Good

Lincolnshire Partnership NHS Foundation Trust

Community-based mental health services for older people

Quality Report

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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)
RP7HQ	Trust Headquarters	Skegness Resource Centre	PE25 1DA
RP7HQ	Trust Headquarters	Windsor House	LN11 0LF
RP7HQ	Trust Headquarters	Johnson Community Hospital	PE11 2DE
RP7HQ	Trust Headquarters	Pilgrim Hospital	PE21 9QS
RP7HQ	Trust Headquarters	Manthorpe Centre	NG31 8DG
RP7HQ	Trust Headquarters	Witham Court	LN6 8UZ

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

Summary of findings

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 Lincolnshire Partnership NHS Foundation Trust and these are brought together to inform our overall judgement of Lincolnshire Partnership 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?	Requires improvement
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 this core service as 'good' because:

- Staff told us they received regular supervision and appraisal.We saw schedules in place, and staff told us that managers were always available to advise and support.
- There was a high level of morale and job satisfaction in all the teams. Staff throughout the services were positive about the trust, their work and their local management
- The teams engaged with people who found it difficult to engage with the services. Two people would visit where risk assessments showed this was beneficial. Visits were able to be arranged outside of the home, if a person wished for this.
- All teams had a duty system that was able to respond to urgent referrals and had good access to psychiatrists in emergencies.Patients we spoke to said they could access help urgently when required.
- The services were committed to ensuring patients had the opportunity to feed back about their care and treatment. The older adult community teams use the "Making Experiences Count" patient feed-back questionnaire. This is being used across all of the older adult community Teams and the services have a high level of returns in terms of overall Trust numbers.
- We observed staff to be respectful, responsive and supportive of patients needs.
- Each team had an allocated "neighbourhood team" member whose responsibility was to attend the Lincolnshire health and care"neighbourhood meeting".This initiative has been developed with the support of the local Clinical Commissioning Groups to help support older adults living in the community and is aimed at promoting independence.
- Staff demonstrated a good understanding of safeguarding and the processes for reporting were clearly displayed in each of the services.
- Staff told us they received feedback from investigations, and were debriefed following incidents.

However:

- The trust had identified on the older adult risk register in 2013, excessive service and staff caseload size within the older adult's CMHT. Since then there have been progressive attempts to reduce the case load for nurses and band 4 workers throughout 2014 and 2015. However, their caseloads remained high at the time of the inspection. This added an additional pressure to their ability to care for the patients.
- On reviewing care records, we found that staff had not completed risk assessments for all patients.
- Staff did not always up date all patients care plans and regular reviews were not always taking place.
- Staff did not always document patients' mental capacity. It was unclear whether staff assessed patients capacity when needed or if they just did not record the assessment of capacity.
- The older adult community teams only had access to one psychologist across the six teams. Staff told us there was a 12-18 month waiting list for access to psychological therapies.
- We were told by staff, patients and carers that none of the older persons community teams were currently running patient or carers support groups.
- Key Performance Indicators were not used by the trust to measure the performance of older persons teams.

Summary of findings

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

Are services safe?

Good

We rated this core service as **'good'** for safe because:

- There were appropriate systems in place for the safe management of medications.
- There was no use of agency or bank staff to cover vacancies or sickness across the services. This meant that the staff team was consistent.
- The teams used a "heat map" to identify areas where staff were out of date with mandatory training and the managers we spoke with were aware of how to access this information easily.
- Staff demonstrated a good understanding of safeguarding and the processes for reporting were clearly displayed in each of the services.
- The services reviewed all serious incidents at band 7/8 meetings every 6 weeks. In addition the trust sent out lessons learnt bulletins to all of the staff informing them of incidents that have happened across the trust to support in learning from incidents.
- Staff told us they received feedback from investigations and were debriefed following incidents.

However:

- The trust had identified on the older adult risk register in 2013 that excessive service and staff caseload size within older adult's CMHT. Since then there have been progressive attempts to reduce the case load for nurses and band 4 workers throughout 2014 and 2015 but their caseloads still remain high. Staff told us they found this difficult to manage and it added an additional pressure to their ability to care for the patients..

Are services effective?

Requires improvement

We rated this core service as '**requires improvement'** for effective because:

- Care plans did not always contain up to date information relating to patients' current needs andthe regular reviews were not taking place.
- The older adult community teams only had access to one psychologist across the six teams. Staff told us there was a 12-18 month waiting list for access to psychological therapies.
- Staff did not always complete risk assessments for all patients and were not consistently recording risk assessments in the same place on the electronic care records system

Summary of findings

However:

- Community teams were offering Cognitive Stimulation Treatment which is an intervention recognised by The National Institute for Health and Care Excellence.
- All staff told us they received regular supervision and yearly appraisals. Records we looked at confirmed this.
- Each team had an allocated “neighbourhood team” member whose responsibility it was to attend the Lincolnshire health and care“neighbourhood meeting”.This initiative has been developed with the support of the local Clinical Commissioning Groups to help support older adults living in the community and is aimed at promoting independence.

Are services caring?

Good

We rated this core service as ‘**good’** for caring because:

- We observed staff to be respectful, responsive and supportive of patients’ needs. We accompanied staff on visits and found the support and treatment offered to patients to be of a high quality.
- Confidentiality was maintained and information was stored securely, both in paper and electronic format. Paper copies of care plans were given to patients and easily identified using the trust initiative “Your Care Plan” initiative.
- The services were committed to ensuring patients had the opportunity to feed back about their care and treatment. The older adult community teams use the “Making Experiences Count” patient feed-back questionnaire. This is being used across all of the older adult community Teams and the services have a high level of returns in terms of overall trust numbers.

However:

- We were told by staff, patients and carers that none of the older persons community teams were currently running patient or carers support groups, as in the past people had not been interested or able to attend. However, all the managers we spoke with told us they would like to re-start some regular support groups.

Are services responsive to people's needs?

Good

We rated this core service as ‘**good’** for responsive because

- All teams had a duty system that was able to respond to urgent referrals and had good access to psychiatrists in emergencies.Patients we spoke to said they could access help urgently when required.

Summary of findings

- We found that the services were aware of the cultural mix within their locality and had ensured that they were offering information leaflets and could access interpreter services when required.
- Older adult services held paper files forpatients subject to a 'fast track' discharge. This meant if the patient deteriorated after discharge, within identified times, they did not need to go through all the referral processes for older adult CMHTsupport.
- The teams engaged with people who found it difficult to engage with the services. Two people would visit where risk assessments showed this was beneficial. Visits were able to be arranged outside the home, if a person wished for this.

However:

- Most of the services we visited were not very welcoming and not considered to be dementia friendly with poor signage, a lack of colour and low furniture.

Are services well-led?

Good

We rated this core service as '**good'** for well led because

- Staff told us they received regular supervision and appraisal.We saw schedules in place, and staff told us that managers were always available to advise and support.
- There was a high level of morale and job satisfaction in all the teams. Staff throughout the services were extremely positive about the trust, their work and their local management
- Staff told us leadership programmes were available within the trust to all staff that showed an interest in professional development.
- Staff told us they were aware of the whistleblowing policy, knew how to use it and were confident in doing so if needed.

However:

- Key performance indicators were not currently being used to measure the performance folder persons teams.

Summary of findings

Information about the service

The six community teams visited are based across the geographical spread of Lincolnshire.

The trust's six older persons community mental health teams (CMHT) provide the following interventions:

Memory assessment and management service provides specialist assessment, diagnosis and early interventions for people with suspected, and/or mild to moderate dementia.

They carry out mental health assessments and interventions for both mental health needs, co-morbid emotional disorders and mild non-cognitive, behavioural and psychological symptoms of dementia.

The older person CMHT provide Mental Health Intermediate care to support access to mainstream physical rehabilitation services by older adults with existing, complex mental health needs or dementia, following or during a period of health rehabilitation. They offer support to patients in their home and the community.

The older person CMHT are staffed with: community psychiatric nurses, occupational therapists, psychiatrists, social worker, support workers and administrative support staff.

The teams work closely with other local mental health providers and residential care homes, as well as inpatient wards and GPs. Support is generally provided Monday to Friday from 9am to 5pm.

The Care Quality Commission has inspected Witham Court once since registration. The last inspection took place in 2013 and they were found to be meeting all Regulations, now known as fundamental standards.

Our inspection team

Our inspection team was led by:

Chair: Stuart Bell, Chief Executive Officer, Oxford Health NHS Foundation Trust

Team Leader: Julie Meikle, Head of Hospital Inspection, mental health hospitals, CQC

Inspection Manager: Lyn Critchley, Inspection Manager, mental health hospitals, CQC

The team that inspected this core service consisted of two CQC inspectors; two nurses, a social worker, an occupational therapist, a psychiatrist, and one expert by experience. Experts by experience are people who have direct experience of care services we regulate, or are caring for someone who has experience of using those services.

The team would like to thank all those who met and spoke to inspectors during the inspection and were open and balanced with the sharing of their experiences and their perceptions of the quality of care and treatment at the trust.

Why we carried out this inspection

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

How we carried out this inspection

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

- Is it safe?
- Is it effective?

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

Before the inspection visit, we reviewed information that we held about these services, asked a range of other organisations for information and sought feedback from patients at three focus groups.

During the inspection visit, the inspection team:

- visited six community teams and looked at the quality of the environment and observed how staff were caring for patients;
- spoke with 17 patients who were using the service;
- spoke with 13 carers of patients who were using the service;
- spoke with the managers or acting managers for each of the community teams;
- spoke with 21 other staff members; including doctors, nurses, social workers and occupational therapists;
- Attended and observed two hand-over meetings and two multi-disciplinary meetings.
- looked at 39 treatment records of patients;
- attended 6 home visits with members of the community teams;
- carried out a specific check of the medication management in all six community teams visited;
- looked at a range of policies, procedures and other documents relating to the running of the services.

What people who use the provider's services say

Patients we spoke with were overwhelmingly positive about the service they were receiving. We were told that staff were polite, caring and respectful and patients felt staff were helpful and interested in their wellbeing. Patients said they were always treated with dignity and compassion.

Carers spoke positively about the kindness, compassion and responsiveness they received from all staff at the teams we visited. Carers said they were always given relevant information about the service and were involved with their person's treatment and reviews.

Good practice

- The trust is heavily involved and committed to dementia research and is currently actively taking part in or applying for a multitude of research projects to improve dementia care across their services.

Areas for improvement

Action the provider SHOULD take to improve

- The trust should continue the planned review of caseloads and identify ways to reduce these.
- The trust should ensure that staff in the Older Person CMHT always record the patient risk assessment in the same location on the electronic patient record system.

- The trust should ensure capacity is clearly and consistently recorded, whether a patient has capacity or whether a patient lacks capacity.
- The trust should review how they are ensuring support groups are available for carers and patients receiving services.
- The trust should ensure that all areas that patients are accessing are dementia friendly.

Lincolnshire Partnership NHS Foundation Trust

Community-based mental health services for older people

Detailed findings

Locations inspected

Mental Health Act responsibilities

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

Staff knew how to contact the Mental Health Act office for advice when needed.

As part of mandatory training, all staff received training in the Mental Health Act.

Staff compliance with the Mental Health Act training across the trust was 72% as of August 2015.

Community Treatment Orders, although rarely used in the services, were completed properly when they were required. Two patients' notes we reviewed at Witham Court that were on a CTO had all their paperwork in good order and we could see tracking systems were in place to ensure they were being effectively reviewed. Staff in Johnson Community Hospital gave us a recent example of when they had to support a community patient back into hospital following the recall of his CTO and we found the paperwork and care plans showed a seamless transition from home to hospital.

Staff told us they could get advice on implementation of the MHA and its Code of Practice from within the trust if required.

People had their rights explained to them appropriately. This was evident on visits to people's homes and in discussions with carers and people directly using the service.

Mental Capacity Act and Deprivation of Liberty Safeguards

Staff were knowledgeable on the principles of the Mental Capacity Act (MCA) and were able to describe how they applied these in practice. Daily progress notes reviewed in

the care records also supported this. We observed that consent was obtained during home visits and the memory clinics, and staff checked people`s understanding throughout.

As part of mandatory training, all staff received regular training in the MCA.

Where patients did not have capacity to make a decision, this was clearly assessed and recorded. These capacity assessments were decision based, rather than 'blanket' assessments.

Of the 39 sets of electronic care records we looked at, 12 had evidence of capacity issues being identified and addressed. However, in the electronic care records there was a box indicating whether capacity issues had been considered for each patient. In 27 sets of records this had not been ticked so it was unclear if these patients had capacity or just not hadtheir capacity considered.

The health professionals we spoke with were who were involved in capacity assessments were all aware that assessments were time and decision specific and there was a presumption of capacity unless evidence indicated otherwise.

Staff told us that they always asked for consent prior to assessment and carried out a capacity assessment proportional to need. We witnessed on all the visits we went on staff checking for consent where appropriate. This indicated that consent was sought and capacity assessed, but that this was not always recorded.

Staff in the care homes we visited told us the older persons CMHT regularly advised them on the use of Deprivation of Liberty Safeguards (DoLS) when issues arose regarding their patients and in this respect the older persons teams were being used as a resource to promote good practice in the use of the MCA.

Good

Are services safe?

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

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

Our findings

Safe and clean environment

- In five of the six services inspected, staff had the access to personal alarms if they were required to interview patients in the meeting rooms.The staff told us they did not usually use them as they normally visited patients in their own homes or in residential services.There was only a system for the maintenance checking of personal alarms in the Manthorpe Centre.
- We visited all the areas where medication was being stored and accessed by staff and found that there were checking systems in place to ensure good medication management processes were being followed.We were told about an incident that had occurred in one of the services where medication had been administered incorrectly and the manager told us in great detail the lessons that had been learnt and the changes that had been made following this incident. There was evidence of learning from this incident across all the services we visited.
- We saw that closed circuit television was being used in the communal areas of the services and there were signs clearly displayed in all relevant areas informing visitors of this.
- None of the services had designated clinic rooms. However, we noted that calibrated medical equipment such as blood pressure monitors were available for staff if they were required.
- All of the services we visited were clean and tidy. However, it was noted that Skegness older person CMHT was in the process of moving site so as a temporary measure some of the interview rooms did not have adequate soundproofing.

Safe staffing

- Staff turnover within the services was generally low. Figures provided by the trust showed that as of the 1 August 2015 the percentage of leavers within the previous 12 months was 5%.Across the whole of the older person CMHT teams there was only 1.7 vacancies for nurses and 0.2 vacancies for health care assistants.The trust reported no use of agency or bank staff to cover vacancies or sickness across the services. This meant that the staff team was consistent and knew their patient group well.Many of the staff we spoke to had worked for the trust a long time.
- Most of the services had low levels of staff sickness. However, at Pilgrim House in Bostonthere were relatively high levels of sickness as two out of the three nurses were on long term sick leave. These vacancies were being covered by the existing staff and manager until staff were recruited into the posts.
- All of the teams we visited had a clear list and understanding of the staffing numbers that were required to meet the needs of the patients they were supporting and could clearly identify where the vacancies were across the services.
- All of the services had access to a psychiatrist when required and the patients and carers we spoke with confirmed they had good access to a psychiatrist.
- The caseloads for the community psychiatric nursesworking within the older persons CMHT ranged from 19 patients in the Johnson Community Hospital to 67 patients in The Manthorpe Centre. The average caseload was 39 patients per staff member.The associate practioners were band 4 staff that carried out six monthly medication reviews.They had an average caseload of 130 patients. These staff had accumulated very high caseloads and across the services staff told us they found this difficult to manage and added an additional pressure to their ability to care for the patients.
- The trust had identified on the older adult risk register in 2013 that excessive service and staff caseload size within older person CMHT. Since then there have been progressive attempts to reduce the case load for nurses and band 4 workers throughout 2014 and 2015 but their caseloads remain high.
- Staff training data showed 84% compliance in mandatory training for the older person's community teams. This is above the average of 75% for the whole trust, but had not met the trust's target of 95%.The

Good

Are services safe?

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

teams used a "heat map" to identify areas where staff were out of date with mandatory training and the managers we spoke with were aware of how to access this information easily.

Assessing and managing risk to patients and staff

- We found not all patients' notes we looked at contained comprehensive risk assessments.19 out of the 39 sets of records we looked at had basic risk assessments and review dates were not completed.At Witham court three out of the six sets of care records we looked at did not have risk assessments on file and could not be found by the staff.
- The patients that were being supported under the Care Programme Approach (CPA) all had an up to date risk assessments and crisis plans in place.
- Staff were clear on what to do in the event of safeguarding alerts, all of the staff offices visited had clear flow charts detailing who to contact in the event of a safeguarding issue being identified. The staff gave examples of where safeguarding concerns had been raised in respect of suspected financial abuse and the actions that had been taken.We attended an multidisciplinary team meeting at Windsor House where safeguarding issues were identified, discussed and referrals made where they were needed.
- There were good safety protocols in place. Some staff had personal alarms that monitored where they were. Not all staff had received these yet, but all staff that did not have them were aware of the protocol of ringing in the office to alert them of their whereabouts.Each of the services had a slightly different local protocol but all staff knew what to do in the event of an issue.

Track record on safety

- Between 1 April 2014 to the 30 June 2015 there were 110 serious incidents recorded by the trust, of which 19% (21 incidents) related to the older people CMHT.Of the 21 incidents, 20 of these related to unexpected or avoidable deaths or severe harm.
- The services reviewed all serious incidents at band 7/8 meetings every 6 weeks.In addition the trust send out lessons learnt bulletins to all staff informing them of incidents that have happened across the trust to support in learning from incidents.
- Most of the services have regular staff meetings where we could see information in relation to trust wide risks were being discussed but at the moment no team meetings were happening at Skegness so this information may not being shared across the whole team consistently.

Reporting incidents and learning from when things go wrong

- Staff were clear on what to report and how to report incidents. They were able to explain the process for recording incidents into the trust's Datix information system.
- Staff told us they received feedback from investigations, and were debriefed following incidents. One member of staff at The Manthorpe Centre told us "the trust doesn't try to hide things".
- Staff at the Skegness Resource Centre detailed the debriefing, feedback and lessons learned following a serious medication incident the previous year. They noted there had been more training on medication management protocols and liaison with the pharmacy as a result.

Are services effective?

Requires improvement

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 39 sets of care records across the six sites we visited.Out of 39 sets only 24 care plans were personalised and holistic and 22 were in date. This meant that care plans did not always contain up to date information relating to patients' current needs andthe care was not being regularly reviewed.Those that were completed were written in a medicalised manner and described what the clinical staff were going to do to the patient and did not reflect shared goals and responsibilities between the patient and the clinical team.
- We found that the way information was stored was secure however we found that risk assessments were being completed on the electronic care record system in three different places and this led to confusion in all services with the staff we spoke to as to where the risk assessments should be documented.
- We saw where capacity assessments had resulted in lack of capacity being noted in specific areas and where subsequent best interest decisions had been made. However, unless there was a lack of capacity identified, nothing was recorded. Because in such cases the check box on the electronic care records system was not being used it was unclear whether someone had capacity, or whether they had just not had an assessment
- Staff told us consistently that capacity was assumed until evidence or concerns indicated otherwise..
- Medication reviews In line with NICE guidance were happening regularly across all sites to monitor prescribing for people with dementia and psychotic disorders .
- Community mental health assessments took place at a person's home and we saw, during home visits, records and risk assessments being updated in light of new information.

Best practice in treatment and care

- Discussions were led by consultant psychiatrists in team meetings and multi-disciplinary handovers.Medicines were prescribed and monitored by appropriate professionals with the experience and knowledge to ensure people were getting optimum benefits from medication. Nurses told us these were only used as little as possible. We observed discussions in meetings where consultants were advising on and monitoring the well-being of patients on particular medications.
- The older person CMHT only had access to one psychologist across the six teams and we were told there was a 12-18 month waiting list foraccess to psychotherapy.This meant that focused work led by a psychologist was not regularly happening across all services.
- Community teams were offering Cognitive Stimulation Treatment (CST) which is NICE recognised intervention.CST is a series of themed, group activity sessions to help people strengthen their cognitive capacity.All of the patients that had attended the CST sessions told us that they had found them to be extremely helpful and enjoyed the sessions.
- Physical health care needs were monitored during home visits. Community psychiatric nurses would do 'baseline' assessments if appropriate. Many patients would already be known to district nurses who shared information with the community mental health teams. This information sharing allowed patient physical well-being to be monitored with minimal duplication.

Skilled staff to deliver care

- All teams had allocated psychiatrists, community nurses, band 4 health care assistants and occupational therapists input.Only one team at The Manthorpe Centre had an allocated social worker as a member of their MDT.We saw evidence through attendance at multi-disciplinary meetings, review of care records and in discussions with staff and patients of input from pharmacists and speech and language therapists.
- All staff we spoke with had received a trust induction before they started in their role.
- All staff told us they received regular supervision and yearly appraisals. Records we looked at confirmed this.Trust data indicated that 95% of staffworking in the older person CMHT had received an appraisal in the last 12 months.Most staff told us they attended regular team meetings apart from Skegness where team meetings were not regularly happening.

Are services effective?

Requires improvement

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 were able to access relevant specialist training. Support workers were able to access training on areas such as physical health monitoring and nurses were undertaking specific training in becoming nurse prescribers.

Multi-disciplinary and inter-agency team work

- There were daily handover meetings within the teams. The handover we attended at Windsor House demonstrated good interactions, communications and teamwork in providing appropriate alternatives to support patients in their own homes in order to prevent admission to hospital.
- Each team had an allocated "neighbourhood team" member whose responsibility it was to attend the Lincolnshire health and care"neighbourhood meeting".This initiative has been developed with the support of the local Clinical Commissioning Groups to help support older adults living in the community and is aimed at promoting independence.The model is made up of a virtual team that can be made up of as many people as is relevant to the individuals care, and identifies short and long term interventions to maximise the person's ability to cope in the community.The neighbourhood team liaison officer at The Manthorpe centre identified how they work closely with the GPs to identify people that may have a higher risk of being admitted in an unplanned way into hospital and then build up a support network around them involving the voluntary sector. This means that the community teams work very collaboratively with the local healthcare providers both public and private but also including the voluntary sector.

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

- Staff knew how to contact the Mental Health Act office for advice when needed.
- As part of mandatory training, all staff received training in the Mental Health Act.
- Staff compliance with the Mental Health Act training across the trust was 72% as of August 2015.
- Community Treatment Orders (CTOs), although rarely used in the services, were completed properly when they were required. Two patients' notes we reviewed at Witham Court that were on CTO had all their CTO paperwork in good order and we could see tracking systems were in place to ensure they were being effectively reviewed.Staff in Johnson Community Hospital gave us a recent example of when they had to support a community patient back into hospital following the recall of his CTO and we found the paperwork and care plans showed a seamless transition from home to hospital.
- Staff told us they could get advice on implementation of the MHA and its Code of Practice from within the trust if required.
- People had their rights explained to them appropriately. This was evident on visits to people's homes and in discussions with carers and people directly using the service.
- Patients had access to advocates and an Independent Mental Health Act advocate. There was a specific organisation, Total Voice (provided by voice ability), used by the trust to provide advocacy services.

Good practice in applying the Mental Capacity Act

- Staff were knowledgeable on the principles of the MCA and were able to describe how they applied these in practice. Daily progress notes reviewed in the care records also supported this. We observed that consent was obtained during home visits and the memory clinics, and staff checked people`s understanding throughout.
- As part of mandatory training, all staff received regular training in the Mental Capacity Act.
- Where patients did not have capacity to make a decision, this was clearly assessed and recorded. These capacity assessments were decision based, rather than 'blanket' assessments.
- Of the 39 sets of electronic care records we looked at, 12 had evidence of capacity issues being identified and addressed. However, in the electronic care records there was a box indicating whether capacity issues had been considered for each patient. In 27 sets of records this had not been tickedso it was unclear if thesepatients had capacity or just not had their capacity considered.
- A nurse at Spalding told us that they always asked for consent prior to assessment and carried out a capacity assessment proportional to need.We witnessed on all

Are services effective?

Requires improvement

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

the visits we went on staff checking for consent where appropriate.This indicated that consent was sought and capacity assessed, but that this was not always recorded.

- Staff in the care homes we visited told us the older persons teams regularly advised them on the use of Deprivation of Liberty Safeguards when issues arose regarding their patients and in this respect the older persons teams were being used as a resource to promote good practice in the use of the MCA.
- Patients had access Independent Mental Capacity advocacy from a specific organisation, Total Voice (provided by voice ability), used by the trust to provide IMCA advocacy services.

Good

Are services caring?

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

Our findings

Kindness, dignity, respect and support

- Staff we observed on visits and in appointments were respectful, responsive and provided appropriate support. We accompanied staff on visits from all services and found the support and treatment offered to people to be of a consistent high quality.
- People using the services consistently told us that staff were good. Two carers we contacted by phone from the Skegness service were extremely positive, saying the staff were “great”. They said they understood problems, sorted out problems and that they “wouldn’t have survived without them”. One carer at Johnson community Hospital said the support worker was extremely good and helped alleviate pressure by their understanding and defusing of stressful situations, again they stated “I couldn’t have coped without their support”.
- Confidentiality was maintained and information was stored securely, whether on paper or electronically. Paper copies of care plans were given to patients and easily identified using the trust initiative “Your Care Plan” initiative.This initiative used a large print card file given to every patient where all information in relation to their mental health care was stored and easily identified as a care plan by the patients group.Patients told us that they found this care plan file really helpful as it contained all contact details and information relating to their care co-ordinator. Electronic copies of care plans were stored securely and password protected in the trust electronic system.

The involvement of people in the care that they receive

- We observed out-patients appointments at Manthorpe Centre and saw that patients were given information about treatments and medication including side effects, and had time to ask questions
- A carer of a patient seen by the Johnson community team told us they had a copy of their relative’s care plan. Another carer said they had been involved in detailed discussions about treatment and care options. We spoke to patients who hadattended a cognitive stimulation therapy group who said that they felt valued and had regained confidence. A patient who had visited the Johnson Community Hospital told us they got a letter after the appointment, with a summary of what had been discussed, current treatment, and details of her next appointment. The letter was addressed to her GP and not to the patient and when we discussed this with the manager we were informed that this system was changing and letters were now being sent to the patient with a copy being sent to the GP.
- We spoke to people who had received carer’s assessments and who received respite. Carers we spoke to said they felt supported.One carer told usthe support of the team had prevented his wife from going into care.
- The services were very committed to ensuring patients had the opportunity to feed back about their care and treatment. The older adult community teams use the Making Experiences Count (MEC) patient feed-back questionnaire. This is being used across all of the older adult community Teams and the services have a high level of returns in terms of overall Trust numbers.
- The information provided us by the trust for the 2015 MECreport shows that the older adults CMHT’s account for 935 returns (or 54.5% of a Trust total of 1714 returns) with an Overall Satisfaction rate of 98.4% for 2015.
- We were told by staff, patients and carers that none of the older persons CMHT were currently running patient or carers support groups as in the past people had not been interested or able to attend however all the managers we spoke to told us they would like to start some regular support groups.

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 Memory assessment and management service (MAMS) had a target that initial assessment should be offered within 10 working days of patient contacting the service and the total time for the whole MAMS pathway is a maximum of 10 weeks from referral to diagnosis. The MAMS teams were regularly meeting this target
- Targets for emergency assessments were four hours to make contact, to be seen within one working day. Urgent assessments were contact within one working day to be seen within two working days and routine referrals, to make contact within two working days and to be seen within 10-20 working days.All older persons CMHT visited were regularly meeting these targets. The average waiting times for the referral to first contact to be seen for patients was two and a half weeks.
- All teams had a duty system that was able to respond to urgent referrals and had good access to psychiatrists in emergencies.Patients we spoke to said they could access help urgently when required.
- Older adult services held paper files forpatients subject to a 'fast track' discharge. This meant if the patient deteriorated after discharge, within identified times, they did not need to go through all the referral processes for older adult CMHTsupport.
- Patients remained with the community teams without discharge for an average of 50 weeks with the patients under band 4 medication reviews due to the long-term monitoring requirements, staying up to a maximum of 110 weeks at Skegness on the band 4s' caseload.This meant that staff had accumulated very high caseloads and across the services stafftold us they found this difficult to manage and added an additional pressure to their ability to care for the patients.We are aware this issue had been escalated to the older adult risk register and there was a process of review in place with the local clinical commissioning groups in the West and South West of the county.
- The teams engaged with people who found it difficult to engage with the services. Two people would visit where risk assessments showed this was beneficial. Visits were able to be arranged outside the home, if a person wished this.

The facilities promote recovery, comfort, dignity and confidentiality

- We saw information racks in waiting area that had a variety of leaflets informing patients and carers about local services including Patient Advice and Liaison Services, advocacy, concerns and complaints and you said we did boards were seen in waiting rooms.
- Most of the services we visited were not very welcoming and not considered to be dementia friendly with poor signage, a lack of colour and low furniture although there we were told by patients and carers there were always staff readily available to assist.There was a more 'user friendly' reception area at The Johnson Community Hospital as it is a much more modern building, with and good disabled access.
- The interview rooms at Skegness did not have adequate sound proofing.

Meeting the needs of all people who use the service

- There are different ethnic groups of patients who are entering the catchment age of the older adult teams in some of the areas of Lincolnshire, particularly Cantonese and Polish speakers in the Spalding area.We found that the services were aware of the cultural mix within their locality and had ensured that they were offering information leaflets and accessing interpreter services.

Listening to and learning from concerns and complaints

- People using the service and their carers told us they knew how to make complaints. The overwhelming majority also told us they did not feel they had any need to complain. One person who had complained told us their complaint "had been resolved very quickly". There were leaflets giving guidance on makingcomments, compliments and complaints available in all sites.

Are services responsive to people's needs?

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- We saw friends and family cards being used across the trust.These asked service users and carers if they would recommend the service to family or people they knew.
- A "Have Your Say" leaflet was available which explained how to make complaints, give compliments or raise concerns.One team based at The Manthorpe Centre had listened to patients concerns regarding the lack of information provided to them after they had received a diagnosis and the team had developed "post diagnosis packs", with relevant information to assist patients in understanding their illness and what could happen next to best support them.
- Trust data from September 2014 to July 2015 showed that older person CMHTs, had 24 complaints. Of these, 18 were formal and 9 upheld, and 6 were informal. The main themes of the below complaints were as follows:

Unhappy about long waiting time for memory assessment

Unhappy due to a memory support group closing

Reception area is close to the acute inpatients ward which can be frightening

Lack of support for patients / lack of visits from the team

Family member unhappy about medication and subsequent death of parent

Complaints about healthcare funding being discontinued

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

- Throughout the older adult core service, in all areas and all grades, staff we spoke with were consistently positive and supportive of the trust's values and information was displayed in the teams' offices.
- Staff were aware of senior managers within the organisation and told us about the chief executive 'roadshows' where the executive team took time to meet staff from aroundthe trust. Staff received regular emails and a newsletter including 'the weekly word' to inform them of trust updates.

Good governance

- Staff received mandatory training, were supervised and appraised and were able to prioritise direct care activities. Incidents were reported and learnt from. There were mixed views from staff on the value of e-learning, which compromised mandatory training. Some staff felt that e-learning was not suited to their learning style and felt that information was difficult to retain.
- Staff told us they received regular supervision and appraisal.We saw schedules in place, and staff told us that managers were always available to advise and support.Trust data told us that 94% of all staff in the older person community teams had received an appraisal in the last 12 months, this was above the trust rate of 89%.
- Safeguarding, mental health act and mental capacity act were agenda items on all MDT meetings.We found good awareness of safeguarding protocols across the teams and mental capacity procedures were adhered to and were embedded in daily practice for all staff.
- Key performance indicators (KPI) help gauge the performance of the team. KPIs were not currently being used to measure the performance of older person teams. The trust informed us that a more robust set of KPIs are currently under development but were not yet finalised or agreed at the time of the inspection, but would be in place by January 2016.
- A trust 'heat map' was developed by the trustand used locally by managers to identify service risks and was reviewed at team coordinator meetings.
- All the teams were aware of waiting times and were meeting these.
- Appropriate risks were being put on the older person risk register by local managers / divisional managers and we saw evidence of action plans being identified and reviewed

Leadership, morale and staff engagement

- There was a high level of morale and job satisfaction in all the teams. Staff throughout the services were extremely positive about the trust, their work and their local management. A nurse at the Manthorpe centre told us it was "the best team I've ever been involved in".Figures given to us by the trust showed sickness levels were well below the national average.
- Staff told us they were aware of the whistleblowing policy, knew how to use it and were comfortable in doing so.
- Staff acknowledged that the nature of the work and the amount of work could be stressful due to the high caseloads, but felt that had improved and would continue to improve. The only concern regarding workload was expressed by staff at The Pilgrim Hospital, where two staff were on long term sick putting pressure on the remaining staff but this had been identified to the local manager.
- Staff told us leadership programmes that were available within the trust and were available to all staff that showed an interest in such development. One member of staff we spoke with had recently been on such a course.

Commitment to quality improvement and innovation

- The trust is heavily involved and committed to dementia research and is currently involved in or applying to the following areas of research:
- Memory Services National Accreditation Programme (Royal College of Psychiatrists 2014)
- Agitation and quality of life in care homes – University College London

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- Brains for Dementia Research (BDR) – Kings College London
- Join Dementia Research (JDR)
- ENRICH (Enabling Research in Care Homes) The Trust's research department hosted the first Lincolnshire ENRICH Forum on Friday 20 March 2015
- Changes in the motivation and performance of activities of daily living in dementia and their relationship to well-being – University of Manchester
- AD Genetics (early on-set arm) – Cardiff University
- Clinical Biomarkers in Dementia Research – University of Cambridge
- Individual Cognitive Stimulation Therapy (iCST) – University College London
- Randomised controlled trial of CBT for anxiety in people with dementia
- PrAISED: falls prevention in early dementia study
- CArers of people with Dementia - Empowerment and Efficacy via Education
- Minocycline in Alzheimer's disease efficacy trial: MADE Trial – Kings College London
- LonDownS (dementia risk in LD) – University College London
- Evaluation of Memory Services– London School of Hygiene (Department of Health commissioned)