Care Quality Commission

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: 0161 882 1000
Website: www.lancashirecare.nhs.uk

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Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RW5GD	Lytham Hospital	Rapid Intervention and Treatment Team, Lytham	FY8 5EE
RW5HQ	Sceptre Point	Rapid Intervention and Treatment Team, Accrington	BB5 5DE
RW5HQ	Sceptre Point	Community Mental health Team, Preston	BB5 5DE
RW5HQ	Sceptre Point	Memory Assessment Services, Central Lancs	PR5 6YA

Summary of findings

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

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Summary of findings

Overall summary

We rated The Lancashire Care NHS Foundation Trust as **good** because:

There was an open and transparent approach to the treatment of people who used services that allowed for identification of safeguarding issues or inefficient practice. Staff prioritised the safety of people using the service and also the safety of people working for the trust. The staff showed knowledge of procedures and requirements that helped maintain their safety.

Staff assessed risk in observance of national guidelines, to the benefit of people who used services.

Care plans were of a high standard. The care plans were thoughtful and fluid, changing as and when needed. Whilst the treatment of people who used services was seen as holistic, it was also person-centred. Team management and governance monitored the completion of care plans through routine audits.

Staff demonstrated a good understanding of the Mental Capacity Act 2005 (MCA). In the multi-disciplinary meeting we attended, a person's capacity was considered in every situation and discussed. Of the 23 care plans reviewed it

was seen that capacity was addressed. However, this was not in a uniform format. Capacity assessments had been carried out only when staff had identified an issue with the capacity of a person who used the service. It was at this time a full capacity assessment was carried out. Staff received training in the MCA and there was an on-going training schedule to ensure they remained skilled.

People who used the service were positive about it, with no adverse comments received during home visits, or in telephone conversations with them or their carers. Staff were observed treating people who used the service and their carers with dignity and respect. People who used services felt that they had been personally involved in the development of their care plans.

Staff were able to manage the development of the service they provided. They took into account the opinions and considerations of people who used the service and where possible other staff. This allowed treatment to be provided in an effective and timely manner. The managers of the individual services were supported by senior managers in this measured and effective approach.

Summary of findings

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

Are services safe?

Good ●

We rated safe as good because:

- The memory assessment clinic carried out assessments on site. The accommodation was clean and well maintained. Access to the memory assessment service was via a shared communal entrance which had good access for people who had mobility problems. Comfortable seating was provided.

- Staffing levels ensured that people received timely appointments for treatment.
- There was a varied skill mix within the teams. Lessons learned were shared using differing methods of communication, allowing good interaction between internal and external healthcare professionals.
- Risks were assessed. There was good use of the lone worker policy. However, different teams had a different alert phrase. This could mean staff who had transferred teams were not able to work in a way that ensured they were safe; policy checked and confirmed alert phrases could be particular to a team.
- Staff had received safeguarding training. All training was up to date for both healthcare and ancillary staff, and all knew the reporting processes for escalation of concerns.
- Systems were in place for the reporting of incidents. Staff told us they reported any serious incidents. Details of the investigation and feedback of concerns were made available to staff when appropriate.
- Processes were in place to cover for sickness and cancellations of appointments.

Are services effective?

Good ●

We rated effective as good because:

- People's needs were assessed. Their care plans were completed and actions delivered in a timely and efficient manner.Care plans were audited by team management to ensure continuity and updating as and when required.
- Staff had the qualifications and skills required to be able to carry out their roles effectively. Staff also completed other training that enhanced their skills.
- Clinical and management supervision was available and regularly utilised by staff to ensure that lines of communication and support were in place. Multi-disciplinary team meetings, complex care meetings and handovers allowed the exchange of professional opinion and suggestions for onward treatment.

Summary of findings

- There was good collaboration/coordination with social care organisations and care homes.
- Mental capacity assessments and a consideration of deprivation of liberty safeguards were present in documentation.

Are services caring?

We rated caring as good because:

- Throughout the assessment and care planning process person centred care was apparent. People who used the service said that staff engaged with them in a caring, compassionate and respectful manner.
- Throughout the assessment and care planning process person centred care was apparent.
- Staff were well motivated, felt that they wanted to be part of these teams and had applied to join these teams.
- Staff ensured the needs of people who used the services were listened to, recorded, and acted upon. Care plans reflected the involvement of people who used services and their carers.
- Knowledge of personal timetables of people who used the service allowed staff to understand when visits or meetings needed to be arranged.

Good ●

Are services responsive to people's needs?

We rated caring as good because:

- Staff adhered to care pathways in a clear, well planned way, flexible to the needs of people who used the service.
- Appointment flexibility allowed meetings to be held in a timely manner. Appointments were only cancelled in emergencies with the person who used the service informed immediately of the cancellation and the meeting re-arranged. Seven day access provided by both RITT teams was deemed "excellent" by people who used services, their carers and local care homes who received support from the teams.
- People who used the service were able to access the correct care for their particular needs.
- People who used the service had access to complaint forms. None of the services had received any complaints since 1 April 2015.
- When people who used services failed to attend planned meetings staff contacted them to re-establish contact with the service.

Good ●

Summary of findings

Are services well-led?	**Good**	🟢

We rated caring as good because:

- Staff were aware of the trust's vision and values and these were reflected in personal development reviews.There were signs in each office outlining the values of the trust, but these were enhanced by staff's personal values and practices.
- Outcomes were measured by internal audit.
- At core service level managers were well respected. They involved staff in decision making and ensured voices were heard.
- There was clear evidence throughout the service giving staff direction if they wanted to 'whistle blow' or complain.

There was evidence of continuous learning for all staff.

Summary of findings

Information about the service

The community mental health services for older people are situated throughout the Lancashire region and include:

- The memory assessment service is based at Charnley Fold Clinic in Preston. The service aims to deliver quick and timely diagnosis to people whose symptoms suggest that they may have dementia.Patients that meet the criteria are provided with a person centred service. This allows people with dementia to make informed decisions about their care to help maximise quality of life.

- The Memory Assessment Service is at Charnley Fold. This holds 160 clinics per month. Facilities are shared with Age UK, a communal entrance being utilised by both organisations.

- The community mental health team (CMHT) for older adults based on the 3rd Floor at Bickerstaffe House in Preston. This was newly formed on 1 April 2015. It was an amalgamation of three teams to form a central point of access to support people over the age of 65

with severe and enduring mental health needs, as well as those under 65 with early onset dementia. When a person was referred the team provided an appropriate health professional to conduct full health and social needs assessment, take the role of care coordinator, and be the primary point of contact for the person using the service and their carer.

- The rapid intervention and treatment team (RITT) based in Lytham hospital. This was formed on 1 April 2015. The team incorporates care home liaison, rapid intervention and single point of access; the team was formed as part of trust re-organisation. The RITT has a key focus on older adults with a severe and enduring mental health treatment need

- The rapid intervention and treatment team (RITT) based at The Mount, Accrington, was also formed on 1 April 2015 as part of the trust re-organisation. The RITT has a key focus on older adults with a severe and enduring mental health treatment need.

Our inspection team

Our inspection team was led by:

Chair: Peter Molyneux, South West London and St Georges Mental Health Trust

Team Leader: Sharon Marston, Inspection manager, Care Quality Commission

Head of Inspection : Jenny Wilkes, Care Quality Commission

The team included CQC inspectors that inspected this core service comprised:

consultant psychiatrist

Two registered mental health Nurse band 9

social worker

Why we carried out this inspection

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

Summary of findings

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 visiting, we reviewed a range of information we hold about the trust and asked other organisations to share what they knew.

During the visit we met and interviewed 37 members of staff who worked within the service, including:

- Area managers
- Band 6 nurses
- Band 7 nurses
- Managers

- Pharmacist
- Pharmacy technician
- Psychiatrists
- Psychologists
- Senior House Officer
- Students
- Support workers,
- Social workers
- We visited a care home where staff were supporting people.

We met with four people who were using the services who shared their views and experiences of the services we visited. The team conducted 6 home visits accompanying trust staff.

We contacted by telephone 11 people who used the service and talked with five carers and/or family members and reviewed care or treatment records of 23 patients. We looked at a range of records including clinical and management records.

What people who use the provider's services say

- People we spoke to described the service as a "very good service" and "courteous".
- Carers we spoke to said the service was "excellent", "relaxed", "knew what they were doing".
- We were told by carers and people who used services that they were fully informed of what was happening, that their treatment was "going to plan".

- We interviewed a person who used the service about their treatment and they said staff were flexible, respectful, understanding, caring and interested in their wellbeing. The person who used the service said treatment was fully explained, and they were pleased with the experience and the way they were treated.

Care Quality Commission

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
Memory Assessment Service, Central Lancashire	Sceptre Point
CMHT, Bickerstaffe House, Preston	Sceptre Point
Rapid Intervention and Treatment Team, Lytham	Lytham Hospital
Rapid Intervention and Treatment Team, Accrington	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.

The use of the Mental Health Act was found to be generally good in the community-based mental health services for older people.Documentation reviewed was found to be compliant with the Act and the code of practice.

Mental Capacity Act and Deprivation of Liberty Safeguards

Staff we met had a clear understanding of their responsibilities under the Mental Capacity Act. Evidence was noted in documentation to show that, where appropriate, capacity was taken into consideration before formulating a decision on action. We attended staff meetings where capacity was discussed in relation to on-

going care. We noted that in one particular case a Deprivation of Liberty Safeguarding imposed by a care home was discussed and considered to be unsafe. As a result of this, the team planned to contact the relevant team to raise concerns.

Are services safe?

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

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

Summary of findings

Our findings

Memory Assessment Service, Central Lancashire

Safe and clean environment

- The interview rooms were set up similar to a doctor's surgery, with a desk, chairs and computer; the surroundings were comfortable, and created a more familiar setting with the people who used the service. The layout of the service allowed good communications; however there was no way staff could summon assistance should it become necessary.
- There was a small therapy room that allowed the use of a mobile electrocardiogram machine. The room was clean and tidy, with access to gloves, alcohol gel, showing infection control was taken into account. However, the therapy room was more suitable to limited assessment and emergencies, in keeping with the service provided. Blood pressure machines were kept by individual nurses, allowing such monitoring to be carried out without delay. Documentation showed a cleaning schedule fully up to date.

Safe staffing

A sustainability paper had been submitted to the trust, relating to capacity demand, in which it was proposed one more Band 5 nurse and one more Band 6 nurse were required, and at the time of inspection was being considered.

- The service was open from 9 am to 5 pm Monday to Friday and all staff were expected on duty unless on leave or sick leave.
- The service used three bank staff covering one to two days a week at the time of the inspection.
- Bank nurses were all familiar with the service and requirements.
- We found that the team had a process in place to cover for unexpected sickness and that annual leave was monitored to prevent overlap and compromising safety.

- We found that there was a psychiatrist on site each day except Wednesday, when the psychiatrist was on call.
- We found that mandatory training was monitored via the computer system and that staff were compliant with requirements. Staff had completed at least 75% of training.

Assessing and managing risk to patients and staff

- The service used an electronic system that displayed risk assessments in care records. An assessment was completed on entry to the service, and updated should any changes be required, in line with the service provided.
- We were shown the safeguarding policies. Pathways were identified; a safeguarding pathway board maintained by a service champion, online training was completed by all. Staff interviewed showed a good knowledge of safeguarding.
- A lone worker policy was in place, robust in monitoring, with an alert phrase to be used in any emergency calls.

Track record on safety

- We found there were no serious Incidents recorded or reported in the last 12 months.

Reporting incidents and learning from when things go wrong

- Staff were aware of the use of the Datix system for reporting incidents and how to use it.
- Staff could make a Datix report and that the service manager had input into the level of action to be taken, with findings displayed on a board for issues to be raised and considered. We found there was a system in place for a team de-brief should a serious incident occur.

Community Mental Health Team (CMHT), Bickerstaffe House, Preston

Safe and clean environment

People who used the service were not seen on site.

Safe staffing

Key Staffing Indicators (report at core service level or, if possible, at ward level)

Are services safe?

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

Good 🟢

Establishment levels: qualified nurses (WTE)

7.4 WTE

Establishment levels: nursing assistants (WTE)

0.6 WTE

Number of vacancies: qualified nurses (WTE)

None

Number of vacancies: nursing assistants (WTE)

None

The number of shifts* filled by bank or agency staff to cover sickness, absence or vacancies in 3 month period

1.6 WTE Bank

The number of shifts* that have **NOT** been filled by bank or agency staff where there is sickness, absence or vacancies in 3 month period

Team only formed on 01/04/2015

Staff sickness rate (%) in 12 month period

Team only formed on 01/04/2015

Staff turnover rate (%)in 12 month period

Team only formed on 01/04/2015

*By shift, it is meant a period of time (often 8 hours) worked by an individual Nurse

- Staffing levels were being negotiated after a recent re-organisation within the trust. Staffing levels had recently been put on the risk register by the team manager as it was believed more staff were needed for the service.
- The working hours for the team were 9 am to 5 pm and that the shifts were adequately covered.
- There was a policy for the use of bank/agency staff and we saw that the policy was used when needed.
- Staff sickness was covered by an initial telephone call and if this was done within 24 hours of reported sickness then appointments could be re-allocated in order to avoid missing the appointment.
- There were four psychiatrists attached to the team, allowing access to a psychiatrist at all times.
- Mandatory training of staff was averaging 87% (including administration staff), except for one staff member on long term sickness; this included Mental Capacity Act 2005 training and Safe Space Training.

Assessing and managing risk to patients and staff

- After referral to the single point of access, a triage assessment was completed, including a risk assessment. The system was on electronic care records blue, staff were able to access previous risks and challenging behaviours that could inform current risk assessments. scales taken into account.
- Every person who used the service had a crisis and contingency plan. A copy was
- kept on file and a copy given to the person who used the service.
- Plans were in place so that if there was ever a deterioration in the health of the person who used the service, the medical emergency services if a physical health problem, and the Rapid Intervention and Treatment Team if out of hours had an understanding of the persons general and mental health issues and could treat accordingly.
- When a person who used the service was initially referred, the team manager immediately took the role of care coordinator and thereby giving the person who used the service a point of contact. The person who used the service was seen within 15 days of the referral
- Level one and level two safeguarding training was carried out. There was a team safeguarding champion who could be approached for advice at any time, and that staff were aware of what do in the case of raising a safeguarding problem. We found that there was a robust use of the lone worker policy, with the use of an alert phrase to be used in an emergency situation.
- Medicine management protocols were in place and that locked cases were used to transport medication. There was a pharmacist specific to the CMHT.

Track record on safety

- We noted that the team was formed on 01 April 2015 and at the time of inspection had not reported any serious incidents.

Reporting incidents and learning from when things go wrong

- Staff knew what constituted an incident and how to report it.
- Staff knew of the requirement to keep people who used the service informed if things went wrong, the team manager discussed duty of candour with staff.

Are services safe?

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

- Information from any incidents (trust-wide) were fed back to the staff in team meetings, "sharing the learning " forums, staff told us they felt supported and would take responsibility for incidents.
- There was a process in place for de-briefing and investigating incidents should they occur.

Rapid Intervention and Treatment Team (RITT), Lytham

Safe and clean environment

People who used the service were not seen on site

Safe staffing

Key Staffing Indicators (report at core service level or, if possible, at ward level)

Establishment levels: qualified nurses (WTE)

12

Establishment levels: nursing assistants (WTE)

Number of vacancies: qualified nurses (WTE)

7*

Number of vacancies: nursing assistants (WTE)

See below

The number of shifts* filled by bank or agency staff to cover sickness, absence or vacancies in 3 month period

Team only formed on 01/04/2015

The number of shifts* that have **NOT** been filled by bank or agency staff where there is sickness, absence or vacancies in 3 month period

Team only formed on 01/04/2015

Staff sickness rate (%) in 12 month period

**Team only formed on 01/04/2015

Staff turnover rate (%)in 12 month period

Team only formed on 01/04/2015

*By shift, it is meant a period of time (often 8 hours) worked by an individual Nurse

*Vacancies: 2.5 WTE Band 6 Nurses; 0.5 WTE Mental Health Practitioner; 2 WTE Band 6 Occupation Therapists; 1WTE Band 5 Occupational Therapist; 1.5 WTE Occupational Therapist

**3 Band 6 nurses on long term sick

- A change in operating hours from 9 am to 5 pm Monday to Friday to 8 am to 6 pm seven days a week had been put in place. This allowed more flexibility for people who used the service. The team had adopted the Newcastle Model: providing a framework for understanding the cause of a person's challenging behaviour and a process by which the interventions were delivered.
- If sickness was reported then the diary of the staff member would be accessed, distributed among staff for that day, or appointments would be rearranged due to the new seven day service to suit the needs of the person who used the service.
- A psychiatrist was attached to the team for rapid access.
- Mandatory training was up to date for staff, both administrative and nursing, the only outstanding training attributed to the three long term sick nursing staff.

Assessing and managing risk to patients and staff

- We checked seven care records for this service and found that risk assessments were complete and up to date.
- Advanced decisions were utilised, two were checked, and found to be correct. Waiting list patients were triaged and put into categories of immediate (seen face to face within four hours), urgent (telephone contact the same day and face to face within five to seven days), and routine (telephone contact the same day and face to face within 28 days), so from triage were assessed and allocated a time frame for contact.
- The pathway for the team was designed to fully assess and treat people who used the service within 12 weeks; we noted that some people who used the service might take more time for treatment. This process was managed through the MDT meetings where the care plan for each person was discussed and what actions the team may take next. We observed MDT meetings and people were discussed in detail with proposed outcomes determined and staff discussed these with the person concerned following the meeting. We observed a complex care meeting involving nursing staff and the psychiatrist; staff discussed risk, safeguarding and full aspect of care for each person who used the service, including follow up actions.

Are services safe?

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

- The lone worker policy was robust, and involved leaving details of visits, a designated telephone line for contacting the team, and the use of an alert phrase to be used in an emergency situation.

Track record on safety

- The team was formed on 01 April 2015, and at the time of inspection had not reported any serious incidents.

Reporting incidents and learning from when things go wrong

- Staff members were aware of the need to report incidents; use of the Datix system was discussed, staff were knowledgeable.
- Staff knew the importance of informing people who used the service of when and if something went wrong. This was discussed in a complex care meeting that was observed and discussed in staff interview.
- Staff were kept informed by feedback after investigation of incidents, including e-mail information and de-briefing sessions, as well as via team meetings. Staff spoke of "sharing the learning" sessions.
- Information boards in the team room were clearly well designed to give information relating to on-going issues, feedback from meetings, and opportunities for staff to put forward suggestions as to taking the service forward.

Rapid Intervention and Treatment Team, Accrington

Safe and clean environment

People who used the service were not seen on site

Safe staffing

Key Staffing Indicators (report at core service level or, if possible, at ward level)

Establishment levels: qualified nurses (WTE)

Fully Staffed**

Establishment levels: nursing assistants (WTE)

Fully Staffed**

Number of vacancies: qualified nurses (WTE)

No vacancies

Number of vacancies: nursing assistants (WTE)

No vacancies

The number of shifts* filled by bank or agency staff to cover sickness, absence or vacancies in 3 month period

Team only formed on 01/04/2015

The number of shifts* that have **NOT** been filled by bank or agency staff where there is sickness, absence or vacancies in 3 month period

Team only formed on 01/04/2015

Staff sickness rate (%) in 12 month period

Team only formed on 01/04/2015

Staff turnover rate (%)in 12 month period

Team only formed on 01/04/2015

*By shift, it is meant a period of time (often 8 hours) worked by an individual Nurse

**Team is deemed fully staffed: one manager, two deputy managers, 17 staff (including one full time occupational therapist and one part time occupational therapist, and two psychologists).

- The team was only formed on 01 April 2015; the caseload was still being managed. It was open to adjustment due to the new seven day working system.

- There was no waiting list for a care coordinator, although the referral rate was expected to rise due to additional work of care home liaison. We attended a handover session, a daily occurrence with an overall handover each Tuesday. We noted the team used a rating system to determine which the more urgent cases were; this allowed staff to prioritise their workloads. Any new referrals received assessed as being urgent were seen within 24 hours. It was also used to monitor progress of people who used the service, allowing improvement and deterioration to be shown. Sickness cover was dealt with by accessing the diary of the staff member, re-negotiating the appointment if there was no cover for that day.

- We noted that annual leave was monitored by a matrix to avoid staff being off at the same time. There was access to a psychiatrist during the daily shift with three doctors named on the rota. We checked the mandatory training matrix and found that the Rapid Intervention

Are services safe?

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

and Treatment Team (RITT) had completed 100% of their mandatory training. A copy of the matrix was on a notice board in the team room in order that members could monitor their own training needs.

Assessing and managing risk to patients and staff

- We checked eight care records for this service and found that risk assessments were complete and up to date.

- People who used the service agreed crisis plans to deal with changes in behaviour.

- The team used a rating assessment to monitor improvement or deterioration of people who used the service, allowing response to any change in health status.
- The safeguarding team regularly attended handover meetings, were accessible for advice or guidance, with a de-briefing service from the team psychologist for when abuse was discovered.
- Staff were knowledgeable about how to report safeguarding issues, and information boards in the team room carried flow charts as a reminder.

- The lone worker policy was robust, involving leaving details of visits, often travelling in pairs, ringing the office when not returning, and the use of an alert phrase in an emergency situation.

Track record on safety

The team was formed on 01 April 2015, and at the time of inspection had not reported any serious incidents.

Reporting incidents and learning from when things go wrong

- Staff knew how to report incidents; we saw examples of Datix incidents that had been reported by staff in relation to external situations that had occurred.
- Staff knew that incidents that should be reported were reported, evidenced in discussion and by checking notes.
- Staff were kept up to date about investigation of incidents by team meetings – "blue light guidance" to disseminate information" – and "sharing the learning "events; information boards were noted to carry information relating to incidents and the "way forward".

Are services effective?

Good 🟢

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

Summary of findings

Our findings

Assessment of needs and planning of care

Memory Assessment Service, Central Lancashire

- There were dedicated triage staff that ensured full assessment on first contact. This was updated on each visit.

- We examined eight care records of people who used the service and found personalised, holistic recovery-oriented care plans that were kept up to date.

- Care records were recorded electronically. This included cognitive testing, a nursing assessment (including physical health, mental state, clinical observations) and an occupational therapy assessment (if required). We saw that all records were available to staff online.

Best practice in treatment and care

- Revision sessions were held around best practice, relating to National Institute for Health and Care Excellence (NICE) Guidelines, and that the team manager received NICE alerts to her computer.

- Physical healthcare was monitored from the initial assessment. If required, staff referred people onto relevant services, but as a service provider the people who used the service would be referred on to the relevant service should the need be noted. We found and checked that anti-dementia medication was monitored by six month and 12 monthly reviews.

- We found that the service ran its own internal audits, as well as trust audits.

Skilled staff to deliver care

- The skill mix of team members for the service was suitable for the requirements to provide the service; it included occupational therapists, registered mental health nurses (RMNs), psychologists, doctors and psychiatrists, mostly in a full time capacity.

- Staff were suitably qualified to fulfil their roles. Research nurses were used to deliver extra training. The manager managed staff performance issues through supervision and appraisals.

- Minutes indicating bi-weekly staff meetings and an information board was used to keep staff up to date with any relevant information and for brainstorming.

- Clinical staff were regularly appraised and appraisals were up to date; administrative staff were appraised by their team lead.

Multi-disciplinary and inter-agency team work

- Multi-disciplinary meetings were termed "consultations". All staff involved in the care of the people who used the service attended.

- There was a good working relationship with dementia advisers, primary care services and the Alzheimer's Society.

Adherence to the MHA and the MHA Code of Practice

- We discussed the Mental Health Act and the Code of Practice with staff, and they displayed knowledge of the Act and stated it was part of their mandatory training.

- Consent forms were recorded on the computer after verbal discussion with the person who used the service.

Good practice in applying the MCA

- Staff were trained in applying the MCA and discussion showed knowledge of the five basic principles.

- We found that there was a policy relating to the MCA on the trust intranet that could be accessed by staff.

- MCA was taken into account before decisions were made both pre and post diagnosis. There was a tool for recording capacity on the electronic system but it is not always used. However, there was evidence in care records throughout to show it was considered.

- Evidence of best interest meetings were recorded in the notes of people who used the service.

- MCA was monitored by the mandatory training matrix for the service and also by the governance team.

Community Mental Health Team (CMHT), Bickerstaffe House, Preston

Assessment of needs and planning of care

- People who used the service had been assessed by triage in a timely manner.

- We reviewed four care records which confirmed personalised, up to date, holistic, recovery-based information.

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.

- Information was stored securely on the electronic care record blue system that displayed clearly information about people who used the service.

Best practice in treatment and care

- Staff followed NICE Guidelines in the administration and prescribing of medication; we were shown intranet access to the guidance.
- Access to psychological therapies was available through the psychologist attached to the team, with therapies such as cognitive behavioural therapy (CBT) given to people who used the service.
- Support was available for employment, housing and benefits, but was rarely required due to the age range of the people who use the service.
- A designated assistant practitioner monitored the use of antipsychotic medication, the practitioner kept records relating to titration of medication, and kept the team informed at team meetings
- We noted that the service used payment by results to monitor severity and outcomes.
- Audits relating to safety thermometer, and internal trust audits relating to care plans, including a monthly trust-wide audit were available to all staff.

Skilled staff to deliver care

- A full range of mental health disciplines worked within the service, including three occupational therapists, a psychologist plus further access to a senior psychologist, and a full time social worker.
- All staff were given a trust induction and an in-house induction, as well as having a buddy system in place.
- Staff were given updated training in risk assessment, suicide prevention training, self-harm training from the Guild of Managing Self Harm, and personality disorder training.
- Personal development reviews (PDRs) were undertaken regularly, and this occurred for both trained and non-medical staff; we noted that it was completely up to date.

Multi-disciplinary and inter-agency team work

- Complex care meetings were held each Tuesday and the use of 'huddles' was active (the team would gather to discuss ongoing issues); staff felt these were effective.
- There were effective handovers between services and teams, using paper and electronic records.

- We were told by the social worker attached to the team that there was a good working relationship within the team. The manager stated that a planned transition meeting to ensure good cooperation with outside services had not yet happened.

Adherence to the MHA and the MHA Code of Practice

- MHA training was mandatory, and as such all staff had received training. We were told that there was provision for face to face instruction from an approved mental health practitioner if this was felt necessary.
- We examined community treatment order (CTO) documentation during a visit to a care home and we witnessed that rights were explained to the person who used the service.
- We were informed that MHA administrators were employed by the trust to ensure that documentation was kept up to date and the team informed.
- We discussed access to an independent mental health advocate (IMHA) services and knowledge was shown of the process of referral; at the point of discussion the service had not been used by the new team.

Good practice in applying the MCA

- MCA training was mandatory and provided online, and there was also a full day of training available to staff. We discussed this with staff who displayed knowledge of the five principles. We found there was a trust-wide policy available on the intranet.
- We examined four care records and found that mental capacity was considered throughout the documents, but no formal tool was used to record the manner in which capacity was assessed; there was a page for recording capacity, but it was not always used. We were told that due to the nature of the people who used the service, capacity was an ongoing assessment.
- We were told that an independent mental health capacity assessor (IMCA) would be called in to assist if necessary, but the team had no reason to do so since inception.

Rapid Intervention and Treatment Team (RITT), Lytham

Assessment of needs and planning of care

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.

- Full physical assessments were carried out by GPs prior to referral to the service, with risk assessments completed at the single point of access (updated regularly).
- We reviewed seven care records which confirmed personalised, up to date, holistic, recovery-based information.
- We found the information was securely stored on the electronic care records) blue system, and was clearly displayed and accessible to relevant staff.

Best practice in treatment and care

- Staff discussed and considered NICE guidelines during team meetings, with the manager disseminating information and the staff following their professional guidelines.
- We were told by staff that the consultant psychiatrist discussed NICE guidelines in MDT.
- Psychological therapies were available to people who used the service, as well as an advisory capacity for staff should the need arise
- Referral for support was available for people who used the service in relation to benefits and housing. Due to the age and diagnosis of the people who used the services, employment was not a consideration.
- We saw from care records that physical examinations were completed prior to acceptance by the team, but that there was evidence of ongoing physical care monitoring.
- We saw care plans were audited regularly by the team manager as well by the trust.

Skilled staff to deliver care

- A full range of mental health disciplines worked within the service, including two occupational therapists, access to a psychologist, a former social worker turned practitioner, and a consultant psychiatrist.
- Staff were suitably experienced and qualified to fulfil their role within the service.
- We noted that as the team was only formed on 01 April 2015, there had been no inductions carried out as each of the staff members were brought in from either single point of access, immediate care support or care home liaison.
- Regular team meetings were held and documented, and staff told us that they were regularly supervised and appraised.

- We were told by the manager that at that time she had not completed the personal development review for all the staff as she needs to review their experience, training level and best position for staff, in view of the newly formed nature of the team.

Multi-disciplinary and inter-agency team work

- There were three MDT meetings a week, plus daily allocation meetings
- We attended a complex care meeting attended by the consultant psychiatrist, team manager, deputy team manager, several staff members.
- They used computers and projectors to show care records at the complex care meeting. This allowedfull access to records and immediate update during the meeting.
- We saw use of inter-agency liaison to deal with ongoing issues relating to people who used the service.

Adherence to the MHA and the MHA Code of Practice

- MHA training was mandatory and all staff had received training.
- Staff took part in Section 117 meetings and had an understanding of the MHA.
- We noted that there were no people who used the service under a community treatment order.
- We discussed access to IMHA services, and knowledge was shown of the process of referral; at the point of discussion the service had not been used by the new team.

Good practice in applying the MCA

- MCA training was mandatory and provided online, and this was supplemented with a full day of interactive training available to staff: as such all staff had received MCA training.
- There was a trust wide policy regarding the MCA available on the trust intranet.
- We saw in care records that capacity was regularly assessed on all the care records checked, although not recorded in a formal tool.
- We saw that best interest meetings were held when applicable and recorded in care records.
- MCA was monitored by the mandatory training matrix for the service and also by the governance team.

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.

Rapid Intervention and Treatment Team, Accrington

Assessment of needs and planning of care

- People who used the service were seen by this service the day after the referral was received.
- The single point of access had a four hour response time when receiving requests for beds from GPs, an improvement since the bed management team formed.
- We reviewed eight care records which confirmed personalised, up to date, holistic, recovery-based information.
- Information was securely stored on the electronic care records blue system, and was clearly displayed and accessible to relevant staff.

Best practice in treatment and care

- NICE Guidelines were discussed and adhered to, and checks of eight care records showed that good practice was standard across the records.
- We observed a visit to a person who used the service and the use of medication was noted and found to be good practice.
- Psychological input within the service was good, including the use of Schwartz Rounds to improve empathy between staff and people who used the service.
- We observed staff consider physical health needs whilst on a visit to a person who used the service.
- The service used the Middlesex elderly state cognitive impairment test to measure severity and outcomes for people who use the service, as well as a clustering tool.

Skilled staff to deliver care

- A full range of mental health disciplines working within the service, including community psychiatric nurses, occupational therapists, a psychologist, and a consultant psychiatrist.
- The skill set of the team was consistent with the needs of the service and the people who use the service.
- Staff were appraised and supervised, with staff being supervised formally every three months and clinical supervision once a month.

- Staff meetings were held weekly.
- Specialist training was available for staff, such as personality disorder in older people (two day course), and staff were taking part in suicide prevention training.

Multi-disciplinary and inter-agency team work

- Regular MDT meetings in which the psychiatrist and psychologist played key roles, these were minuted and precise.
- We attended a handover, and found that there was a handover each morning and an in-depth handover weekly.
- There was an effective handover between the service locations, as well as care homes and external organisations.

Adherence to the MHA and the MHA Code of Practice

- MHA training was mandatory, and all staff had received training.
- Staff had a good understanding of the MHA.
- Staff felt well supported in their involvement in the MHA, and felt they were kept up to date during meetings of any changes in practice.

Good practice in applying the MCA

- MCA training was mandatory, and all staff had received training.
- There was a trust wide policy available on the trust intranet.
- We discussed the MCA with staff and found them knowledgeable and aware of how to seek advice.
- We reviewed eight care records for this service and found that capacity was considered throughout the documentation, although it was not recorded in a formal tool.
- We found evidence of support to make decisions within care records reviewed.

The MCA was monitored by the manager for the service and also by the governance team.

Are services caring?

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

Good ●

Summary of findings

Our findings

Memory Assessment Services, Central Lancashire

Kindness, dignity, respect and support

- Staff respected the dignity of the people using the service and their carers.
- We accompanied staff on a visit to a person who used the service, and found that the visit was conducted with respect, a caring attitude, and gave relevant information to the person who used the service.
- We interviewed one service user after their initial assessment and were told that they were "delighted" with the service, and the "lady" was "lovely". We made telephone contact with two out of five people who used the service, and they reported "getting good service" and were "treated well".
- Staff were aware of the individual needs of the people who use the service.

The involvement of people in the care they receive

- Evidence that the perspective and wishes of the person who used the service were documented in the initial assessment documents and subsequent documentation
- Staff signposted to other services such as Age Concern for extra support
- Patient satisfaction surveys, done electronically by support staff after appointments, showed a high level of satisfaction in treatment and service

- We were shown leaflets and hand-outs informing people who use the service of information relating to aspects of treatment such as medication
- Evidence that the perspective and wishes of the person who used the service were documented in the initial assessment documents and subsequent documentation
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- We were shown leaflets and hand-outs informing people who use the service of information relating to aspects of treatment such as medication

Community Mental Health Team (CMHT), Bickerstaffe House, Preston

Kindness, dignity, respect and support

- We observed a visit to a care home by the social worker attached to the service, and it was noted that the interaction was thorough, thoughtful and respectful.
- We observed a visit to a nursing home by the consultant psychiatrist; there was evidence of care and dedication from trust staff, further evidenced by a resultant telephone call observed between the consultant and a carer about the case.
- We observed a visit to the home of a person who used the service by a community psychiatric nurse. It was noted that the perspective of the person who used the service were considered and they were involved in the process of planning care.
- Patient records were recorded on a secure computer system.

The involvement of people in the care they receive

- We examined four care records and found evidence of involvement in care planning, personalised care, and copies of care plans given to people who used the service.
- People who used the service were actively involved in decision making, along with their carers; there was a referral process to carer's central (a Lancashire County Council social service) where carers could get information about available support.
- We noted that as part of the assessment process there was an offer of access to advocacy, and to translation services if required.
- We were told that at this time no new staff had been recruited, so no involvement by people who used the service, but that this had happened in the past.

Rapid Intervention and Treatment Team, Lytham

Kindness, dignity, respect and support

- We accompanied an occupational therapist and visited a person who used the service at a care home, and observed that the relationship between the person who used the service and the staff member was professional, friendly and respectful.

Are services caring?

Good 🟢

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

- We viewed feedback forms, finding all comments positive, "excellent" ratings given by all.
- Comments indicated that wishes and views were considered, all people who used the service were treated with courtesy and respect.
- Patient records were recorded on a secure computer system, ensuring confidentiality.

The involvement of people in the care they receive

- We examined seven care records and found evidence of involvement in care planning, personalised care, and copies of care plans give to people who used the service.
- We saw evidence of person-centred care planning that included support to people who used the service and their carers.
- We noted that staff were keen for families of people who used the service to sort out lasting power of attorney for health and finance and this was documented.
- Due to the nature of the diagnosis of the people who used the service being predominantly dementia-related, their involvement in staff recruitment and service provision was limited.
- We saw feedback forms from people who used the service and their carers, and all were positive.

Rapid Intervention and Treatment Team, Accrington

Kindness, dignity, respect and support

- We observed three visits to people who used the service, one declined trust staff entry, and staff were found to be respectful, supportive, compassionate, and professional.
- We interviewed a person who used the service and a carer, and they reported staff and service as "outstanding".
- We contacted a care home and received excellent reports on the work of the service.
- Patient records were recorded on a secure computer system, ensuring confidentiality.

The involvement of people in the care they receive

- We examined eight care records and found evidence of involvement in care planning, personalised care, and large print copies of care plans give to people who used the service.
- We witnessed support given to people who used the service and carers during visits.
- We noted that with the diagnosis of the people who used the service being predominantly dementia-related, their involvement in staff recruitment and service provision was limited.
- We were told by staff that there was interest in recruiting an expert by experience for the service.

Are services responsive to people's needs?

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

Summary of findings

Our findings

Memory Assessment Services, Central Lancashire

Access and discharge

- Referrals to the memory clinic were looked at by staff within 72 hours and this was followed up with a full assessment within four weeks. Diagnosis and the development of a care package or referral to another service took between eight and 14 weeks. This was monitored and rates were displayed on the team information board, showing the pathway operated well.

The facilities promote recovery, comfort, dignity and confidentiality

- There was a full range of rooms in which to conduct interviews. The rooms allowed for adequate privacy during interviews.

- The service had access to and provided a full range of leaflets relating to local services, how to complain, patients rights.

Meeting the needs of all people who use the service

- Access to the location included a ramp for wheelchair access, and the doors to the location opened automatically, wide enough to accommodate two people side by side, as well as toilets for disabled people who used the service.
- Information leaflets were available in languages spoken by people who used the service in the reception area, as well as access to an interpreting service.
- Leaflets at reception clearly designated and set out to allow for complaints.

Listening to and learning from concerns and complaints

- We saw that complaints forms were readily available, and the procedure was also laid out in referral correspondence with people who used the service.

- We found that staff knew the procedure for handling complaints, but that the service had not received any.

Community Mental Health Team, Bickerstaffe House, Preston

Access and discharge

- The service aimed to see the person who used the service within 15 days of referral, but also that the person who used the service would have already been assessed by single point of access within that time.
- We saw that there was no waiting list, as the team manager was named care coordinator on referral before re-allocation within the team.
- There was a buddy system and duty staff rota that allowed for quick response if a person who used the service rang in to the team.
- People who used the service were vulnerable adults because of diagnosis, the service actively supported them where needed.
- If a person who used the service did not attend an appointment, efforts would be made to contact the person who used the service at home, if safe or appropriate.
- We were told that appointments were only cancelled in an emergency, at which point the person who used the service would be informed and alternative arrangements that suited them would be made, with the reasons for cancellation given.
- We were told that appointments run on time and people who used the service would be informed of any late arrivals.

Meeting the needs of all people who use the service

- We found that information leaflets in different languages were available on the service intranet.
- We saw that there was a contract with an interpretation service affixed to the office wall if translation services were required.

Listening to and learning from concerns and complaints

- Complaint and compliment forms that outlined the procedure to complain/compliment were available to people who used the service in a mobile rack.

Are services responsive to people's needs?

Good 🟢

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

- We discussed complaints policy with staff and found they were aware of the policy and knew how to handle complaints.
- We found that, as the team had only formed on 01 April 2015, they had not received any complaints at that time.
- We were told by staff that feedback on complaints would be given either individually or in a team meeting, leading to an action plan to ensure it did not happen again, although there had been no complaints to the team.

Rapid Intervention and Treatment Team, Lytham

Access and discharge

- On referral a single point of access would complete triage, with initial risk assessment completed. From access to discharge the service aimed to discharge people who used the service within 12 weeks.
- The service used the Newcastle model of care as its psychosocial profile suited working with care homes.
- The seven day shift pattern of the team meant that urgent referrals could be dealt with in a timely manner.
- Due to the seven day shift pattern of the team, flexibility of appointments meant that any cancellations could be dealt with at the convenience of the person who used the service.

Meeting the needs of all people who use the service

- People who used the service did not attend the location for appointments.
- Information leaflets in different languages were available on a rack near to the exit, allowing staff to take them if needed when visiting people who used the service.
- The trust had a contract with an interpretation service affixed to the office wall if translation services were required.

Listening to and learning from concerns and complaints

- Complaint and compliment forms that outlined the procedure to complain/compliment were available to people who used the service, and were stored in a rack near the exit for staff to take with them when visiting people who used the service.

- We discussed complaints policy with staff and found they were aware of the policy and knew how to deal with complaints.
- We discussed with staff how they would be informed of complaints and findings, we were told that they would be informed by the manager in a team meeting, but they had not received any complaints.

Rapid Intervention and Treatment Team, Accrington

Access and discharge

- A "referred today, seen tomorrow" approach was in place, with risk assessment taking place when seen, and a six week re-enablement package leading to discharge from the service within 12 weeks.
- Due to the seven day shift pattern of the team, urgent referrals could be dealt with immediately.
- We were told that before the formation of this team, they received one referral a day on average, but expected this to rise with the addition of care home liaison.
- The seven day shift pattern allowed for flexibility in appointments for people who use the service.

Meeting the needs of all people who use the service

- People who used the service did not attend the location for appointments.
- Information leaflets in different languages were available on a rack on the office wall, allowing staff to take them if needed when visiting people who used the service.
- There was a contract with an interpretation service affixed to the office wall if translation services were required.

Listening to and learning from concerns and complaints

- Staff had access to complaints forms that they gave to people who used the service and care homes for their use.
- We discussed complaints with staff who were aware of the trust policy for dealing with complaints.
- We found that staff knew that the findings of complaints would be discussed in a meeting or individually, but the service had not received any complaints since inception.

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.

Summary of findings

Our findings

Memory Assessment Service, Central Lancashire

Vision and values

- There was evidence of the vision, values and statement of the trust signposted throughout the location, and discussion with staff showed knowledge of these values.
- Team objectives were based on these values.
- We noted that staff could give names and details of senior management and that they had recently been visited by a senior manager.

Good Governance

- Staff received mandatory training, and were appraised and supervised regularly.
- Shifts were covered by sufficient staff numbers to support the service
- We found active participation in clinical audit.
- We saw excellent use of an information board to keep staff informed about performance, including times, values, predictions and targets.

Leadership, morale and staff engagement

- We found that sickness rates were low and that there was only one long term period of 18 months related to an administrative staff member.
- We found no evidence of bullying or harassment cases within the service.
- We noted that staff were aware of the whistle-blower procedures and a service called "Dear Derek" was available for staff to raise concerns.
- Staff morale was high; they enjoyed working in the service, and felt they could approach their manager if there were any concerns.
- We found that staff gave explanations to people who used the service if there were problems, such as delays in appointments or waiting for results.

Commitment to quality improvement and innovation

- We were shown involvement by the research practitioner, and told of the Helping occupational performance and engagement programme for carers, a seven week course to help carers to support people who use the service to engage in everyday tasks; there are trials ongoing for 2 medications, "assistive technology" trials.

Community Mental Health Team, Bickerstaffe House, Preston

Vision and values

- Trust values were included in appraisals and training, as well as situated about the location in the form of signage. Staff showed knowledge of the values.
- Staff understood the trust strategy, a five year plan and we were shown a copy of the strategy.
- We noted pictures of senior managers with their designation on the wall of the office.
- We were told that the service had not received a visit from senior management since the formation of the team, and not above the level of Assistant Director.

Good Governance

- Staff received mandatory training and that this was up to date.
- Referral times were monitored, as were finances and staffing.
- Staff were supervised and appraised regularly and that information from governance meetings was passed on to staff in team meetings.
- We found active participation in clinical audit, such as the Safety Thermometer.
- Staff had the ability to submit items to the trust risk register, and we were shown an entry to the risk register made on 16 March 2015 with reference to staffing levels.

Leadership, morale and staff engagement

- We discussed whistleblowing procedures with staff and found they were fully aware of procedures.
- We found no evidence of any bullying or harassment cases within the service.
- We were told by staff they could raise concerns with managers, the culture was open and approachable.
- Staff said that morale was good within the team with, there was good team cohesion: staff talked of a "red nose day event" that was successful.
- Staff were open to accepting responsibility if something went wrong, and felt supported in the need to inform the people who used the service.

Are services well-led?   Good ⬤

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

Commitment to quality improvement and innovation

- We found that "Sharing the Learning" forums were held to improve quality.
- We found Schwartz Rounds held, "When professional and personal lives meet", every month, to discuss issues that may affect staff and people who use the service.
- We noted a "30 day challenge" to staff to make 15 changes over 30 days to improve quality of service.
- We found a "blue wave of change" process to improve quality: this encourages nurses to let go of their voices of judgement, cynicism and fear by reconnecting with their deeper purpose.

Rapid Intervention and Treatment Team, Lytham

Vision and values

- Trust values were included in appraisals and training, as well as situated about the location in the form of signage. A discussion with staff showed knowledge of the values.
- We were told by staff that the team manager was highly respected and they felt they could approach her.

Good governance

- Staff received mandatory training and the training records showed that this was up to date,
- We confirmed with staff that they had regular supervision and appraisals, confirmed by diary entries in manager diary
- The new seven day shift pattern allowed for people who use the service to receive care at a time that suited them.
- Incidents were reported efficiently, and viewed this in care records.
- Staff reported they participated in clinical audit, such as the safety thermometer
- We noted that staff had the ability to submit items to the trust risk register, and saw that staff had put staffing concerns on the risk register before the team had formed.

Leadership, morale and staff engagement

- We found no reports of bullying or harassment, and staff told us that they were not aware of any such reports or problems within the team.
- We discussed whistleblowing procedures with staff and found they were aware of procedures.

- We discussed staff morale and found that it was high within the team, and staff attributed this to the efforts of core service management.
- Staff told us that they had discussed development of their role with management.
- Duty of candour and the need to act was discussed in a witnessed complex care meeting over an incident in A&E that could affect a person who used the service.

Commitment to quality improvement and innovation

- We found that "Sharing the Learning" forums were held to improve quality.
- We found Schwartz Rounds held, "When professional and personal lives meet", every month, to discuss issues that may affect staff and people who use the service.
- We noted a "30 day challenge" to staff to make 15 changes over 30 days to improve quality of service.
- We found a "blue wave of change" process to improve quality: this encourages nurses to let go of their voices of judgement, cynicism and fear by reconnecting with their deeper purpose.

Rapid Intervention and Treatment Team, Accrington

Vision and values

- Trust values were included in appraisals and training, and noted a copy of the trust values on the wall of the location.
- We discussed the team values with staff and found they were consistent with the trust values.
- We were told that staff had seen lots of senior management recently, but this was only due to consultation about jobs.

Good governance

- We viewed mandatory training records and found them up to date.
- We found that both clinical and management supervision both took place regularly.
- We saw that the new seven day coverage allowed for better involvement in care planning for people who use the service.
- We saw evidence that incidents were reported using the appropriate channel.
- We found active participation in clinical audit, such as the safety thermometer

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.

- We found that the team utilised the risk register, in relation to the RITT model, to bring awareness to the changes in the team.

Leadership, morale and staff engagement

- We found no evidence of bullying or harassment in the service.
- We discussed whistleblowing with staff and they were aware of how to use the policy
- We discussed with staff their ability to raise concerns and staff assured that they felt they could approach their managers.
- We spoke with staff who told us they had applied to their role in the service because they wanted to work with the team, morale was high.
- We found that teamwork was very good within the service.

- Staff were involved in service development leading to the formation of the new team.

Commitment to quality improvement and innovation

- We found that "Sharing the Learning" forums were held to improve quality.
- We found Schwartz Rounds held, "When professional and personal lives meet", every month, to discuss issues that may affect staff and people who use the service.
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