Inadequate

Somerset Partnership NHS Foundation Trust

Community mental health services for people with learning disabilities or autism

Quality Report

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Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RH5AA	Mallard Court	Mendip Community Team Adults with Learning Disabilities	BA4 5BT
RH5AA	Mallard Court	Sedgemoor and West Somerset Community Team Adults with Learning Disabilities	TA6 4RL
RH5AA	Mallard Court	South Somerset Community Team Adults with Learning Disabilities	BA21 3BB
RH5AA	Mallard Court	Taunton Community Team Adults with Learning Disabilities	TA1 2BD

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

Summary of findings

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 Somerset Partnership NHS Foundation Trust and these are brought together to inform our overall judgement of Somerset Partnership NHS Foundation Trust.

Summary of findings

Ratings

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

Overall rating for the service	Inadequate
Are services safe?	**Inadequate**
Are services effective?	**Inadequate**
Are services caring?	**Requires improvement**
Are services responsive?	**Requires improvement**
Are services well-led?	**Requires improvement**

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 people with learning disabilities or autism as **inadequate** because:

- We asked the provider to take immediate action to address concerns and also took enforcement action, serving a warning notice. The warning notice served notified the trust that CQC had judged the quality of care being provided as requiring significant improvement. The warning notice was to ensure the safety, care and welfare of patients.
- Staff did not always assess or manage risks, which put patients at risk of harm. Staff did not always complete or review risk assessments and risk formulations. We found no consideration by staff of risk of intervention, treatment or therapy to patients documented in any of the 28 case notes reviewed. There was no evidence in the risk assessments or risk formulations to show consideration of risk to staff.
- Staff told us that the trust did not operate a waiting list for the community learning disabilities services or the Rapid Intervention team. The service did not mitigate risks for patients waiting for assessment or treatments. The service did not put proactive control measures in place to ensure that patients who did not meet the urgent referral criteria were not at risk.
- There was a lack of incident reporting through datix for the CTALD. We found that staff did not always log incidents and safeguarding concerns on datix. Datix is a web form used in healthcare to report risk management, incidents and adverse events that may affect patient, staff or visitor safety.
- Initial patient assessments and care plans completed by staff varied in detail and quality. Behavioural support plans were not in place where needed and there were generic care plans for patients.
- Staff did not always involve patients in their care planning. Care plans were not always formatted in a way that patients would easily understand.
- There was limited active partnership working between staff, both internally and externally, to make sure that care and treatment remained safe for patients. The CTALD were unable to access the trust mainstream community health team's clinical notes. This meant that when a patient received care and treatment from both the CTALD and mainstream community health team, risk management data was not shared or accessible to all staff.
- Inadequate governance processes did not ensure the service provided was monitored. The systems to identify, assess and manage risks within the CTALD did not operate effectively.

However:

- Patients, relatives and carers told us they found staff across the CTALD to be caring, respectful and supportive. They also felt involve in treatment and therapies. Staff we met were professional and committed to providing the best care and service they could to support people with learning disabilities.
- The trust took part in the quality improvement programme by POMH-UK CCQI, Prescribing Observatory for Mental Health-UK College Centre for Quality Improvement, which looked at antipsychotic prescribing in people with a learning disability.
- The trust carried out an audit to look at 'Epilepsy in Adults' which looked at care planning, access to epilepsy services and emergency plans.

Summary of findings

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

Are services safe?

Inadequate

We rated safe as **inadequate** because:

- The safe care and treatment of patients was inadequate at the time of inspection. We served a warning notice which required the trust to make improvements by 10 November 2015 and undertake an immediate review of the services case-load focusing on risk assessments for all patients with safety plans being put in place to mitigate the risks to those patients presenting the highest risk. This was to be the start of a comprehensive review of the assessment and care planning in the service which should be completed within six months.
- The service did not carry out regular or effective case-load audits and reviews.
- Staff did not always assess or manage risks, which put patients at risk of harm. Staff did not always complete or review risk assessments and risk formulations. We found no consideration by staff of risk of intervention, treatment or therapy to patients documented in any of the 28 case notes reviewed. There was no evidence in the risk assessments or risk formulations to show consideration of risk to staff.
- The trust did not operate a waiting list for the community learning disabilities service or the Rapid Intervention team. Staff could not tell us how they mitigated risks while patients awaited assessment or treatment.
- The trust did not monitor people who required services but could not access the service due to not meeting the eligibility referral criteria.
- There was a lack of incident reporting through datix for the CTALD. We found that staff did not always log incidents and safeguarding concerns on datix. Datix is a web form used in healthcare to report risk management, incidents and adverse events that may affect patient, staff or visitor safety.

Are services effective?

Inadequate

We rated effective as **inadequate** because:

- Initial patients assessments and care plans completed by staff varied in detail and quality.
- There was limited evidence of staff completing positive behavioural support plans for patients where needed and there were generic care plans for patients.

Summary of findings

- The CTALD were unable to access the trust mainstream community health team's clinical notes. This meant that when a patient received care and treatment from both the CTALD and mainstream community health team, risk management data was not shared or accessible to all staff.
- There was limited active partnership working between staff in the CTALD, local authority social work teams and mainstream community health teams to ensure that patient care and treatment remained safe.
- Training in the Mental Health Act (MHA), Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLs) was not mandatory within the trust. Records provided by the trust showed that no staff had undertaken MHA, MCA or DoLs training. Some staff had no awareness of the MHA or MCA. There was not always clear evidence in some care records to show that, where appropriate, staff had taken into consideration a patients mental capacity before a decision on action was taken.

Are services caring?

Requires improvement

We rated caring as **requires improvement** because:

- Staff did not always involve patients in their care planning. Most care plans completed by staff were generic, written in the third person and not person centred. Care plans were not always formatted in ways that patients would easily understand.
- Few patients were able to get involved in decisions about the service or give feedback on the care they received. The trust did not keep them up to date with changes or improvements made to the service.

However:

- Patients, relatives and carers told us they found the staff to be caring, respectful and supportive and patients felt involved in their treatment and therapies.
- Staff we met were professional and committed to providing the best care and service they could to support people with learning disabilities.

Are services responsive to people's needs?

Requires improvement

We rated responsive as **requires improvement** because:

Summary of findings

- Each health-care profession within the CTALD had its own referral matrix to define criteria for access or refusal of services. The trust did not monitor unmet needs or referrals to the service that may not meet criteria. This lack of monitoring, meant people who could not access the service may be at risk.
- There were no set waiting time targets for the CTALD to ensure people were seen in a timely manner.
- There were no information leaflets specific to the services provided on view at any of the CTALD bases. Staff told us that information leaflets about treatments available, how to make a complaint and advocacy were given to patients at their initial assessments. However, some patients told us they did not receive these leaflets.
- Staff did not always receive feedback about the outcome of complaints.

Are services well-led?

Requires improvement

We rated well-led as requires improvement because:

- There were poor governance processes in place to safely monitor the service, make required improvements or mitigate risks. Risks were not assessed and managed, which put people who used services at risk of harm. None of the concerns entered onto the local risk register were on the trust wide risk register.
- Although staff were aware of the trust's vision and values and these were displayed in each of the teams neither the community teams for adults with learning disabilities (CTALD), the better health team nor the rapid intervention team had team objectives in place which reflected the organisation's values and objectives.

However:

- Staff demonstrated that they were motivated and dedicated to deliver the best care and treatment they could for people who use services. However, there were mixed levels of staff morale across the four CTALD bases.
- The trust took part in the quality improvement programme which looked at antipsychotic prescribing in people with a learning disability and carried out an audit to look at 'Epilepsy in Adults'.
- At the time of our follow up inspection we saw that the new divisional manager was actively addressing the concerns identified in a supportive way. Staff told us that they felt well supported and listened to.

Summary of findings

Information about the service

Somerset Partnership NHS Foundation Trust's learning disability service is a specialist service for adults with learning disabilities. There are four community teams for adults with learning disabilities (CTALD) across Somerset. These teams are staffed by professionals from psychiatry, community nursing, physiotherapy, occupational therapy, psychology, and speech and language therapy.

The CTALD are based in local authority premises and work closely with local authority social work teams in each of the four CTALD areas: Mendip, Sedgemoor and West Somerset, South Somerset, and Taunton.

Two teams work alongside the CTALD. The Rapid Intervention team is based in South Somerset and leads on assessment, treatment and expert intervention for people with learning disabilities who have highly complex behaviours that challenge and/or mental health need. The Better Health team works across all four CTALD . This team supports annual-health-checks and works with general practitioners to support people with learning disabilities. It also provides information, training and support on healthy lifestyle, health and medical conditions to people with learning disabilities as well as their, relatives and care providers.

Our inspection team

Chair: Kevan Taylor, Chief Executive, Sheffield Health and Social Care NHS Foundation

Head of Inspection: Karen Bennett-Wilson, Head of Hospital Inspection, CQC

The inspection team consisted of six people: three inspectors; two social workers; and the CQC's learning disability policy manager who has expertise in learning disability.

Why we carried out this inspection

We inspected this core service as part of our ongoing comprehensive mental health inspection programme.

How we carried out this inspection

To fully understand the experience of people who use services, we always ask the following five questions of every service and provider:

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

Before the inspection visit, we reviewed information that we held about these services and asked a range of other organisations for information.

During the inspection visit, the inspection team:

- visited all four community team bases;
- spoke with six patients, six relatives/carers and seven external care providers;
- looked at the treatment records of 28 patients;
- spoke with 24 members of staff including speech and language therapists, a consultant psychiatrist, occupational therapists, psychologists, nurses and administrators;
- spoke with the managers or acting managers for the service;
- attended one meeting;
- observed nine episodes of care, including at on-site clinics and during patient home visits;
- reviewed staff supervision records; and
- looked at policies, procedures and other documents relating to the running of the service.

Summary of findings

What people who use the provider's services say

We spoke with six patients and six relatives and seven external care providers. All were mostly positive about the service provided by the community learning disability teams. They told us that they found the staff to be caring, respectful and supportive and that the therapies and treatments offered involved patients, their families and carers. Patients told us they felt happy raising any concerns and knew how to complain.

However, some patients told us they were not always involved in their care planning and did not receive the easy-to-read leaflets. Some patients told us that waiting times for therapies and treatments were long and information about services provided was not always easily available or in a format that they could understand. Patients, their relatives and carers told us they were not provided with feedback about the service's performance.

Good practice

- The trust took part in the quality improvement programme by POMH-UK CCQI, Prescribing Observatory for Mental Health-UK College Centre for Quality Improvement, which looked at antipsychotic prescribing in people with a learning disability.

Areas for improvement

Action the provider MUST take to improve

Action the provider MUST take to improve

- **Assess, monitor and improve the quality and safety of services provided and improve governance processes.**
- **Assess, monitor and mitigate risks for patients and staff.**
- **Seek feedback from patients, relatives and carers and engage them in evaluating and improving services.**

Somerset Partnership NHS Foundation Trust

Community mental health services for people with learning disabilities or autism

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Mendip Community Team Adults with Learning Disabilities	Trust Headquarters
Sedgemoor and West Somerset Community Team Adults with Learning Disabilities	Trust Headquarters
South Somerset Community Team Adults with Learning Disabilities	Trust Headquarters
Taunton Community Team Adults with Learning Disabilities	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.

At the time of our inspection we were told that there were no people who were using the service who were subject to a Community Treatment Order (CTO).

Mental Health Act (MHA) training was not mandatory within the trust. Records provided by the trust showed that no staff had undertaken MHA training.

Detailed findings

Mental Capacity Act and Deprivation of Liberty Safeguards

Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLs) training was not part of the trust mandatory training requirements. Records provided by the trust showed that no staff had undertaken MCA or DoLS training.

Staff told us that the local authority social work teams took the lead in MCA and best interest meetings.

We spoke with 26 staff. Some staff interviewed had a good understanding of the MCA, the code of practice and the five statutory principles. However, there was not always clear evidence in some care records to show that, where appropriate, staff had taken into consideration a patients mental capacity before a decision on action was taken.

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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

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Safe and clean environment

- Each of the four community bases were owned and managed by the local authority. Staff told us the local authority took full responsibility for maintenance, infection control and ligature risk assessments in the community bases. The trust did not have access to these records and so we were unable to view them at the time of the inspection.
- Most interview rooms were fitted with alarms. There was a telephone in each room. Staff told us that, if the room did not have an alarm and they required assistance, they would call for help.
- Areas were visibly clean, well presented and maintained.
- None of the community teams for adults with a learning disability (CTALD) stored medications onsite at the bases.
- There was a lack of easy-to-read signage at each of the CTALD bases to support people with learning disabilities. We were informed by staff that this was in part due to the buildings being owned by the local authority.

Safe staffing

- Staff of different disciplines worked across the CTALD and Rapid Intervention team. The teams compromised of learning disability nurses, psychologists, consultant psychiatrists, primary care liaison nurses, speech and language therapists, occupational therapists and physiotherapy technicians.
- The learning disability services had 45 staff at the time of inspection and the vacancy level provided by the trust was 2.8%. The total number of substantive staff who left the service within the last 12 months was eight.
- The Rapid Intervention team had four staff at the time of the inspection and the vacancy level provided by the trust was 20%. There were no substantive staff leavers within the last 12 months.
- On the day of the inspection there were two occupational therapists covering the county. The Band 7 occupational therapist had further clinical leadership duties which reduced their clinical time in the CTALD.
- As of the 1 September 2015 the speech and language therapists from the learning disability services had been integrated with the speech and language therapists for adult services. Staff were not aware as to what impact this may or may not have on services due to the integration having only recently taken place. We were informed by staff that at the time of the inspection there were no plans to move the speech and language therapists away from the CTALD's bases to a central base.
- We were informed by the trust that no agency or bank staff were used by the CTALD or Rapid Intervention team to cover vacant posts, sickness or annual leave during the last five months.
- The sickness absence rates from 1 April 2014 to 31 March 2015 were 3% for the learning disability services and 6% for the Rapid Intervention team. The manager told us that the percentage of sickness was higher in the Rapid Intervention team due to a member of staff on long term sick leave.
- As of the 21 September 2015 there were a total of 799 patients who were receiving care from the learning disability services and Rapid Intervention team.
- Staff told us their regular caseloads were mostly manageable, weighted by individual need and assigned to the most appropriate health care professional to meet those needs.
- The service were not carrying out regular or effective case-load audits and reviews. We reviewed 28 care records and found patients who were no longer receiving a service from the CTALD, some for considerable periods of time, who were still on a staff member's case load. Staff had not completed discharge plans for patients who no longer required a secondary learning disabilities service.

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- A 'buddy' system for staff was in place across the four CTALD bases to support cover of caseloads during periods of annual leave and sickness. However, staff reported that at times this caused an impact on the quality of care provided due to the increase in case load management and poor handover of information from colleague to colleague. For example, during the inspection we observed staff covering caseloads. One staff member had to coordinate and attend a safeguarding meeting and had to spend considerable amounts of their time going through care records to understand if the patient had capacity and the safeguarding concerns raised. This impacted on the time they spent on their own caseloads and delivering care.
- There was rapid access to a psychiatrist when needed and staff were aware how to contact. Patients did not report a delay in seeing a psychiatrist if they needed to.
- Staff received mandatory training. We saw training records which showed that as of August 2015 overall the teams had completed between 94.4% to 100% required mandatory training. Staff told us that this was a mix of e-learning and face to face classroom based training.

Assessing and managing risk to patients and staff

- We reviewed 28 risk assessments and risk formulations as part of case record reviews across the four community teams. Risk assessments and risk formulations were not always completed or reviewed. For example, there were generic risk assessments for service users at risk of sudden unexpected death in epilepsy (SUDEP) with no individualised assessment or approach completed.
- We found no consideration of risk of intervention, treatment or therapy to people who used services documented in any of the 28 case notes reviewed. There was no evidence in the risk assessments or risk formulations that consideration of risk to staff had taken place. For example, where a person had a history of physical or sexual violence what action should be taken to protect staff.
- Staff did not always complete emergency plans for patients to help inform staff, relatives and carers, what action to take in the event of an emergency.
- The service had a process for assessing people referred to each of the CTALD. Referrals were screened daily by the duty person in charge to ensure that anything that required urgent attention was dealt with promptly. A weekly meeting to discuss all referrals took place and cases were allocated to the most appropriate health care professional.
- The acting service manager told us that due to staff shortages and demand for services, neither the consultant psychiatrist or the occupational therapists attended the weekly referrals/allocation meeting. This meant that they were not kept fully up to date or able to share information about patient risk management.
- The trust did not operate a waiting list for the CTALD or the Rapid Intervention team. We reviewed the minutes from the weekly referrals/allocation meetings and found for one of the CTALD, seven cases had been referred and were actioned to be carried forward to the following weeks meeting due to further information needed. Staff could not tell us how they mitigated the risks posed by people who had been referred to the service, whilst further information about the referrals was sought.
- Capacity to respond to occupational therapy (OT) referrals was limited. On the day of the inspection there were only two occupational therapists covering Somerset. The Band 7 occupational therapist had further clinical leadership duties which reduced their clinical time in the CTALD. This was identified as a risk by the service and put on the local risk register. We were told by managers that due to this they could currently only accept urgent referrals. The managers told us that there was no monitoring of people who required OT services but could not access the service due to not meeting the urgent referral criteria. People who were referred for OT services were not always receiving a service elsewhere and therefore were not being monitored by another health care professional. The service had not put any control measures in place to ensure that people who did not meet the urgent referral criteria were not at risk.
- Some staff told us about their concerns for people who did not meet the eligibility criteria for the service. For example, individuals with a mild learning disability would not always be considered suitable for treatment within the learning disability community teams. Staff told us that when this happened they would support a referral to adult services. However, if adult services declined those individuals as they did not meet their criteria for treatment, this resulted in people not being

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able to access services for which they needed help and support. The trust did not monitor people who required services but could not access the service due to not meeting the eligibility referral criteria.

- Staff responded promptly, within 24 hours of referral for dysphagia assessments. This reduced the risks of choking to patients. Staff worked with patients care providers and offered training in dysphagia. We observed staff discussing patients risks and how to reduce this.
- The trust had an informal integration between the local authority social services team and the CTALD. Both teams used separate electronic recording systems. CTALD used RiO and the local authority used AIS. Only the administrators had access to both IT systems. This was identified as a risk by the service and put on the local risk register. Staff told us that risk information should be recorded on both systems. However, due to the limited number of staff who had dual access this was not always possible. Patient risk information was not always readily available to all staff when needed.
- There were inconsistent lone working procedures across the CTALD and within each health care profession. We observed some staff at Taunton CTALD signing in and out when attending visits off site. At South Somerset and Sedgemoor and West Somerset CTALD we observed that this practice was not always adhered to by staff and found the signing in and out board contained details of staff movements for a staff member who had left some weeks before the inspection. As per the trust Lone Working Policy we asked staff and managers what monitoring of the effectiveness of the local lone working procedures was taking place. The managers told us that they were not aware of any monitoring taking place. This meant that they were not operating as per the trust policy and could not be sure that their policies and procedures were safe.
- Staff undertook safeguarding training as part of their mandatory training. Records from the trust show that completion of safeguarding training ranged from 100% for both the speech and language and occupational therapy departments to 85.7% for learning disability nurses and 75% for the Rapid Intervention team.
- All staff we spoke with demonstrated a good knowledge on how and where to report safeguarding concerns. Staff told us that the local authority social work teams led on safeguarding within each of the community learning disability teams. The local authority social work teams managed the overall log of safeguarding referrals and these were discussed in the weekly team meetings.
- The teams did not store, transport or dispense any medicines on site. This was managed through the general practitioners, community pharmacies and care providers.

Track record on safety

- There were no serious untoward incidents reported by the CTALD between 15 April 2014 and 24 March 2015. However, the service did not monitor or investigate all incidents. Staff told us that patients received services from other health care providers, for example care homes. When incidents occurred the CTALD would not always investigate or learn from the incidents and would leave the investigation up to the primary care provider.

Reporting incidents and learning from when things go wrong

- There was an electronic incident reporting system in place called datix. The trust used the datix system to report incidents. Datix is a web form used in healthcare to report risk management, incidents and adverse events that may affect patient, staff or visitor safety.
- There was a lack of incident reporting through datix for the CTALD. During the inspection we requested details of the number of incidents reported through datix for the CTALD. Staff were unable to provide these details. We found that staff did not always log incidents and safeguarding concerns on datix. For example, during the inspection we were informed that a safeguarding meeting had been urgently arranged due to concerns for a patient's safety. Staff told us that the safeguarding concern had been raised by a member of staff from the learning disability community team. We asked to view the datix record. We were told by the acting service manager that they were unable to locate the datix record and could therefore only assume that it had not been completed.
- Staff told us they were not confident in their use of datix. We were told that the trust had planned to provide training so that staff could use the datix reporting system but as yet that had not happened.

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- We reviewed four serious incidents requiring investigation (SI) records completed by staff, reported between 2014 and 2015, and found them to be of variable quality. One was well completed with a detailed comprehensive investigation and actions taken. Three were not completed as well and lacked basic information such as dates as to when information had been requested as part of the investigation and who from. We spoke with the acting service manager who confirmed that only managers complete the SI investigation reports. However, not all managers had received root cause analysis training. The trust had not equipped staff with the skills necessary to carry out the investigations. The acting service manager told us they were the only staff member within the CTALD who had completed root cause analysis training.
- We reviewed twenty four records of staff team meetings. We were able to see that some discussions had taken place with regards to the findings of incident investigations. However, this was not consistent across each of the CTALD. It was not clear if improvements had been made as a result and if staff understood the learning from these incidents. For example, the number of deaths of patients in the community learning disability service as a secondary service was not known. During the inspection conflicting information was given by staff and managers and there was no monitoring of such incidents.

Additional information regarding this key question following an unannounced, focussed inspection (see also provider report for more detailed information)

- We served a warning notice which required the trust to make improvements by 10 November 2015 and undertake an immediate review of the services case-load focusing on risk assessments for all patients with safety plans being put in place to mitigate the risks to those patients presenting the highest risk. This was to be the start of a comprehensive review of the assessment and care planning in the service which should be completed within six months.
- We carried out an unannounced, focussed inspection on 24 November 2015 to assess if the trust had addressed the concerns and to check the progress that had been made. During our inspection we spoke with three staff; two clinicians and a manager and reviewed 17 care records.
- On the day of our inspection staff within the services were receiving training that included incident reporting and safeguarding. The trust had also provided staff with training on clinical assessment and the management of risk.
- The trust had undertaken a review of all 900 open patient cases and had identified the key risks for each patient. All 17 records that we sampled had been reviewed and the risks identified. However, despite the detailed action plan and progress made, we were concerned that in 14 of the 17 records we viewed the care plans had not been updated to reflect the risks or risk information identified by during the review. The care plans in these records were of poor quality. Patients' physical health risks had not been addressed and staff had not considered the impact of patients' previous histories, for example, if there had been a history of aggressive, disturbed or inappropriate behaviour that could pose a risk for the patient or to others. The risks identified by the trust had focussed on the risks to patients but had not considered risks to staff or others.

Are services effective?

Inadequate

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

Are services effective?

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

Assessment of needs and planning of care

- Staff completed patients initial assessments and care plans and these varied in detail and quality. We reviewed 28 case notes, 11 cases we found limited or no evidence of comprehensive or holistic assessments that included health, personal care, emotional, social, cultural, religious and spiritual needs.
- Staff did not always complete behavioural support plans for patients where needed. There were generic care plans for patients who were at risk of sudden unexpected death in epilepsy, with no individualised assessment or approach completed.
- Staff did not keep care records up to date. Most did not identify patients individual goals and strengths. Staff did not complete reviews regularly on any of the 28 care records reviewed.
- We found good, detailed care plans for patients requiring treatment for dysphagia that were planned with staff in line with the patient and their relatives and carers.
- The Better Health team had developed health action plans where appropriate to assist in communicating patients individual needs within their support setting and when accessing other health services.
- The CTALD were unable to access the trust health team's clinical notes. This meant that when a patient was receiving care and treatment from both the CTALD and mainstream community health teams, risk management data was not shared between or accessible to all staff. There was an identified risk regarding communication between the CTALD and Yeovil District Hospital in notifying when patients were admitted to hospital with a learning disability. This was put on the local risk register by the service. The current control measure on the local risk register stated that a verbal agreement with Yeovil District Hospital in notifying Mendip and South Somerset CTALD should patients with a learning disability be admitted. We spoke with staff who were not aware of the process of notification or the verbal agreement.

Best practice in treatment and care

- Staff assessed patients with Health of the Nation Outcome Scales. These scales covered 12 health and social care domains and enabled the clinicians to build up a picture over time of their patients' responses to interventions.
- The psychology department offered family intervention therapy to support families and patients and to help answer any questions and look at ways of finding solutions to any concerns or problems that there may be.
- The occupational therapy department ran sensory clinics and offered training and support to carers in line with their sensory integration therapy when needed. However, best practice guidance states that a functional assessment needs to be completed before hand. We found no evidence of this happening.
- The community learning disability team helped deliver training. Learning Curve was a trust wide initiative that offered training programmes to meet and support the needs of the public, private and third sector organisations with the aim of meeting the additional and specialist needs of people with learning disabilities. Training courses offered included dysphagia, epilepsy and rescue medication for epilepsy.
- At the time of the inspection we were told by staff that clinical audits such as care plans were taking place. These were then discussed further in supervision. We reviewed six staffs supervision records. It was not clear from supervision records if audits were looking at the quality of care plans or just if a care plan was in place.

Skilled staff to deliver care

- Patients had access to occupational therapists, nursing and psychology. Each team had access to a consultant psychiatrist. There were some vacancies that the trust were recruiting to. For example, specialist physiotherapist. Some staff worked across the CTALD to ensure that patients had access to professionals when needed.
- We were told by the acting service manager that the role of the specialist physiotherapist had been vacant for a

Are services effective?

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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.

period of two years and the trust continued to struggle to recruit to the post. There were physiotherapy technicians in post and they were supported by the physiotherapist for adult services.

- On the day of the inspection there were two occupational therapists covering Somerset. The Band 7 occupational therapist had further clinical leadership duties which reduced their clinical time in the CTALD.
- The trust had an informal arrangement with the county council where the community learning disability teams were integrated with the local authority social work teams. Access to approved mental health professionals was provided by the local authority.
- Staff confirmed that they received appropriate induction for their role.
- Staff received appropriate training, supervision and professional development. Staff told us they had undertaken training specific to their role including safeguarding children and vulnerable adults, clinical risk assessment and management and infection control. Records showed that most staff were up-to-date with statutory and mandatory training.
- Information provided by the trust showed that 100% of staff had been apprised within the last 12 months for both the learning disabilities services and the rapid intervention team.
- Staff attended continuing professional development groups. For example, nursing, speech and language therapists, occupational therapists and psychologists met monthly with their colleagues to discuss clinical practice and share ideas.
- There were regular team meetings and most staff told us they felt supported by their local management structure and colleagues.

Multi-disciplinary and inter-agency team work

- There was limited active partnership working between staff, both internally and externally, to make sure that the care and treatment remained safe for patients. There was an identified risk regarding communication between the CTALD and Yeovil District Hospital in notifying when patients were admitted to hospital with a learning disability. The acting service manager had put this on the local risk register. The current control measure on the local risk register stated that a verbal agreement with Yeovil District Hospital in notifying Mendip and south Somerset CTALD should people with a learning disability be admitted. We spoke with staff who were not aware of the process of notification or the verbal agreement.
- There were significant barriers to effective joint working between teams. For example, healthcare professionals worked in isolation at each of the CTALD bases. There was limited evidence that each of the CTALD worked cohesively together to ensure consistency in learning disability care across the county. For example, there were various electronic recording systems used by the learning disabilities services, mainstream community health teams and the local authority which made accessing and sharing informing between staff and teams difficult as staff did not have access to all the different systems.
- The CTALD were based in the local authority and worked with the local authority social work teams in each of the four CTALD areas. There was an informal arrangement between the trust and the local authority that each of the CTALD would be managed locally by the local authority social work teams.
- There were weekly multidisciplinary team (MDT) meetings to discuss new referrals, case allocations and specific patients. However, a full MDT team did not always attend the meetings. We were told by the acting services manager that occupational therapists and consultant psychiatrist did not attend due to staff shortages and the need to spend more time in clinical practice.
- The quality of handovers between staff varied. Some staff reported good handovers between teams and colleagues. They told us that the internal referral process within the CTALD ensured that patients were not waiting long periods of time for treatment. However, other staff told us that when they were covering for a colleague during annual leave or sickness they often did not have any details about the patients on the case load that they would be supporting and were therefore not fully aware about patients individual needs and risks. There was no handover or sharing of information between the trust mainstream community health teams or the CTALD.
- The green light toolkit had been implemented. The green light toolkit is an audit that care providers carry out to look at improving mental health services to make them more effective in supporting people with learning

Are services effective?

Inadequate

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disabilities and autism. The service had rated themselves as doing well in care planning and access to services. The audit tool stated they had clear criteria for access to services and that nobody would be excluded from accessing generic mental health services or specialist learning disability services. However, we found concerns relating to care planning and the audit tool acknowledged that access to services did not work for people who had a mild or borderline learning disability and there was a risk that people could fall between the services. This was not escalated as a risk onto the local or trust wide risk register.

- The primary healthcare facilitators, as part of the Better Health team had a key strategic role to ensure the promotion of the health agenda for people with learning disabilities.
- The Better Health team had been actively building links with local general practitioner surgeries to support both patients and external professionals with learning disability awareness.
- As part of the trust Learning Curve programme the community learning disabilities team provided training. For example, we saw evidence that speech and language therapists had provided dysphagia training to care providers so that they could continue to promote the safety and wellbeing of the people they supported.

Adherence to the MHA and the MHA Code of Practice

- Training in the Mental Health Act (MHA) was not mandatory within the trust. Records provided by the trust showed that no staff had undertaken MHA training.

Good practice in applying the MCA

- Training in the use of Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) was not part of the trust mandatory training requirements. Records provided by the trust showed that no staff had undertaken MCA or DoLS training.
- Staff told us that the local authority social work teams took the lead in MCA and best interest meetings.
- Some staff interviewed had a good understanding of the MCA, the code of practice and the five statutory principles. However, some staff had no awareness. There was not always clear evidence in care records to show that, where appropriate, mental capacity was taken into consideration by staff before a decision on action was taken. For example, in some care records we noted capacity assessments that cited learning disability and autism as reasons why a person lacked capacity.

Requires improvement

Are services caring?

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

Our findings

Are services caring?

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

Kindness, dignity, respect and support

- We spoke with six patients and six relatives and seven external care providers, who told us they found the staff to be caring, respectful and supportive and felt involved in their treatment and therapies.
- The expertise and support offered by the staff from the learning disabilities community services was valued by patients, relatives and carers.
- We observed nine episodes of care including at on-site clinics and during patient home visits. We saw staff interacting with patients in a respectful, professional manner.
- Staff we met with were professional, caring and committed to providing the best care and service they could to support people with learning disabilities, within their current resources and commissioning arrangements.
- Staff demonstrated a good understanding of confidentiality of patients, their carers and external agencies.

The involvement of people in the care they receive

- Staff did not always involve patients in their care planning. Most care plans were generic, written in the third person and not person centred. Care plans were not always formatted in a way that patients would easily understand. For example, most were just a print out from the electronic records system. This meant they were in small print which made them difficult to read. However, we saw some care plans completed by the speech and language therapists for dysphagia, that were provided in a pictorial format and printed as a place mat. For one patient the speech and language therapist had produced a pictorial shopping list that enabled the patient to plan and prepare for shopping trips independently.
- The trust used he national friends and family feedback tool. However staff told us that this was not always suitable or easy to use for people with learning disabilities. There was no information displayed in any of the CTALD bases which gave results from the latest friends and family test. Staff were not aware how results were feedback to patients. Patients and their carers and relatives told us they were not provided with feedback.
- The trust provided patients with access to advocacy via the independent advocacy services.
- Staff told us that few patients were able to get involved in decisions about the service provided but this was not open to everyone and at the time of the inspection the trust was only engaging patients that they had used previously.
- The trust had a learning disabilities advisory group and some of the forum members were actively involved in the recruitment and interviews of two speech and language therapists in the south Somerset CTALD. They were also involved in the development of service delivery. For example, they were helping with the newsletter and easy read documents. However, staff acknowledged that this did not reach out to all patients and they currently only used a small number of patients.

Are services responsive to people's needs?

Requires improvement

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

Our findings

Are services responsive to people's needs?

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

Access and discharge

- Referrals to the CTALD came from GP, self-referral, paid carer and third sector, social care and other health care professionals. The teams had capacity to respond to urgent referrals. However, referrals for occupational therapy and dysphagia assessments were only accepted if they met the urgent referral criteria. Capacity to respond to routine referrals for occupational therapy was limited. The acting service manager told us this was due to shortage of staff.
- Each CTALD had a system in place which ensured all new referrals were made through a single point of triage. The referrals were then discussed weekly at the Rapid meeting and assigned to the most appropriate health care professional.
- Each health care profession within the CTALD had their own referral matrix which defined the criteria for access or refusal of services. Staff could not confirm if these matrices had gone through any internal governance processes to ensure consistency. The service did not monitor unmet need, which meant people who needed to access services but could not maybe at risk.
- Figures provided by the trust showed that emergency access waiting times from referral to assessment for first point of contact was 5 days. Emergency access waiting times from assessment to treatment was 13.2 days. Emergency access waiting times from referral to treatment was 18.2 days.
- Figures provided by the trust showed that routine access waiting times from referral to assessment for first point of contact was 12.2 days. Routine access waiting times from assessment to treatment was 58.6 days. Routine access waiting times from referral to treatment was 70.8 days.
- There were no targets set for the CTALD for waiting times to ensure that patients were seen in a safe and timely manner. The figures provided by the trust did not state if the above waiting times were acceptable or as to what action was taken if they were not.
- It was not clear if data about internal referrals was being monitored. We requested figures for this during the inspection but they were not provided.
- We requested information about monitoring of patients who did not attend appointments. Staff told us that they would telephone patients if they did not attend. The acting service manager told us she was not aware of this happening and was unable to provide any information.

The facilities promote recovery, comfort, dignity and confidentiality

- Community team locations were accessible for patients. Teams undertook home visits, saw patients with care providers or wherever it was identified that the patient would prefer to be seen.
- None of the community bases were equipped with clinic rooms which contained necessary equipment to carry out physical examinations. Patients were supported by the teams to access appropriate healthcare facilities and services to meet their medical and physical needs when required.
- There were no information leaflets specific to the services provided on view at any of the CTALD bases. Staff told us this was because the buildings were owned by the local authority and not the trust. Staff told us that information leaflets about treatments available, how to make a complaint and advocacy were given out to patients at their initial assessments. However, some patients told us they did not receive these.
- Staff had a good understanding of confidentiality and demonstrated a good understanding as per the trust policy and procedure who they could share information with.

Meeting the needs of all people who use the service

- The Better Health team developed and promoted the use of health plans and hospital passports when appropriate. These assisted in aiding patients to communicate their individual needs within their support setting and when accessing other health services.

Listening to and learning from concerns and complaints

- Between the 1 April 2014 to 26 March 2015 there were two formal complaints. One of those complaints was upheld. No further information was provided as to

Are services responsive to people's needs?

Requires improvement

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

which community learning disability team the complaints related to or the nature of the complaints. Staff were not aware of the two formal complaints made and had not received feedback about the outcome of those complaints.

- Staff demonstrated that they knew how to process and support patients to make complaints appropriately.
- Patients knew how to complain and told us they felt happy raising any concerns. Staff told us that leaflets on how to complain were available in an easy to read format and were given to patients during their initial assessments. However, some patients told us that they did not receive the easy to read leaflets.

Are services well-led?

Requires improvement

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

Are services well-led?

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.

Vision and values

- The community teams for adults with learning disabilities (CTALDS), the better health team and the rapid intervention team did not have team objectives in place which reflected the organisation's values and objectives. However, staff were aware of the trust's vision and values and these were displayed in each of the teams.
- Most staff we spoke with did not feel that the executive team had a good understanding of the community learning disability team. However, at our follow up inspection we saw that the executive team had put in place a learning disability improvement group to lead on addressing the concerns identified, including staff engagement with the trust.

Good governance

- There were effective systems in place to ensure staff received supervision, appraisals and professional development. Staff told us that they had regular clinical and line management supervision. Staff attended continuing professional development groups and met monthly with their colleagues to discuss clinical practice and share ideas.
- There were effective systems in place to ensure staff received training. However, training in the Mental Health Act, Mental Capacity Act and Deprivation of Liberty Safeguards was not part of the trust mandatory training requirements. Records provided by the trust showed that no staff from the CTALD had completed the training. At our follow up inspection, we saw that a full training program, including risk assessment, incident reporting and and Mental Capacity Act had been implemented to address the training needs.
- There was some evidence of incident monitoring however, this was not consistent across the CTALD and it was not clear if improvements had been made as a result and if staff understood the lessons learnt from these incidents. There was a lack of incident reporting through datix for the CTALD. The number of incidents reported through datix for the CTALD was not available to the acting service manager and was not monitored by the service. We found incidents of safeguarding concerns that were not logged on datix. Reviews of serious incidents requiring investigation records were variable in quality. On the day of our follow up inspection, the leadership team had put in place training on the incident reporting system. There were improvements in staff understanding and reporting of incidents.
- Staff did not receive feedback from complaints and were not aware of the two formal complaints that had been made against the CTALD. Staff who we spoke with were not aware of the results from the latest friends and family test and could not tell us what improvements had been made to the service as a result of feedback.
- Audits and reviews were not completed effectively. As part of staff supervision caseloads were discussed and care plans selected for review. However, it was not clear if the reviews were to check if a care plan was in place or just checked the quality of the care plan. There was no formal record to monitor the outcome of the audits and reviews of care plans and it was not clear if action was taken and what improvements were made as a result. We found that care plans and initial assessments varied in detail and quality.
- Risks were not assessed and managed, which put people who used services at risk of harm. None of the concerns entered onto the local risk register were on the trust wide risk register. The acting service manager told us that they had escalated the risks to the corporate team but they did not include them on the trust wide risk register. Staff did not have the ability to submit to the local risk register and were not able to access the local risk register on the computer system.
- The systems to identify, assess and manage risks were not operating effectively to identify, assess and manage the risks that existed within the CTALD. The governance processes had not ensured that the service provided was being monitored. No control measures had been

Are services well-led?

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put in place to ensure that people who required services but did not meet the eligibility criteria, particularly for occupational therapy where only urgent referrals were being accepted, were not at risk.

- However, at our follow up inspection there had been a full review of how risk was managed within the service, which included asking a service which had been rating as good by the CQC to come and help identify and develop actions required.
- Key performance indicator data was not in place. There was no monitoring of the number of appointments missed through people not attending. The service did not have any formal waiting lists and were not mitigating the risks for people waiting for assessment or treatment to commence. There were no targets set by the trust for the CTALD for waiting times to ensure that people who needed services were seen in a safe and timely manner.Internal referrals were not being monitored. At the time of our follow up inspection, we saw a draft dashboard that would be present for each individual clinician and would give the service manager oversight and assurance in relation to a range of key performance indicators, this was due to be implemented imminently.

Leadership, morale and staff engagement

- Leadership within the CTALD was in a period of transition with an acting service manager in post who was due to leave imminently.At the time of our follow up inspection we saw that the new divisional manager was actively addressing the concerns identified in a supportive way. Staff told us that they felt well supported and listened to.
- The CTALD were based in the local authority and work closely with the local authority social work teams in each of the four CTALD areas. There was an informal arrangement between the trust and the local authority that each of the CTALD teams would be managed locally by the local authority social work teams.
- Most staff told us that they felt the integrated working arrangements with the social work teams from the local authority were beneficial. However, some staff told us that they were not always kept up to date with information and there were breakdowns in communication. For example, staff from south Somerset CTALD reported that they had only just been told of the imminent departure of the local authority social work team leader and were not aware who would be taking over.
- Sickness and absence rates from 1 April 2014 to the 31 March 2015 were 3% for the learning disability services and 6% for the rapid intervention team. The manager told us that the percentage of sickness was higher in the rapid intervention team due to a member of staff on long term sick leave.
- Staff demonstrated that they were motivated and dedicated to deliver the best care and treatment they could for people who use services. There were mixed levels of staff morale across the four CTALD bases. Some staff told us that they felt happy and well supported in their roles; other staff told us that due to staff shortages and high demand for services they felt burnt out and often worked well above their contracted hours due to work pressure.
- At the time of our inspection there were no grievance procedures, allegations of bullying or harassment reported across the teams.
- Staff told us they were aware of the whistle-blowing process and were confident they could raise concerns if needed.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2014 Good governance The trust did not have adequate governance process in place to assess, monitor and improve the quality and safety of services provided. This was in breach of Regulation 17(1)(2)(a)

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2014 Good governance The trust did not have systems in place to mitigate the risks for people who were awaiting treatment or access to the services. The trust did not monitor did not attend appointments nor did they mitigate the risks for people who required services but could not access due to not meeting the eligibility referral criteria. This was in breach of Regulation 17(1)(2)(b)

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 CQC (Registration) Regulations 2009 Statement of purpose Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2014 Good governance The trust did not actively seek feedback from all people who used services. It was not clear that feedback was listened to, recorded or responded to when appropriate. It was not clear that improvements were made as a result of feedback being sought. This was in breach of Regulation 17(1)(2)(e)

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The trust did not take measures to prevent avoidable harm or risk of harm for people who used services. Care and treatment was not always based on an assessment of people's needs and preferences. Staff did not always respond appropriately to meet people's individual needs to ensure their welfare and safety. Risk assessments and risk formulations were not always being completed or reviewed. There was no monitoring or mitigation of risks for people awaiting treatment. This was in breach of Regulation 12(1)(2)(a)(b)(I)