Good

South West London and St George's Mental Health NHS Trust

Community mental health services for people with learning disabilities or autism

Quality Report

Trust Headquaters
Building 15, 2nd floor
Springfield University Hospital
61 Glenburne Road
London SW17 7DJ
Tel:020 3513 5000
Website:www.swlstg-tr.nhs.uk

Date of inspection visit: 14th – 18th March 2016
Date of publication: 16/06/2016

Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RQYXX	Trust Headquarters	Merton and Sutton Mental Health Learning Disabilities Team	SM6 0EX
RQYXX	Trust Headquarters	Wandsworth Mental Health Learning Disabilities Team	SW17 7DJ

This report describes our judgement of the quality of care provided within this core service by South West London and St George's Mental Health 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.

Summary of findings

Where applicable, we have reported on each core service provided by South West London and St George's Mental Health NHS Trust and these are brought together to inform our overall judgement of South West London and St George's Mental Health 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?	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

Contents

Summary of findings

Overall summary

Community mental health services for people with learning disabilities were **good** because:-

People who used services and carers told us that staff were kind, caring and helpful. Staff had a very good awareness of the individual needs of people who used services and this was reflected in comprehensive, detailed and individualised care plans and thorough risk assessments which involved people who use services and reflected the communication needs of people who used the services.

Staff had a good understanding of how to report incidents and were able to give examples of incidents in the service and reflect learning from incidents and complaints. Staff undertook a wide range of clinical and non-clinical audits within the teams and worked to improve outcomes through these.

There were no waiting lists for the service. People referred to the service were seen in a timely manner and had access to out of hours emergency support if necessary.

Staff were very positive about the local leadership both from their line managers and from the consultants within the team and this was the basis of positive team work in a multidisciplinary setting.

However, the team manager post for Wandsworth community mental health learning disability team was vacant and had been vacant for 15 months at the time of our inspection. This post was being covered by the manager of the Merton and Sutton team. Efforts had continuously been made to recruit into this post but it did leave both teams without a full time manager on site.

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:

- Teams were based in purpose-built buildings with clean environments and accessible interview rooms. The team visited people who used services at home as well as offering them the opportunity to meet within the team base.
- Staff were up to date with mandatory training.
- Records we checked had extensive, current risk assessments which were updated regularly. Staff had a good understanding of safeguarding and know how to raise alerts.
- All staff had a good understanding of the trust and local lone working policy.
- Staff knew how to report incidents and the team manager had oversight of incidents which were reported. These were discussed in team meetings and staff were able to give examples of recent incidents in the service and changes to practice which had been made as a result.

However:

- While there were vacancies in the Wandsworth team, this was not having an adverse effect on patient care.

Are services effective?

Good

We rated effective as**good**because:

- People who used the service had comprehensive, person-centred care plans which were available in accessible formats including easy read.
- Staff embedded best practice in their approach to care and treatment including ensuring that people had access to a range of psychological therapies and therapeutic support relevant to their needs including couples therapy and parenting interventions.
- Staff had regular supervision. Team meetings took place weekly which discussed clinical issues as well as updating staff about clinical governance.
- Staff worked with a range of connected agencies including local authorities, community health trusts and GPs.
- All people who use services had comprehensive health passports.

Summary of findings

- Staff had received specific training relating to the Mental Health Act (1983) and Mental Capacity Act (2005) and had a good understanding of capacity and consent as it related to people who used the service.

However:

- The three boroughs had different team configurations with health and social care so the teams worked flexibly with partners. There were different routes to provide support which included referring to social work staff for support with broader social issues including benefits advice. This meant that the pathway to receive cohesive care and support from all involved agencies could potentially be more complex for people who used the service.

Are services caring?

Good

We rated caring as **good** because:

- Feedback from people who use services and their carers was predominantly very positive.
- We observed care being delivered in a kind and thoughtful way which was respectful towards people who used services.
- Staff had a very good understanding of the individual needs of people who used the service and we saw that they made a great effort to reflect the needs, hopes and wishes of people who used services in how they delivered care.
- People who used services were involved in staff recruitment in Wandsworth.

However:

- The trust has a real real time feedback system designed for people with learning disabilities which was being uploaded onto a portable handheld device as the kiosks at the team base were not accessible to all who used the service. This work had commenced and was due to be implemented shortly after the inspection visit.

Are services responsive to people's needs?

Good

We rated responsive as **good** because:

- The service did not have waiting lists for assessment or treatment. They had targets for referral to assessment and assessment to treatment which they were meeting.
- The service had an emergency referral system so that, if necessary, people could have a prioritised response.

Summary of findings

- Information was available including easy read leaflets about mental health needs and local services.
- The service was able to meet the needs of the local community. We saw good examples of using interpreting and translation services as well as using a range of communication adaptations to ensure that information was clear. There was also a good example of meeting the needs of people who used service who experienced gender dysphoria.
- Information was available about complaints in an easy read format and complaints were encouraged. We saw that complaints were logged and followed up and learning from complaints and compliments were discussed in team meetings.

Are services well-led?

Good

We rated well-led as **good** because:

- There was extensive use of clinical audit to improve services.
- Information collected from the team was fed to the team manager and shared at team meetings to drive improvement.
- Staff very positive about local leadership from both team manager and consultant psychiatrists.
- Staff told us that their colleagues were very supportive of each other.
- The trust had developed a specific strategy to improve care for people with learning disabilities in mainstream services which included e-learning packages and learning disabilities champions in teams and wards across the trust.

However:

- The Wandsworth team had a vacancy for a team manager for 15 months. At the time of the inspection, this role was being covered by the team manager for the Merton and Sutton mental health learning disabilities team on an interim basis in addition to their clinical caseload. This meant that there was not a full time manager available at both team sites.
- While recruitment had taken place to fill most other vacancies, there was a lack of coherent succession planning where staff had moved out of the team in order to progress their career.

Summary of findings

Information about the service

South West London and St George's Mental Health NHS Trust provides a community mental health learning disability team for the boroughs of Sutton, Merton and Wandsworth. There are two teams which provide this service, one based in Merton and Sutton at the Jubilee Health Centre and one based in Wandsworth at Springfield Hospital.

These teams provide secondary mental health services for people over the age of 18 who have a learning disability and a mental health problem and associated needs. The teams work closely with community health and social care teams in the respective boroughs.

The teams work with people who are resident in the respective boroughs, regardless of borough of origin and they are multidisciplinary teams which include medical and nursing staff as well as allied health professionals and support workers.

These services were last inspected in March 2014 and there was no outstanding regulatory action.

Our inspection team

The team that inspected community mental health services for people with learning disabilities consisted of one inspector, one expert by experience, one speech and language therapist, one social worker and one observer from CQC.

Why we carried out this inspection

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

How we carried out this inspection

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

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

Before the inspection visit, we reviewed information that we held about these services and sought feedback from patients and carers at nine focus groups. One focus group was specifically for people with a learning disability.

During the inspection visit, the inspection team:-

- Visited both the Merton and Sutton community mental health learning disability team (CMHLDT) and the Wandsworth CMHLDT.
- Spoke with ten people who used the service and six people who provided care or support for family members who used the service.
- Spoke with the manager of the teams

Summary of findings

- Spoke with thirteen members of staff including nurses, support workers, psychiatrists, psychologists and administrative staff.
- Observed two clinic appointments
- Observed three home visits
- Reviewed care records for ten people who used the service.
- Looked at a range of policies, procedures and documentation relating to the service.

What people who use the provider's services say

During the week of the inspection, we spoke with ten people who use the service and six family members of people who use the service. Most of the feedback we received was positive with people telling us that staff were kind, approachable and responsive. However, three people who were seen in the Merton and Sutton team told us that they weren't sure how to make a complaint. One person told us that they did not feel involved in their care planning and they did not get information about the service. However, three people told us that they felt involved in their care.

We did not receive any comments cards which related specifically to this core service.

Good practice

All people who used the service had accessible health passports which ensured that key needs and preferences where highlighted and shared with relevant healthcare professionals to benefit people who used the service.

Areas for improvement

Action the provider SHOULD take to improve

- The trust should ensure that a permanent manager is recruited to each of the teams which ensures that local leadership is robust and supportive.
- The trust should ensure that succession planning is more formally embedded within the service. This is to ensure that there is scope for staff to develop within the service if they choose to.

South West London and St George's Mental Health 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
Merton and Sutton Mental Health Learning Disabilities Team	Trust Headquarters
Wandsworth Mental Health Learning Disabilities Team	Trust Headquarters

Mental Health Act responsibilities

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

Staff in the two mental health learning disabilities teams undertook training which included the Mental Health Act. All the clinical staff in the service had completed this. Staff were also aware how to access support and information related to the Mental Health Act if it was required.

Mental Capacity Act and Deprivation of Liberty Safeguards

Staff in the two teams we visited had undertaken training related to the Mental Capacity Act 2005, the Mental Capacity Act Code of Practice and the Deprivation of Liberty Safeguards. Staff showed a good understanding of the implementation of the Mental Capacity Act and how it was used in practice within the service.

Detailed findings

We checked some records of people who used the service and saw that they reflected an understanding of the principles of the Mental Capacity Act and a respect and understanding of the autonomy and rights of people who used the service.

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

- The two teams were based in very different locations. Merton and Sutton team was in a multi-team health centre in Wallington which had accessible interview rooms with alarm systems. Wandsworth team were based in an office at the Springfield Hospital site in an office which was shared with the learning disabilities community health care team provided by a neighbouring trust. While most visits took place in people's homes, where there were rooms, they were adequately and comfortably furnished.

Safe staffing

- In the Merton and Sutton MHLD team, between March 2015 to the end of February 2016, there were 11 members of staff and one leaver. There were no vacancies in the team.
- In the Wandsworth MHLD team, between March 2015 to the end of February 2016, there were 9 members of staff. There was a 10% vacancy rate as well as one member of nursing staff who was on maternity leave. The manager post in the team was vacant with the manager of the Merton and Sutton team, covering the Wandworth team at the time of the inspection. They had been covering the management of these two teams for 15 months at the time of the inspection. Some staff told us that with the lack of a permanent manager in the Wandsworth team for an extended period of time, there was a risk that the direction could be lost.
- The team manager had oversight of the current caseloads of staff. In the Merton and Sutton team, the nursing staff, occupational therapist and support workers worked across both boroughs while the psychiatrists and psychologists worked specifically in either Merton or Sutton. This meant that nursing staff, support workers and the occupational therapist had mixed caseloads between the boroughs.
- Average caseloads per care coordinator were 14 in Merton and Sutton and 22 in Wandsworth where there was an additional vacancy and one member of staff was on maternity leave.
- The caseloads for the medical staff were higher because they included people who the doctors saw that were not allocated within the mentalhealth learning disabilities team. However, medical staff told us that they felt their caseloads were manageable.
- The psychiatrists in the teams operated a discrete duty out of hours psychiatrist rota to cover the community learning disabilities services to ensure that specialist assistance was available out of hours.
- Mandatory training was close to 100% across the teams.There were some gaps in specific training related to information governance and equality and diversity training where there were one or two members of staff who had not completed this. However, due to the small numbers in the team, this affected the percentages substantially. All staff who were required to had completed safeguarding training related to adults and children, consent to treatment and Mental Capacity Act, infection control and prevention and conflict resolution training.

Assessing and managing risk to patients and staff

- We checked ten care records across the two teams we visited. We saw that the risk assessments were up to date and comprehensive. They were updated following incidents which occurred.
- Care records had detailed crisis plans which were shared with people who used the service, their families where this was relevant and between professionals. We saw good examples of specific contingency planning in advance around crisis care and support. For example, for one person, there was a specific note about their needs when an inpatient admission was needed. This included organising in advance with commissioners access to specific services in the event of them being needed.
- Staff had a good understanding of safeguarding and how it applied within the service in which they worked.

Good

Are services safe?

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

Relationships had been developed with the relevant local authorities. We saw examples of joint working with local authorities around protection plans and proactive work by the team to ensure that issues were raised with local authorities when concerns were identified. Information was available in the team bases about local safeguarding contacts, both within the trust and within the local authorities in which they were based.

- The community teams had a lone working policy including use of a 'safe word' to ensure assistance could be accessed if necessary. Staff in the team were aware of the policy and knew how to ensure that assistance could be accessed when they were working in the community.

Track record on safety

- In the year prior to the inspection, there were no serious incidents in the community mental health learning disabilities teams which we inspected.Staff were aware of a serious incident which occurred in 2014 which had led to some changes in practice in terms of learning.

Reporting incidents and learning from when things go wrong

- Staff in the teams we visited had a good understanding of the incident reporting procedures in the trust .They were able to share with us examples of recent incidents in the service.
- Information from incidents was shared at the team meetings. We saw the minutes from these meetings and saw that there was an opportunity for incidents across the service to be discussed.

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

- We looked at ten care plans across the teams which were comprehensive and holistic. They included physical healthcare, social and psychological needs and were recovery orientated. People who used services were able to access easy read care plans and plans which were developed according to the specific communication needs and preferences of people. We saw that people had been involved in the planning and reviewing of their care and the language in the care plans we saw reflected the needs and preferences of people who used the service.
- The service was developing collaborative crisis plans which were being rolled out. These were written in the first person and developed by people who used the service as far as was possible.
- Staff we spoke with had a very good understanding of individuals who used the service, their preferences and needs. As their service was often planned, this allowed relationships to build between staff and people who used the service.

Best practice in treatment and care

- There were clinical psychologists attached to both teams and people could access individual and group therapeutic programmes.
- The teams had a good understanding of current, relevant NICE guidance and how it was used in the service. This included specific guidance related to the management of behaviours which may challenge services. The team was equipped to refer to this guidance to promote best practice.
- Cognitive behavioural therapy was available to people in accordance with guidance. One psychologist in the Wandsworth team had undertaken specific training to deliver eye movement and desensitisation and reprocessing (EMDR) therapy which related specifically to managing trauma. The service was also able to offer specialist couples therapy and specialist parenting advice to people who used the service. The Wandsworth team gave us examples of people who had been supported to provide care for their children with this additional support. This demonstrated a wide range of skills which were accessible and which improved the broader quality of life for people who used the service.
- Staff working in the service liaised with GPs to ensure that annual physical health checks were completed and followed up on this information as necessary.
- The service used health passports to ensure that people who used the services were able to share information about their needs both in terms of the physical health needs but also emotional and psychological needs with other health professionals. Staff and people who used the service gave us examples of where these health passports had been used to facilitate a more person-centred hospital admission or discharge meaning that information had been shared beneficially.
- The teams used a range of outcome measures, including the health of the national outcome scales which were specific for learning disabilities services. Variants on these scales were used across the trust. In addition to this, staff specifically used a modified behaviour and mood score which a psychiatrist in the Merton and Sutton team had adapted for the service.
- Clinical and non-clinical audits were undertaken in both teams to improve the effectiveness of the service delivered. For example, the teams had participated in the national prescribing observatory for mental health audit to understand the use of prescription practices within the service as well as specific audits of safeguarding referrals.

Skilled staff to deliver care

- The teams combined a range of professionals working together, including psychiatrists, psychologists, nurses and support workers. There was an occupational therapist who worked in the Merton and Sutton team.
- Support workers in the team were able to provide additional services such as accompanying people who use the service to medical appointments and supporting people to access voluntary work or paid work opportunities. This additional flexibility ensured that people had broader access to support within the teams.

Are services effective?

Good

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

- The turnover in the teams was low with staff working for long periods in the service. Staff have access to monthly supervision and annual appraisal. We checked the supervision records and saw that this was the case for most staff.
- There was a nursing vacancy in Wandsworth and some staff referred to an unsettled period in the Wandsworth team due to the most recent team manager having left over a year prior to the inspection. The team manager for the Merton and Sutton team was covering this role while the trust advertised the position.

Multi-disciplinary and inter-agency team work

- The three boroughs had links with local community teams for people with learning disabilities as well as adult social care teams. In Merton and Sutton, the consultant psychologist based in the team had spent 18 months seconded to the community team for people with learning disabilities. This had facilitated strong working relationships with these teams and ensured that the teams worked well together. They also provided supervision for psychologists based in these teams.
- < >
  The associated community teams for people with learning disabilities had access to speech and language therapists and dieticians in Merton and Sutton. Staff in the community mentalhealth learning disability team were able to make referrals to these services.
- Staff in the teams provided inreach services to residential homes and and trust wards and provided additional support when needed on an individual basis.
- In Wandsworth, staff told us that the move of the social care team who had been based in the same office to a different site had created a further barrier to close working. However, the teams were committed to work together. This meant that there was the potential to confuse service users regarding which services were delivered by which team. When we received feedback from some people who used the services, they were not always clear which services were delivered by the mental health learning disabilities team and which were provided by the community team for people with learning disabilities and which were provided by the adult social care team. This was reflected in some of the feedback we received.

Adherence to the MHA and the MHA Code of Practice

- All staff in the teams had undertaken training which related to the Mental Health Act as a part of the 'consent to treatment' mandatory training.
- Staff in the team told us that they were able to access advice and support relating to the Mental Health Act if required.

Good practice in applying the MCA

- Staff had a good understanding of the Mental Capacity Act. We saw that specific training had been delivered and this was reflected within the team.
- Records we checked referred to relevant assessment of capacity and an understanding of the assumption of capacity as a starting point and appropriate use of assessment relating to health interventions.

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 used the service and family members who we spoke with told us that staff were kind, respectful and listened to them. We observed staff interact with people on home visits, in clinics and in the reception area while waiting for appointments and saw that staff were sensitive and responsive to people who used the service.
- Some of the feedback we received from people who used the service included people telling us particularly that the staff were good and that the staff were approachable.
- Staff in the team had a very good understanding of the individual needs of people who used the service and were able to explain this to us.

The involvement of people in the care they receive

- There was clear evidence in the records that we looked at that people were provided with information about their care and treatment pathways. Two people who we spoke with told us that they did not have a clear understanding of their care.
- We spoke with six family members or informal carers of people who used the service. They told us that they were generally involved in care decisions where their family member had given consent.
- People who used services had been involved in the recruitment for a support worker post in the Wandsworth team.
- Information about the service was collected through feedback kiosks that had questions adapted for people with learning disabilities. However because not all service users attended the team base for their appointments, the survey was in the process of being uploaded onto hand held devices to enable clinicians to take them on home visits.
- Staff in the service told us that people who used learning disabilities services within the trust were not linked in to the patient experience forums and channels which the trust had established.

Are services responsive to people's needs?

Good

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

Our findings

Access and discharge

- People were generally referred to the service either through GPs or the community teams for people with learning disabilities. Self-referrals were possible but we were told by staff in the teams that they were not common. Other methods of referral were from other community teams within the trust such as recovery and support teams.
- In the Wandsworth team there was a triage meeting once a week to look at the appropriateness of referrals with discussions about referrals happening once a week in a multidisciplinary team meeting. In Merton and Sutton there was a weekly meeting where referrals were discussed.
- Between August 2015 and October 2015, the average time between referral and assessment was twelve days in the Merton and Sutton team and eight days in the Wandsworth team. Staff confirmed that there was no waiting list for the service.
- There was scope within the two teams to see people more quickly if there was an emergency or crisis situation and the team allowed some flexibility in order to manage this.
- At the time of our inspection, the Merton and Sutton team had fifty one people allocated to it and the Wandsworth team had forty four people allocated.
- The service had revised its operating policy as of March 2016. This set out clear parameters for the service and the criteria for referral to this team.
- People were seen predominantly at home but there were facilities to see people in both of the office locations.

The facilities promote recovery, comfort, dignity and confidentiality

- At both sites there were clear noticeboards in the reception areas which provided relevant and informative guidance for people who used the service. In the Jubilee Health Centre, where the Merton and Sutton team was located, the building was shared with a number of other trust services. Each service had a specific noticeboard and there was a noticeboard designated for carers information. Easy read information was available relating to a number of relevant areas including how to access services, making complaints and some information about specialist mental health difficulties, for example, eating disorders.
- Interview rooms on both sites were accessible and ensured confidential conversations could take place.

Meeting the needs of all people who use the service

- The service ensured that easy read information was available regarding the services which were offered and also care plans, recovery plans and information about personal recovery goals was available in easy read but also in a number of formats.
- Staff who worked in the two teams had access to interpreters including community languages and British sign language. We saw an example of a situation where staff used an interpreter to communicate with someone who used the service and their family and provided information about their care in an easy read care plan both in English and in the family's native language so that it was clear.
- We saw an example of a situation where staff displayed understanding and sensitivity relating to a person who used the service who identified as transgender. This involved work with the placement as well as with the individual to manage this and to ensure that their preferences were reflected.

Listening to and learning from concerns and complaints

- Between the end of November 2014 and December 2015 there were six formal complaints about community mental health services for people with a learning disability. All of these complaints related to the Merton and Sutton team. None of the complaints were upheld.
- Staff had a good understanding of recent complaints, both formal and informal within the service and there was scope to discuss complaints both within the team meetings and if relevant, in supervision sessions.
- Clear and accessible information was available about the trust complaints procedure. Two people who we spoke with told us that they did not know how to make complaints about the service.

Access and discharge

Are services responsive to people's needs?

Good

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

- People were generally referred to the service either through GPs or the community teams for people with learning disabilities. Self-referrals were possible but we were told by staff in the teams that they were not common. Other methods of referral were from other community teams within the trust such as recovery and support teams.
- In the Wandsworth team there was a triage meeting once a week to look at the appropriateness of referrals with discussions about referrals happening once a week in a multidisciplinary team meeting. In Merton and Sutton there was a weekly meeting where referrals were discussed.
- Between August 2015 and October 2015, the average time between referral and assessment was twelve days in the Merton and Sutton team and eight days in the Wandsworth team. Staff confirmed that there was no waiting list for the service.
- There was scope within the two teams to see people more quickly if there was an emergency or crisis situation and the team allowed some flexibility in order to manage this.
- At the time of our inspection, the Merton and Sutton team had fifty one people allocated to it and the Wandsworth team had forty four people allocated.
- The service had revised its operating policy as of March 2016. This set out clear parameters for the service and the criteria for referral to this team.
- People were seen predominantly at home but there were facilities to see people in both of the office locations.

The facilities promote recovery, comfort, dignity and confidentiality

- At both sites there were clear noticeboards in the reception areas which provided relevant and informative guidance for people who used the service. In the Jubilee Health Centre, where the Merton and Sutton team was located, the building was shared with a number of other trust services. Each service had a specific noticeboard and there was a noticeboard designated for carers information. Easy read information was available relating to a number of relevant areas including how to access services, making complaints and some information about specialist mental health difficulties, for example, eating disorders.
- Interview rooms on both sites were accessible and ensured confidential conversations could take place.

Meeting the needs of all people who use the service

- The service ensured that easy read information was available regarding the services which were offered and also care plans, recovery plans and information about personal recovery goals was available in easy read but also in a number of formats.
- We saw an example of a situation where staff displayed understanding and sensitivity relating to a person who used the service who identified as transgender. This involved work with the placement as well as with the individual to manage this and to ensure that their preferences were reflected.

Listening to and learning from concerns and complaints

- Between the end of November 2014 and December 2015 there were six formal complaints about community mental health services for people with a learning disability. All of these complaints related to the Merton and Sutton team. None of the complaints were upheld.
- Staff had a good understanding of recent complaints, both formal and informal within the service and there was scope to discuss complaints both within the team meetings and if relevant, in supervision sessions.
- Clear and accessible information was available about the trust complaints procedure. Two people who we spoke with told us that they did not know how to make complaints about the service.
- Staff who worked in the two teams had access to interpreters including community languages and British sign language. We saw an example of a situation where staff used an interpreter to communicate with someone who used the service and their family and provided information about their care in an easy read care plan both in English and in the family's native language so that it was clear.

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

- Most staff we spoke with were aware that the trust had values and reflected those values in their day to day work.
- Some staff were familiar with the senior management team including the board level management within the trust.
- While there was some concern that the profile of learning disabilities services were not high within the trust centrally, staff told us that they felt relationships with local authorities had improved over the past few years.

Good governance

- The trust collected information monthly from each team which reported back on key information including staff vacancies, sickness rates, complaints and incidents. Information which, when collated was able to provide an overview of the teams.The team manager had access to this data and was able to use it to plan the priorities for the team. The trust were able to use this information to pick up on any concerns or strengths within the services.
- Learning disabilities services were located in the Sutton and Merton borough management directorate. Across the directorate there was a monthly newsletter which was sent through email to all staff. Team managers across the borough directorate met monthly.
- In the year to March 2016, the sickness rate in the two teams was between 3% and 4%.The team manager had a good overview of the training needs of staff and ensured that supervision and mandatory training was updated.
- The service used peer reviews and action plans which had been developed from audits in order to drive service improvement.
- There was a modern matron in post who oversaw the community services as well as a number of other services.
- Although teams did not have discrete risk registers, the team and the team manager had a very good understanding of the current risk levels within the service and where the priorities were for improvement.

Leadership, morale and staff engagement

- At the time of our inspection visit, there was a vacancy for the team manager in the Wandsworth team. This was being covered by the manager who worked in the Merton and Sutton team. This post had been covered in this way for fifteen months. The trust had advertised this post several times but had not been able to recruit someone with the skill and experience which they were looking for in this period. This meant that one manager covered both teams across two sites. During the inspection, we were told by the manager that additional money had been allocated to allow more targeted advertising for this post. However, there had not been robust succession planning and opportunities for the development of nursing staff within the team to enable staff to develop their skills to undertake management roles.
- Morale among the staff team was generally very positive. The teams worked closely together and were committed to provide the best possible service for people they worked with. There was a pride in the work which they were undertaking.
- Some staff told us that they recognised positive changes in the direction of leadership within the senior management in the trust. However, other members of staff told us that they felt learning disability services were not recognised sufficiently within the trust plans and that there was a risk of the services being sidelined as they were so small.
- Staff were aware of the trust whistleblowing policy and told us that they would feel confident to raise concerns with their immediate managers.
- We received very positive feedback about the team manager from both teams and the work that had been done to cover both teams effectively. Some members of staff told us that it would be helpful to have permanent management in place in both teams.
- Staff across the service told us that the medical leadership provided by consultants within the teams was strong and supportive of staff.

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.

Commitment to quality improvement and innovation

- The trust quality account for 2015/16 specifically included a learning disabilities strategy as one of the targets over a two year period. We saw evidence of some of the work which had been done in this area. For example, teams across the trust had identified 'learning disabilities champions'. There was a learning disabilities champion in the learning disabilities team to coordinate communication with these champions and to provide a link for information so that people who used the services across the trust who had learning disabilities and not just those who were allocated within the specialist teams would have access to better tailored and skilled support.
- As a part of this development, the trust had rolled out e-learning specifically related to learning disabilities to make this training available for all staff.