovation

During our inspection process we observed good practice and innovative working in relation to a dementia pathway which was been developed by the Burnley, Pendle and Rossendale Team. From this initiative, patients diagnosed with dementia were receiving appropriate treatment. The team were also offering support to carers and providers around communication, information and health.

Options were being explored in relation to implementing an electronic records system to improve information sharing within the teams and also other services such as the trust's mental health teams.

Teams were working proactively with social care providers to provide awareness and education regarding alternative approaches to working with people presenting with challenging behaviour in order to reduce the number of physical restraints used within these services.

The service was aware of gaps in their provision such as people with a single diagnosis of autism and people in transition from children's services to adult services. Senior managers were in discussions with clinical commissioning groups to seek a solution. The service had an overall business plan which showed a clear understanding of the gaps within service delivery within individual teams. This plan involved meeting with commissioners to address the differences in service provision and to consider alternative options for crisis situations for patients with learning disabilities.

There were no inpatient learning disability facilities within the trust at present. Managers recognised that often psychiatric intensive care units (PICU) were used to poor effect as an alternative. The business support manager for the service had identified a possible facility that could be commissioned to serve as a "crisis bed or rehabilitation facility" to safely prevent patients from being admitted inappropriately to psychiatric wards. This had been presented to the commissioners for their consideration.

The business support manager also highlighted that there had been some forward planning with regards to recruitment and retention as many staff members were approaching retirement age. The plan was to hopefully stagger these retirements whilst also recruiting more nurse consultants, nurse prescribers and advanced nursing practitioners.

Other improvement strategies in the longer term included plans to offer a more flexible service which would be staffed from 8am to 8pm and available for all vulnerable people from birth to adulthood. This had been presented to the commissioners for their consideration.