Not sufficient evidence to rate

Sheffield Health and Social Care NHS Foundation Trust

Community mental health services for people with learning disabilities or autism

Quality Report

Fulwood House
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South Yorkshire
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Locations inspected

Name of CQC registered location	Location ID	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
Fullwood House	TAHXK	Community Learning Disability Team	S3 8NW

This report describes our judgement of the quality of care provided within this core service by Sheffield Health and Social Care 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.

Where applicable, we have reported on each core service provided by Sheffield Health and Social Care NHS Foundation Trust and these are brought together to inform our overall judgement of Sheffield Health and Social Care 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 services for people with learning disabilities or autism - Community-based	Not sufficient evidence to rate
Are services for people with learning disabilities or autism - Community-based safe?	**Not sufficient evidence to rate**
Are services for people with learning disabilities or autism - Community-based effective?	**Not sufficient evidence to rate**
Are services for people with learning disabilities or autism - Community-based caring?	**Not sufficient evidence to rate**
Are services for people with learning disabilities or autism - Community-based responsive?	**Not sufficient evidence to rate**
Are services for people with learning disabilities or autism - Community-based well-led?	**Not sufficient evidence to rate**

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 found that the community learning disability team (CLDT) had safe staffing levels and assessed and managed risk to people. However we found basic and detailed risk assessments were not easily accessible to staff to ensure risks were always known.

Staff reported incidents and learned from these when things went wrong.

We identified issues around effective management of staff sickness and the impact this had on workload and waiting lists. However the provider provided us with assurances that these issues were being addressed at the inspection.

We found the CLDT assessed the needs of people, planned care and followed best practice in the treatment and delivery of care.

There were skilled staff and multi-disciplinary and inter-agency team working in place. Mandatory training was up to date for most staff. However there were some gaps in training such as Mental Capacity Act 2005 and equality and diversity training. We also found mandatory training such as RESPECT had not been completed or updated for some staff.

We found that the CLDT involved people in the care they received and treated them with kindness, dignity and respect.

We found issues around the effective management of new referrals. However the provider provided us with assurances that these issues were being addressed at the inspection.

We found there was an effective system in place for respsonding to and learning from formal complaints. However staff and patients were unclear about expectations around informal complaints.

We found the CLDT were committed to quality improvement and innovation and that effective leadership, morale and staff engagement were in place. There were good governance systems in place and staff understood and followed the trust's vision and values. There were however issues around risk registers not being accessible and editable by the service managers.

Summary of findings

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

Are services safe?

The office base was a suitable and safe environment for people to be assessed.

There were systems in place which ensured staff could keep themselves safe whilst visiting people in the community.

There was a complement of suitably qualified staff in place. Although there were some vacancies, there was a plan in place to fill these.

Staff sickness had impacted on workload and waiting lists. This had been identified by the service as a risk and action had been taken to address this.

Mandatory training uptake was up to date for most staff, however there were some gaps around RESPECT training and equality and diversity training.

New referrals to the service were assessed and the immediate needs of the person were fully considered following a detailed risk assessment.

There was an effective system in place for the reporting and monitoring of safeguarding.

There was an effective system in place for reporting clinical incidents.

Not sufficient evidence to rate

Are services effective?

A range of assessment clinics ensured that people's needs were identified ensuring they received the right kind of care.

There was an effective care planning process in place and this addressed a range of physical and psychological issues.

Most people had health action plans in place which identified people's physical, emotional and psychological health needs.

The service demonstrated best practice in treatment and care, specifically around cognitive behavioural therapy (CBT), positive behavioural support (PBS) and least restrictive practices.

Professionals used a range of tools to measure the outcomes for people which assisted in identifying if further support or services were required.

There was an effective system in place to audit the service and integrate lessons learned.

Not sufficient evidence to rate

Summary of findings

There was evidence of effective multi-disciplinary team (MDT) working within the service.

There were effective systems in place to ensure staff were supervised and appraised.

There were some gaps in training such as Mental Capacity Act 2005 (MCA) training and data base training (INSIGHT). However there was in plan in place to ensure that staff were brought up to date.

Are services caring?

Not sufficient evidence to rate

People told us they were involved in care planning.

The service was proactive in its approach to gaining feedback from people who used the service and their families. There was evidence that changes had been made based upon feedback.

Are services responsive to people's needs?

Not sufficient evidence to rate

The trust had employed an external company to assist the them develop a robust system to improve team productivity and reduce the number of people on the waiting list. We were satisfied the steps taken had reduced the risks of people not receiving a service at a time which they need it.

We observed good use of the easy read signage and easy read information available.

There was an effective system for dealing with formal complaints and we saw evidence of lessons learned. People told us that they knew how to make a complaint.

Prior to our visit, the Trust had identified concerns regarding the management of new referrals because people had waited significant periods of time before being assessed by professionals within the service. The Trust had completed a full review of each patient in response to this and we could see evidence of improvements beginning to be made.

Are services well-led?

Not sufficient evidence to rate

The CLDT staff showed an awareness of the trusts wider organisation's values. Staff were committed and passionate to improve the services they provided.

The CLDT team had lines of accountability and management structures in place as well as a governance structure for learning disability services.

Staff told us they felt supported in their roles and had support from the managers of the service.

Summary of findings

There were a range of regular governance meetings in place with attendance from senior members of the CLDT. Issues such as clinical incidents, risk registers, safeguarding, safety alerts and complaints were discussed at these meetings as evidenced by meeting minutes. Information from these meetings was relayed back to staff effectively.

There was good teamwork and multidisciplinary working within the team.

There was a directorate risk register in place and staff were able to tell us what the highest risks were in the team which were the waiting lists and recruitment of staff.

Due to the reconfiguration of the learning disability service and newly appointed interim managers in place, we found they did not have a full oversight of issues we found during the inspection.

Summary of findings

Background to the service

The Community Learning Disability Team (CLDT) is based in a shared building with the local authority (LA). The CLDT is the first point of access for health related care, treatment and support for adults with a learning disability and autism. They have close working links with the local authority social care services.

The CLDT run a range of clinics including: Eligibility, Assessment, Posture, Autism and Dementia all across a number of locations. When necessary joint eligibility clinics are held with the local authority colleagues. Each professional group manages a separate waiting list with an identified lead clinician, however at the time of the inspection, professional specific waiting lists were being merged into one CLDT waiting list.

Each professional group manages a separate waiting list with an identified lead clinician.

The CLDT has not been inspected by the CQC before.

Our inspection team

Our inspection team was led by:

Chair: Alison Rose-Quirie, Chief Executive Officer, Swanton Care

Team Leader: Graham Hinchcliffe, Care Quality Commission

Head of Inspection: Nicholas Smith, Care Quality Commission

The team included CQC inspectors. We also had a variety of specialist advisors which included a consultant psychiatrists, senior nurses, as well as experts by experience who had used services. These are not independent individuals who accompany an inspection team; they are part of the inspection team.

Why we carried out this inspection

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

How we carried out this inspection

To get to the heart of patients who use services' experience of care, 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 visiting, we reviewed a range of information we hold about learning disability services in Sheffield Health and Social Care NHS Foundation Trust and asked other organisations to share what they knew, including speaking with local Healthwatch, independent mental health advocacy services and other stakeholders. We held public listening events, as well as listening events with carers during the inspection.

We carried out an announced visit and an unannounced visit on 29 October 2014 and 12 November 2014. During the visits we spoke with nine members of staff including community nurses, physiotherapists, speech and language therapists, psychologists, health support workers and managers of the community learning disability team. We talked with eight people who use service and their carers. We reviewed seven care and treatment records of people who use the service.

Summary of findings

What people who use the provider's services say

During the inspection, we spoke with four people who used the service and four carers. Overall, people told us that staff treated them with respect and dignity, and they were positive about staff's attitude towards them.

People who used the services told us that they felt safe.

People also said they knew how to make a complaint and told us there was an easy read complaint form. People and carers told us they would feel confident raising any issues with the team.

People and their carers told us they had been involved in developing their care plans and had a copy of these. Carers said they had been informed about their relative's medication and people told us they felt the staff were skilled in meeting their needs.

All of the people that we spoke with were happy with way they were treated by the team in regards to kindness, dignity and respect.

People using the service were positive about the staff and the care they received and felt involved.

Good practice

Staff had been provided with electronic tablets, this meant time was saved as staff completed their patient records sometimes during their visits or immediately following their visit allowing staff to spend more time out of the office base.

Areas for improvement

Action the provider MUST or SHOULD take to improve

- The provider should ensure there is a long term strategy to manage staff sickness and impact on workload and waiting lists.
- The provider should ensure mandatory training is up to date for all staff.
- The provider should ensure basic and detailed risk assessments are easily accessible to staff to ensure risks are always known.
- The provider should ensure there is a long term strategy for the management of new referrals.

Sheffield Health and Social Care 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
Love Street, Community Learning Disability Team	Fulwood House

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.

We did not look at the MHA application at this service as this was a community learning disability team and was not applicable.

Mental Capacity Act and Deprivation of Liberty Safeguards

We observed easy read literature on the trusts internet page about the Mental Capacity Act 2005.

We looked at nursing staff mandatory training which identified some gaps in core training areas such as, Mental Capacity Act 2005 (MCA) training.

Not sufficient evidence to rate

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

The office base was a suitable and safe environment for people to be assessed.

There were systems in place which ensured staff could keep themselves safe whilst visiting people in the community.

There was a complement of suitably qualified staff in place. Although there were some vacancies, there was a plan in place to fill these.

Staff sickness had impacted on workload and waiting lists. This had been identified by the service as a risk and action had been taken to address this.

Mandatory training uptake was up to date for most staff, however there were some gaps around RESPECT training and equality and diversity training.

New referrals to the service were assessed and the immediate needs of the person were fully considered following a detailed risk assessment.

There was an effective system in place for the reporting and monitoring of safeguarding.

There was an effective system in place for reporting clinical incidents.

Our findings

Safe and clean environment

The offices where the team were located were generally well maintained. The community learning disability team (CLDT) primarily visited people in their own homes or in mutually agreed locations in the community. At times however people could be seen in the team office. We looked at the room where people were assessed and found these were fit for purpose.

Access to the building was controlled by the reception staff and the teams had an established process in place for staff to sign in and out so their movements were known throughout the day. Any visitors or people attending for assessments were also signed in and out.

There was a managing access and exit policy in place for staff (previously called the lone working policy) so that staff in the office knew the whereabouts of their staff team. All staff that we spoke with were familiar with the policy and how to keep themselves safe during community visits.

Safe staffing

The staffing complement within the CLDT consisted of a range of professionals such as learning disability nurses, occupational therapist, psychologists, speech and language therapist, a psychiatrist, a physiotherapist as well as a range of healthcare support staff.

The service did have some vacancies particularly in psychology and speech and language therapy. The service recognised this had an impact on the current workload of staff working in the service and waiting lists as identified as a high 'red' risk on the service specific risk register. The service was able to show us what action they had taken to recruit people to the vacant posts whilst they maintained a service for people who used and were referred to the service.

We looked at the arrangements in place for caseload management and found weekly meetings were held within teams to discuss people and then assign them to specific clinical leads.

Staff told us they often felt pressure and stressed when staff were on sick leave or special leave. A quality and monitoring tool showed a higher level of absence in August 2014. Staff told us there were no additional staff to assist with the management of a person's portfolio, and therefore work had to be distributed amongst the staff team. This had also been identified as a high 'red' risk on the service specific risk register.

Mandatory training records for community nurses demonstrated staff had received training and this was up to date for:

- Basic life support

Not sufficient evidence to rate

Are services safe?

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

- Adult protection
- Information governance.

We did find however there were some gaps in training relating to:

• Clinical risk assessment

• Equality and diversity

We found people had access to emergency and out of hours cover. This was provided by access to the accident and emergency department and the crisis teams within the mental health directorate.

Assessing and managing risk to patients and staff

The trust had developed a new referral and service pathway for adults with learning disabilities accessing health related services and this was still being implemented. People were able to self-refer to the local authority. GPs, their carers and other services were also able to refer people into the service.

The service had a team who accepted referrals and if needed sign posted people to the most appropriate service. The referrals were screened and prioritised according people's needs. We saw an example of a referral that had been received by the team. There was an identified risk of possible harm to others. We were told this type of referral had gone to a clinical lead, who liaised with the person's social worker because this person was known to their services. We were told due to the person's risk it was essential the person was prioritised for assessment and treatment.

The teams risk assessed people using the brief risk assessment management tool (BRAM) and had also started to complete the detailed risk assessment management tool (DRAM) for all referrals. We found these assessments were not easy to locate within their computerised system (insight). We therefore asked the management and staff working within the service to access the records for us. They equally encountered problems locating them as it took hours for them to find the risk assessments for us. This meant that risk assessment could not be accessed promptly. This was brought to the attention of the management who acknowledged our concerns and told us they would improve access to the system to ensure staff were able to identify quickly people's identified assessed risks.

Staff told us they would sometimes undertake visits in pairs where a risk assessment had identified a higher risk to staff. We were told this was highlighted on the person's case records.

The CLDT held weekly multi-disciplinary team (MDT) meetings which looked at and discussed all referrals into the service. Weekly meetings took place which allowed the team to summarise the person's required needs and any risks that were associated with the person staff needed to be aware of.

There was evidence of the safeguarding process being used within the team. The trust's safeguarding policies and procedures were accessible on their intranet. A safeguarding flow chart from the trust was seen in the team base which described to staff how they would escalate and report any safeguarding concerns in relation to people. All staff we spoke to were able to adequately report and escalate any safeguarding concerns that occurred. Staff from the CLDT told us that they received feedback regularly from these safeguarding referrals due to the fact that they are co-located in the team base with the local authority social workers.

Reporting incidents and learning from when things go wrong

There was an incident reporting system in place which was completed following any incidents which allowed the relevant line managers and clinical leads to review and grade the severity of incidents. Staff was aware of how to complete an electronic incident form and their responsibilities in relation to reporting incidents.

Staff and managers were able to describe the process and their responsibilities in relation to reporting. The staff we spoke to also described 'lessons learnt' by way of reflective practice within team meetings and weekly review of caseloads.

Staff were aware of the whistleblowing policy and the process they would follow and also how they could escalate issues to the trust.

Are services effective?

Not sufficient evidence to rate

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

A range of assessment clinics ensured that people's needs were identified ensuring they received the right kind of care.

There was an effective care planning process in place and this addressed a range of physical and psychological issues.

Most people had health action plans in place which identified people's physical, emotional and psychological needs.

The service demonstrated best practice in treatment and care, specifically around cognitive behavioural therapy (CBT), positive behavioural support (PBS) and least restrictive practices.

Professionals used a range of tools to measure the outcomes for people which assisted in identifying if further support or services were required.

There was an effective system in place to audit the service and integrate lessons learned.

There was evidence of effective MDT team working within the service

There were effective systems in place to ensure staff were supervised and appraised.

There were some gaps in training such as Mental Capacity Act 2005 (MCA) training and data base training (INSIGHT). However there was in plan in place to ensure that staff were brought up to date.

Our findings

Assessment of needs and planning of care

Each professional group managed a separate waiting list. A new assessment tool was in place which determined criteria, risk and suitable pathways.

The CLDT had a process for identifying their eligibility criteria that was applied to all referrals into the service. The CLDT provided a range of services which included health promotion; complex health needs assessments such as depression, psychotic disorders, dementia, autistic spectrum disorder as well as physiotherapy assessments, speech and language therapy and psychological interventions.

We looked at eight care records across the service. We viewed people's electronic records and notes. There was a care planning process in place and this addressed a range of physical and psychological issues. Five of the records contained detailed risk assessments which all members of the health professional team could access. This meant all staff who were involved in a particular person's care were able to look at the care being planned and delivered and also the risks associated with the person.

Teams undertook an initial assessment which was based on the referral they had received. The service had set up a range of assessment clinics so they could be sure that all of the person's needs and access needs were identified, ensuring people received the right kind of care.

Some people were on the Care Programme Approach (CPA) and this was also recorded on the electronic records. Full action plans were completed at the end of the meeting and this showed people's involvement.

We looked at how people's healthcare needs were planned and found that most people had health action plans in place which identified people's physical, emotional and psychological needs.

Where people required additional support to remain healthy such as advice on health eating, epilepsy, dental, women's breast care, and other sexual health support, the team provided specific individual or group work for people to access. The service also had access to a range of professionals within the general hospital teams to ensure people's needs could be met.

Best practice in treatment and care

The multi-disciplinary team included consultant psychiatrist, health support works, nurses, occupational therapists, speech and language therapists, physiotherapists and psychologists. The psychological approach was guided by the positive practices framework (Improving access to psychological therapies NHS 2009), as well as best practice in cognitive behavioural therapy (CBT).

Positive behaviour support (PBS) was also used in line with 'Positive and Proactive Care: reducing the need for

Are services effective?

Not sufficient evidence to rate

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.

restrictive interventions' (DOH 2014) which also encompassed 'Transforming Care: a national response to Winterbourne View Hospital' (DH 2012) and 'Mental Health Crisis Care: physical restraint in crisis' (MIND June 2013).

Psychologists also delivered training to the wider MDT in positive behaviour support.

The service provided care and support to people in a range of settings such as residential homes, their own homes and other alternative community settings. In order for the service to effectively measure the care and treatment provided, each professional used a range of tools to measure the outcomes for people which assisted in identifying if further support or services were required.

We saw that there were a number of clinical audits in place including medication, care planning, restraint, Do Not Attempt Resuscitation (DNAR) audits and Deprivation Of Liberty Safeguards (DOLS). The team also participated in national audit programmes such as Learning disability (LD) national benchmarking as well as Commissioning for Quality and Innovation (CQUINS). Each audit had an action plan in place to monitor progress on lessons learnt. These were shared regularly though the governance meetings and coordinated in a directorate audit programme overseen by the trusts audit department.

Skilled staff to deliver care

Staff worked within a multi-disciplinary team (MDT) framework. There was good evidence of effective MDT team working within the service which included input from , medical staff nurses, occupational therapists, psychologists, physiotherapist's and speech and language therapists.

Nursing staff mandatory training identified some gaps in core training areas such as, Mental Capacity Act 2005 (MCA) training and data base training (INSIGHT). However the trust had set up a number of training dates for staff.

Staff received regular clinical and managerial supervision. There was also monthly practice development sessions available for staff to discuss clinical matter in a group setting. Staff we spoke with confirmed they had an annual appraisal and were aware of their own personal development goals.

Supervision structures were in place for all levels of staff that included line management and peer supervision. We interviewed seven staff across the teams and all stated they felt they were supported in their role both formally through the supervision structures but also informally with peers or their immediate line manager.

The community team regularly had student nurses allocated to them on placement at varying stages of their course. Both teams had developed bespoke packages to assist with their training which included weekly supervision.

Are services caring?

Not sufficient evidence to rate

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

Summary of findings

People told us they were well supported by the team and they were treated with respect and kindness.

People told us they were involved in care planning.

The service was proactive in its approach to gaining feedback from people and their families. There was evidence that changes had been made based upon feedback.

Our findings

Kindness, dignity, respect and support

We spoke with four people and four family carers during our inspection face to face and via telephone. People told us they were well supported by the team and comments included "The staff were good", "I don't have to wait long" and "The staff are lovely."

People told us they were treated with respect and kindness. They also told us they were supported with accessing other services outside the CLDT such as sexual and physical health screening and support.

People told us that staff respected their privacy and dignity when providing support such as personal care.

The involvement of people in the care they receive

People told us they were involved in their care planning and were aware of its contents. One person was able to inform us of their positive behavioural support plan and how it supported them to manage their complex needs and provide a better quality of life.

We looked at seven peoples care records and found they did not always contain clear objectives and goals for people.

One of the care records we looked at contained "easy read" care plans which were given to the patient who had difficulties in communication. We saw good use of pictorial assessment/ treatment plans completed by the physiotherapist in relation to people's mobility and posture management health needs.

We saw the person's family, carers and the individual person had been fully involved in the planning of their care. Family carers told us that they were involved in care planning and could raise issues.

We found the team was proactive in its approach to gaining feedback from people and their families through measures such as the 'Family and friends test' and 'How did you find us' questionnaires. There were groups and events in place such as the big health event, coffee mornings, links with the local Mencap and groups such as the improving health group and complex needs group where feedback on services was gathered and collated by the team.

Evidence that changes had been made to the service based on people's feedback and complaints was seen during the inspection. The learning disability partnership board has representation from family and parents which allowed them to feed back to the service.

Not sufficient evidence to rate

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

Prior to our visit, the Trust had identified concerns regarding the management of new referrals because people had waited significant periods of time before being assessed by professionals within the service. The Trust had completed a full review of each patient in response to this and we could see evidence of improvements beginning to be made.

The organisation had also employed an external company to assist the trust to develop a robust system to improve team productivity and reduce the number of people on the waiting list. We were satisfied the steps taken had reduced the risks of people not receiving a service at a time upon which they need it.

We observed good use of easy read signage and easy read information available.

There was an effective system for dealing with formal complaints and we saw evidence of lessons learned.

Our findings

Access, discharge and bed management

Prior to our visit, the Trust had identified concerns regarding the management of new referrals. Records showed people had waited significant periods of time before being assessed by professionals within the service. Examples of this were speech and language therapy (SALT),occupational therapy (OT) and psychology had waiting lists of between 31-38 weeks in September 2014. We brought this to the attention of the interim head of service who acknowledged our concerns and gave us assurances they would investigate our concerns and report the findings to us.

We returned to the service on the 12 November 2014 to complete the inspection and check for immediate improvements. We found steps had been taken to rectify our concerns in relation to management of referrals. A full review of each person on the waiting list had been completed which identified the needs of the person and the service they required as well as identifying designated professionals who would be responsible for ensuring these people received care and treatment in a timely manner.

The organisation had already employed an external company to assist the trust to develop a robust system to improve team productivity and reduce the number of people on the waiting list. We were satisfied the steps taken had reduced the risks of people not receiving a service at a time upon which they need it.

Meeting the needs of all people who use the service

People using the service had varying levels of cognitive functioning and literacy. For many this meant that written information and leaflets needed to be simplified and available in a form accessible for their needs. We observed good use of easy read signage and information displayed in the team bases. There was also easy read literature on the trusts internet page, such as a referral leaflet and information about the Mental Capacity Act 2005.

We also found where people spoke different languages the service had access to interpreters to assist staff and people to identify the care and treatment needs of people.

Listening to and learning from concerns and complaints

Complaints and concerns which people had raised were discussed at the service's quarterly complaints meeting, monthly governance meetings and in the weekly team meetings. We found evidence to show that the manager had taken timely action in response to complaints which they had received. There was evidence that action plans had been put in place following complaints and lessons learned.

There were copies of easy read complaint leaflets available in the community teams, staff members were fully aware of the complaints process and knew about the advocacy service and how they could direct people and carers to the department.

People and carers we spoke with told us they knew how to complain about the service.

Are services well-led?

Not sufficient evidence to rate

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

The CLDT staff showed an awareness of the trusts wider organisation's values. Staff were committed and passionate to improve the services they provided.

The CLDT team had lines of accountability and management structures in place as well as a governance structure for learning disability services.

Staff told us they felt supported in their roles and had support from the managers of the service.

There were a range of regular governance meetings in place with attendance from senior members of the CLDT. Issues such as clinical incidents, risk registers, safeguarding, safety alerts and complaints were discussed at these meetings as evidenced by meeting minutes. Information from these meetings was relayed back to staff effectively.

There was good teamwork and multidisciplinary working within the team.

There was a directorate risk register in place and staff were able to tell us what the highest risks were in the team which were the waiting lists and recruitment of staff.

Due to the reconfiguration of the learning disability service and newly appointed interim managers in place, we found they did not have a full oversight of issues we found during the inspection.

Our findings

Vision and values

The CLDT staff showed an awareness of the trusts wider organisation's values. Staff were committed and passionate to improve the services they provided albeit working with limited staff. Staff were aware the service needed to change and an external consultancy agency had been brought in to address issues around the waiting list and staff efficiency. Most of the staff we spoke with told us this had already had an impact on the efficiency in providing a service. Examples provided;

- Staff diaries had been pre-populated with pre-assessment slots booked in which reduced their waiting list and access to a service for people.
- Staff had been provided with electronic tablets. This meant time was saved as staff completed their patient records sometimes during their visits or immediately following their visit. This meant staff did not have to keep returning to the office thus saving time.

Good governance

The CLDT team had lines of accountability and management structures in place and a governance structure for learning disability services. However, due to the reconfiguration of the learning disability service and newly appointed interim managers in place, we found they did not have a full oversight of issues we found in relation to this team. These were;

- Clinical leads were managing their own waiting lists and management did not have full insight or oversight of this.
- Access to risk assessments was difficult to locate on their computerised system, as individual staff had stored them in different places.

We discussed the first point during our initial visit with the service manager and following our second visit to the service we could see improvements had been made. We fed this back to the service managers about easy access to the risk assessments, who assured us they would address this issue.

Staff told us they felt supported in their roles and had support from the managers of the service.

We spoke with staff that had been identified as the clinical leads within the team. Clinical leads monitored the clinical supervision of their team which were all up to date.

We were aware the overall mandatory training of nursing staff had gaps however we did not see records relating to other professions training within this team.

Staff told us that guidance on incident reporting was available as part of induction and training. Incidents were analysed by the clinical lead to identify any trends and appropriate action was taken in response to these. Any serious untoward incidents (SUIs) would be reviewed by the clinical lead and the risk management department. The investigation would be assigned to another service to carry

Are services well-led?

Not sufficient evidence to rate

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.

out a root cause analysis independently. Any actions from the investigation would be monitored through the senior management meeting and directorate wide governance meeting

The clinical leads attended a monthly service meeting with attendance from the trust risk manager. Minutes of these meetings were available for staff and key messages were fed back through the weekly staff and service meetings. The meeting covered agenda items which included safeguarding, learning from incidents and safety alerts. Minutes of the meetings were made available for staff who were unable to attend the meetings. Staff also told us that feedback from incidents were distributed through email updates and 'global alerts'. Incidents were also discussed in regular practice development sessions.

We were told by staff that there was a corporate trust wide risk register in place, as well as a directorate risk register that was specific to the learning disabilities directorate. We were told that any members of staff could escalate a new risk or update an existing risk. Staff were able to tell us what the highest risks were in the team which were the waiting lists and recruitment of staff.

Leadership, morale and staff engagement

Staff in the community team told us they felt supported by their direct line managers and there was good teamwork and multi-disciplinary working within the team. Some staff told us they had a high staff vacancy rate at the service due to staff retirement and staff leaving the service. Posts had not been 'back filled' when staff left their position. We spoke to the service manager about this who confirmed adverts had gone out to fill vacant post within the learning disability directorate.

All staff we spoke to mentioned a sense of "team support" and staff were committed to the people they provided a service to. They told us there were informal support structures in place as well as formal ones for example appraisal and clinical supervision.

Commitment to quality improvement and innovation

The service had a register which kept the details of all people living in Sheffield who had a learning disability they were aware of. The service used the register to identify areas where health promotion could be achieved. For example, work had been done to ensure each person had a hospital passport and a health action plan.

The service also used the register to develop research. For example, the organisation had completed a study to look at epilepsy in people with a learning disability and developed care pathways to support people in the management of epilepsy in the community.

There was also a process which had been developed between the acute hospital and the community learning disability team which informed staff on the number of times a person may present at hospital for minor health problems. The service used this information to identify any mental health related issues and planned an effective way to support people.