Good

Mersey Care NHS 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)
RW400	Trust HQ Princes Dock	Liverpool Learning Disabilities Team	L11 5BS
RW400	Trust HQ Princes Dock	Sefton LD Community team	PR9 0LT
RW400	Trust HQ Princes Dock	Community Focus Team	PR9 0TP

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

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

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

Summary of findings

Ratings

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

Overall rating for the service	Good 
Are services safe?	**Good** 
Are services effective?	**Good** 
Are services caring?	**Good** 
Are services responsive?	**Good** 
Are services well-led?	**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 this core service as good because:

•The service had developed clear, evidence based clinical pathways to support effective assessment, treatment and management of clinical needs. The teams worked effectively and collaboratively with other services to ensure continuity and safety of care across teams, including involvement of external agencies. We found that there were inconsistencies between the localities we visited, in relation to caseload management and service delivery. This meant that people may have a different experience of care or outcome of treatment, depending on where they receive their care. However, the community learning disabilities teams worked hard to meet the varied demands on the service despite challenges they faced at times with limited resources.

•People who used the service were treated with kindness, respect and dignity. Individuals were positive about the way staff treated them and were involved in the planning of their care. Clinician`s kindness, expertise and skills within the teams were highly regarded by all carers and patients we spoke with. The staff we met ensure the people who use the service at the centre of what they did.

•The service operated an open referral system and had capacity to respond in a timely manner. The teams were confident that they all worked within the assessment targets agreed by the trust, however the systems in place to monitor compliance with waiting and response times did not appear to accurately reflect this. The teams worked flexibly to meet individual`s needs and worked closely with a number of different agencies to meet their needs, promote community involvement and social inclusion.

•The trust had a system to identify and monitor quality and safety of the services they provided. However, there were concerns with accuracy of recording and quality of data to monitor compliance with waiting and response times. There were not effective systems in place to monitor referrals, waiting lists, unmet need and the potential impact of gaps in service provision. There was a clear system in place to report incidents. However, we were concerned about the lack of comprehensive investigation into a serious incident affecting a member of staff last year.

• The community learning disabilities service was undergoing a comprehensive review of service delivery, local team performance monitoring and management structures, as part of the service re-design.Some teams, for example, both of the Asperger`s teams, and the administrative teams, did not have a line manager. Meeting structures were not in place which would support effective oversight monitoring across the whole service, for example, there were no management meetings or administration meetings in place. Most staff were concerned that there could be reduced learning disability representation within the senior management team with the restructuring.

•We saw good examples of local leadership from the team managers we met. Staff told us that they felt well supported by their team managers and were able to raise concerns and contribute to service development. The service manager and modern matron showed a good understanding of the current challenges for this service and staff.

Summary of findings

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

Are services safe?

Good

We rated services safe as good because:

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

• Staff had an understanding about how to report incidents. Staff felt confident in raising concerns and knew how to escalate them if necessary.

•Risks were assessed and clearly documented. There was an alert system on the care records which immediately highlighted specific risks for the individual. Risk assessments were comprehensive and linked to care plans and actions taken in daily progress notes. The teams undertook a human rights based risk assessment that they had developed called “keeping me safe”, it was a shared risk assessment between the service user and the service.

However:

•The trust had a system to identify and monitor risks in the services they provided, including to report incidents. However, we were concerned about the lack of comprehensive investigation into a serious incident affecting a member of staff last year.

•It was not clear how the lone working policy would fit in with the new hub and spoke model of working, where staff movements may be less known and administrative staff may not be onsite.

Are services effective?

Good

We rated Effective as good because:

•The service had developed clear, evidence based clinical pathways to support effective assessment, treatment and management of clinical needs. The teams worked effectively and collaboratively with other services to ensure continuity and safety of care across teams, including involvement of external agencies.

•The community learning disabilities teams worked hard to meet the varied demands on the service despite challenges they faced at times with limited resources.

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

However:

Summary of findings

•We found that there were inconsistencies between the localities we visited, in relation to service delivery, due to variation in staffing and commissioning arrangements. This meant that people may have a different experience of care or outcome of treatment, depending on where they receive their care.

•Frontline staff reported that there was pressure on services. Allied health professionals were at times only able to prioritise urgent cases or where there was concern about potential placement breakdown. This had an impact on teams being able to consistently provide specialist complex sensory, communication and psychology input. There were not effective systems in place to monitor referrals and unmet needs.

Are services caring?

Good

We rated Caring as good because:

•We observed a number of visits and clinic appointments and saw staff were caring and respectful in all their interactions.

•Patients told us they were treated with kindness, dignity and respect. Carers and patients spoke of the positive and supportive care that they received.

•Clinician`s kindness, expertise and skills within the teams were valued by individuals who use the service, carers and other professionals we spoke with.

Are services responsive to people's needs?

Good

We rated Responsive as good because:

•In line with the national guidance, we saw evidence that the teams worked with mainstream services to ensure reasonable adjustments were made, to support access. The teams remained actively involved in discharge and transition planning for individuals who were in placements out of area. The teams offered a wide range of health courses and social groups, as well as effective signposting and collaborative work with other agencies to promote social inclusion.

•The teams were able to respond to urgent referrals and there was a specialist learning disabilities on-call service outside of working hours. The teams had access to specialist learning disabilities in-patient and respite facilities when required.

•Easy read complaints information had been developed and given to individuals when they came into the service. Patients and carers told us that they felt able to raise concern or make a complaint.

Summary of findings

However:

•The service operated an open referral system, which meant that anyone could refer into this service. The teams reported that not all referrals were appropriate for the service. There was not a system in place to track and monitor referrals in order to identify the impact of this issue on the service. The teams reported that they all worked within the targets agreed by the trust. However, the systems in place to monitor compliance with waiting and response times, were not effective in gathering accurate data to reflect this.

Are services well-led?

Requires improvement

Are services well led? We rated well led as requires improvement because:

•The trust `business information` report was generated for each team to monitor overall performance, for example, training and referral waiting times. The administrative team supported this process with team managers in each team. However, we raised concerns with the trust in relation to the accuracy of recording, and quality of data to monitor compliance with waiting and response times. There were not effective systems in place to monitor referrals, waiting lists and unmet need, in order to identify the potential impact of gaps in service provision and provide assurance that waiting lists were being managed consistently and effectively.

Meeting structures were not in place which would support effective oversight monitoring across the whole service. For example, managers meetings and administration meetings.

•The community learning disabilities service was undergoing a comprehensive review of service delivery, local team performance monitoring and management structures, as part of the service re-design. Staff told us that there had been a number of significant changes to the management structure. Some staff were concerned that due to recent senior management restructuring, there could be reduced representation from the learning disability service at senior level.

•Staff and service users told us that they did not feel that there had been enough consultation and information for individuals using the service relating to the current service review and changes.

However:

•We saw good examples of local leadership from the all of the team managers we met. Staff told us that they felt well supported by their

Summary of findings

team managers and felt able to raise concerns or contribute to service development. The service manager and modern matron showed a good understanding of the current challenges for this service and staff.

Summary of findings

Information about the service

The adult learning disability community service is part of Mersey care NHS Trust. The community teams provide specialist health assessments and interventions for people with learning disabilities. The service worked alongside other statutory health and social care providers, voluntary and private organisations, to support adults with health needs associated with learning disabilities. There are two multi-disciplinary community teams providing this service one based in Liverpool, one based in Sefton and Southport. There were two Aspergers teams who also cover these localities. There is a social inclusion hub in Liverpool and community focus team in Sefton, which provide a range of health courses and sessions, as well as social activities for individuals with learning disabilities.

The community learning disabilities service was undergoing a comprehensive review of service delivery, local team performance monitoring and management structures, as part of the service re-design. There had been a number of significant changes to the management structure. The community services were moving towards a hub and spoke model of care; where a range of services can be provided by central point (the hub) over a defined geographical area to people in the community. Currently few appropriate community venues have been identified to act as the `spokes`. There was a hub and spoke project group who were responsible for identifying suitable venues.

Our inspection team

The team was led by a CQC inspector and three specialist advisors experienced in learning disabilities provision. The specialist advisors included a social worker, nurse and psychologist. On two of the site visits an expert by experience and additional specialist advisor were part of the team. On one of the site visits, a Mental Health Act reviewer was part of the team.

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?

We visited two community locality teams, which provide a service for adults with learning disabilities. We also met with the two Asperger`s teams based within each locality and the community focus team who are based on the Sefton.

•We reviewed trust information relating to the whole service, as well as specific to these localities.

•We spoke with seven carers, and spoke or met with 23 people that use the service.

Summary of findings

•We spoke with 31 staff, from a range of disciplines, including service managers, consultants, administrative support staff, clinicians and allied health professionals.

•We spoke with other professionals who work with the service, for example, commissioners, advocates and care managers.

•We undertook four home visits and clinic appointments with staff, we attended a service user forum, social inclusion hub, and two service user health groups.

•We attended a training session run by the service in collaboration with service users for other health and social care providers.

•We reviewed information and records used to manage the service and 17 patient care records in detail.

What people who use the provider's services say

People who used the service, and their carers, told us that they valued the caring expertise and skills of clinicians within the teams.

Good practice

The learning disability service has developed a human rights based approach to risk assessment and risk management.

There were identified team members who were police and criminal evidence (PACE) trained, to support the police with interviewing individuals with learning disability who may be perpetrators or victims of crime. Where appropriate there was an arrest plan for individuals on the police database, which the senior manager on-call could also access, to ensure that individuals were supported effectively.

The service worked with the learning disability advisory group, which promoted service user involvement in service development within the learning disabilities teams. The service and group used the principles of the human rights act: FREDA stands for fairness, respect, equality, dignity and autonomy, and the group has produced the first booklet about human rights by people with learning disabilities, for people with learning disabilities.

The service had developed and used technology to engage and communicate with people, for example, the development of an app with service users to help support staff to understand the human rights act and good and bad practice.

The green light toolkit had been well integrated, which ensured that staff working in mainstream health services understood good practice around responding to individual needs effectively. Staff continued to work proactively engage health and social care providers. For example, collecting the data for individuals with learning disabilities who presented at accident and emergency departments in order to help develop effective action plans.

The service operated a specialist learning disabilities out of hours on-call service; initially telephone support and advice was offered, although if required there was capacity for staff to undertake face to face assessments.

Areas for improvement

Action the provider MUST take to improve

The trust must ensure that systems and processes accurately assess and monitor the quality and safety of services provided. Quality assurance in relation to referral and waiting times must be recorded accurately. There must be an effective system to record and monitor waiting lists, and when the service is unable to meet needs of individuals.

Summary of findings

Action the provider SHOULD take to improve

The trust should ensure appropriate investigations are undertaken following serious incidents, in line with the NHS England Serious Incident Framework guidance.

The trust should incorporate the hub and spoke model into the lone working policy.

The trust should establish a system for equitable and safe caseload allocation or management as part of the caseload review.

The trust should establish clear plans to monitor staff health and wellbeing during the service review and redesign, ensuring learning disabilities input within the senior management team.

The trust should ensure that all teams have a clearly allocated line manager.

The trust should ensure that teams are resourced with a full range of skilled staff to undertake all requirements of the service effectively and consistently, as part of the service review.

Mersey Care NHS 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
Liverpool Learning Disabilities Community Team	Trust HQ, 8 Princes Parade, Princes Dock, St Nicholas Place, Liverpool, L3 1DL
Sefton Learning Disabilities Community Team	Trust HQ, 8 Princes Parade, Princes Dock, St Nicholas Place, Liverpool, L3 1DL
Community Focus Team	Trust HQ, 8 Princes Parade, Princes Dock, St Nicholas Place, Liverpool, L3 1DL

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.

The Mental Health Act documentation reviewed, within the care records, was completed in line with the Code of Practice.

Mental Capacity Act and Deprivation of Liberty Safeguards

• Staff were up to date with training around the Mental Capacity Act. Staff explained how they embedded consent and capacity in their daily practice. We saw some excellent examples of comprehensive capacity assessments and best interest decisions. However, capacity assessments were not always consistently clearly documented in the care records.

Detailed findings

• We observed that capacity was routinely discussed in clinics, assessments, multi-disciplinary team meetings and during the visits we attended.

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

Summary of findings

We rated services safe as good because:

Our findings

Safe and clean environment

• The Liverpool community team had moved into a brand new base a few days before our inspection, there was a second building which will be used to see patients, this was not yet in use. The community focus team building in Sefton had been identified as not suitable for purpose, therefore the service was due to move to the Hesketh Centre once the decoration has been completed. In the meantime, staff had clear processes in place to manage any local risks. For example, two members of staff were always present when patients were in the building and the front door was opened via an intercom.

• The community bases were clean. We reviewed infection control audits from July 2014 which did not reflect any serious concerns. There was an allocated infection control nurse within each team, who had responsibility for hand washing audits and the weekly equipment checks.

•The community learning disabilities service was undergoing a comprehensive review of service delivery, local team performance monitoring and management structures, as part of the service re-design. The community services were moving towards a hub and spoke model of care; where a range of services can be provided by a central point (the hub) over a defined geographical area to people in the community. Currently few appropriate community venues have been identified to act as the `spokes`. There was a hub and spoke project group who were responsible for identifying suitable venues.

Safe staffing

•The staffing numbers in all teams had been affected by sickness, maternity leave, redundancies as part of the cost improvement scheme and staff being redeployed to other areas, over recent months. This had left an imbalance of skill mix within teams and generated additional workload for other team members.

• There was no clear system for caseload allocation or management. There was a disparity in caseload allocation. This was particularly noticeable in the Liverpool community learning disabilities team. The trust provided information which reflected that 41% of the Liverpool team held caseloads over 30, and 46% held caseloads under 10. Within the Liverpool Asperger`s team 87% of the caseloads were over 30. The highest caseload figure was 68 people allocated to one worker. The management team were aware that there was an uneven allocation of caseload. The Sefton caseload data showed that 23% of caseloads were over 30. The Sefton Asperger`s team 39% of individual staff caseloads were over 30. We looked at fifteen supervision records for staff. Seven out of ten from the Liverpool team reflected that staff had raised concerns about workload pressures. Ten staff we spoke with told us that they had concerns about managing their workload. Some staff told us that they frequently worked above their hours and some had cancelled annual leave to cover the workload. Both of the acting community team managers held full caseloads, in addition to their management role. The manager of the community focus team also held a caseload.

• Caseload audit and review had been identified as an important part of the service redesign. A discharge tool had been developed to help staff implement discharge plans for individuals who no longer required a secondary learning disabilities service. This process had already commenced within the Sefton team and the new acting manager in the Liverpool team had identified it as a priority action.

• Allied health professionals working in the teams reported holding waiting lists, although there was not a clear, consistent system in place to record and monitor them effectively. We requested information from the trust, although it was not clear whether this accurately reflected the unmet need and number of referrals to some of the specialists within the teams. For example, the information provided stated that there is no waiting list for occupational therapy in Sefton, however, the team has

Good

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identified this as a gap in service provision, as there is no occupational therapist in the Sefton team. The data provided showed that in Sefton, seven individuals had waited over six months, and four individuals over a year, for speech and language therapy (SALT) intervention. The trust advised us that the "majority of delays are awaiting SALT assistant input in relation, primarily, to communication related therapy". The Sefton team also documented that, for several months, SALT and physiotherapy assistant sessions have been cancelled due to sickness. In the Liverpool team, six individuals had waited over six months and one individual over year for physiotherapy intervention. Sixteen individuals had waited over six months, and five over a year for SALT input. Without effective monitoring and reporting, the waiting lists cannot be managed appropriately and consistently.

• There was an on-call service outside of working hours. Calls were initially triaged by telephone by a senior nurse. There was also an on-call support worker, this meant if required they could provide a face to face assessment. However, there were difficulties ensuring that there was enough staff to cover the shifts, and we saw that this had been noted in on-call meeting minutes. We analysed on-call rotas from January 2015 until May 2015. In January, three days were not covered by a senior practitioner, and 15 days were not covered by support worker. In February, 12 days were not covered by a support worker. In March, five days were not covered by the senior practitioner and nine days were not covered by support worker. In April one day was not covered by the senior practitioner, eight days were not covered by a support worker. In May, 13 days were not covered by a support worker. This meant that the service was not always consistently provided.

• We saw training records for all the teams, these showed that teams had 100% completed required mandatory training. The mandatory training was a mixture of E-learning and face to face training.

Assessing and managing risk to patients and staff

• We reviewed a sample of 17 care records across the two community teams. Risks were assessed and clearly documented. There was an alert system on the care records which immediately highlighted specific risks for the individual. Risk assessments were comprehensive and linked to care plans and actions taken in daily progress notes. The teams undertook a human rights based risk assessment that they had developed called "keeping me safe". This was a shared risk assessment between the service user and the service. The service had also developed a comprehensive risk assessment which was undertaken with the psychologist when indicated.

•The modern matrons at the Liverpool Broadgreen hospital and the primary health care facilitator, had developed a system to ensure alerts were in place for individuals with particular risks who may present to accident and emergency, for example, epilepsy. There were identified team members who were police and criminal evidence (PACE) trained, to support the police with interviewing individuals with learning disability who may be perpetrators or victims of crime. Where appropriate there was an arrest plan for individuals on the police database, which the senior manager on-call could also access, to ensure that individuals were supported effectively.

• Each team held weekly multi-disciplinary meetings (MDT). We observed one MDT meeting at Liverpool, and reviewed meeting minutes for all the teams. These showed a range of risk issues, such as safeguarding and clinical risks, were discussed within the MDT. Teams also worked closely with other teams within the trust, for example, the mental health stepped up care team, to undertake assessments where indicated. Staff told us that they felt well supported in discussing and managing risks. However, none of the medical staff attended the MDT meeting at Liverpool, which meant that they were not able to contribute to discussions about risk management across the team as a whole.

• Staff demonstrated a good knowledge on how and where to report safeguarding issues. However, the teams did not have systems to record and monitor safeguarding alerts currently open for their clients'. There was no overarching log of current safeguarding referrals, which would allow them to monitor actions and potentially identify trends across the teams. The teams told us that it was often difficult to get feedback from the local authority in relation to safeguarding investigations.

• There was a 'lone working' policy and we were informed that the administrative staff had access to staff diaries to monitor whereabouts. However, there was not a clear system where staff logged in and out. Staff advised that initial assessments, or visits where risks were clearly identified, were undertaken with two members of staff or on site. It was not clear how the lone working policy would be incorporated within the hub and spoke model which

Good

Are services safe?

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was being rolled out. This model meant that staff would not necessarily work from a site where there were administrative or other staff based there. It was not clear how staff would record the location, time-scales of visits or appointments, and nominate an individual to monitor this. It was not clear how learning in relation to lone working practice, and patients with identified risks, had been shared following a serious assault of a staff member last year.

Track record on safety

• Information provided by the trust reflected that there had been 99 reported incidents over a 12 month period across the community learning disabilities teams. There had been no serious untoward incidents, which had resulted in serious harm to an individual between June 2014 and June 2015, within the community learning disabilities teams.

Reporting incidents and learning from when things go wrong

• We requested further information about a serious incident involving a physical assault of a member of community staff, during a lone home visit, last year. The NHS England Serious Incident Framework guidance states that incidents should be graded for severity and where indicated an investigation should be undertaken. A serious incident is defined as: “unexpected or avoidable death or severe harm of one or more patients, staff or members of the public”. NHS Protect (2012) states: "The measures that all NHS bodies must take include appointing a Local Security Management Specialist (LSMS) to have overall responsibility for security, including assisting investigations into assaults on and abuse of staff". We requested the root cause analysis investigation which should have been undertaken. The trust stated that it was felt that the incident had not indicated further investigation. We reviewed the recommendations from the brief initial review (the 72 hour report), which was completed four weeks after the incident. These were in relation to the patient involved and there was no evidence of wider learning for other teams or recommendations for staff in relation to lone working practices.

• There was an electronic incident reporting system to report and record safety incidents, concerns and near misses, which all staff had access to. All incidents were reviewed by the team managers, the modern matron and the risk management team for the trust, who would then monitor them for trends. The acting manager for the Liverpool team had been in post for three weeks and did not have access to the system. There were weekly divisional surveillance meetings where a range of performance, quality and safety data, including incident reports, were reviewed.

• Staff we spoke with described the incident reporting process. Staff were able to access effective support from within each team. Staff reported they were given time to discuss learning from incidents in team meetings. However, when we reviewed the team meeting minutes following the serious incident involving the member of staff last year, we did not see any discussion around this in relation to lone working practices or reviewing clients or situations where increased risks had been identified.

Are services effective?

Good

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

Summary of findings

We rated Effective as good because:

Our findings

Assessment of needs and planning of care

• The teams provided assessment, diagnosis and interventions in relation to behaviours that challenge, sensory integration, epilepsy, mental health, autism and dementia. The service had developed clear, evidence based clinical pathways to support effective assessment, treatment and management of varied clinical needs.

• We reviewed 17 care records, spoke with staff and patients and carers. We found that staff assessed and planned care in line with the needs of the individual and, where appropriate their carers. The care records we reviewed were personalised and patient centred with detailed, clear plans to meet complex behavioural and physical needs. The service had developed health action plans to assist in communicating individual`s needs within their support setting and when accessing other health services. We saw comprehensive crisis plans, and these were linked to risk assessments and care plans. Consent to treatment and information sharing was recorded. We noted during the visits and meetings we observed, that staff checked understanding and consent throughout.

• Staff effectively supported individuals to get physical health needs met in the least distressing and intrusive way possible. The learning disability steering group and health action group was made up of representatives from the trust, clinical commissioning group, acute health trusts, primary care services and voluntary sector. Meeting minutes showed that they worked effectively together to ensure the promotion of the health agenda for people with learning disabilities. For example, developing an action plan to improve the numbers of patients with learning disabilities attending their annual health check. A specialist optician and dentist worked flexibly with staff, for example undertaking home visits if necessary. The service had developed a blood care pathway, which was a comprehensive pathway to support individuals, staff and phlebotomists taking blood safely and in the least distressing way possible.

• The trust had identified areas for improvement in relation to quality of care records, following an audit of records undertaken in November 2014. We saw evidence in for Sefton team supervision records, that this was being implemented within the teams through individual supervision. The acting manager in Liverpool had only been in post three weeks and was yet to start this work within the Liverpool team.

Best practice in treatment and care

• Mersey Care provided early assessment, treatment and management for adults with a moderate to severe learning disability, which took into account NICE guidance, for example, implementing positive behaviour support plans and supporting people to access mainstream services, where appropriate.

• A number of recognised multi-disciplinary assessment tools were used to plan and monitor care needs. For example, the Asperger`s teams used the diagnostic interview for social and communication disorders (DISCO). The trust did not use the standardised outcome measurement health of the nation outcome scale (LD). The teams implemented `every contact counts`, a public health initiative across all pathways to deliver messages about healthy living.

Skilled staff to deliver care

• We found that there were inconsistencies between the localities we visited, in relation to service delivery, due to variations in staffing and commissioning arrangements. This meant that people may have a different experience of care or outcome of treatment, depending on where they receive their care. The current operational policy did not reflect that the service was undergoing review or give a clear overview about current structure of staffing and resources. The teams included specialist nurses, doctors and specialist allied health professionals to provide effective assessment and treatment. For example, physiotherapists, speech and language therapists (SALT) and occupational therapists (OT). However, there were gaps in service provision, for example, parts of the locality in Sefton did not have access to an OT, a SALT, or physiotherapist. Staff sickness had also meant that a number of SALT and physiotherapist assistant sessions

Are services effective?

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have been cancelled. There were different commissioning agreements which contributed to the gaps in service provision, for example, there was no commissioned specialist SALT in North Sefton.

• Each team had access to a consultant psychiatrist. There were no approved mental health practitioners within any of the teams; however, staff reported that they were able to request one from the local authority when required. Medical and nursing staff reported that they worked well with other specialities and therapy services to provide good multidisciplinary care.

• Staff confirmed that they were able to access additional and external training where appropriate. We were given examples by staff who had been supported to undertake additional vocational qualifications and conferences attended. Frontline staff had access to regular management and performance supervision. We reviewed a sample of supervision records in each team, we looked at ten in Liverpool and five in Sefton. These varied in quality and detail, although showed that clinicians discussed caseload management and other work related issues. We saw examples of how staff performance issues, or additional staff support requirements, had been addressed by team managers.

•The teams support students and trainees from a variety of professions and have developed good links with the universities. Students and trainees we interviewed spoke highly of the professionalism and support they have had throughout placements with the teams.

Multi-disciplinary and inter-agency team work

• The teams worked effectively and collaboratively to plan and develop appropriate interventions with other health, voluntary sector and social care providers. There were regular interface meetings with commissioners, primary and acute care of health providers, which the service manager attended. The primary healthcare facilitators worked closely with a number of mainstream services.

• Each team had administrative support and there were effective administrative processes in place. The administrative staff told us that they felt supported by the team managers and integrated within the teams. The administrative staff felt confident in their interactions with individuals who use the service and carers. There was an administrative review underway and there was no line manager in place for the administrative staff. They had not had supervision or an administrative team meeting since March 2015.

• Staff reported good relationships with other teams within the trust, such as supporting transition from Children`s services and joint working with the mental health teams where appropriate. The community teams supported mental health staff if an individual with learning disabilities was admitted to one of the local mental health units.

• The green light toolkit had been implemented effectively, the teams worked proactively with the learning disabilities liaison nurses in primary care, acute care and secondary mental health care, to link a wide range of mainstream health services. The primary healthcare facilitators had a key strategic role to ensure the promotion of the health agenda for individuals with learning disabilities.

• The teams have developed a range of training sessions for colleagues within the trust, carers and other professionals. Service users also contribute to training. An example of training we observed was facilitated by the service users and presented to GPs.

• The teams accessed appropriate support for complex care planning, for example, multiagency public protection arrangements (MAPPA). We observed a `continuing health care` assessment and a community treatment order renewal meeting; both of which were conducted effectively, clearly identifying actions and ensuring that the individual was at the centre throughout.

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

• A Mental Health Act Reviewer found that Mental Health Act documentation reviewed, within the care records, was completed in line with the Code of Practice.

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

Good practice in applying the Mental Capacity Act

• Staff were up to date with training around the Mental Capacity Act. Staff we spoke with demonstrated a good understanding about obtaining a person's consent, or if required, relatives and/or their representatives. In the care records, we saw evidence of good practice documented

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.

throughout the daily progress notes and clinic letters. We saw some excellent examples of capacity assessments, however we found these were not consistently, clearly documented.

• Documentation showed that capacity was routinely discussed during routine visits, clinical reviews and MDT meetings. Staff also checked consent and capacity in the visits and meetings we observed.

Good

Are services caring?

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

Summary of findings

We rated Caring as good because:

Our findings

Kindness, dignity, respect and support

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

• Staff we met were all professional, caring and committed to providing the best service and care they could, within their current resources and commissioning arrangements. The service they provide reflected person centred care, and the teams were committed to promoting human rights and social inclusion.

• Clinician `s expertise and skills within the teams were valued by all individuals who use the service, carers and other professionals we spoke with.

The involvement of people in the care that they receive

• The care records reflected that staff worked hard to involve people in developing care plans and assessing risks, where possible. Patients and carers we spoke with confirmed that they were well informed and involved in their care. However, care plans provided were not always given in a format that individuals could understand. For example, the care plans we were shown were print-outs of the electronic records, which may be difficult for people to follow if they had poor literacy skills. However, the speech and language therapists provided pictorial care plans for the patients that they worked with. The community focus team used easy read, person centred care plan developed with the individual.

• The trust had a learning disabilities advisory group and service users were engaged with the service to help inform and develop service delivery. The service and advisory group applied the principles of the human rights act, using FREDA (FREDA stands for fairness, respect, equality, dignity and autonomy). The group has produced the first booklet about human rights by people with learning disabilities, for people with learning disabilities. We saw that the teams were proactive in ensuring individuals had the opportunity to engage with the local community and service development. For example, participating in running training events and developing easy read materials. However, it was less clear how the wider trust involves individuals with learning disabilities. For example, we attended a trust wide service user event, and there was little understanding of the reasonable adjustments that need to be considered in order to involve individuals with learning disabilities effectively. Staff and service users told us that they did not feel that there had been enough consultation and information for individuals using the service relating to the current service review and changes. This was also reflected on the trust risk register.

• There was evidence that carers were involved where possible. Carers we spoke with confirmed that they received information and support from the teams. The teams referred carers for carers assessments with the local authority when required. Staff, carers and patients confirmed that they were supported to access advocacy services when required.

• Staff told us that the main patient feedback tool, the national `friends and family`, used by the trust was not always suitable and easy to use for individuals with learning disabilities. The Asperger`s teams did not collect patient feedback. However, the healthcare facilitators and community focus team collected feedback from the sessions and courses that they run. We also saw service user meeting minutes which reflected that people were able to feedback and contribute to service developments at a local level, for example, improving signage.

Good

Are services responsive to people's needs?

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

Summary of findings

We rated Responsive as good because:

Our findings

Access and discharge

• The service was in the process of review and redesign. The trust had commissioned an independent review by an external consultancy company. The trust was also moving towards a . `hub and spoke model` of care. This meant that there would be two central hubs identified, where learning disabilities and mental health services would be based together; and then a number of community-based venues (spokes) throughout the trust, for example, GPs surgeries, where staff would see people. The hubs had been identified but there was currently a lack of suitable community venues identified.

•Part of the service review included looking at the eligibility criteria. The aim of the review was to ensure the focus of the service is on individuals with complex needs whose requirements cannot be met by mainstream services. Frontline staff reported that there was pressure on services and gaps in service provision. Allied health professionals were at times only able to prioritise urgent cases or where there was concern about potential placement breakdown, and reported that this had an impact on teams consistently being able to provide specialist complex communication and psychology input, which could then in turn have an impact on positive behaviour support plans. For example, there was no occupational therapist in the Sefton team, which meant no access to sensory integration work. There was not an effective system in place to monitor waiting lists and unmet need, inorder to assess the impact of potential gaps in service provision.

• The service operated an open referral system, which meant that anyone could refer into this service. The community learning disabilities service had received 1407 referrals from May 2014 to May 2015. 509 for the Liverpool team, 306 for the Liverpool Asperger`s team; 375 for Sefton community team and 217 referrals to the Asperger`s team in Sefton. Each team held an intake meeting weekly to discuss referrals and agree the most appropriate professional to undertake the initial assessment. Whilst not all referrals where appropriate to the service, there was not an effective system in place to track and monitor referrals in order to assess the impact of this issue.

• The teams were confident that individuals were seen for initial assessment within four to six weeks of referral. However, the data we were provided with showing individual waiting times from May 2014 to May 2015, did not support this. The data showed that 40% of individuals waited over 35 days for assessment with the Sefton Aspergers team; 25% of individuals waited more than 35 days in the Liverpool Aspergers team; 31% of individuals waited more than 35 days, and 12% more than 100 days in the Liverpool community team; 13% of individuals waited more than 35 days, and 3% over 100 days in the Sefton community team. The trust advised us that they have looked into the quality assurance information for assessment and treatment timescales, and found a number of recording and data quality concerns. We saw meeting minutes that stated this issue had been raised in March 2015 in relation to the Asperger`s service. The trust provided an immediate action plan to review and address this.

• The two Asperger`s teams were currently under pressure regarding the high number of referrals the teams were receiving and the complexity of diagnostic assessments. There was no waiting list for diagnostic assessments held by the trust. However, staff working within the services told us that following an initial brief screen there was a six to eight month wait for people to commence the diagnostic assessment. There was no intervention or contact with people during this waiting time.

•The trust had in-patient facilities for individuals with learning disabilities. The in-patient team also made referrals to the community allied health professionals when assessments and specialized treatment was required. The trust did not hold data to record and monitor the number of referrals made or potential impact of this on the community services.

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

Good

Are services responsive to people's needs?

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

• The teams were able to respond to urgent referrals and there was a specialist learning disabilities on-call service outside of working hours. Carers and patients confirmed that calls were returned in a timely manner and staff were able to respond effectively if they needed additional visits or contacts. The service operated a specialist learning disabilities out of hours on-call service; initially telephone support and advise was offered, although if required there was capacity for staff to undertake face to face assessments.

•The teams had access to specialist learning disabilities in-patient and respite facilities when required. Access to beds was managed by the modern matron for the inpatient services. The teams reported that they were able to access beds where they needed to. Data provided by the trust showed that there had been one out of area admission, and that was because the person was in a different part of the country when they needed admitting. The teams remained actively involved in discharge and transition planning for individuals who were in placements out of area.

•Caseload management and discharge planning had been identified as a priority within the overall service review. The locality teams were working to identify the number of cases that could be discharged to GPs. However, there was no clear discharge process within the operational policy, and the service manager confirmed that formal work was not yet underway with the commissioners and GPs to look at 'shared care', where patients identified as clinically appropriate for GPs to undertake reviews, rather than secondary learning disabilities services. This would help improve the ability of teams to provide effective services within the current resources.

The facilities promote recovery, comfort, dignity and confidentiality

•The community services were moving towards a hub and spoke model of care; where a range of services can be provided by central point (the hub) over a defined geographical area to people in the community. Currently few appropriate community venues have been identified for the spokes, which could affect how close to home people could be seen. There was a hub and spoke project group undertaking this work. However, the teams worked flexibly to meet individual needs and would undertake home visits when required.

• The service used the trust electronic records system. Access to these records was secure and password protected. The care records system was difficult to navigate and information was not always stored in chronological order. The trust was in the process of replacing it with a new system. Staff had a good understanding of confidentiality.

Meeting the needs of all people who use the service

• Staff worked with a variety of statutory and non-statutory health and social care providers to meet the needs of people and promote social inclusion. The teams offered a wide range of health courses and social groups, as well as effective signposting.

• The teams had access to interpreting services. The service had developed easy read information based on cultural and religious needs of the local population. There was a wide range of easy read information about a range of health needs and services, accessible to all staff on the trust intranet. The speech and language therapists developed effective communication packages for individuals.

• Carers were working with the service to develop a carer's plan. This would assist in communicating individual`s needs within their support setting and when accessing other services.

Listening to and learning from concerns and complaints

• We saw the trust`s complaints records which showed that there had been 21 complaints across the community learning disabilities teams, between May 2014 and May 2015. Of these complaints ten had been upheld, or partially upheld, and none had been referred to the ombudsman. We saw examples of how complaints had been responded to. For example, the executive team had visited the Liverpool Asperger`s team to understand concerns raised, after a complaint was made to the board.

• There was a complaints procedure, although in the first instance people were encouraged to speak with a member of staff involved in providing the care. Easy read complaints information had been developed and given to individuals when they came into the service. Patients and carers told us that they felt able to raise concern or make a complaint.

Good

Are services responsive to people's needs?

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

• We saw that formal complaints were discussed in the divisional surveillance group meetings. A review of formal complaints had been undertaken in February 2015 to identify potential themes. However, some complaints were addressed at a local level and were not recorded on an overarching log. There was a risk that complaints may get `lost`. For example, we noted that a concern had been raised with a member of the Liverpool team, who then went off sick. This complaint was not followed up until the complainant re-contacted the team two months later. It was also not clear that this system would identify themes and share learning points across all teams, or ensure that there was an understanding about complaints relating to the individual localities.

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.

Summary of findings

We rated well led as requires improvement because:

Our findings

Vision and values

• Staff were aware of the organisation`s values and some of the wider trust work underway for the `perfect care` and `no force first`. The community learning disabilities service was undergoing a comprehensive review of service delivery, local team performance monitoring and management structures, as part of the service re-design. There had been a number of significant changes to the management structure. Some staff were concerned that due to recent senior management restructuring, there could be reduced representation from the learning disability service at senior level.

•Staff and service users told us that they did not feel that there had been enough consultation and information for individuals using the service relating to the current service review and changes.

Good governance

• The trust `business information` report was generated for each team to monitor overall performance, for example, training and referral waiting times. The administrative team supported this process with team managers in each team. However, we raised concerns with accuracy of recording and quality of data, in particular to monitor compliance with waiting and response times. There were not effective systems in place to monitor referrals, response times, waiting lists and unmet need, in order to identify the potential impact of gaps in service provision, staff capacity, and provide assurance that waiting lists were being managed consistently and effectively across the whole service. The trust provided an immediate action plan to review and address this.

Meeting structures were not in place which would support effective oversight monitoring across the whole service. For example, there were no manager`s meetings with the team and locality managers, or administration meetings in place, to monitor and share team performances, and potential impact of the service review.

•The teams were up to date with mandatory training, received regular management supervision, held regular team meetings and demonstrated a good understanding of the incident reporting and safeguarding processes. However, we were concerned that the serious incident investigation process had not been undertaken in line with guidance, following a serious incident last year.

• There were no current clinical audits taking place, meeting minutes reflected that resources to facilitate audits were limited currently. Although we were shown a number of examples of research that staff had published and work which has led to development and improvement in service provision. For example, the use of I-Pad technology to improve communication, integrating the human rights act into risk assessments and care planning, also developing a human rights board game to increase understanding.

• The teams did not operate locality risk registers. The process to escalate concerns to the corporate risk register had been agreed, although the managers had not yet received training on how to do this. The key risks identified by the trust and placed on the risk register, in relation to community learning disabilities services were: the lack of suitable community sites to deliver clinical activity, lack of preparation for service users and staff in relation to moving Liverpool community teams to the new hub, and changes to partnership agreements with local authorities and the increase pressure this may place on services.

Leadership, morale and staff engagement

• Both community team managers were in `acting` positions, the Liverpool manager had been in post for three weeks, the Sefton manager for a year. All of the team managers still carried full caseloads in addition to their managerial responsibilities. We saw good examples of local leadership from the team managers we met. Staff told us that they felt well supported by their team managers and felt able to raise concerns or contribute to service development. However, in relation to the Asperger`s teams and the administration teams, none of the staff in these teams, or other managers we met during inspection, were able to identify who their line manager was, although

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.

the trust subsequently stated that managers had been identified for these teams. The service manager and modern matron showed a good understanding of the current challenges for the learning disabilities community service and staff.

• A service review had just been commenced, two weeks prior to our visit. There had also been a number of significant changes to the management structure during the previous two months. Some staff told us that there had been little communication or consultation from the senior management team, and they felt uncertain about the future. There was not a clear plan in place to support staff and monitor the impact of the service review, location and management changes, on staff health and wellbeing.

• However, we saw that an initial consultation meeting had taken place in May 2015 with the independent consultancy team to inform staff about the purpose of the review and timelines. There was a team building day being facilitated by an external company for the Liverpool team due to take place in June 2015. We saw that the executive team had visited the Liverpool team before they were relocated, to listen to staff concerns. Concerns shared with us which included; staff not knowing where they will be working from, the lack of identification of appropriate venues in the community; workload pressures and having the right skill mix to meet needs. In relation to the hub environment staff raised concerns about: maintaining individual team identity, not having individual work areas and the absence of line managers for some teams.

Commitment to quality improvement and innovation

• There was work underway with primary health care and commissioning services, focussing on enabling adults with learning disabilities access their annual health checks with GPs, after the service was found that only about 40% of individuals entitled, currently do so.

• The development and use of technology to engage and communicate with people, for example, the development with service users of a phone "app" to help support staff to understand the human rights act and good and bad practice.

• The green light toolkit had been well integrated, which ensured that staff working in mainstream health services understood good practice around responding to individual needs effectively. Staff continued to work proactively and engage health and social care providers to ensure that health needs were met, including routine health screening available to the whole population. For example, collecting the data for individuals with learning disabilities presenting at accident and emergency departments in order to help develop effective action plans.

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
Accommodation for persons who require nursing or personal care Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Nursing care Personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance Systems and processes did not effectively assess, monitor and improve the quality and safety of the services provided. We found concerns with accuracy of recording and quality of data to monitor compliance with waiting and response times. There was no effective systems to ensure referrals, waiting lists and unmet needs through gaps in service provision, were monitored consistently across the service. This is a breach of Regulation 17(2)(a)

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.