Good

Berkshire Healthcare NHS Foundation Trust

Community mental health services for people with learning disabilities or autism

Quality Report

Berkshire Healthcare NHS Foundation Trust
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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)
RWX58	Church Hill House	Reading CTPLD Wokingham CTPLD Windsor and Maidenhead CTPLD Slough CTPLD Learning Disability Specialist Services	RG30 4BZ RG40 1JX SL6 6PS SL1 3UF RG4 8LJ

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

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

Summary of findings

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

Summary of findings

Ratings

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

Overall rating for the service	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Good

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

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

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

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

Summary of findings

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Summary of findings

Overall summary

We rated community mental health services for people with learning disabilities as Good because:

- People referred to the service were safe because good systems were in place to ensure the people with the most urgent needs were seen first and that people who waited longer were monitored while they waited.
- The teams were responsive to the needs of the local populations and found innovative ways to meet the needs of people who use services.
- Staff sought people's views on the care that they received.
- Staff were motivated to provide good care by a strong leadership team.

Summary of findings

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

Are services safe?

Good

We rated safe as good because:

- Though staff teams were under pressure, most teams manged risks well to ensure that people were provided with the service they needed.
- A wide range of assessments were available to staff to help manage risks to people who used the service.
- There was a multi-disciplinary approach to risk management with evidence in most cases of good team discussion around risks

However:

- We found poor risk assessments in a significant number of care plans at the Reading CTPLD.

Are services effective?

Good

We rated effective as good because:

- Care plans were based on person centred planning principles and followed best practice in following the Care Programme Approach, where this was required.
- Professionals worked together to provide good solutions to people's needs.
- A wide range of training was provided for staff to support them in their role.
- Where staffing pressures were great we saw excellent management of team resources to manage waiting lists.
- We observed good practice across the service in promoting choice and seeking to enhance people's understanding and capacity to make decisions for themselves.
-

Are services caring?

Good

We rated caring as good because:

- People were treated with respect for their rights and supported to express their views.
- People had opportunities to have a say in how services were provided.
- People told us that they were able get involved in different initiatives through local Learning Disability Partnership Boards.

Summary of findings

For example, in Wokingham these included health promotion groups with the learning disability liaison nurse and primary care liaison nurse and other professionals to improve access to general health services people with learning disabilities.

Are services responsive to people's needs?

Good

We rated responsive as good because

- Services were made accessible to people with a diverse range of needs.
- Teams developed services that met particular local needs.
- The teams found innovative ways to meet the needs of people who use services.
- The speech and language service had developed tools specifically to help people with profound disabilities to communicate more clearly.
- Meeting rooms were available at three team bases to have discussions. We found that the rooms at Slough and Windsor and Maidenhead afforded a good level of privacy.

However:

- The meeting rooms at Wokingham had poor soundproofing, so that meetings in neighbouring rooms were audible through the walls. This did not protect people's privacy.

Are services well-led?

Good

We rated well-led as good because:

- Staff felt inspired by management to contribute to the development of the Trust.
- Leadership teams regularly reviewed aspects of the service with team leaders and provided a regular forum through clinical governance meetings to promote learning and best practice.
- There were clear lines of communication from teams up to the board level. Risk registers were used at team level and corporately to manage presenting problems. Risks that were not managed at this level were escalated to the quality concerns list at which was overseen by the board.
- Many staff we spoke with felt very engaged in the direction and development of the Trust. They particularly praised the listening into action forums where teams from different parts of the trust got together to raise concerns and take a team approach to discussing how to tackle them.

Summary of findings

However:

Monitoring of training for staff did not cover mental capacity and mental health awareness.

Summary of findings

Information about the service

The community teams for people with learning disability (CTPLD) provide a range of health services for people with learning disabilities across Berkshire. The services are provided from six localities; Reading, Wokingham, Windsor and Maidenhead, Slough, Bracknell, and West Berkshire. All the teams, apart from Wokingham, are co-located with adult social care teams that provide social work services to people with learning disabilities. These teams have team leaders co-funded by the Trust and the local authority. However local authority social care services are not covered by this inspection.

Some of the psychology, behavioural therapy, dietician, and speech and language services for Berkshire CTPLDs are centrally administered from Emmer Green in Reading, though members of these teams often spend the majority of their time based at a CTPLD location.

Our inspection team

The overall team that inspected the trust was led by:

Chair: Dr Ify Okocha, medical director, Oxleas NHS Foundation Trust

Head of Inspection: Natasha Sloman, Care Quality Commission

Team leader: Louise Phillips, inspection manager, Care Quality Commission

The team that inspected this core service comprised: five CQC inspectors, one Mental Health Act reviewer, one qualified psychologist as special advisor and one expert by experience.

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, asked a range of other organisations for information and sought feedback from patients at three focus groups.

During the inspection visit, the inspection team:

- visited four out of the six locality teams that provide community mental health services for people with learning disabilities (CTPLDs)
- visited the specialist services team base at Emmer Green to meet professionals who provide services across all six localities
- spoke with ten patients who were using the service collected feedback from 16 patients using comment cards
- spoke with four carers of people who use the service
- spoke with the health team leads for each CTPLD visitied
- spoke with the joint health and social care team leaders for hree spoke with 21 other staff members; including doctors, nurses and social workers

Summary of findings

- interviewed the head of learning disability services for this Trust
- attended and observed three hand-over meetings and three multi-disciplinary meetings.
- attended six home visits and two consultations with people who used services
- looked at 23 care plans.
- looked at a range of policies, procedures and other documents relating to the running of the service

What people who use the provider's services say

People we spoke with were very positive about services they received and the relationships they had with staff. They told us that staff tailored services to their specific communication needs.

People's comments reflected that the services offered usually address a specific need rather than offering long term support.

Good practice

We saw good examples of innovative service being developed to address emerging needs in the local population. These included a wheelchair prescription service that served profoundly disabled people in their own homes rather than a clinic.

Where staffing pressures were great we saw excellent management of team resources to manage waiting lists.

We saw an innovative project in development to socially engage people with profound and multiple disabilities.

We observed good practice across the service in promoting choice and seeking to enhance people's understanding and capacity to make decisions for themselves.

Areas for improvement

Action the provider SHOULD take to improve

- The trust should ensure that all people using the service have accurate up to date risk assessments. These were not always in place and this could create a risk of harm to the person, staff working with the person or the wider public.
- The trust should ensure that there is clear responsibility within teams for updating risk tools such as the risk register. These were mostly used very effectively across the services we inspected, apart from Slough CTPLD, where the absence of a health team lead led to poor management of waiting lists.

Berkshire Healthcare 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
Reading CTPLD Wokingham CTPLD Windsor and Maidenhead CTPLD Slough CTPLD Learning Disability Specialist Services	Berkshire Healthcare NHS Foundation Trust Fitzwilliam House, Skimped Hill Bracknell, Berkshire, RG12 1BQ

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 teams we inspected were generally knowledgeable about the Mental Health Act. Staff knew when to seek support from the appropriate professionals when they were concerned about people subject to the Act. For example people on leave from hospital or on conditional discharge from hospital.

Mental Health Act training was listed as essential for this staff group. However, it was not included in the training monitoring processes by the learning disability operations team.

Detailed findings

Mental Capacity Act and Deprivation of Liberty Safeguards

The community teams contributed regularly to mental capacity assessments for people. We observed good practice across the service in promoting choice and seeking to enhance people's understanding and capacity to make decisions for themselves.

All the staff we spoke to were knowledgeable about the Act and were able to discuss challenges they face in implementing.

Community teams were not responsible for implementing the Deprivation of Liberty Safeguards (DoLS) but were knowledgeable about the Safeguards and contributed to assessments for people who might be subject to DoLS.

Mental Capacity Act and Deprivation of Liberty Safeguards training were listed as mandatory training for this staff group; however compliance with this was not adequately monitored.

Good

Are services safe?

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

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

Our findings

Safe and clean environment

- Three of the office bases for the teams provided meeting rooms where staff could consult with people who use services. The Reading team base was not accessible to the public, and staff arranged to meet people in their own homes or another suitable location such as a day centre.
- Where meeting rooms were available they were clean, comfortable and well lit. Notices were displayed showing when areas had been cleaned and when they were next due to be cleaned. Responsibilities for maintenance issues varied from location to location as some sites had many different teams in addition to the CTPLDs. However we saw that issues around maintenance were reported and addressed in a timely way at all the services we visited.

Safe staffing

- Staff we spoke with in four out of five of the services told us that they had manageable caseloads. The exception to this was the Slough CTPLD, where staff reported feeling under pressure to manage their work. Caseload sizes varied between teams. In Reading the average nurses caseload was 16, while in Windsor and Maidenhead the average was 29. Managers tracked caseloads according to complexity of the needs of the people being supported.
- All four CTPLD teams we visited had been understaffed in the year leading up to the inspection. This was because long term leave of staff was not fully covered by the Trust or because vacant part time posts had been difficult to fill.
- For example a full time staff member was on maternity leave in one team, but only ten hours per week were provided to cover the full time post. One team (Wokingham) reported to CQC that there was one meber of staffon long term sick leave for the whole year out of a team of twelve people.
- In general, the trust managed staff shortages well. Wokingham CTPLD had a gap in occupational therapy provision while a part time worker was recruited. The service raised the shortfall with senior management through the team risk register. When the new occupational therapist was appointed, the trust brought in a senior therapist from a neighbouring team to help the Wokingham team leader and the new worker to prioritise the waiting list. This minimised the risk to people on the waiting list for occupational therapy.
- We saw other examples of how the health team leads had used the risk register in this way to manage waiting lists when there were staff shortages.
- We also saw processes in three teams for managing waiting lists and monitoring the changing needs of people on waiting lists.
- The Slough CTPLD had had no lead worker for the health team for over two years. This had been highlighted by the head of learning disability on the governance team risk register for 18 months and interim support had been provided from senior clinicians. An interim health team lead had been appointed four weeks before the inspection, for two days per week. An interim joint team leader for Health and Social Care was also in post at the time of the inspection.
- We found that in the absence of a permanent lead for the health team, the Slough team risk register had not been consistently used to highlight issues around waiting lists and that staff were not fully aware of the needs of people on the waiting lists. This was highlighted to the new health team lead and interim joint team leader during the inspection.
- The interim health lead also told us that since taking on the role, they had begun to identify cases on current caseloads that could be closed. Staff had previously lacked guidance on when it was safe to close cases, but this was now being addressed through supervision. This would then allow the team to work with the people on the waiting list. Staff told us they had a great deal of confidence in the new health team lead to resolve the issues around case-load management.
- We reviewed the learning disability training matrix for December 2015. This showed that training of professional staff was up to date for 85% for some courses with 95% being the highest uptake for any

Good

Are services safe?

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

course across the available mandatory training. However the matrix may have included a small number of staff on long term leave. Statutory training was up to date for 90% to 100% of professional staff

- We were not able to review detailed records of staff appraisals and supervision. All staff we spoke with had supervision every four to six weeks. All staff that had more than a years service had received an annual appraisal.

Assessing and managing risk to patients and staff

- We reviewed client records at all four CTPLD services. These were recorded on the RIO electronic records system. We found tools in place for assessing risks to people in relation to their mental health needs, their learning disability and issues related to mobility such as pressure sores. These risks assessments also addressed whether the person might pose a risk to other people, including staff. In most records we found that staff had completed these appropriately and updated them regularly. We found there was a multi-disciplinary approach to risk management with evidence in most cases of good team discussion around risks.
- However at the Reading CTPLD three out eight of the care records we reviewed had risk assessments that team members had not updated at appropriate times, for example, following discharge from hospital. We also found that team members did not always discuss risks with the appropriate professionals. For example a care provider had arranged a work placement for a person who posed a risk to others, and had discussed the placement with the team. However the team had not fully recognised the risks, and did not ensure it was discussed with the full multi-disciplinary team of professionals who would have been aware of the risks. The care provider arranged the placement, but the employer was not informed of the risks the person posed to others. However, within two weeks of the placement starting an experienced nurse within the team identified the risks and, following discussions with relevant professionals and the employer, was able to end the work placement. This highlighted that systems in place did not always work effectively to protect people. We brought these issues to the attention of the Reading CTPLD team managers at the time of the inspection.
- Staff received mandatory training on safeguarding adults and safeguarding children. Records we reviewed showed that 87% of CTPLD staff had up to date training on safeguarding children and 90% had up to date training on safeguarding adults.
- Staff were very clear on how to identify possible abuse and how to report their concerns. We saw records of safeguarding referrals made through the Datix reporting system. All teams had lone working policies in place for team members carrying out home visits and working out of normal office hours. Staff we spoke with were aware of the policy and we observed that staff used visiting diaries and other systems to make the team aware of their planned visits.

Track record on safety

- We received records from the Trust relating to serious incidents as defined by the NHS Commission Board Serious Incident Framework 2013. These covered the period August 2014 to July 2015 and showed there were no serious incidents relating to the learning disability community services in that period. Some serious incidents, such as pressure sores would have been referred to district nursing and recorded against that service, but we found there had been no incidents referred on in this way in the year leading up to the inspection.

Reporting incidents and learning from when things go wrong

- The Trust used the Datix electronic incident reporting system. We reviewed records of reports including Safeguarding Adults reports. The Datix system delivered reports to the appropriate lead manager for the specific safety issue. Safeguarding reports were also printed and sent to the local authority safeguarding team. For most of the locality teams this was within the same building. Wokingham CTPLD sent safeguarding referrals electronically to the local authority safeguarding team.
- We saw that managers were able to draw up themed reports from the Datix system, for example on manual handling risks, and use these to plan the response of the service to presenting needs. We found that use of the Datix system was consistently good across all the locality teams that we visited.
- We found the Trust had a clear path for risks to be escalated up from locality teams to lead officers, the learning disability governance team and to the Trust

Good

Are services safe?

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board. There was also clear communication down from board level to clinical governance groups and on to individual teams to share responses to risks and incidents.

- Staff were able to tell us the “whistleblowing" process to raise concerns about the service. Some staff members were not confident that they would be protected if they chose to raise an issue through the process. However one member of staff told us that they had raised an issue as a “whistleblower” and that the issue raised was dealt with positively and that they felt supported in the process.

Are services effective?

Good

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

Our findings

Assessment of needs and planning of care

- The trust uses the RIO electronic records system. We saw that when staff completed paper records on home visits, these were promptly copied to the RIO system by the admin support staff, who then safely disposed of the paper record. This meant the Trust had a single complete record for each person that all authorised staff could access.
- We saw that the information for each person was comprehensive. For example, one person had recently been an inpatient at a Trust location. We could see on the electronic record the interventions by both inpatient and community teams had been documented as was the joint planning of the person's discharge from hospital.
- However, staff did not always record information in the correct place and this led to difficulties in accessing information in a timely manner. We observed that one professional had not read all the relevant information on a person before visiting them.
- Where the health and adult social care teams were co-located we saw that the trust had put protocols in place for information sharing between teams.

Best practice in treatment and care

- People had care plans that met their needs. Where people were discharged form hospital under the Care Programme Approach, then they had a care co-ordinator named in their care plan.
- The teams used a person centred planning tool, "Planning Live" that was being implemented across community and inpatient services to ensure that people were involved in their care planning so far as they were able.
- Occupational therapy and speech and language therapy teams had worked together to develop a range of initiatives. These included:
- "Switch Olympics," a costed and resourced proposal for a sport/social activity for people with profound and multiple disabilities that would promote their social participation with reduced need for support.
- A pilot study on accessible information for NHS England. This was carried out with a group of people with diverse sensory and cognitive limitations.
- The Trust had created an initiative to develop a care pathway for early onset dementia in people with learning disabilities. The individual locality teams were then asked to carry the work forward. We observed a multi-disciplinary workgroup at Windsor and Maidenhead discussing individual people's needs and how to best create indicators for future need as part of the care pathway. The team discussed recently published research and evaluated it and used it to reconsider the work they had carried out up to that point.

Skilled staff to deliver care

- Disciplines included in the learning disability teams were nursing and health support, occupational therapy, physiotherapy, dietician, speech and language therapy, psychology, behavioural support and psychiatry.
- Staff of all disciplines had access to mandatory and statutory training to support them in their roles. Topics covered included basic life support, safeguarding adults, safeguarding children, clinical risk infection control.
- We saw that the training needs of the teams were on the agenda for the monthly operational leadership team meeting that took place during the inspection.
- However, although training in the Mental Capacity Act, Deprivation of Liberty Safeguards and Mental Health Act were stated to be either mandatory or essential for this staff group, these were not listed on the mandatory training records we were shown or on the training needs documents reviewed at monthly leadership meetings. This may lead to staff not having the essential knowledge to work effectively with the people who use the service.
- The teams also used opportunities for secondments to other services to develop the skill base of the team. For example, a nurse from an inpatient service was on secondment to the Reading CTPLD and was able to share knowledge of working with people subject to the Mental Health Act.

Multi-disciplinary and inter-agency team work

Are services effective?

Good

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

- We saw good and often innovative partnership working between disciplines at home visits or in group work sessions.
- Psychiatry services were provided from hospital based clinics but all others were provided in the locality teams.
- There was evidence of good partnership working with other teams, for example partnership working with hospital staff to plan the discharge of people to the care of the community team and taking part in the post discharge follow up meeting with the person and the hospital team.
- Wokingham CTPLD was not co-located with an Adult Social Care team as Wokingham Borough Council had commissioned these from an external provider. In order to build relationships the Wokingham CTPLD manager had arranged team meeting between health and social care at the offices of the social care provider in order to build relationships. We spoke with the manager of the adult social care team who confirmed that the Wokingham CTPLD had made a lot of effort to build relationships when the new provider was first commissioned. The two teams had co-designed referral forms and agreed referral routes between the two teams.

Adherence to the MHA and the MHA Code of Practice

- The community team provided services to some people who were subject to the Mental Health Act. This included people on section 17 leave from hospital; that is they were detained in hospital but were able to return home on a short term basis as part of their recovery program.Team members we spoke with were able to discuss the implications of section 17 leave and had access to the professionals they would need to contact if they had concerns about the person's mental health.
- Some other people using the service were on conditional discharge from hospital. This meant that their psychiatrist was responsible for monitoring their mental health and associated risks and submitting reports on this at regular intervals to the Ministry of Justice.
- Some people using the service were subject to community treatment orders that required them to comply with their prescribed treatment. We found that documentation relating to these people's status was completed correctly. However, Mental Health Act documents were not always stored in the correct part of the care record which meant that new staff would not always be able to find the information on a person's legal status.
- Although the Trust's training matrix indicated that Mental Health Act training was essential for this staff group, figures for staff training were not included in the training records made available to CQC or used in the monthly operational team meetings. This may lead to staff not having the essential knowledge to work effectively within this legislation.

Good practice in applying the MCA

- We found staff across all locality teams were very knowledgeable about the Mental Capacity Act and most staff had taken part in mental capacity assessments of people using their service.
- Staff were able to discuss in detail some of the challenges in applying the Act in working with people with learning disabilities, for example in supporting people who were resistant to medical interventions such as blood tests.
- We found examples of mental capacity assessments on peoples care records. We saw that where people lacked capacity to make a specific decision the principle of the least restrictive practice was followed.
- We observed many instances where team members sought consent from people to share information, for example between the CTPLD staff and care home staff. Team members were specific about what information they were seeking or sharing.
- We met with a person who was assessed as lacking capacity to make a decision on their care. We observed the multi-disciplinary meeting relating to this person's care. We observed that team members made every effort to help the person understand the issue being discussed and the reason why a particular decision was reached.
- Many people using the community services were subject to the Deprivation of Liberty Safeguards (DoLS); that is a best interest decision had been made about where they should live or what restrictions should be placed on them in their home environment. Community health professionals do not make decisions relating to DoLS, but can be consulted.
- We found that staff had a good knowledge of the DoLS process in all the locality teams we visited.

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.

- However, although the Trust's training matrix indicated that Mental Capacity Act and Deprivation of Liberty Safeguards training was mandatory for this staff group, figures for staff training were not included in the training records made available to CQC or used in the monthly Operational team meetings. This may lead to staff not having the essential knowledge to work effectively within this legislation.

Good

Are services caring?

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

Our findings

Kindness, dignity, respect and support

- People who use services who were able to speak to us described their care as being very supportive, particularly in accessing good healthcare. People were particularly pleased to have the support they needed to live independently.
- Family carers we spoke with told us that the teams responded quickly if a need was urgent. However a few told us that they felt they had waited too long for routine services though they did not say if the twelve week waiting time stated in the team's literature was exceeded.
- We observed team members visiting people with a wide range of needs to carry out assessments and to enable staff or family carers to provide better care. For example we observed the physiotherapist and occupational therapist from Windsor and Maidenhead CTPLD working with a person with profound and multiple disabilities and giving support staff clear guidance (including photographs) on sleep posture awareness for the person.
- We also observed an MDT meeting with a client who was presenting challenges to the service and was a potential risk to the public. The person was fully involved in the discussion and CTPLD staff showed a great deal of sensitivity in communicating with the person the ways in which they presented a risk to others. The person was then able to understand the changes to their care and support that were required to manage the risk.

The involvement of people in the care they receive

- People told us that they were able get involved in different initiatives through local Learning Disability Partnership Boards. For example, in Wokingham these included health promotion groups with the learning disability liaison nurse and primary care liaison nurse and other professionals to improve access to general health services people with learning disabilities.
- We observed that care plans indicated the level of involvement that the person had in creating their plan. Scanned documents showed the person's signature or gave a reason why they had not signed.
- People who used services were included in any meetings about their care to the level of their capacity to take part. This included Care Programme Approach meetings relating to the person's ongoing care following discharge from detention under the Mental Health Act.

Good

Are services responsive to people's needs?

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

Our findings

Access and discharge

- We reviewed the waiting times compared to the Trust targets for waiting times for people to be seen and assessed following referral. We found that all were seen within the 18 week target with more urgent cases seen sooner with clear guidelines on rating referrals according to urgency. The CTPLD brochures for the public gave a commitment to see people within 12 weeks of referral.
- All teams had waiting lists for most disciplines. The size of waiting lists was roughly proportionate to the existing caseload and team size. For example Bracknell CTPLD had 10 whole time equivalent (WTE) staff, 359 open cases and a waiting list of 41 cases (cases are not necessarily separate people as one person might represent a case for more than one worker). Slough CTPLD had 4.45 WTE staff, 126 open cases and a waiting list of 17 cases.
- Waiting lists in most teams we visited were well managed. Referrals were managed by the health team lead supported by admin staff so that referrals for teams based in Emmer Green support service could be quickly passed on. Emmer Green also had an effective triage system in place to ensure that people were on the referral list for the right professional.
- However Slough CTPLD had not had a health team lead for over two years. An interim health lead had been appointed on a part time basis four weeks before the inspection took place. They found that the referrals had not always been passed on correctly. Some referrals for Emmer Green support services were in the waiting list for nursing support.

The facilities promote recovery, comfort, dignity and confidentiality

- Meeting rooms were available at three team bases to have discussions. We found that the rooms at Slough and Windsor and Maidenhead afforded a good level of privacy. However the meeting rooms at Wokingham had poor soundproofing, so that meetings in neighbouring rooms were audible through the walls. This did not protect people's privacy.
- There were no clinic rooms available for treatments because the focus of nurses in the teams was to promote and enable access to other community based facilities including General Practice services. The Reading team office was not intended to be accessible to the public so meetings were arranged off site.
- We found many examples of teams developing services to meet local needs and improve the range of services delivered. In the psychology team a therapy group had been developed to address the needs of people with learning disability that may have also had personality disorder. This work was clinically audited and shown to have positive outcomes including reduced hospital admissions for the group. The psychology team had prepared a presentation on the group to take to health conferences.
- The Wokingham CTPLD had developed a display and presentation based on the Mencap report "Death by Indifference" on the treatment of people with learning disabilities in general hospital settings. During learning disability awareness week they took this to the staff area of the local acute hospital and engaged staff in discussions on how to make reasonable adjustments for people with Learning Disabilities. They made hospital staff aware that there was a learning disability liaison nurse based in the hospital to help them understand people's needs. The team reported that they had formed a good relationship with the Accident and Emergency department as a result of this event.
- The Windsor and Maidenhead CTPLD served a high proportion of people with profound and multiple disabilities. These people had particular needs around specialist wheelchair use, moving and handling and skin integrity. The occupational therapist and physiotherapist in this team had created a wheelchair prescription service for this client group that would assess them in their own homes. This meant that they did not need to attend a hospital or clinic and that more of their support staff or carers could be involved in their assessment.

Meeting the needs of all people who use the service

- We found that the CTPLDs were very well adapted to the needs of different populations.
- Slough and Reading teams both served urban town centres where some needs, such as homelessness,

Good

Are services responsive to people's needs?

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

substance misuse and sexual health were more predominant than they were in Windsor and Maidenhead or Wokingham localities which included more suburban populations and some rural areas.

- The Windsor and Maidenhead team had a high proportion of people with profound and multiple disabilities due to there being long established set of services in the area for this client group.
- The Wokingham team had a large service provider in their area that worked with people with challenging behaviours. We saw that the CTPLD worked in close partnership with the clinical staff employed by the provider to address the specific needs of this group.
- The occupational therapist and physiotherapist based at Windsor and Maidenhead had developed particular services for people at risk of pressure sores. The Reading team were developing services for parents with learning disabilities and looking for local services that could assess parenting ability where there were potential safeguarding children issues.
- The newly appointed health lead at Slough was aware that the team served a diverse population, but that they needed to do some work to find what the presenting needs of their client group would be.
- The teams had online toolkits for creating easy read literature. One person who used the Wokingham service told us that the team had been able to provide relevant literature for them very quickly when they were facing a particular challenge in their life.
- The speech and language service had developed tools specifically to help people with profound disabilities to communicate more clearly.
- Staff from advocacy services told us that they had good relationships with staff, but that some things could be better. For example, the Trust had a contract for interpreters, but not much literature in different languages.

Listening to and learning from concerns and complaints

- There were regular listening events held and many forums for people to make their views known. People were invited to learning events with the professionals and able to present their views on services.
- New feedback forms had been developed to gather the views of people using services as the Trust board felt that they were getting less feedback from people using the services than from carers and services. We saw these forms being used during visits to people.
- We saw that feedback from people using the service was an agenda item for the Learning Disabilities Operational Leadership Team meeting.

Are services well-led?

Good

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

Our findings

Vision and values

- The staff we spoke with were clear about the values of the trust and were very happy with the senior leadership team. They knew how peoples and staff views were communicated and felt they were listened to.
- One staff member told us that it was easier to discuss problems with services when good practice was praised.

Good governance

- There were clear lines of communication from teams up to the Board level. Risk registers were used at team level and clinical governance level to manage presenting problems. Risks that were not managed at this level were escalated to the quality concerns list overseen by the board.
- Key messages from the board and clinical governance teams were passed down to the teams via team leaders.
- The Operational leadership team met monthly to discuss issues relating to the safety and quality of the service and addressed staffing and finance issues. For example, the December agenda included a review of winter resilience for the service.
- The clinical governance board also met every month. These meetings discussed more detailed aspects of the service such as reviewing existing care pathways and progress on newer care pathways such as the early onset dementia groups. Clinical governance meetings also included a sharing of learning from Safeguarding reviews, external and internal clinical audits, and included updates on NICE guidelines relevant to the service.
- This provided an effective basis for ensuring teams were up to date with all relevant information for their roles.
- Staff that were not part of the meetings told us that there was a lot of information to digest but their team leaders are effective at highlighting the most relevant parts.

Leadership, morale and staff engagement

- Many staff we spoke with felt very engaged in the direction and development of the Trust. They particularly praised the listening into action forums where teams from different parts of the trust got together to raise concerns and take a team approach to discussing how to tackle them.

Staff told us that there were career development opportunities for nurses and other professionally qualified staff. However there was a good retention rate for senior staff, so there were not many opportunities for promotion within the trust. The trust was able to show evidence of leadership development programmes for qualified staff.

Commitment to quality improvement and innovation

- We found many internal and external audits were taking place. The Psychology team carried out internal audits and we were able to review the most recent of these.
- Several external audits had taken place related to prescribing anti-psychotics for different disorders within the learning disability population.

Additionally we found innovative interventions being developed throughout the service by Psychology, Occupational Therapy, Speech and Language Therapy and Physiotherapy.

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.