Good

Bristol Community Health C.I.C.

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)
1-304870639	Bristol Community Health Headquarters	Bristol North and Central Community Learning Disabilities Team (CLDT)	BS16 1EQ
1-304870639	Bristol Community Health Headquarters	Bristol South Community Learning Disabilities Team (CLDT)	BS13 8QA

This report describes our judgement of the quality of care provided within this core service by Bristol Community Health C.I.C. 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 Bristol Community Health C.I.C and these are brought together to inform our overall judgement of Bristol Community Health C.I.C.

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 community mental health services for adults with learning disabilities or autism as good because:

Teams assessed risk to patients and staff promptly. We reviewed 16 care and treatment records and found there was evidence of risk assessment beginning when referrals were received by teams. Staff triaged referrals using guidance for each discipline in the multi-disciplinary team.

Staff we spoke with from a range of disciplines told us how they found the electronic patient record system beneficial in providing up to date patient care. A consultant psychiatrist told us how they were able to access up to date information from GP's such as, recent blood results, physical interventions, changes in medication.

The team's provision for young people transferring from children's services to adult services had a clear pathway including eligibility. Young adults were identified in line with government directives at the age of 14, with assessments of individuals at approximately 17 years, prior to transfer to the adult services.

Staff delivered compassionate care and understood their patients' needs. We observed positive staff interactions with patients and their carers. We saw how staff clearly and gently explained to patients the purpose of their visits. During clinical meetings staff spoke about patients in a positive and knowledgeable way.

Teams told us they had been offered the opportunity to be involved in past reviews of community learning disability services. They told us they were also included in the development of commissioning for quality and innovation (CQUIN) targets from commissioners. Staff said they felt listened to by senior managers and cited the example of not going ahead with the office move from south Bristol as an example.

Summary of findings

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

Are services safe?

Good

We rated safe as good because:

- Both facilities we visited were clean and reasonably well maintained. Furniture and flooring was in a good state of repair and artwork completed by patients was displayed on the walls.
- Vacancy rates as of October 2016 showed that the overall percentage of vacancies for community learning disability teams was 4%.
- The team operated an open referral system where patients could be referred by anyone including themselves.
- Staff showed us they had good knowledge and practical experience of identifying and responding to safeguarding concerns. Safeguarding adults and children training was a mandatory training requirement for all the staff.

However,

- Both reception areas had large open spaces above the reception desks, which meant administrative staff could not control access to their work areas.

Are services effective?

Good

We rated effective as good because:

- Information needed to deliver care was stored securely on an electronic computer based system. Staff told us how this system had been purchased by the provider over a year ago, as it was the same system the GP's in Bristol used. Staff we spoke with from a range of disciplines told us how they found this beneficial in providing up to date patient care.
- There were a range of psychological therapies recommended by National Institute for Health and Care Excellence (NICE) available.
- Staff provided training to primary care staff and supported general practitioner surgeries, increasing the quality and uptake of annual health checks, and health action plans for people with a learning disability.
- The teams ran three "fit clubs" in locations across the city, usually leisure centres. These were 12 week courses run in conjunction with public health and leisure centre staff.

However,

Summary of findings

- Managers and other staff we spoke with told us of the negative impact on the work of the team that the withdrawal of social services staff had. We heard examples of delays to community care assessments and associated packages of care.

Are services caring?

Good

We rated caring as good because:

- Patients told us that staff were kind, respectful and caring. Patients reported being happy with the services and they had good relationships with staff. Patients said that staff supported them to make their lives better.
- We observed positive staff interactions with patients and their carers. We saw how staff clearly and gently explained to patients the purpose of their visits.
- We saw that care plans were written in language which patients could understand. The care programme approach documents we saw all contained evidence that the patient had been involved in the decision making process.
- Two patients we spoke with told us that they had been involved in recruiting new staff for the team that they received services from. Managers told us this was something they had undertaken over numerous occasions in the past and wished to continue in the future if patients wanted to participate.

Are services responsive to people's needs?

Good

We rated responsive as good because:

- Community learning disabilities teams received referrals through the team managers, who screened referrals and triaged against referral criteria.
- Patients who found it difficult or were reluctant to interact with services were actively engaged with by staff.
- Staff at the Withywood centre told us that there had been plans to relocate them into New Friends Hall earlier this year. They told us they had expressed concerns over the loss of the patient facilities within that community and that the provider had postponed the plans as a consequence.
- Information was displayed by teams about how to make a complaint in an easy read format.

Are services well-led?

Good

We rated well-led as good because:

Summary of findings

- The teams had clear objectives which reflected the provider's values, and set out to reduce health inequalities to people with learning disabilities.
- Managers had access to team training records and could identify when staff required training. All staff had access to their own training records through the internal electronic training system.
- Staff told us they could raise concerns or issues with their managers at the first instance, and were confident these would be addressed appropriately.

Summary of findings

Information about the service

Bristol Community Health provides community mental health services for people with learning disabilities and autism across Bristol. Three teams provided these services at two different sites. The team bases that we visited were located at: New Friends Hall in north Bristol and the Withywood Centre in south Bristol.

Community learning disability teams consist of staff from a range of different professional backgrounds, which include: community team managers, clinical leads, consultant learning disability psychiatrists, clinical psychologists, learning disability nurses, student nurses, dietitians, speech and language therapists, physiotherapists, occupational therapists and administrative staff.

A range of services are provided by teams to facilitate and support the independence, health and well-being of patients. The teams provide assessment, diagnosis and treatment, advice, training and consultation with carers and other health and social care agencies. Support is available around managing needs such as: behaviour, communication, eating and drinking, nutrition, emotional, physical and mental health.

We last inspected community mental health services for people with learning disabilities or autism in October 2014. We did not rate this core service at the last inspection. There were no compliance actions (now called requirement notices) following this inspection either.

Our inspection team

Our inspection team was led by:

Chair: Robert Aitken, invited independent chair

Team Leader: Alison Giles, Care Quality Commission

The team included a CQC inspector and two learning disability nurses as specialist professional advisors. We were also supported by two experts by experience who talked with patients and their carers who had consented to talk with us by telephone about their views and opinions.

Why we carried out this inspection

We inspected Bristol Community Health C.I.C. as part of our comprehensive community health services 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?

Before the inspection visit, we reviewed information that we held about these services, asked a range of other organisations for information and sought feedback from patients at focus groups.

During the inspection visit, the inspection team:

- visited the three community learning disability teams, looked at the quality of the team environment and observed how staff were caring for patients

Summary of findings

- spoke with eight patients who were using the service and collected feedback using comment cards
- spoke with four carers of patients who were using the service
- spoke with the managers for each of the teams
- spoke with 26 staff members including: consultant psychiatrists, nurses, occupational therapists, speech and language therapists, dieticians, physiotherapists, student nurses, psychologists and administrative staff.
- attended and observed three multidisciplinary meetings
- attended and observed four episodes of care
- looked at 16 care and treatment records of patients
- looked at a range of policies, procedures and other documents relating to the running of the service

What people who use the provider's services say

During our inspection we collected feedback from patients and their carers.

During our visits we spoke to eight patients and four carers. We also collected feedback from patients using comment cards. All were very positive about the care and services they received.

They described staff as being very friendly, accommodating, skilful and dependable.

Outstanding practice

- Two patients we spoke with told us that they had been involved in recruiting new staff for the team that they received services from. Managers told us this was something they had undertaken over numerous occasions in the past and wished to continue in the future if patients wanted to participate. They told us of the support was available to patients from the training department to enable them to feel confident in such a role.
- For 2016-17 the team had a commissioning for quality and innovation (CQUIN) target around developing strategies for improving engagement for people with a learning disability. The programme covered raising awareness of domestic violence, developing strategies and supporting accessible materials for staff to assist in engagement with patients. It was known as the freedom programme. The staff went onto develop and pilot an accessible programme for people with a learning disability which could then be rolled out as part of the ongoing freedom programme work.

Areas for improvement

Action the provider SHOULD take to improve

- The provider should complete the remedial work in both reception areas to ensure the safety of administrative staff based there.
- The provider should investigate the impact on staff capacity and caseloads that have occurred following the withdrawal of social services staff.

Bristol Community Health C.I.C.

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
Bristol North and Central Community Learning Disabilities Team (CLDT)	Bristol Community Health Headquarters
Bristol South Community Learning Disabilities Team (CLDT)	Bristol Community Health 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.

Staff told us that they did not regularly work with patients subject to the Mental Health Act such as those who might be subject to guardianship or community treatment orders. Staff confirmed that they had previously received training and if required they would speak to their managers, colleagues and consultants for advice around the act.

Information provided showed that at the time of our inspection there were only two patients subject to community treatment orders receiving services from the teams that we visited.

Community learning disability teams used the care programme approach when working with patients who had a mental health need that impacted on their physical, psychological, emotional or social needs.

Detailed findings

Mental Capacity Act and Deprivation of Liberty Safeguards

We do not rate responsibilities under the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards. We use our findings as a determiner in reaching our overall judgement about the Provider:

During our inspection we looked at the application of the Mental Capacity Act and Deprivation of Liberty Safeguards.

Training in the Mental Capacity Act and Deprivation of Liberty Safeguards was a mandatory requirement for all staff. Overall, 96% of staff from the teams we visited had received training in the Mental Capacity Act and Deprivation of Liberty Safeguards at the time of our inspection.

All staff told us that if they needed support with the application of the Mental Capacity Act then they sought advice from:

- the policy on the intranet page
- their colleagues and consultant psychiatrists in the team

We reviewed 16 care and treatment records and found that most care records contained consideration and assessment of patients' capacity to make decisions about their care and treatment.

Good

Are services safe?

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

* People are protected from physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse

Our findings

Safe and clean environment

- We visited three community learning disability teams as part of our inspection. Teams provided these services at two different sites. The team bases that we visited were located at: New Friends Hall in north Bristol and the Withywood Centre in south Bristol.
- The interview rooms at New Friends Hall were not fitted with call alarms but staff could access personal alarms via reception if required. At the Withywood Centre there were two interview rooms fitted with alarm systems linked to the main reception area. In both locations staff were able to discuss the protocols for assessing risk when interviewing patients.
- Both reception areas had large open spaces above the reception desks. Administrative staff could not safely prevent or control access to their work areas because of these spaces. We were shown how this had been risk assessed and the plans in place to provide more secure environment's for the staff. However, no dates had been set for when this work was to be achieved.
- There were no clinic rooms in either location. Staff told us they would access a patients GP surgery if any physical health checks were required.
- Both facilities we visited were clean and reasonably well maintained. Some areas were decorated in neutral colours. Furniture and flooring was in a good state of repair and artwork completed by patients was displayed on the walls. We saw general maintenance work had taken place in both bases.
- There was good cleaning and infection control procedures in place. Cleaning took place on a daily basis by contract cleaners. We saw details of colour coded equipment used to clean specific areas and designated waste disposal bins for different types of waste.
- There was an equipment store room at New Friends Hall, and we saw how this equipment was maintained and cleaned by external agencies.

Safe staffing

- There were 80 whole time equivalent (wte) staff funded across all three teams, with 71 wte in post at the time of the inspection. Managers told us that staffing and skill mix requirements for the three community learning disability teams had been set up when the teams were formed approximately ten years ago. Staff told us that there was not a recognised tool used to forecast staff required per team. However, managers told us they would review the staffing mix on each vacancy and were considering a wider skill mix review in the future. Staff told us that when vacancies occurred these were recruited to.
- Vacancy rates provided by the provider as of October 2016 showed that the overall percentage of vacancies for community learning disability teams was 4%. Overall sickness rates were average at 4%. There was one agency member of staff used in the last six months.
- We looked at information about caseloads and found significant variations across the disciplines. The average amount of cases per community nursing staff was 25, therapists were in the range of 10 – 28 and psychiatrists were the highest at 78. We spoke to staff across all the disciplines and they felt that caseloads were manageable.
- Staff told us that caseloads were managed and regularly reassessed through supervision and we saw evidence on the records system to confirm this. Managers showed us how they monitored caseloads, referrals and waiting lists on this system.
- Across the teams we visited there was adequate medical cover. Staff told us that prompt access to psychiatry was available when needed. Teams had consultant psychiatrists attached to them, but employed by the local partnership trust.
- The provider set out mandatory training requirements which included such items as; basic life support, Mental Capacity Act, fire safety, safeguarding for all staff. Information provided showed that overall mandatory training completion rates were 94%. The provider was

Good

Are services safe?

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

aiming for 100% and managers were able to monitor and report on any variation. We were shown how staff absence resulting in non-attendance of training had contributed to the variation.

Assessing and managing risk to patients and staff

- Teams assessed risk to patients and staff promptly. We reviewed 16 care and treatment records and found there was evidence of risk assessment beginning when referrals were received by teams. Staff triaged referrals using guidance for each discipline in the multi-disciplinary team. Guidance for staff detailed the level of patient risk and need and the priority of the patient for allocation to staff caseload for assessment and treatment. For example, speech and language therapy referrals such as patients at high risk of choking were a priority and would be seen within two days of referral.
- The team operated an open referral system where patients could be referred by anyone including themselves. Staff collected information about referrals prior to making contact with patients. They told us that they checked the electronic patient record system and contacted referrers for further information if required. They also told us they checked for any warning alerts recorded on the electronic patient record system before making initial contact. These warning alerts could be added to patient records to represent information about known risks.
- Managers reviewed the team's waiting lists and showed us how they would assess and contact patients and/or referrer's to review levels of risks. These reviews occurred twice a week and were included at weekly multi-disciplinary meetings. Teams made regular contact by letter to patients on waiting lists. Staff told us that when teams accepted a referral, an easy read letter was sent to patients to inform them that they had been accepted and placed on the team waiting list.
- Community learning disability teams used a wide ranging risk assessment in the initial triage of referrals. This considered different aspects of patient risk including: personal history, social circumstance, forensic history, treatment related risks, clinical symptoms and behaviour as indicators of risk. The Bristol Intensive Response Team (BIRT) used a comprehensive risk and management plan (CRAMP) risk assessments for the patients who were referred to them. In all 16 care records we reviewed these were complete and up to date.
- There was the appropriate use of crisis plans in the records we reviewed. These were also integrated into four care programme approach care plans we reviewed, for patients with more intensive support.
- Community learning disability teams had systems in place to respond to any sudden changes or deterioration in patients' needs. This was the responsibility of the Bristol Intensive Response Team (BIRT). They would respond to any urgent concerns which had been triaged by the team. Staff told us that when needed other members of the team had been able to support the BIRT but this was not a normal part of their duties. Support included completing urgent home visits to patients. Staff told us that multi-disciplinary professionals meetings were called to discuss the approach to a patient's health deteriorating.
- Staff showed us they had good knowledge and practical experience of identifying and responding to safeguarding concerns. Safeguarding adults and children training was a mandatory training requirement for all the provider staff, with 100% attendance. Staff described to us the different types of safeguarding concerns they experienced and how they ensured concerns were reported to their managers and the relevant local authority teams.
- Staff worked in the community as lone workers and we saw how the teams used the provider's lone worker policy. Local managers were responsible for completing local lone worker risk assessments. Staff recorded their planned visits on whiteboards which detailed where they would be and the time they expected to return to the team base. If staff did not arrive back at the expected time staff from the administrative team would contact the worker to check their welfare. Staff had a code word which they could state to covertly raise the alarm to their colleague that they needed assistance. All community staff had mobile telephones that they could use to summon help whilst lone working. Where increased risks were identified visits were completed by two staff.

Good

Are services safe?

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

Track record on safety

- There had been no serious incidents recorded by the team over the last six months.
- Previously there had been an incident where a patient did not have the correct prescription of thickener for a food supplement. As a result of the root cause analysis staff developed a new template for the GP to assist with prescribing, in addition to specific competencies that were reviewed for all new staff and followed up in supervision.

Reporting incidents and learning from when things go wrong

- A web based reporting system was used for reporting incidents, accidents and near misses. All staff we spoke with told us that they had access to the incident reporting and used this to report incidents. All staff could tell us what types of occurrences they reported as incidents and team managers had responsibility for signing off each incident before it was reported.
- As part of our inspection we reviewed information relating to incidents. We found that a range of different types of incidents were reported appropriately. Some of the types of incidents reported included: safeguarding concerns, patient accidents and medication errors.
- Incidents were investigated and lessons learnt as a result. Managers told us that information regarding lessons learnt following investigations of incidents was shared with teams. We saw minutes of team meetings which highlighted this had occurred. An example we saw was how a door to a staff area was secured following an unauthorised visit by a member of the public. Staff told us that incidents were discussed in supervision and staff had received a de-brief following incidents from their manager with support from colleagues.

Duty of candour

- Incident forms automatically reminded staff to complete the duty of candour section. Staff had to explain how it was applied and if not, then give a rationale. Such an example would be for very minor incidents. Duty of candour ensures providers are open and honest when things go wrong.

Are services effective?

Good

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

Our findings

Assessment of needs and planning of care

- During our inspection we visited three community learning disability teams in Bristol and we reviewed 16 care and treatment records.
- Community learning disability teams completed assessments focussed on the involvement and intervention the patients required. Different disciplines in the team completed assessments relevant to their involvement with the patient. For example, speech and language therapists would assess the potential for any increased risk of choking.
- We found care records were recovery orientated and focussed on maximising the potential for independence of patients. Care records were solution focussed with future goals and identified potential outcomes documented.
- Information needed to deliver care was stored securely on an electronic computer based system. Staff told us how this system had been purchased by the provider over a year ago, as it was the same system the GP's in Bristol used. Staff we spoke with from a range of disciplines told us how they found this beneficial in providing up to date patient care. A consultant psychiatrist told us how they were able to access up to date information such as, recent blood results, physical interventions, changes in medication. Although some medical staff still used traditional paper medical records these were in the process of being replaced by the new electronic records system. We saw how these records were stored securely and appropriately in both of the bases we visited.

Best practice in treatment and care

- Medical staff followed National Institute for Health and Care Excellence (NICE) guidelines when prescribing medicines. There were no nurses employed as prescriber's at the time of our inspection. Staff that we spoke to told us that guidance from the National Institute for Health and Care Excellence was followed.
- There were a range of psychological therapies recommended by National Institute for Health and Care Excellence available. Community learning disability teams that we visited had clinical psychologists and psychological therapies were provided to patients such as, cognitive behavioural therapy, acceptance and commitment therapy, cognitive analytic therapy.
- The teams that we visited provided some limited support with housing and benefits. Where more specific knowledge was required teams worked with and signposted to other organisations more appropriate to advise patients.
- For 2016-17 the team had a commissioning for quality and innovation (CQUIN) target around developing strategies for improving engagement in the for people with a learning disability. The programme covered raising awareness of domestic violence, developing strategies and supporting accessible materials for staff to assist in engagement with patients. It was known as the freedom programme. The staff went onto develop and pilot an accessible programme for people with a learning disability which can then be rolled out as part of the ongoing freedom programme work. As part of the inspection process we saw a session of this programme. Patients we spoke with were very complimentary about it and told us they were finding it useful and informative. Staff explained to us that later in the year the outcomes of the programme will be evaluated and a report for the commissioners produced.
- Staff provided training to primary care staff and supported general practitioner surgeries, increasing the quality and uptake of annual health checks, and health action plans for people with a learning disability. Some of the health needs identified through annual health checks were in relation to: blood monitoring, lifestyle, bowel screening, medication reviews, skin conditions and memory concerns.
- Teams considered the physical health care needs of patients. Teams did not carry out physical health checks at their team bases but did so at the patients GP surgery. Any additional physical health checks were requested to be completed by patients' GP surgeries. Teams arranged for patients to access clinics for monitoring of specific medications.
- Teams used patient rated outcome measures to measure the effectiveness of care and treatment provided to patients. Allied health professionals used a therapy outcome measures tool.

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.

- We reviewed the use of clinical audit across the three teams and found they were all positively engaged in the process. Each year two or three audit areas were identified and carried out. One example we saw was from last year and was designed to test the use of 'easy read my care plan' documentation to see how effective this was as a patient held record of their engagement with the team. The results showed this type of care plan was suitable for 50% of the patients in contact with the service. For the others, further work was planned to review what would prove effective to meet their needs.
- The teams ran three "fit clubs" in locations across the city, usually leisure centres. These were 12 week courses run in conjunction with public health and leisure centre staff. The groups were for people with learning disabilities and their carers, with the aim to support weight loss and a healthy diet and lifestyle. At the time of the inspection the provider was still in the process of evaluating their effectiveness.
- The team's provision for young people transferring from children's services to adult services had a clear pathway including eligibility. Young adults were identified in line with government directives at the age of 14, with clear formatting of assessments of individuals at planning stage (approximately 17 years). There was a clear overview of the services area of specialisms they provided within the team, together with the identified funding stream, and an allocated worker from the team. All standards were attached to correspondence and all information was provided in an easy read leaflet, together with photo symbols.

Skilled staff to deliver care

- The staff working in the three teams came from a variety of different professional backgrounds. Teams comprised of consultant psychiatrists, psychologists, community team managers, learning disability nurses, occupational therapists, physiotherapists, dieticians, speech and language therapists and administrative staff. However, staff told us that since the withdrawal of social services staff 18 months ago, it was proving difficult to access the same level of skills which previously existed in the team.
- Staff told us that they felt supported by their colleagues and could turn to any profession for advice and support when needed. They described the overall experience of the teams as very good, with each profession having the relevant qualifications and skill sets to make positive contributions to patient care.
- The provider had a monthly induction process which included training courses and an on-site induction to the provider. Induction training met the Care Certificate standards for care. Staff had access to their own training record on the electronic training system where they could see their own training compliance, plus available training courses.
- Regular team meetings took place in each of the bases. All staff attended team meetings which were completed weekly and with all members of the multi-disciplinary teams attending.
- Staff performance was measured through the appraisal process. The appraisal process was completed every six months and all staff were up to date. We reviewed the staff supervision process within the local bases, and staff told us that they received regular supervision when required. There was no formal reporting process of compliance, but team managers monitored the supervision arrangements and kept their own records to check on its effectiveness.
- Managers told us that specialist training was acquired where there was a need. Managers told us that poor staff performance was managed through the provider's human resources policies.

Multi-disciplinary and inter-agency team work

- Regular and effective multi-disciplinary meetings took place which involved all members of the various professions. Teams met at least once a week and all staff groups ensured that they were represented at team meetings. During our visit we observed allocation meetings and part of a business meeting. These were well organised and had a clear focus with outcomes and actions for staff.
- Managers and other staff we spoke with told us of the negative impact on the work of the team that the withdrawal of social services staff had. We heard examples of delays to community care assessments and associated packages of care. During a meeting over case load allocation and monitoring, we were shown how team members were waiting up to six months 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.

discharge patients to social services care packages. Staff described to us that when local authority staff had been co-located with the teams that communication and inter agency work worked better, and did not significantly delay care transfers.

- Teams held professionals meetings regularly or when needed to discuss patient needs and concerns. Meetings were used to contribute and develop patient care and treatment plans.

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

- Staff had a reasonable level of understanding of the Mental Health Act, Code of Practice and guiding principles. Information provided showed that there were no patients subject to community treatment orders receiving services from the teams that we visited during our inspection. Staff confirmed that if they needed advice they would speak to their managers, colleagues and consultant psychiatrists.
- At the time of our inspection, there were no patients receiving services from the team that were subject to the Mental Health Act. Therefore we did not review any Mental Health Act documentation.
- Information about access to independent mental health advocates was displayed by teams in the reception areas and formed part of the initial information package to new patients.
- Community learning disability teams used the care programme approach (CPA) when working with patients who had a mental health need that impacted on their physical, psychological, emotional and/or social needs. We reviewed four CPA care treatment records and found these were comprehensive and up to date.

Good practice in applying the Mental Capacity Act

The Mental Capacity Act is a piece of legislation that maximises an individual's potential to make informed decisions wherever possible and processes and guidance to follow where someone is unable to make decisions. As part of our inspection we looked at the application of the Mental Capacity Act.

- Training in the Mental Capacity Act was a mandatory requirement for all staff. We reviewed information relating to staff training records and found that 96% of staff across the teams that we visited had completed training. All staff told us that if they needed support with the Mental Capacity Act then they sought advice from either from the policy on the intranet page or colleagues and consultant psychiatrists in the team.
- We found that consent to care and treatment was obtained in line with legislation and guidance. We reviewed 16 care and treatment records and found that most care records contained consideration and assessment of patients' capacity to make decisions about their care and treatment. We found six care records did not refer to patients' capacity to consent to care and treatment. Although, staff explained to us individual reasons why patients' records did not reference capacity, such as supporting patients' to make their own decision before assessing capacity.
- We observed one care episode where there was consideration of a patient's capacity and after a discussion with staff plans for a best interest meeting were arranged.
- During our inspection we did not see the use of advance decisions.

Good

Are services caring?

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

Our findings

Kindness, dignity, respect and support

- The feedback that we received from patients and their carers about the way staff treated patients was positive. During our inspection we spoke to eight patients and four carers. Patients told us that staff were kind, respectful and caring. Patients reported being happy with the services and they had good relationships with staff. Patients said that staff supported them to make their lives better. For example, a patient told us that they reported to staff difficulties they had experienced with some members of the public and staff had supported them to report the concerns to the police. Carers told us that staff worked well with patients' and that their well-being was their priority.
- Staff delivered compassionate care and understood their patients' needs. We observed positive staff interactions with patients and their carers. We saw how staff clearly and gently explained to patients the purpose of their visits. During clinical meetings staff spoke about patients in a positive and knowledgeable way.
- Communication with patients was clear and individualised. Staff used open questions and clear plain language to help patients understanding. Staff gave patients time to respond and provided appropriate levels of verbal prompting. We saw how staff had a warm approach and a good rapport with patients and carers. At the end of the visits they asked them if they had any questions. Staff involved carers appropriately in discussions and showed empathy and understanding of their views.

The involvement of people in the care they receive

- Patients told us that they felt involved in the decisions made about their care. They told us if they wanted a copy of their care plan they could get one from staff and this would be in an easy read format. We found that care plans contained interventions aimed at improving patients' independence, health and well-being. For example, care plans were in place regarding safe eating and drinking following speech and language assessments. These outlined safe food and drink options. We saw that care plans were written in language which patients could understand. The care programme approach documents we saw all contained evidence that the patient had been involved in the decision making process.
- Teams told us they valued the involvement of carers in the care and treatment of patients. Carers told us that the staff involved them, and they were invited in attending visits and appointments. We saw how teams invited carers where appropriate, to attend multi-disciplinary meetings to discuss care and treatment. Carers told us that teams were flexible and would arrange meetings to a suitable time and day so they could attend. They also told us that staff asked about how they were coping, and gave practical advice for patient care.
- Two patients we spoke to told us that they had been involved in recruiting new staff for the team that they received services from. Managers told us this was something they had undertaken over numerous occasions in the past and wished to continue in the future if patients wanted to participate. They told us support was available to patients from the training department to enable them to feel confident in such a role.
- Patients had the opportunity to give feedback on the care that they received. Most patients and their carers told us that they received stakeholder surveys in an accessible, easy to read format. Staff told us they aimed to send out about 15 patient questionnaires each month. In October 2016 we saw there had been eight returned that month, which staff felt was an average response rate. The comments seen were all positive about their experiences. We also saw how guidance around promoting patient empowerment had been converted into an easy read format.

Are services responsive to people's needs?

Good

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

Our findings

Access and discharge

- Service specifications and an operational plan outlined the remit and referral criteria, team establishment and therapies available. Teams would accept referrals from any source within the Bristol area. Referrals from outside of the area were also accepted where this had been agreed by the commissioners. All non-urgent referrals were seen with an 18 week target which the commissioners had set and monitored. Urgent referrals could be seen on the same day. Evidence showed how an average of 97% of referrals were seen within 18 weeks and approximately 70% were seen within six weeks.
- Community learning disabilities teams received referrals through the team managers, who screened referrals and triaged against referral criteria. Referral criteria specified teams would work with adults that had a learning disability and whose primary need exceeded what primary care services could provide. Referrals were accepted where patient need was not or could not be met by any other more appropriate secondary care service.
- Waiting lists and referrals were discussed as a regular agenda item in the team business meetings. Waiting lists and referral to treatment times were monitored and reported onto the local Clinical Commissioning group (CCG). These were identified at the number of weeks waiting up until 18 weeks when these would be in breach of their contract with the CCG. We were shown information that confirmed only two cases had breached this target in the last six months. In both, cases the patients were in receipt of services but were waiting for specific therapies.
- Patients and their carers told us that when they contacted the team they could speak to staff normally the same day about their concerns. Although this was only during normal working hours.
- Crisis plans were in place for patients, though these were primarily for those working with the Bristol intensive response team (BIRT). Although we did see one example of a patient needing potential support in a care home. These plans clearly indicated the support available and how to contact teams. They also indicated trigger events or described symptoms exhibited when a patient was stressed.
- Teams worked actively to promote engagement with patients who found it difficult or who were reluctant to engage with services. Teams provided patients with various opportunities to engage with services, such as community meetings, open groups and open door policies. They would rearrange appointments, send out reminder letters and contact patients by telephone to remind them about meetings and appointments.
- Teams operated Monday to Friday from 09:00 – 17:00 each week. Patients were seen in a variety of locations such as team bases, GP surgeries or the patient's home. The intensive response team saw patients in the community where complex needs resulted in being unable to attend clinics, so patients were mainly seen in their home setting. Administrative staff informed patients either by phone or in person if there was to be any delay if appointments ran behind schedule.

The facilities promote recovery, comfort, dignity and confidentiality

- We visited two teams that were based at New Friends Hall, and one team at the Withywood centre. Staff told us that there were normally an adequate range of rooms to assess or work with patients in either base. However, they told us that space for staff in New Friends Hall was more limited as there was a hot desk system in place. Staff at the Withywood centre told us that there had been plans to relocate them into New Friends Hall earlier this year. They told us they had expressed concerns over the loss of the patient facilities within that community and that the provider had postponed the plans as a consequence.
- We found all interview rooms had adequate sound proofing to protect patients' confidentiality.
- Accessible information was available for patients who were provided with easy read format information for their care plans, information leaflets, customer stakeholder surveys and information about complaints procedures.

Are services responsive to people's needs?

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Meeting the needs of all people who use the service

- Reasonable adjustments were made for people requiring disabled access. All locations that we visited had disabled toilet facilities, level access at the main entrances, and lift access was available at the Withywood centre. At New Friends Hall patients were seen in interview rooms only on the ground floor.
- Teams had access to interpreter and sign language services. Teams accessed this through either a contract with the local authority or with staff identified with the relevant skills.

Listening to and learning from concerns and complaints

- Three complaints had been received about community mental health services for adults with learning disabilities over the last nine months. Of these one was partially upheld and none were referred onto the ombudsman.
- Most patients and their carers said that they did not know the complaints process although if they needed to complain they would speak to their worker or contact the team manager. Information was displayed by teams about how to make a complaint in an easy read format.
- Staff knew how to deal with complaints appropriately and they told us that they saw complaints as a way of improving the service and reflecting on lessons for the future. Feedback from complaints was discussed in team meetings.
- Feedback from patients was requested by teams through the friends and family surveys. This showed consistent positive feedback across all three teams.

Are services well-led?

Good

By well-led, we mean that the leadership, management and governance of the organisation assure the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

Our findings

Vision and values

- The provider had developed values which were on display in reception and staff areas: "for all our communities to lead healthier, better lives" and a mission: "to provide person-centred patient care.
- The teams had clear objectives which reflected these values, and set out to reduce health inequalities to people with learning disabilities.
- Staff knew who their immediate senior managers were and spoke very highly of the impact they had on the teams. They also knew some of the senior executives and told us that they had visited their teams occasionally.

Good governance

- The provider had systems in place to ensure that staff received mandatory training. Managers had access to team training records and could identify when staff required training. All staff had access to their own training records through the electronic training system. Staff could book places on training through this system to ensure that they were compliant with training requirements. Across the teams that we visited the average completion rate for mandatory training was 96%.
- Systems were in place to ensure that staff were appraised and supervised regularly. Key performance indicators were in place and staff told us the appraisal process had integrated values into the appraisal format. Staff told us that they received regular supervision and there was a process in place to ensure all staff had an observed supervision session each year. This was monitored by team managers to ensure compliance.
- Managers told us that they had sufficient authority to make decisions and escalate issues to senior management. Managers attended regular governance meetings and told us that they escalated concerns and issues. Where necessary items were agreed to be place on the risk register.
- Incident reporting procedures were embedded into teams. All staff reported incidents using the electronic incident reporting system. Incidents and complaints were investigated appropriately by band seven and above staff. The findings of incidents were communicated back to teams through team meetings and electronic mail communication from the central governance team.
- There was evidence of clinical audits taking place across all three teams. Examples we saw included: auditing of eligibility process, delivery of direct enhanced services, consistency of data entry on new records system.
- Team managers told us that they felt they had sufficient authority in the teams to make decisions in order to make local improvements to patient care. They told us that although there were administrative staff available to support the teams, getting cover for absence was at times difficult.
- Managers told us they were able to raise risks to the providers risk register if required. We were shown the local risk register which highlighted the issue of the reception areas. Although the impact of withdrawal of social services staff had not been placed on to the risk register, managers told us they were collating examples of the impact on the service to include. In the interim, increased risk to patients which were evidenced as a result of this impact are reported as risks through the Ulysses system. For example, in the month running up to Christmas of 21 incidents the majority of these related to issues with care packages or changes in support levels.

Leadership, morale and staff engagement

- Staff told us they could raise concerns or issues with their managers in the first instance, and were confident these would be addressed appropriately. Staff were aware that there was a whistleblowing policy and they told us that they could find information on the staff intranet. Staff told us that teams were supportive and morale was good.
- Overall, sickness rates in the three teams were 4%. There were no reported cases of bullying and harassment.
- Staff explained to us that if something went wrong with patient care and treatment there was transparency during the process of investigation. Patients would be informed and would receive an explanation and an apology where appropriate.

Are services well-led?

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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.

- Teams told us they had been offered the opportunity to be involved in past reviews of community learning disability services. They told us they were also included in the development of commissioning for quality and innovation (CQUIN) targets from commissioners. Staff said they felt listened to by senior managers and cited the example of not going ahead with the office move from south Bristol as an example.

Commitment to quality improvement and innovation

- In 2015 the teams in conjunction with The Queen's Nursing Institute (QNI) devised a recording system based around the GP registers for direct enhanced services (DES) to identify those people with a learning disability who were eligible to participate in bowel screening. Once identified these people were approached and supported to participate in the national bowel screening programme. This required the production of accessible information , education and community liaison with support networks and GP practices. By the end of the program there was an increase in uptake from 8% to 18-22% in Bristol for this hard to reach group.