

Lancashire Care NHS Foundation Trust

# Community-based mental health services for older people

## Quality Report

Sceptre Point  
Sceptre Way  
Walton Summit  
Preston  
Lancashire  
PR5 6AW  
Tel: 01772 695300  
Website: <http://www.lancashirecare.nhs.uk>

Date of inspection visit: 13 to 15 September 2016  
Date of publication: 11/01/2017

### Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/unit/team)	Postcode of service (ward/unit/team)
RW5HQ	Sceptre Point	Fylde Coast rapid intervention and treatment team	FY8 5EE
RW5HQ	Sceptre Point	Blackpool, Fylde and Wyre community mental health team	FY1 5JW
RW5HQ	Sceptre Point	West Lancashire community mental health team	L39 2JW
RW5HQ	Sceptre Point	West Lancashire memory clinic	L39 2JW
RW5HQ	Sceptre Point	Central Lancashire community mental health team	PR1 1LB

# Summary of findings

RW5HQ

Sceptre Point

Central Lancashire rapid  
intervention and treatment team

PR1 1LB

This report describes our judgement of the quality of care provided within this core service by Lancashire 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 Lancashire Care NHS Foundation Trust and these are brought together to inform our overall judgement of Lancashire 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 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 this inspection

	Page
Overall summary	5
The five questions we ask about the service and what we found	6
Information about the service	11
Our inspection team	11
Why we carried out this inspection	12
How we carried out this inspection	12
What people who use the provider's services say	12
Good practice	13
Areas for improvement	13

---

### Detailed findings from this inspection

Locations inspected	14
Mental Health Act responsibilities	14
Mental Capacity Act and Deprivation of Liberty Safeguards	14
Findings by our five questions	16

---

# Summary of findings

## Overall summary

We rated community based mental health services for older people as good because:

- There were safe lone working practices which were standardised across each of the localities. This promoted staff safety when visiting patients' homes. Staff had manageable caseloads which helped to promote staff keeping patients safe. Referral information was coordinated and actioned quickly to minimise risk. Care plans had crisis care plans to inform patients and carers on what to do in crisis. Patients' records contained comprehensive risk assessment and were stored securely on the electronic patient record.
- Staff were up-to-date with mandatory training. Staff had regular supervision and there was a new structured appraisal process which had quarterly review intervals. The new appraisal included key objectives and the trust's visions and values.
- Teams had effective multidisciplinary working in the delivery of care and treatment. There was good interagency working with voluntary and third sector organisations. Staff took action to ensure that patients' physical health needs were monitored and treated.
- The service had good systems to ensure the Mental Health Act was followed where patients were on a community treatment order. Staff had a good understanding of the Mental Health Act and Mental Capacity Act.
- There was a process in place so that patients on a community treatment order were informed about the availability of the independent mental health advocacy service and had their rights read to them.

- Patients spoke highly about the care they received from the staff within each of the older adult services. Patients told us about staff going the extra mile to support patients. Patients and those close to them were involved in the decisions around care and treatment.

- Access to services was coordinated through a single point of entry in each locality. There were some waiting lists but these were within the guidelines from the standard operating procedure of the service delivery timescales. This meant that teams were meeting the targets expected of them.

- There were low numbers of complaints and these were well managed. The service received 238 compliments within the last 12 months.

- Staff understood the trust's vision and values. Teams were well-led by committed managers and staff felt respected and supported. Effective managerial operational meetings took place where incidents were discussed, team performance was reviewed and staffing and sickness in teams was considered. There was a commitment to service improvement to meet the needs of different patient groups.

However:

- The Fylde Coast rapid intervention and treatment team had changed their operational hours as a result of vacancies and safe staffing levels.

- The services were not routinely undertaking fire drill testing at each of the team localities.

- The executive management team were not fully visible and in some cases staff did not know who they were.

# Summary of findings

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

### Are services safe?

We rated safe as good because:

- The service had well-structured lone working arrangements in place across all localities to support staff when visiting patients in their homes.
- Staff used the trust's electronic incident recording system to report incidents. There was a trust wide system where learning was shared between teams. This identified learning themes across teams and the service as a whole.
- Staff checked clinic room, resuscitation and emergency equipment daily.
- Staff mandatory training was up to date and managers used a training tracker tool to maintain the trust's target levels.
- The service had safe medicine management practices at sites which used prescription pads or where medicine was stored on the premises.
- Patients had risk assessments and crisis plans which told them or their carers what to do in a crisis.
- Staff reviewed referrals into the service and coordinated quickly to prioritise assessments of patients according to their level of risk.
- There was a process to monitor the waiting list to detect any patients waiting beyond agreed levels.
- Team offices were safe and clean environments with environmental risk assessments for the premises being conducted annually.

However:

- The services were not routinely undertaking fire drill testing at each of the team localities. There were seven out of 17 teams who had not completed a fire drill within the last six months.
- Staffing levels at the Fylde coast rapid intervention and treatment team had impacted on the service delivery due to vacancies. The team had used bank and agency staff to maintain service delivery. However, the team had temporarily reduced their hours of operation from 8am to 8pm to 9am to 5pm due to concerns for safe staffing levels. This was detailed on the risk register.

Good



### Are services effective?

We rated effective as good because:

- The service used a range of recognised monitoring scales for assessing patients and measuring patient outcomes.

Good



# Summary of findings

- Staff regularly reviewed patient care records. Care records included evidence of patient and family or carer involvement in care and treatment planning and decisions.
- Community mental health team staff undertook some physical healthcare monitoring in partnership with GPs for high dose antipsychotic monitoring in line with best practice.
- Staff completed a range of audits to benchmark the service against best practice.
- The trust had a best practice meeting where information was discussed around changes to national guidance. This information was disseminated to teams at team meetings, for implementation and reflective practice discussions.
- Teams had good interagency working with the voluntary and third sector care. For example teams had a care home liaison service with staff visiting nursing homes to support patients and care home staff in caring for patients.
- The trust held a daily videoconference bed management meeting which the community teams joined.
- Teams had local induction programmes for new staff.
- Teams had specialist training programmes delivered internally by community mental health team staff who were trained to deliver particular courses.
- Teams had good systems in place to ensure that the Mental Health Act was followed where patients were on a community treatment order.
- Staff had a good understanding of Mental Health Act and Mental Capacity Act.
- Independent mental health advocacy services were accessible to patients on community treatment orders.

## Are services caring?

We rated caring as as good because:

- Patients complimented the care and treatment they received from experienced, compassionate staff. Patients told us they were involved in the decision making and care planning.
- All patients and carers we spoke with knew about their risk management plans and crisis plans.
- Patients told us how staff go the extra mile for them.
- We observed interactions between staff and patients, which showed staff treating patients with compassion, kindness and patience.
- Staff treated patients, carers and family members with dignity and respect.

Good



# Summary of findings

- Patients received a welcome pack outlining contact details for the team and guidance on how to complain, compliment or raise concerns.
- The teams had a volunteer worker proactively conducting the Friends and Family Test by making phone calls to patients or their carers to obtain feedback.
- A research paper on patient and carer experiences of older adults community mental health teams spoke with 60 people and most people were either very satisfied or satisfied with the service they received.

## Are services responsive to people's needs?

We rated responsive as good because:

- Access into the service was coordinated through a single point of entry in each of the localities with staff designated to consider each referral and determine the most appropriate response. There was a rating of priority using a traffic light system (green being low priority, amber medium and red high)
- The trust used an electronic gatekeeper system where GPs sent referrals electronically to the teams.
- The trust had implemented a standard operating procedure across the service within each locality. This included the prescribed referral criteria for accessing the community mental health and rapid intervention and treatment teams along with an outline of the treatment pathways for each of the different teams.
- The memory service had a procedure and decision tree to triage patients suitable for the service.
- The trust had a policy for the transition of patients between adult and older adult services and this was being followed.
- Teams inspected had no waiting list for urgent and immediate referrals. Waiting lists for routine referrals were meeting the standard operating procedure wait times.
- One of the teams had restructured their caseload into neighbourhood teams to be more effective in the delivery of care. This meant that members of staff were assigned to a smaller area within a neighbourhood which reduced travelling times between visiting patients and increased quality time spent with patients and carers.

Good





# Summary of findings

- Teams reported that 100% of patients discharged from hospital were followed up within 7 days of discharge.
- The service had a high number of compliments and a low number of complaints during the last 12 months.
- The trust used the sharing the learning memo to disseminate information to teams about learning from complaints.

However:

- Patients from West Lancashire had long travelling distances to access an appropriate inpatient bed which could be up to 55 miles away in some cases.

## Are services well-led?

We rated well-led as good because:

- Staff understood the trust's visions and values.
- Staff told us that the team worked well together and received good support from managers. Senior management for the service were visible; however the executive management team were not fully visible and in some cases staff did not know who they were.
- Team managers held risk registers for local issues and these were escalated to a service risk register as required.
- Effective service operational meetings took place where incidents were discussed, team performance was reviewed and staffing levels and sickness was considered. Also reviewed in these meetings was team level supervision, appraisal, training and caseload allocation. The trust had team dashboards to support performance monitoring.
- Staff and managers had good relationships with representatives from clinical commissioning groups, local authorities and other agencies to improve practice.
- Staff morale was good throughout the service.
- Staff and managers within teams were committed to service improvement and listening to feedback. The teams had completed patient and carer surveys. The teams had a volunteer worker conducting the Friends and Family Test by making phone calls to patients or their carers to obtain feedback.
- One team was involved in a national randomised controlled trial of assistive technology and telecare with people who were living with dementia.

Good



# Summary of findings

- The trust had developed innovative partnership working with the police to make it safer for people with dementia to follow well-established patterns of going out under a 'safer wandering scheme' protocol.

However;

- Administration staff felt unsettled as there was still an ongoing staffing review in progress. This meant there had been freezing of vacancies for recruitment which also prevented opportunities for promotions.

# Summary of findings

## Information about the service

Lancashire Care NHS Foundation Trust provides community based services for older people across the footprint of Blackpool, North, East, Central and West Lancashire and Pendle, Hyndburn and Ribble Valley.

The current community mental health teams were formed in April 2015 following a transformation process.

The community mental health teams for older people support people over the age of 65 with severe and enduring mental health needs. There is also an early onset dementia service for people under the age of 65.

The teams comprised community mental health nurses, social workers, approved mental health professionals, occupational therapists, psychiatrists, clinical psychologists, support workers for carers, support time and recovery workers and administration staff.

We sampled the community mental health service teams as part of our comprehensive inspection process. We visited six services which were part of the community older people's mental health teams. The teams we visited were:

- Blackpool, Fylde and Wyre community mental health team operating Monday to Friday 9am to 5pm.
- West Lancashire community mental health team (Ormskirk integrated team) operating Monday to Friday 8am to 6pm.
- Central Lancashire community mental health team operating Monday to Friday 9am to 5pm.

- West Lancashire memory assessment service operating Monday to Friday 9am to 5pm.
- Central Lancashire rapid intervention and treatment team, operating 8am to 6pm seven days a week.
- Fylde Coast rapid intervention and treatment team which is commissioned to operate 8am to 8pm seven days a week but the team were operating 9am to 5pm seven days a week due to staffing levels at the time of our visit.

In most areas, referrals were screened by the rapid intervention and treatment team. The rapid intervention and treatment team held the single point of access function, providing urgent and immediate crisis support to service users where required. Routine referrals were signposted to the community mental health teams for longer term support.

The exception was in West Lancashire where the community mental health team had an integrated team with no separate single point of access or rapid intervention and treatment team.

We previously inspected the community mental health services for older people during our comprehensive inspection of the trust in April 2015. We found that the community mental health services for older adults were good overall. We rated each core question as good (safe, effective, caring, responsive and well led).

## Our inspection team

Our inspection team was led by:

Chair: Neil Carr OBE, Chief Executive South Staffordshire and Shropshire Healthcare NHS Foundation Trust

Head of Inspection: Nicholas Smith, Care Quality Commission

Inspection Managers: Sharon Marston and Nicola Kemp, Care Quality Commission

The team that inspected the community based services for older people comprised of a CQC inspector, a team manager, a senior nurse practitioner, a clinical lead with a background in older adults nursing and an expert by experience. An expert by experience is someone who has experience of using mental health services as a patient or a carer.

# Summary of findings

## 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 held focus groups with patients, carers and staff. We also conducted key interviews with executive, non executive and senior management team members.

During the inspection visit, the inspection team:

- visited three community mental health teams and checked the quality of the environment
- visited one memory assessment team

- visited two rapid intervention and treatment teams
- observed staff providing care and treatment to one patient on a home visit, one new patient meeting and one staff member supporting care home staff to support a patient in residential care
- spoke with three patients
- spoke with one carer
- spoke with the managers for each of the teams
- spoke with 16 other staff members individually; including doctors, nurses, occupational therapist, and social workers
- looked at 26 treatment records of patients
- held two staff group interviews
- reviewed 11 individual patient medication administration records
- carried out a specific check of the medication management within the teams
- 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

We spoke with three patients and one carer, and attended one visit to a patient's home. Patients spoke positively about the care they received from the service. Patients told us they were treated with dignity, respect and kindness with staff showing a genuine interest in patients' wellbeing. Patients and the carer told us that staff were responsive and knowledgeable. Patients felt that they received appropriate information about their condition, treatment options and other information including financial and future welfare decisions. Patients confirmed that they knew who to call if they were in crisis and they knew they had crisis plans in place.

Patients told us that staff went the extra mile. For example, one patient had no family members and the staff had supported them to take their pet to the vets. One patient told us they wouldn't know where they would be without support from staff in the service.

The carer told us that staff responded quickly to give them support with their family member and that the carer and patient were involved in the care planning.

Patients and the carer told us they knew how to complain should they need to. One patient told us how they had written to the service to tell them how impressed they were with the service.

# Summary of findings

As part of the inspection we left comment cards boxes at various locations across the trust for people to tell us their experiences. On this occasion we received no completed comment cards for the older people's community mental health services.

## Good practice

- The service had a volunteer who worked one day a week to make proactive contact with the patients, their family members and carers to gain meaningful feedback for the Friends and Family Test survey.
- Staff from the Fylde rapid intervention and treatment were involved in a national randomised controlled trial of assistive technology and telecare with people who were living with dementia. The aim of the study was to establish whether assistive technology and telecare can safely extend the time people with dementia can continue to live independently in their own homes. Its purpose was to reduce the number of incidents involving serious risk to safety and independent living and improve the quality of life of people living with dementia and their care givers.
- The trust had developed partnership working with the police to make it safer for people with dementia to follow well-established patterns of going out without unnecessary and unhelpful interventions. The police used the 'safer wandering scheme' protocol for sharing information to enable them to respond appropriately to concerns from the public. The police in turn have produced guidance to the public on safer wandering.

## Areas for improvement

### Action the provider SHOULD take to improve

- The provider should continue to review and address safe staffing levels within the rapid intervention and treatment teams and the subsequent impact on service delivery. Lytham rapid intervention and treatment team had reduced their operational hours as a result of vacancies and safe staffing levels. Central rapid intervention and treatment team were supporting patients outside of their core operational hours.
- The provider should ensure that each locality undertakes routine fire drill testing to prepare them in the event of a fire.

## Lancashire Care NHS Foundation Trust

# Community-based mental health services for older people

## Detailed findings

### Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Fylde Coast rapid intervention and treatment team	Sceptre Point
Blackpool, Fylde and Wyre community mental health team	Sceptre Point
West Lancashire community mental health team	Sceptre Point
West Lancashire memory clinic	Sceptre Point
Central Lancashire community mental health team	Sceptre Point
Central Lancashire rapid intervention and treatment team	Sceptre Point

### 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.

There were systems in place to ensure that the Mental Health Act was being adhered to within the community

older people's teams. Mental Health Act administrators in the trust had systems and checklists to remind teams of their responsibilities including ensuring staff kept to key deadlines for patients on a community treatment order.

Across the nine community based services for older adults teams, there were 10 patients in total who were subject to a community treatment order

# Detailed findings

We reviewed a sample of the records and found they contained a full copy of the community treatment order. The records showed renewals occurred appropriately and that the conditions of the community treatment order were monitored.

Patients were informed of their rights and about the independent mental health advocacy service.

## Mental Capacity Act and Deprivation of Liberty Safeguards

People using the service of the community mental health teams for older adults were living in the community with a degree of autonomy and patients' capacity was assumed unless it was indicated otherwise.

Staff recorded mental capacity and consent when significant decisions were made.

Staff supported patients to put legal frameworks in place while they still had capacity to help them plan for future decisions before they became more cognitively impaired.

Staff had an understanding of their responsibilities in working within the Mental Capacity Act and had completed appropriate training.

The teams had care home liaison staff that provided professional support to patients in care homes and nursing homes.

# 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

Staff within community based services for older adults mostly provided care and treatment to patients in their own homes. If there were any concerns about staff safety, staff would see patients in pairs or arranged to see patients in safer alternative venues. In these cases, patients could be seen within interview rooms on site at most team bases apart from Central community mental health team, Fylde Coast rapid intervention and treatment team and Blackpool, Fylde and Wyre community mental health team.

Staff would also invite patients to attend team locations for various reasons including for memory assessment or to see the consultant psychiatrist. The rooms used to see patients were clean with welcoming reception areas and well equipped clinic rooms. Rooms equipped to see patients at the team base were fitted with alarm call points or staff wore personal alarms.

There was a system in place for visitors attending the building to sign in and out.

The environment was clean and well maintained. There was information about infection control displayed in relevant areas with facilities being dementia friendly to support patients and those close to them. Staff carried out environmental risk assessments for the premises. These were conducted annually with the teams' last environmental risks assessments carried out in July or August 2016. There was evidence to show that staff took action to respond to and improve the health and safety of the premises. For example, the risk assessment in the Fylde Coast rapid intervention and treatment team showed that action was taken to address the need for improved fire evacuation signage and repair the perimeter fence.

Staff checked clinic rooms, resuscitation and emergency equipment daily at team bases. Defibrillators were kept on site and were checked on a daily basis with no errors or omissions seen in the records we sampled.

Most patients would receive their own medication from the GP and store it in their homes. Where stock medication was held, medication was stored safely and appropriately within team offices. Medicines were held in locked storage

cupboards, locked cabinets and locked fridges with a key held in a key safe accessible by appropriate staff only. Where medicines required cold storage, these were stored in a locked fridge. There were recorded checks on the temperature of the medicines fridge to ensure that the correct temperatures were maintained.

Staff within teams were not routinely undertaking fire drill testing at each of the team offices. There were seven out of 17 teams who had not completed a fire drill within the last 6 months. There had been no significant fire safety incidents for the community older people's mental health teams. However, the lack of regular fire drills meant that staff were not practising how to safely evacuate themselves and any visiting patients and carers to help in the event of a real fire.

### Safe staffing

The older people's community mental health teams each had a team manager and a number of community psychiatric nurses, support workers and a range of social workers and allied health professionals working as part of a multidisciplinary team.

The figures below, from April 2016, show the staffing allocated for each of the teams, listing the number of vacancies for qualified nurses and support workers. The details are shown for the number of shifts covered by bank and agency staff as well as the number of shifts which had not been filled.

#### Central rapid intervention and treatment team

Number of qualified nurses – 17 whole time equivalent

Number of vacancies qualified nurses – 3 whole time equivalent

Number of support workers – 3 whole time equivalent

Number of vacancies support workers - 0.5 whole time equivalent

Shifts filled by bank staff - 20

Shifts filled by agency staff - 0

Shifts not filled by bank or agency staff – 3

Total number of substantive staff – 25



# Are services safe?

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

Average of total percentage vacancies overall (excluding seconded staff) – 15%

Total number of substantive staff leavers within last 12 months – 2

Average of total percentage permanent staff sickness overall – 14%

## Central community mental health team

Number of qualified nurses – 9 whole time equivalent

Number of vacancies qualified nurses – 0.5 whole time equivalent

Number of support workers – 2 whole time equivalent

Number of vacancies support workers – 1.4 whole time equivalent

Shifts filled by bank staff - 23

Shifts filled by agency staff - 0

Shifts not filled by bank or agency staff - 0

Total number of substantive staff – 22

Average of total percentage vacancies overall (excluding seconded staff) – 7%

Total number of substantive staff leavers within last 12 months – 1

Average of total percentage permanent staff sickness overall – 11%

## Lancaster & Morecambe rapid intervention and treatment team

Number of qualified nurses – 10 whole time equivalent

Number of vacancies qualified nurses - 0.5 whole time equivalent

Number of support workers – 4 whole time equivalent

Number of vacancies support workers – 0

Shifts filled by bank staff - 8

Shifts filled by agency staff - 0

Shifts not filled by bank or agency staff - 0

Total number of substantive staff – 20

Average of total percentage vacancies overall (excluding seconded staff) – 8%

Total number of substantive staff leavers within last 12 months – 1

Average of total percentage permanent staff sickness overall – 8%

## West Lancashire community mental health team

Number of qualified nurses – 9

Number of vacancies qualified nurses - 0

Number of support workers – 1

Number of vacancies support workers - 0

Total number of substantive staff – 13.53fte

Average of total percentage vacancies overall (excluding seconded staff) – 0%

Total number of substantive staff leavers within last 12 months – 0

Average of total percentage permanent staff sickness overall – 13.87%

## Blackpool, Fylde and Wyre community mental health team

Number of qualified nurses – 12 whole time equivalent

Number of vacancies qualified nurses – 0

Number of support workers – 5 whole time equivalent

Number of vacancies support workers - 0

Shifts filled by bank staff - 12

Shifts filled by agency staff - 0

Shifts not filled by bank or agency staff - 0

## Fylde coast rapid intervention and treatment teams

Number of qualified nurses – 21 whole time equivalent

Number of vacancies qualified nurses – 2 whole time equivalent

Number of support workers – 3.5 whole time equivalent

Number of vacancies support workers - 0

Shifts filled by bank staff - 8

Shifts filled by agency staff - 0

Shifts not filled by bank or agency staff - 3

# Are services safe?

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

Total number of substantive staff – 36

Average of total percentage vacancies overall (excluding seconded staff) – 5%

Total number of substantive staff leavers within last 12 months – 2

Average of total percentage permanent staff sickness overall – 3%

Staffing levels at the Fylde coast rapid intervention and treatment team had impacted on the service delivery due to vacancies, sickness and maternity leave. The team had used bank and agency staff to maintain service delivery. However, the team had temporarily reduced their hours of operation from 8am to 8pm to 9am to 5pm due to concerns for safe staffing levels. This was detailed on service local the risk register.

Staff within the community mental health teams reported having manageable caseloads which enabled them to monitor patients to provide safe and effective care. For example, community mental health team staff were managing an average caseload of between 12 and 24 patients at any one time and staff from the rapid intervention and treatment team managing an average caseload of between 19 and 25 patients.

The caseloads for the memory assessment services were allocated to the whole team rather than to individuals under the supervision of the nurse team leader. The caseloads per team were Memory assessment service Blackpool – 765

Memory assessment service Fylde and Wyre – 560

Memory assessment service East – 976

Memory assessment service Central and West – 1963

Memory assessment service Lancaster and Morecambe – 504

Mandatory training rates were at 51% according to data provided to us by the trust prior to the inspection. However, local data shown to us on inspection by the team managers was considerably better than these figures. We were able to see evidence of where staff were booked on courses or had attended them and this had improved

compliance levels. Mandatory training included moving and handling, basic and immediate life support, fire safety, conflict resolution training, infection control, health and safety and safeguarding children and adults.

Staff who had recently started were complimentary about the induction they had received which included a four week period rotating through teams.

There were pressures on hospital inpatient beds for older people which impacted on the staff within the rapid intervention and treatment team. Staff were staying after operational hours to support patients in an acute hospital or care home due to no beds for patients under the rapid intervention and treatment team. An example of this was a staff member stayed at the hospital until midnight when the service was only contracted to 6pm.

Each team had a consultant psychiatrist which meant that there was quick access to medical cover when needed. Out of hours cover was provided by an on call system which worked across the trust. This meant that there was quick access to a doctor in an emergency.

## Assessing and managing risk to patients and staff

Referrals were screened by the single point of access worker or duty member of staff within the rapid intervention and treatment teams. They would then assess the information on each person and determine if the person was accepted into the service for a more formal assessment.

Staff undertook comprehensive assessments of the risks that patients posed to themselves or others including vulnerability. Staff completed risk assessments at initial referral and updated them when necessary. This also included an annual care programme approach review or sooner if there was significant changes in patients' risks. Patients' care plans were clear in relation to guiding patients on what to do in a crisis. Most of the risk assessments were kept up-to-date and reviewed such as when patients were first accepted by the team, due to incidents or changes in circumstances or annually at the care programme approach review. Risk assessments were of a good standard to enable any staff member to understand the risks presented for each patient. On three out of 26 files, risk assessments had not been updated for some time. The three risk assessments were for patients in three different teams. We brought these to the attention of the relevant managers. In one case, the risk assessment for

# Are services safe?

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

one patient had not been updated since April 2014. Risks had clearly been identified in the patient's care plan and running records but not reflected in the patient's risk assessment. This patient was in residential care and we were assured that risks were being managed and would be reflected in the risk assessment on record.

Staff reviewed referrals into the service and coordinated quickly to prioritise according to information regarding risks posed to patients or others. There was also a process to monitor the waiting list to detect any deterioration.

The service had well structured lone working arrangements in place across all localities to support staff when visiting patients in their homes. This included staff using a white board to record their visits to patients in the community, staff visiting in pairs on first assessment and where risk assessments indicated and staff using a buddy system. There was a well known safe password that staff used whilst visiting in the community to alert office based staff where staff required assistance. If staff were working after hours, there were other arrangements in place. For example staff would contact nearby ward based staff to identify a buddy who would act as a point of contact and check community staff whereabouts. All staff who attended community visits had mobile phones. Lone working arrangements was a standard agenda item at staff meetings.

There was a clear system for handling medication with a good audit trail from ordering, receipt and dispensing of medicines. For example in the Blackpool community mental health team, there was a medication lead nurse who oversaw the ordering and checks on stock levels.

We looked at 11 patients' medicine charts and saw that these were completed appropriately with signatures and dates against all medicines administered. There was a clear record for the reconciliation of medicine that showed no errors or omissions. The service had safe medicine management practices at sites which used FP10s (prescription pads) or where medicine was stored on the premises.

There were details of patient's allergy status completed on the medicines chart to ensure that prescribers and staff administering medicines were aware of medicines which may cause a patient to have an adverse reaction. Patients' medicines were prescribed within recommended levels so for example patients were prescribed within the British

National Formulary levels. The British National Formulary is a reference book that contains evidence based information and advice on prescribing medicines including indications, contraindications, side effects, and recommended doses.

Two out of 11 patient records did not include full details of the strength and dosing instructions for physical health medicine that the patient was prescribed by their GP. Clinicians agreed to address this during the inspection.

Safeguarding matters were considered as part of the initial referral, assessment and on an ongoing basis through care review and risk assessment review for patients receiving treatment. Staff were trained in safeguarding matters and had a good understanding of how to raise a safeguarding alert. The uptake of training was good with 92% of staff having received updated safeguarding children training and 91% of staff having received updated safeguarding adults training.

## Track record on safety

We looked at the incidents data reported by the trust. The trust was required to report serious incidents to the Strategic Executive Information System. The trust reported 118 incidents to this system between 2 April 2015 and 27 March 2016. Of these, four incidents related to community mental health services for older adults. Two of these incidents were still ongoing at the time of our inspection. These included incidents of expected and unexpected deaths of people receiving services from community older people's mental health teams.

There had been four significant adverse events in relation to community mental health teams for older adults for the period between 2 April 2015 to 27 March 2016. All were unexpected or avoidable death or severe harm of one or more patients, staff or members of the public which included one patient suicide, one assault on a patient and a patient acquiring an infection.

There had been no recent coroner's ruling about any aspects of the work of the community mental health teams for older people.

## Reporting incidents and learning from when things go wrong

The trust used an electronic system for reporting incidents. Staff knew how to raise safety incidents and the types of incidents to report. Managers reviewed all incidents which were reported looking for themes. Most incidents reported by staff from the community mental health teams were

# Are services safe?

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

safeguarding matters and deaths of patients. Care home liaison staff reported incidents of care home staff inadvertently missing medication when patients were in residential care. Staff told us of incidents where de-briefing had occurred after a serious incident.

Incidents were discussed in team meetings, complex case meetings and at individual staff supervision to ensure lessons were learnt were properly disseminated. Following one serious untoward incident, the learning identified a need for greater collaborative working which had since been actioned.

There was a trust wide sharing the learning memo which identified the lessons learnt and the particular services the learning impacted on. The memos were discussed in staff meetings.

## **Duty of Candour**

There had not been any recent incidents that met the harm threshold identified in the duty of candour regulations relating to community mental health teams for older adults.

Staff were aware of the need to apologise when things went wrong and aimed to resolve problems at a local level. Managers ensured that an incident review took place if there had been actual or potential harm to the patient. Managers were further supported to meet the requirements of the duty of candour regulations as the trust's incident reporting system had been updated to prompt staff to identify incidents that met the duty of candour threshold.

# 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 26 care and treatment records of patients across the community mental health services for older people. Patients had well documented assessments and care plans that described how their needs would be met. There was only one record without a care plan formulated by community mental health services as the patient had recently been referred into the service and the patient had since been admitted into hospital.

Patients were receiving care under the framework of the care programme approach which meant that patients had a named worker, a care plan which outlined the care they would receive and had regular reviews of care. Care plans covered a range of holistic needs including patients' medical needs (physical and mental health needs and medication), nursing interventions and social needs (accommodation, finance, employment and leisure).

Staff maintained care records to keep them up-to-date. The records included evidence of patient and family or carer involvement in care and treatment planning or decisions. The trust used a personal outcome tool. This was a recovery based tool to assess and work with patients similar to the mental health recovery star tool. The tool helped staff and patients focus on the areas of most concern to patients in their recovery so that staff could prioritise support, care and treatment to meet patient identified outcomes. These included looking at various areas such as money, activities, safety, independence, health, support and hopes. Where a patient was able they would be involved in drawing up their care plan and it would be written up by staff in the first person.

Patient needs and care were reviewed following each interaction and formally at care programme approach review meetings. Care plans identified support to address the symptoms of mental disorders.

A physical health care plan was in place for 17 patients. Records showed that physical health monitoring was carried out. Assessments included both medical and nursing assessments including consideration of physical health problems. Teams worked with GP services as part of the shared care protocols to ensure people received relevant physical health checks.

We saw evidence of discussions about smoking cessation. Additionally, records showed staff intervened to protect the cardiovascular and metabolic health of patient prescribed antipsychotics. Specific care plans were in place describing the use of medicines that required any additional monitoring such as Lithium and Clozapine. There were no recorded physical health care plans recorded on six out of seven patient records in the Fylde Coast rapid intervention and treatment team. This was because this team provided short term crisis interventions aimed at stabilising patient's mental health.

Patient records were held securely on an electronic system. Staff had ready access to patient information including out of office hours and when patients moved between teams.

The care home liaison staff had a simple help sheet for care home and nursing home staff to help them manage patients' challenging behaviour. This provided a simple prompt for care home staff to look for non verbal signs and reasons for patients presenting with challenging behaviour. The care home liaison staff also provided care home staff with training on understanding challenging behaviour. The training utilised the phrase 'pinch me' to remind staff to the key areas look out for to understand and alleviate challenging behaviour. This stood for:

- pain
- infection
- nutrition
- constipation
- hydration
- medication
- environment

### Best practice in treatment and care

Staff within the older people's community mental health teams used standardised assessments to assess patients, to plan care, to communicate with colleagues, to track patients' progress and measure clinical outcomes. Older adult mental health services used a core set of approved initial and outcome measures around mood, cognition and challenging behaviour. Staff had a flowchart which showed the process of using the standardised assessments at assessment and throughout the treatment pathway. There was written guidance and training available for staff on using the standardised assessment tools. This also

# 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.

informed staff of the risks of using certain assessments. For example, the guidance stated that staff should not rely only on the mini mental state examination as it can give inaccurate results with people with impaired intellect or education as they would score low at any time in their lives.

The service used a range of monitoring scales, including:

- The Depression, Anxiety and Stress scale
- The General Anxiety Disorder Scale-2 for generalized anxiety disorder
- The Addenbrookes Cognitive Examination tool for the detection and classification of dementia.
- The Challenging Behaviour Scale to record reports of the incidence, frequency and management difficulty of an individual's behaviours
- The Cornell Scale for Depression in Dementia for measuring depression in people with dementia, using a combination of observed and informant-based information.

The measures chosen had been selected because they were supported by research, were free to use in NHS clinical practice and were recommended by the National Institute of Health and Care Excellence.

The written guidance recognised that identifying mental health needs in patients with chronic physical health problems was difficult due, in part, to physical symptoms mirroring those of depression. Staff used the Patient Health Questionnaire-2 scale as a brief and simple screening tool followed by a more indepth scale questionnaire where indicated to overcome this as recommended by the National Institute of Health and Care Excellence.

Occupational therapists used the Pool Activity Level tools, Challenging Behaviour Scales, Model Of Human Occupation Screening tool and the Canadian Occupational Performance measure. These tools were used with patients who were assessed by occupational therapists for their level of occupational need and to measure the outcomes of occupational therapy. These were internationally standardised outcome measures that measured a patient's experience of occupational performance and satisfaction.

There were designated physical healthcare nurses who kept a database and monitored patients on antipsychotics to ensure that their physical health was optimised. This included checks on patients when antipsychotics were initiated, during titration when medication levels were checked to make sure they were at therapeutic levels and

at six months. This exceeded best practice guidance issued by the National Institute for Health and Care Excellence. At 12 months the ongoing prescribing and monitoring of antipsychotics was passed to the patient's GP as part of a shared care agreement. The designated physical healthcare staff were also trained in phlebotomy (taking blood) and were undergoing training to interpret blood results. Staff used the Observer Anti-Psychotic Side Effects scale to monitor common side effects of anti-psychotics especially where patients were cognitively impaired and could not describe any side effects they were experiencing.

While routine pharmacist support was not extended to the older adult community mental health teams, pharmacists would attend complex case forums on request and were available to discuss any medication or treatment monitoring enquiries. A pharmacist prescriber held clinics one day a week at the memory assessment service in East Lancashire. Working with the consultant psychiatrists, the pharmacist assessed and reviewed patients' treatment and provided medication-related advice to the patient and their carer.

The care home liaison staff had a structured interview form to fully inform them and care home staff when working with patients in residential care. This included ensuring care staff understood a patient's life story as part of good dementia care. It also considered the checks for signs of physical health problems including deteriorating physical health in advanced forms of dementia. Training with care and nursing home staff reinforced the importance of psychosocial interventions for people with dementia rather than antipsychotics in line with the national dementia strategy and guidance from the National Institute for Health and Care Excellence.

The trust had a best practice meeting where information was discussed around changes to national guidance. This information was disseminated to teams at team meetings, for implementation and reflective practice discussions.

The trust carried out an audit of its memory assessment services in February 2016. The audit collected data on spending, aspects of service provision, and take up of accreditation by the Memory Services National Accreditation Programme. The results demonstrate that the trust's services were providing services which were similar to the national average on the majority of the key standards used. The memory assessment services had assessed a significantly higher proportion of patients in the

# 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.

previous 12 months when compared to the national average with 1214 assessments compared to the national average of 576. The composite waiting time from referral to diagnosis was slightly longer than the national average. The report identified that the trust's memory assessment clinics provide patients with specialist post-diagnostic counselling on more occasions than the national average.

## Skilled staff to deliver care

The teams were comprised of community mental health nurses, social workers, approved mental health professionals, occupational therapists, psychiatrists, clinical psychologists, carer support workers, support time and recovery workers and administration staff. The nursing staff were experienced band 6 staff.

Teams had local induction programmes for new staff. Teams had specialist training programmes delivered internally by community mental health team staff that were trained to deliver particular courses. As well as mandatory training, staff could also access specialist training including brief intervention alcohol awareness training, training on understanding and managing various conditions or presentations including self injury, obsessive compulsive disorder and personality disorder, mental health cluster tool training, crisis contingency planning and carers' needs training.

Staff told us and records confirmed that caseloads were managed in supervision and reviewed regularly. Staff received regular supervision. For example in the Fylde Coast rapid intervention and treatment team supervision uptake rates were 85%.

The trust told us that most staff within the teams we visited had an annual appraisal in the last year. The trust had introduced a new appraisal recording system which meant that we did not receive robust appraisal figures for every team as the figures only related from April 2016 onwards. The appraisal rate for non-medical staff in community-based mental health services was therefore recorded as 42%. Five teams across the core service had a 100% appraisal rate. For example, 100% of the Central Lancashire rapid intervention and treatment team and 81% Central Lancashire community mental health team staff had received a recent appraisal. Staff confirmed that they had received an appraisal. Staff felt supported and were aware of took responsibility for their personal and professional development.

## Central rapid intervention and treatment team

Percentage appraisals (non-medical) – 100%

## Central community mental health team

Percentage appraisals (non-medical) – 81%

## Lancaster & Morecambe rapid intervention and treatment team

Percentage appraisals (non-medical) – 65%

## West Lancashire community mental health team

Percentage appraisals (non-medical) – Information not available

## Blackpool, Fylde and Wyre community mental health team

Percentage appraisals (non-medical) – Information not available

## Fylde coast rapid intervention and treatment teams

Percentage appraisals (non-medical) – 76%

Staff had weekly complex care meetings where they could discuss individual patient's care and treatment and seek support and advice from their peers and the wider multi-disciplinary staff team. Staff also attended regular team meetings to comment on services and proposed developments and staff told us that their views were considered and taken into account.

Managers reviewed individual and team performance. For the teams we visited, there were no staff on formal suspension or formal supervised practice. Across all of the trust's community older people's mental health services, there were two staff on formal suspension or formal supervised practice between April 2015 and March 2016.

The trust carried out an audit which looked at sampling consultant psychiatrist job plans which included job plans for consultant psychiatrists in community older adult's services. The job plan was a professional agreement that sets out the duties and objectives of the consultant and the support and resources provided by the trust. The review reported that job planning was undertaken and reviewed on a yearly basis, consistently in most of the records (20 out of 22 records). A small number of minor areas were

# 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.

identified in the review that required action including ratification of the job planning policy, review of job plan formats, identifying personal and corporate objectives and sharing best practice.

## Multidisciplinary and inter-agency team work

Staff attended multidisciplinary meetings to collaboratively manage referrals, risks, treatment and appropriate care pathways options. Staff attended a weekly multidisciplinary clinical discussion meeting where they were able to discuss complex cases with the team. We observed very good multidisciplinary working in the teams during these meetings.

Staff within the core community mental health teams operated shared care with GPs and primary care services. The teams linked in with the inpatient services for people who have been admitted to hospital under a section of the Mental Health Act or informally. For example, the trust held a daily videoconferencing bed management meeting which the staff from the community teams joined. Teams had good interagency working including with the voluntary and third sector care. For example staff had developed links and kept information resources on services to support patients to utilise community activities and support.

In some teams, mental health staff from older people's teams and staff in primary care (such as district nurses) were working closely together to better meet patients' needs as part of offering more integrated services.

Some teams had a care home liaison service with staff that regularly linked in with care homes and nursing homes to support patients and care home staff in caring for patients with severe and enduring mental illness or dementia. Care home liaison nurses gave examples of where

they had provided professional advice and input such as supporting care home staff to manage patients' challenging behaviour.

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

The average training take up level across the entire adult mental health team directorate (which included older people's community mental health teams) for Mental Health Act training was 36%. However data across older people's community mental health teams showed that the take up was better with an average at 71% across seven teams. Staff we spoke to had a good understanding of the

Mental Health Act. In addition staff could seek information about the Mental Health Act from approved mental health professionals and section 12 approved doctors working within the teams

However there were systems in place to ensure that the Mental Health Act was being adhered to within the community older people's teams. Mental Health Act administrators in the trust had systems and checklists to remind teams of their responsibilities including ensuring staff kept to key deadlines for patients on a community treatment order.

Across the nine community based services for older adults teams, there were 10 patients in total who were subject to a community treatment order; the Fylde Coast older adult mental health community mental health team had two community treatment order patients with one patient on a community treatment order in each of the eight other teams.

We reviewed the record of one community treatment order for one patient and found it contained a full copy of the community treatment order. The record showed renewals occurred appropriately and that the conditions of the community treatment order were monitored. There was evidence that the patient had received a manager's hearing when the community treatment order was reviewed. The patient was consenting to the treatment and involvement with the community mental health team.

Patients were informed of their rights and about the independent mental health advocacy service.

An independent mental health advocacy service was accessible to patients throughout the teams we visited.

## Good practice in applying the Mental Capacity Act

The data provided to us by the trust prior to the inspection showed that 81% of staff in community mental health teams for older people had received recent training on the Mental Capacity Act. People using the services were living in the community with a degree of autonomy and patients' capacity was assumed unless it was indicated otherwise. Records did show that staff had considered capacity assessments when necessary, for example when patients had fluctuating capacity.

Staff recorded mental capacity and consent when significant decisions were made. This included recording the patient's wishes and views.



# 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.

Staff supported patients to put legal frameworks in place while they still had capacity to help them plan for future decisions before they became more cognitively impaired. Staff also took account of these frameworks when providing care, for example, the care plan of one patient reflected that a carer had power of attorney over financial decisions.

Staff had a good understanding of their responsibilities in working within the Mental Capacity Act. For example, staff were able to discuss the five principles that underpinned

the Mental Capacity Act and gave practical examples from their clinical practice. There was evidence of formal best interest meetings when important decisions were taken about a person who was assessed as lacking capacity to consent to that decision. For example, there was a best interest meeting for a patient to consider whether they should receive covert medication; the meeting included seeking agreement from the family for covert medication to be given.

# 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

We spoke with three patients and one carer and attended one visit to a patient's home. We attempted to speak to more patients and carers over the telephone but people either did not answer or did not wish to speak with us. Due to the low numbers of people we spoke with we were unable to provide a rating for the caring key question.

Patients spoke positively about the care they received from the service. Patients told us they were treated with dignity, respect and kindness with staff showing a genuine interest in patients' wellbeing. Patients and a carer told us that staff were responsive and knowledgeable. Patients felt that they received appropriate information about their condition, treatment options and other information including financial and future welfare decisions. Patients confirmed that they knew who to call if they were in crisis and they knew they had crisis plans in place.

Patients told us that staff went the extra mile. For example, one patient had no family members and the staff had supported them to make arrangements on Christmas day so they would not be alone and had helped the patient select a pet as a companion. One patient told us they wouldn't know where they would be without support from staff in the service.

The carer told us that staff responded quickly to give them support with their family member and that the carer and patient was involved in the care planning.

At the home visit we observed compassionate and caring interactions between the staff member and patient. The staff member was knowledgeable and professional, showing kindness and respect to the patient throughout the visit.

We observed staff carrying out a seven day follow up visit following a patient being discharged from hospital; staff were clearly knowledgeable about the needs of the patient. Staff treated the patient with dignity and respect. The patient was reassured about their progress and at the conclusion of the appointment all were clear about the care plan and follow up actions. On another observation, staff were compassionate towards the patient and family member remaining professional throughout.

In June 2016, the trust carried out a piece of research asking patients and carers their experiences of older adults' community mental health teams in Lancashire Care. This involved face-to-face and telephone in-depth interviews. In total 60 patients and 40 carers were contacted and 30 people in each category were interviewed. They were asked nine questions about their experience.

The results were extremely positive. This included 90% of patients agreed or strongly agreed that mental health staff treated them with compassion with only one service user disagreeing. Nearly all patients (93%) agreed or strongly agreed that mental health staff treated them with respect, with only one service user disagreeing. The same number (93%) stated that mental health staff worked as a team with the patient and with others, with only two service users remaining neutral. All 30 patients rated their overall experience as satisfied or very satisfied.

The response was as positive from carers with 83% of carers agreeing or strongly agreeing that the mental health staff treated them with compassion, with only one carer disagreeing. Nearly all carers (87%) agreed or strongly agreed that mental health staff treated them with respect, with only one carer disagreeing. All of the carers agreed or strongly agreed that mental health staff work as a team with them and with others. The overall satisfaction rate for carers was 93% rating their experience as satisfied or very satisfied with only one carer dissatisfied.

The trust's research also included comments from patients and carers about what the service did well including "amazing staff", "they know my problems and what I need" and "support the whole family as well as me". In response to what the teams could do better, there were four comments; these related the referrals sometimes taking too long, staff could be more informed on physical health, staff could help patients set goals in better ways and staff could involve families more.

### The involvement of people in the care they receive

The patients we spoke with said they were involved in care planning, with one outlining how the whole family were involved in providing support and informing the care plan. The carer we spoke with confirmed they had been involved in every decision taken about their partner's treatment. Patients confirmed that they felt involved, supported and aware of their care plans.

## Are services caring?

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

We looked at 26 care and treatment records. Records showed that staff were providing patients with copies of their care plans or it was recorded in the care records when a copy had been declined by the person, with an explanation. In all but one of the relevant care records we looked at, we saw a patient had been given or offered a copy of their care plan. For the one patient who had not yet received a copy, they had just been referred and had not yet been seen by a doctor. Patients and carers were involved and encouraged to be part of care and treatment decisions.

Nearly all of the records (21 out of 23 relevant records) had current and updated care plans where we would expect to see a current care plan completed by the community mental health team staff.

There was clear evidence that the wishes and needs of the service user were reflected within the care plans. One record provided information that, with the patient's agreement, a neighbour had been involved in the development of the patient's care plan and had been provided with a copy.

The community teams had a volunteer worker who contacted patients and carers to obtain feedback for the friends and family test. The volunteer was independent of the clinical teams to help receive honest feedback from patients and carers.

Comments and results from the friends and family test informed the "You said, we did" approach which has been implemented across the older peoples community mental health team network. Feedback messages were recorded and action taken by managers in teams. One comment about the memory service pointed out that post diagnostic support was limited when patients were not prescribed anti-dementia medication. Staff had responded by forming a living well with dementia group to address this gap. All the comments and responses were displayed within the treatment areas.

There was also a range of advocacy services across Lancashire to support patients to have a say and be involved in their care and treatment decisions. This included non-instructed advocacy services for patients with significant cognitive impairment such as dementia, acquired brain injury, or a learning difficulty. Non-instructed advocates work with patients who lack capacity to support decisions in the patient's best interest.

# 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

The trust had implemented revised standard operating procedures across the older adults' community mental health teams within each locality. This included a clear description of the referral criteria for patients accessing the community mental health and rapid intervention and treatment teams along with prescribed ways of working, standards expected and an outline of the treatment pathway for each of the different teams. The memory service had a procedure and decision tree to triage patients suitable for the service.

Most areas had rapid intervention and treatment teams. Staff within the rapid intervention and treatment teams focused on assisting patients to deal with crisis, remain within the community and avoid admission to hospital where possible. The exception was the team in Ormskirk where the rapid intervention function was integrated within the community mental health team with no separate single point of access or rapid intervention and treatment staff.

The rapid intervention and treatment teams operated at different times in each locality according to the commissioning arrangements in that locality. For example the Fylde Coast rapid intervention and treatment team was commissioned to operate 8am to 8pm seven days a week but the team were operating seven days a week 9am to 5pm due to staffing levels at the time of our visit. The rapid intervention and treatment function at Ormskirk was available Monday to Friday 8am to 6pm.

The trust used an electronic gatekeeper system where GPs sent referrals electronically to the teams. In most areas, referrals were screened by the rapid intervention and treatment team with urgent and immediate crisis support provided by staff from the rapid intervention and treatment team. Across the rapid intervention and treatment teams, 83% of referrals were triaged within 24 hours. The Fylde and Wyre Coast rapid intervention and treatment teams had recently changed the way they triaged referrals moving from a duty worker to a system where staff attended a daily triage of referrals using a multidisciplinary approach. The manager reported the new approach was working well.

Access into the service was coordinated through a single point of entry in each of the localities with staff designated to consider each referral and determine the most

appropriate response. There was a traffic light rating of priority (red, amber and green) depending on patient need and presentation. Routine referrals were signposted to the community mental health teams for longer term support

Most of the community mental health teams operated during office hours from 9 am to 5 pm.

Across the core community mental health team function, 64% of referrals were triaged within 48 hours. This meant that most patients' needs and risks were considered quickly when patients were newly referred.

Teams inspected had no waiting list for urgent and immediate referrals. Waiting lists for routine referrals were meeting the trust's standard operating procedure wait times. The waiting times at August 2016 for referral to treatment for the community mental health teams was as follows;

- Community mental health team Central Lancashire – 3 weeks
- Community mental health team North Lancashire - 15 days
- Community mental health team East Lancashire – 6 days
- Community mental health team Fylde Coast Lancashire – 4 weeks

The rapid intervention and treatment teams had waits of 9 or 10 days to provide treatment to patients accepted into the service as non urgent referrals across most teams including Central,

North, and East rapid intervention and treatment teams. The exception was the wait for treatment from the rapid intervention and treatment teams for the Fylde Coast with a wait for treatment of 6 weeks for patients accepted on a non urgent basis. There was an established process to regularly review waiting lists.

There was variation in the waiting time from referral to patients initially being triaged by the memory assessment services. The figures provided by the trust showed that at August 2016 that the waiting time for memory assessment service for the team we visited were all within the 6 weeks expected by the trust. For example, in West Lancashire the wait was between 3 and 6 weeks for last six months. However in most other areas the waiting times were much

# Are services responsive to people's needs?

Good 

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

less. For example the wait for triage in the memory assessment service in Blackpool was between 4 and 7 days within the last six months and in East Lancashire was between 1 and 6 days within the last 6 months.

There was also varying waiting times once patients had been accepted into the service. The waits were as follows:

- Memory assessment service Blackpool – 6 weeks
- Memory assessment service Fylde and Wyre – 4 weeks
- Memory assessment service East – 7 weeks
- Memory assessment service West – 11 weeks
- Memory assessment service Central – 11 weeks
- Memory assessment service Lancaster and Morecambe – 14 weeks

The trust had a protocol for transition of patients between adult and older adult services. This was written in 2004 and reviewed in 2009 and 2013 and was due for further review in October 2016. The protocol prescribed the arrangements that should occur between the adult and older people's community mental health teams. As the protocol had been written some time ago it did not reference current national policy and these had not been identified in the review process. For example, there were no reference in the protocol on the Mental Capacity Act to guide staff on the transition of patients who may lack capacity to agree to their care being passed from one team to another. For example, looking at the patient's best interests and considering involving an independent mental capacity advocate to support unbefriended patients during the care review. The protocol did not reference more recent national guidance such as 'No Health Without Mental Health'

Staff within the community mental health teams had good links with the staff within the rapid intervention and treatment teams and older people's wards to make sure that people who used services were admitted to and discharged from hospital when clinically appropriate. Aftercare support was agreed and patients were followed up within seven days by community mental health staff. The data from the trust showed that staff were exceeding the 95% target for carrying out follow ups within 7 days of discharge from hospital, with 100% adherence over the two months prior to the inspection. Patients transferred to care and nursing homes continued to receive support from care home liaison nurses within the teams.

Staff rarely cancelled appointments with patients. For the six month period April to August 2016 across the older

people's mental health community teams we visited there were low cancellation rates. Four teams had no cancelled appointments in the period. The Fylde Coast rapid intervention and treatment team did not routinely record data on cancelled appointments. The exception was the Blackpool, Fylde and Wyre community mental health team who cancelled 73 appointments over past 6 months equating to an average to 12 cancellations per month due to unexpected staff sickness.

One of the teams had restructured staff caseload into neighbourhood teams. This meant that members of staff were assigned to a smaller area within a neighbourhood which reduced travelling times between visiting patients and allowed staff to be more responsive in the delivery of care.

Due to bed occupancy levels on the older adults' wards, there were delays in patients accessing a bed and staff from the rapid intervention and treatment team had to manage patients' risks in the community until a bed became available. This included episodes of patients waiting regularly over two weeks so staff from the rapid intervention and treatment team were supporting patients for this length of time. This was generating complaints from patients and carers for the team which was out of their control.

Due to the configuration of the older person mental health inpatient services across Lancashire some patients and carers had to travel significant distances to get to the nearest hospital. For example, for some patients from West Lancashire, the nearest older person mental health ward was 55 miles.

## **The facilities promote recovery, comfort, dignity and confidentiality**

Staff provided a range of flexible support to meet patients' needs. This included telephone contact and face to face visits to patients in their own homes or at team offices. Patients received a welcome letter and information pack about the services available to them which included all contact numbers. Patients had access to a texting service offering support during office hours and a freephone telephone helpline during weekday evenings and weekend afternoon and evenings. This provided choice to patients about how they wished to contact the mental health services.

# Are services responsive to people's needs?

Good 

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

At the locations where the community older people's teams were based, the waiting areas and interview rooms were welcoming and comfortable. The buildings that were well maintained, clean and had appropriate comfortable furniture. Rooms were available for individual consultations.

Patient information was displayed on notice boards at the team offices; information included service user feedback forms, friends and family test results, dementia buddies information, dementia progress boards, information about patients' rights and advocacy services and details on how to make a complaint.

## Meeting the needs of all people who use the service

The trust provided services to communities with diverse ethnic backgrounds. For example there were higher than the national average representation of South Asian communities especially in East and Central Lancashire. Staff could access interpreting services which provided face to face and telephone interpreting services. Staff had a good understanding of the needs of their local communities.

Staff were observed to be knowledgeable, professional, caring and enthusiastic. The observation of meetings showed that patients' individual, cultural and religious beliefs were taken into account and respected during appointments and within the development of agreed care plans.

The trust advertised that the leaflets produced by the trust could be provided in different languages, large print, audio or Braille. Most leaflets produced by the trust explained this in most of the main languages spoken in south Asia (such as Urdu and Punjabi), Chinese and Polish. We saw that one patient for whom English was not their first language, had been given a leaflet about the medication they were prescribed in their preferred language.

All locations had disabled toilet facilities and some toilets included a hoist for patients with mobility difficulties who were unable to bear weight. The exception was the West Lancashire community mental health team offices at Bickerstaffe House where access was restricted. However the team were moving to new premises in October 2016 in response to that issue.

As well as physical access, staff had considered and adapted the environment of some team offices to make

them more dementia friendly. For example at the Fylde Coast rapid intervention and treatment team, there was a Poppy room which was used by patients who had been diagnosed with dementia and their family members. The room was adapted to make it more dementia friendly due to the sensory facilities and the colouring of equipment and furnishings.

## Listening to and learning from concerns and complaints

Patients and those close to them told us they knew how to complain should they need to. Staff gave patients information on complaints as part of a welcome pack and introductory information when they were first seen.

One patient told us how they had written to the service to tell them how impressed they were with the service. We saw that a carer had commented that it was insensitive to request feedback after experiencing upsetting situations such as a relative being placed in a care home. Staff then considered each individual case before deciding whether it was appropriate to ask patients and carers to complete feedback questionnaires.

The older people's community mental health teams across Lancashire had received 238 compliments during the last 12 months, which had been recorded formally at trust headquarters. The Blackpool, Fylde and Wyre older people's community mental health team received the most with 54 compliments, followed by the Fylde rapid intervention and treatment team with 48 compliments.

The older people's community mental health teams had received 27 complaints from patients between 1 April 2015 and 31 March 2016. These included complaints against 11 different teams in locations. No individual team received more than three complaints. The community mental health teams received 12 complaints, the memory teams received nine complaints and the rapid intervention and treatment team received six complaints.

Of these 27 complaints, 12 complaints were upheld, seven were partially upheld, three were not upheld, four complaints were withdrawn and one complaint had an unknown outcome. Out of 19 upheld and partially upheld complaints, 73% related to communication problems between trust staff and patient or carers and 15% related to complaints about service provision. There was only one complaint about treatment delivered by a member of staff. Between this same period (1 April 2015 to 31 March 2016),

# Are services responsive to people's needs?

Good 

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

no complaints about the older people's community mental health teams had been referred to the second stage of the complaints process which involved referring the case to the parliamentary and health service ombudsman.

The trust used the sharing the learning memo to disseminate information to teams about learning from complaints. Where complaints had been raised, we saw that the trust had worked to resolve and learn lessons from these complaints. For example the older adults' community team operated a 'you said, we did' system to

show to staff, patients and carers what action had been taken following complaints or comments. This included the development of a new post-diagnostic support group for patients with early stage dementia following comments that the current services only supported patients' prescribed anti-dementia medication.

This meant that the older people's community mental health teams received relatively low levels of complaints, complaints were taken seriously and most complaints (70%) were either upheld or partially upheld.

# 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

Lancashire Care NHS Foundation Trust had the following vision:

- high quality care, in the right place, at the right time every time.

The trust had the aim that everything they did fitted in with, and reinforced, the following values:

- teamwork - share it
- compassion - offer it
- integrity - show it
- respect - earn it
- excellence - reach for it
- accountability - accept it

The trust expected all staff to show these values by:

- treating people with dignity and respect
- caring for each other and showing compassion
- remaining professional at all times
- dressing smartly and appropriately
- ensuring that work areas were clean and tidy
- working effectively with partners
- sharing good practice and celebrating success
- being appreciative - focusing on the positives and what is working well
- taking responsibility for the standard of care or service that they provide
- taking positive action to make improvements where they saw the need

Staff reported that that there was a focus on delivering quality patient centred services in line with the trust's values. Staff understood and could tell us the trust's vision and values.

Senior manager for the service were visible; however some staff told us that the executive management team were not visible and in some cases staff did not know who they were.

### Good governance

Team managers held a risk register for local issues and these were escalated to a service risk register as required.

Effective service operational meetings took place where incidents were discussed, team performance was reviewed and staffing levels and sickness was considered. This included a team leaders meeting, service managers meeting and governance meetings. Managers oversaw the performance in these meeting including levels of team level supervision, appraisal, training and caseload allocation. The trust had team dashboards to support performance monitoring.

Managers checked that staff were meeting performance targets and the teams were meeting their targets across key performance indicators. This included key performance indicators for clustering information, day follow up adherence, annual care plan approach review performance, contacts recorded, waiting lists for triage and treatment and other key performance indicators. Performance on waiting lists were actively monitored. For example, the memory assessment service produced a weekly overall performance report. Team leaders monitored the waiting lists to ensure waiting list rules were followed and appointments were being booked. There were monthly performance management meetings which identified performance, shortfalls and action required to improve any shortfalls.

Managers carried out routine audits which included sampling records in relation to care planning, risk assessments, clustering data compliance, carer assessments, safeguarding and capacity. Where any identified shortfalls were found, these were addressed with individual members of staff including identifying any additional support required. This ensured that records were kept to a consistently high standard. Our checks of records corroborated the good standard of records overall.

Team managers told us that they felt well supported by their line managers and from their teams or staff within other departments of the trust.

### Leadership, morale and staff engagement

Staff told us that the teams worked well together and spoke of good support from their peers and managers. Staff stated that managers were accessible, friendly and calm. Staff reported that there was shared ownership of decisions with approachable and receptive managers.



# 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.

Teams had occasional away days to reflect on their performance and consider service developments. Consultant psychiatrists we spoke with reported good relations and information sharing with staff and team managers. Staff reported good job satisfaction levels and high levels of support.

Notice boards displayed information for staff on team performance, team meeting details and minutes.

Staff had an opportunity to attend operational staff meetings. In some teams there were solution focused staff group meetings which gave staff an opportunity to outline and feedback their solutions on problem areas that prevented them from doing their job.

Whilst staff reported their jobs as busy, staff we spoke with told us that they felt supported and did not feel or get overwhelmed with carrying out their professional responsibilities.

Each team was well-led by experienced managers who were committed to patient centred care. Managers reviewed individual and team performance.

Staff morale was good throughout the service. Staff told us that they felt confident to raise concerns without fear of victimisation. Staff had regular team meetings to comment on services and proposed developments and staff told us that their views were considered and taken into account.

However, administration staff across the teams felt unsettled as there was an ongoing administrative staffing review in place. This meant there had been a freeze on recruiting administrative staff against any vacancies for recruitment and also temporarily prevented opportunities for promotions.

## **Commitment to quality improvement and innovation**

Teams had a commitment to service improvement and listening to feedback. The teams had completed patient and carer surveys. The teams had a volunteer worker conducting the Friends and Family Test by making phone calls to patients or their carers to obtain feedback. Managers were committed to ensure service improvements were made following comments from patients and carers. The improvements to services were clearly identified through the “you said, we did” approach which had been implemented across the older peoples community mental health team network

The trust’s older people’s community mental health teams or the memory assessment services had not applied for accreditation of their service through the Royal College of Psychiatrists’ accreditation schemes which aimed to work with teams to assure and improve the quality of community mental health services. The internal audit report for memory assessment services found that the trust’s clinics had assessed a significantly higher proportion of patients in the last 12 months when compared to the national average whilst only receiving a slightly higher level of funding compared to the national average. The audit report concluded that managers would review the situation for applying for Memory Services National Accreditation programme when sustainably commissioned model of service (matching demand with staffing levels) could be achieved with an assurance that referrals and wait times were manageable.

Staff from the Fylde rapid intervention and treatment team were involved in a national randomised controlled trial of assistive technology and telecare with people who were living with dementia. The aim of the study was to establish whether assistive technology and telecare is an effective way of supporting people living with dementia. In particular to

- establish if telecare can safely extend the time people with dementia can continue to live independently in their own homes
- establish if telecare can reduce the number of incidents involving serious risk to safety and independent living
- establish whether telecare can increase the quality of life of people living with dementia and their care givers.

An assistant practitioner within the older adult community mental health team in North Lancashire had developed partnership working with the police to make it safer for people with dementia to follow well-established patterns of going out without unnecessary and unhelpful interventions. The police used the ‘safer wandering scheme’ protocol for sharing information to enable them to respond appropriately to concerns from the public. The police in turn have produced guidance to the public on safer wandering.

The trust was also working as a partner in new health vanguard projects which are projects aimed at more integrated health services and meeting patients’ holistic needs in better and more streamlined ways. For example on the Fylde Coast, a new community based service called

# 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.

'extensive care' was providing proactive support for people aged 60 and over, who have two or more long-term conditions. In North Lancashire integrated care communities were being developed to improve the health of individuals and tackle public health inequalities. These

projects involved mental health staff from older people's teams and staff in primary care such as district nurses working more closely together to meet patients' needs more effectively.