

Lancashire Care NHS Foundation Trust

Community mental health services for people with learning disabilities or autism

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)
RW5HQ	Sceptre Point	Adult learning disability community health team (West Lancashire)	L39 2JW
RW5HQ	Sceptre Point	Adult learning disability community health team (Chorley and South Ribble)	PR26 6TR
RW5HQ	Sceptre Point	Adult learning disability community health team (Lancaster and Morecambe)	LA1 4XQ

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?

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 community based services for people with a learning disability or autism as good because:

- Person-centred therapeutic interventions were being delivered to patients to support them to achieve improved independence and wellbeing.
- Interactions between staff and patients demonstrated personalised, collaborative, recovery-oriented care planning.
- Comprehensive risk assessments for patients were completed and reviewed and clear crisis plans were in place where patients were assessed as
- Staff had a good understanding of the principles and application of the Mental Capacity Act.
- Patients were protected and safeguarded from avoidable harm and incidents were appropriately reported.
- Patients' individual care and treatment was planned and best practice guidance was implemented, ensuring outcomes were monitored and reviewed.
- Staff had knowledge and skills to deliver effective care and treatment and staff received support and supervision from their managers and peers.
- Patients and their carers were positive about the care and treatment they received and staff behaviours were responsive, respectful and caring. Staff involved patients and their carers in the care and treatment they received.

- Managers were able to provide information into the governance meetings and staff received regular feedback from these meetings. They were kept up to date about their team's performance.
- The management and governance arrangements within the directorate were effective and teams were able to feed information about risk into the risk register. The trust had identified 38 items on their risk register in relation to learning disability and autism community services and these were being reviewed and monitored by the trust.

However;

- There were gaps in the mandatory/essential training that staff should have received and not all staff had received an appraisal.
- Commissioning arrangements meant that the staffing skill mix and provision of psychiatric cover across the trust was variable.
- Information about complaints, concerns and compliments was not adapted to meet the needs of some patients with a learning disability.
- An audit of antipsychotic prescribing in people with a learning disability identified that there was action required against standard three of a quality improvement programme-prescribing audit. There were no clear dates for the action plan implementation following the audit.

Summary of findings

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

Are services safe?

We rated safe as good because:

- Staff discussed referrals and waiting lists at weekly meetings and addressed areas of risk.
- The teams managed and responded to any changes in identified risks to patients.
- Teams were reporting incidents and learning when things had gone wrong.
- Staff were aware of procedures in safeguarding children and adults and reported safeguarding concerns accordingly.
- Community bases where patients were seen were safe, clean and well maintained. Staff had access to alarm systems. Teams had good lone working policies and practices in place to keep staff safe.
- Managers and staff apologised to patients and their families when things went wrong and were aware of the duty of candour.

However;

- Staffing and skill mix across the three teams was variable dependent on commissioned services in the particular teams. There was limited psychiatric input throughout Lancashire for patients with a learning disability.
- There were some low compliance rates for mandatory training.

Good



Are services effective?

We rated effective as requires improvement because:

- Not all staff had received mandatory/essential training in relation to the Mental Health Act, the Mental Capacity Act and prevent training.
- Psychological services, speech and language therapy and occupational therapy were not accessible in all learning disability community teams.
- An audit of antipsychotic prescribing in people with a learning disability identified that there was action required against standard three of a quality improvement programme-prescribing audit. There were no clear dates for the action plan implementation following the audit.

However;

- Patients received a comprehensive assessment of their needs.

Requires improvement



Summary of findings

- Patients' care and treatment was coordinated when other teams and services were involved. Staff worked together to meet the range and complexity of patient needs.
- Staff had appropriate skills and knowledge to deliver effective care and treatment.
- Staff took part in national and local audits to improve care and treatment outcomes for patients.
- Staff were supported to deliver effective care and treatment through supervision, team and management support.
- All staff had a good understanding of the principles and application of the Mental Capacity Act.
- Staff coordinated care and treatment with other services and providers.
- The team managed referral to treatment times and where additional risks were identified the teams responded by priority.

Are services caring?

We rated caring as good because:

- Patients and carers were positive about how staff treated them.
- Staff attitudes and behaviours were responsive, respectful, sensitive and caring.
- Patients and carers reported they were involved in the care they received.
- Staff encouraged patients and their carers to maintain and develop their independence within the community.

Good



Are services responsive to people's needs?

We rated responsive as good because:

- Patients, carers and professionals could refer patients into the services.
- Teams were able to respond quickly to patients in crisis.
- Staff informed all relevant people when patients were discharged from the service.
- Information about advocacy and complaints, and information in other languages was available in all the teams we visited.
- The teams had access to some easy read materials and pictorial images as well as specific materials developed by the teams to meet the communication needs of their patients.
- Staff reviewed complaints, compliments and concerns within their teams to improve services.

Good



However;

Summary of findings

- Staff provided information about complaints, concerns and compliments, which was not adapted to meet the needs of some patients with a learning disability.

Are services well-led?

We rated well led as good because:

- Staff were aware of the trusts vision and values.
- Teams had a strong identity and were committed to helping people with a learning disability achieve improved independence and wellbeing.
- Managers attended directorate governance meetings, and received regular feedback on their teams' performance.
- Staff received regular supervision and support from their managers and team members.
- Managers at team level were able to submit items onto the risk register and these were regularly reviewed and actioned.
- There were plans in place to address the transforming care agenda in the trust.
- The teams were committed to quality improvement and innovation.

However;

- Mandatory training and appraisals were not fully completed in the learning disability community teams.

Good



Summary of findings

Information about the service

Lancashire Care NHS Foundation Trust provided eight adult learning disability community health teams for adults with learning disabilities throughout Lancashire.

We visited three out of the eight adult learning disability community health teams. The teams we visited were:

- adult learning disability community health team (West Lancashire)
- adult learning disability community health team (Chorley and South Ribble)
- adult learning disability community health team (Lancaster and Morecambe)

The teams worked primarily with people with a learning disability who were 18 years and over. They also worked with 16 to 18 year olds who were in transition from children's services into adult services. The teams work with people with a learning disability to promote health and wellbeing. They also provide support and advice to carers, care providers and other professionals to improve the ways they help people with a learning disability.

The trust was last inspected between 28 and 30 April 2015 and three learning disability community teams were inspected. The community mental health services for people with learning disabilities or autism were rated as good overall.

Our inspection team

Our inspection team was led by:

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

Head of Inspection: Nicholas Smith, Care Quality Commission

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

The team that inspected the community learning disability teams was comprised of a CQC inspector, a nurse specialist advisor working in learning disability and a social work specialist advisor.

Why we carried out this inspection

We inspected this core service as part of our on-going 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 a range of information that we held about these services, and asked a range of other organisations for information.

During the inspection visit, the inspection team:

- visited three teams across three locations and looked at the quality of the rooms where patients were interviewed in one location
- observed how staff were caring for patients
- spoke with five patients who were using the service

Summary of findings

- spoke with four carers
 - spoke with three managers of each team
 - spoke with 11 other staff members; including nurses, physiotherapists, clinical psychologists and occupational therapists
 - attended and observed one referral meeting
 - attended a day centre to observe an assessment
 - visited one patient group meeting
- We also:
- Looked at 19 treatment records of patients.

What people who use the provider's services say

We spoke with five patients and four carers. Patients told us that staff listened to them and did not judge them; they felt safe and able to talk to staff. Patients also told us they enjoyed group activities and had experienced different and interesting things. They also said they had

received comprehensive care plans and lots of information about the service in pictorial and simplistic sentences. Carers said that they felt supported by the teams and were involved.

Good practice

Two patient groups had been developed in the Lancaster and Morecambe team. One of these was a health in action group where patients were fully involved in making decisions about the group and arrangements for speakers to attend. The aim of the group was to encourage independence by accessing different resources in the community and to learn new skills as

well as providing health and wellbeing awareness. They also had a co-design experience based project for patients. Patients provided feedback about services and their feedback made improvements and changes to services. This meant that patients were listened to and were consulted with to shape services.

Areas for improvement

Action the provider **MUST** take to improve

The trust must ensure that staff have received their mandatory (core and essential) training.

Action the provider **SHOULD** take to improve

The trust should continue to review the staffing skill mix and provision of psychiatric cover, access to psychology and speech and language therapy across the trust.

The trust should ensure that gaps in appraisals across the directorate are resolved.

The trust should ensure complaints material is available for patients with a learning disability or autism, and have this information in accessible formats that meets all patients needs.

The trust should ensure the audit of antipsychotic prescribing for people with a learning disability is fully reviewed, implemented and actioned for all patients prescribed antipsychotic medication.

Lancashire Care NHS Foundation Trust

Community mental health services for people with learning disabilities or autism

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)

Name of CQC registered location

Adult learning disability community health team (West Lancashire)

Adult learning disability community health team (Chorley and South Ribble)

Adult learning disability community health team (Lancaster and Morecambe)

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.

Overall, we found there was a small amount of patients who were subject to the Mental Health Act in the community-based services for people with a learning disability or autism. We checked the records of one patient subject to a community treatment order. This is a legal order and sets out the terms under which a person must accept medication, therapy, counselling, management and

other services whilst living in the community. These records were in order and the Mental Health Act documentation within this care record was completed in line with the Code of Practice.

Staff were not up to date with training in the Mental Health Act and not all staff had sufficient understanding to be able to coordinate care for patients under a community treatment order. Some staff commented they would like further training in the Mental Health Act to give them confidence in supporting patients coming out of hospital as part of the transforming care agenda.

Detailed findings

Staff were aware of how to initiate a Mental Health Act assessment and were aware of who to contact in the trust should they need further advice and guidance.

Mental Capacity Act and Deprivation of Liberty Safeguards

Staff demonstrated a good level of understanding of the Mental Capacity Act. They helped patients to make decisions about their care and treatment by using a variety of communication methods and information sheets. Staff had received additional training in relation to learning

disability patients accessing health screening. This was to assist staff in understanding the need to consider the application of the Mental Capacity Act where patients lacked capacity to consent.

Staff assumed capacity unless it was indicated otherwise. Staff recorded mental capacity and consent when significant decisions were made.

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

One of the three teams visited saw patients on their premises. The West Lancashire team had 11 interview rooms. The rooms we were able to visit were clean and well maintained and individual personal alarms were accessed via the reception area. Staff from the ward adjacent to the team responded to the personal alarms if activated. There were environmental risk assessments in place in the West Lancashire team. Patients were usually escorted by a family member/carer and were not left unattended in the visiting rooms. We did not observe any clinic rooms being used.

Safe staffing

The staffing levels (whole time equivalents) for each team were as follows:

Adult learning disability community team (West Lancashire)

- Service Leader: 1
- Qualified nurses:3
- Number of vacancies: 0
- Staff sickness rate in the last 12 month period: 0.75%
- Staff turnover rate in the last 12 month period: 0%

Adult learning disability community team (Chorley and South Ribble)

- Service Leader :1
- Qualified nurses: 5
- Nursing assistant:1
- Number of vacancies: nurses: 1
- Number of vacancies: nursing assistants: 0
- Staff sickness rate in the last 12 month period: 4%
- Staff turnover rate in the last 12 month period: 16%

Adult learning disability community team (Lancaster and Morecambe)

- Service Leader:1
- Qualified nurses: 3

- Nursing assistant: 3
- Number of vacancies: nurses: 1
- Number of vacancies: nursing assistants: 0
- Staff sickness rate in the last 12 month period: 6%
- Staff turnover rate in the last 12 month period: 19%

The makeup of the teams also varied with some teams having access to a full multidisciplinary team where others did not.

The trust informed us that the issue had been escalated to both commissioners and the transforming care team and a draft service specification has been produced to address varying disciplines of staff in the future. There was no recognised staffing tool used to determine staffing levels in the teams. However, on the day of inspection we found that there was sufficient staffing to ensure the safety of people using the service.

The average caseload varied across each team and this reflected the different commissioning arrangements across each locality and service specification.

The figures provided below are the average caseloads per team per profession;

West Lancashire team average case load

- Community nurses had 11 patients
- Psychology and psychotherapy had three cases provided by sessional staff (person not employed under a contract of employment to meet varying need).
- Psychiatry had 83, provided by sessional staff
- Speech and language therapy, the service was not commissioned
- Physiotherapy and occupational therapy had 33 patients provided by sessional post holders

Chorley and South Ribble average case load

- Community nurses had 11 patients
- Psychology and psychotherapy had 20 patients.
- Psychiatry had 213 patients

Are services safe?

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

- Speech and language therapy had 40
- Physiotherapy and occupational therapy had 48 patients provided by sessional post holders

Lancaster and Morecambe average case load

- Community nurses had 20 patients
- Psychology and psychotherapy had 20 patients.
- Psychiatry was not commissioned
- Speech and language therapy 31
- Physiotherapy and occupational therapy had 25

There were five patients awaiting allocation who were on the nurse waiting list with the longest wait being 11 weeks at West Lancashire team. Chorley and South Ribble had 22 patients with the longest wait being 38 weeks for nursing and four patients were on a waiting list at Lancaster and Morecambe with the longest wait being seven weeks for nursing input. The waiting lists were reviewed regularly and weekly intake and allocation meetings effectively monitored patients on their waiting lists to detect increases in levels of risk.

Caseloads were managed, reassessed and allocated regularly by the managers. Caseload numbers varied depending on the patient needs and experience of the staff. These were addressed in supervision and at the weekly intake and allocation meetings.

Cover arrangements for sickness, leave and or vacant posts were managed within the teams and where necessary managers would work with patients to ensure patient safety.

There was minimal use of bank staff and Chorley South Ribble team had only used bank staff to cover a 0.21 whole time equivalent vacant nursing post. There was no use of agency staff reported.

The arrangements for access to a psychiatrist varied across the teams due to local commissioning arrangements.

Lancaster and Morecambe had no psychiatrist commissioned. However, they had arranged psychiatrist cover for four days per month from another trust. West Lancashire team had a sessional post holder in place. Chorley and South Ribble had access to a psychiatrist 0.5 whole time equivalent post with an average caseload of 213. The impact of this was that patients and their carers

would have access to the duty on call psychiatrist out of hours, attend A&E or contact the emergency duty teams provided by the local authority. Most people we spoke with said they had no problems accessing a psychiatrist if needed.

The Lancaster and Morecambe team told us how they were co-located in the same buildings as the mental health teams and crisis teams and how they were able to access a consultant for emergencies. This included access to a duty psychiatrist when needed out of hours.

In eight of the community teams throughout Lancashire, two of the teams had no psychiatrist commissioned. The trust had identified that having no commissioned psychiatry time for the Lancaster and Morecambe and Fylde and Wyre teams was a risk and added it to their risk register.

West Lancashire team informed us a learning disability pharmacist attended the managers meetings monthly to review the agenda for stopping the over medication of people with a learning disability. Staff could contact the pharmacist at other times by email or phone.

The trust had a target of 85% for staff who should have completed their core and essential mandatory training. Core training was for all trust staff, and essential training was for specific job roles. Chorley and South Ribble team had an overall compliance of 89%, West Lancashire 100% and Lancaster and Morecambe 90%.

The essential training for staff working in learning disability community services that were less than 75% included;

- Mental Capacity Act level 1 training: Chorley and South Ribble 73%.
- Mental Capacity Act level 2 training: Lancaster and Morecambe and Chorley and South Ribble were 47%.
- Prevent: Chorley and South Ribble 53%, Lancaster and Morecambe 37%.
- Workshop to raise awareness of Prevent Chorley and South Ribble 47%, Lancaster and Morecambe 47%.
- Mental Health Act level 2: Chorley and South Ribble 10%, Lancaster and Morecambe 0%.

On reviewing the risk register provided by the trust, staff from the learning disability teams highlighted that they were not routinely trained in breakaway techniques. This

Are services safe?

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was to work with patients whose behaviour challenges and in anticipation of the transforming care agenda, will result in staff working with more patients whose behaviour challenges. The trust had reviewed the presenting risk and was seeking alternative training for staff.

Assessing and managing risk to patients and staff

We examined 19 care records within the three teams we visited. We found that staff completed a risk screening assessment and a safe to visit risk assessment prior to any first home visit. Crisis plans were also in place for patients where needed. Staff uploaded these onto a computerised system so that other teams could access this information when a patient was in crisis. Risk assessments were updated where any presenting risks changed.

Teams effectively monitored patients on their waiting lists to detect increases in levels of risk. Each team had a weekly 'huddle', intake and allocation meeting to discuss new referrals. Chorley and South Ribble team had 22 patients on their waiting list. They had introduced a monthly nurse waiting list meeting to allocate new patients and prioritise allocation. Contact was made with the referrer, patients and their carers to update them on the progress of the waiting lists and to seek any further information of presenting risk issues. The team used a high, medium and low indicator with descriptors to determine risk.

We observed a weekly intake meeting at the West Lancashire team where all of the team members were present. They discussed new referrals, referrals in triage, case closures, first contacts, waiting lists, safeguarding issues and cases that were a cause of concern.

The teams we visited were able to respond to a sudden deterioration in a patient's health. This was managed within teams and arrangements were made to see patients whose health needs had deteriorated. Patients and their carers were able to contact the community teams to discuss any deterioration.

Referrals into the teams were assessed and managed by staff within 24 hours where a safety check was completed and where further information was gathered. The referral then proceeded onto an enhanced information check. This included checks with GPs regarding their learning disability register, checking of safeguarding referrals and checking previous service contact. If deemed appropriate a one off appointment was arranged to determine eligibility using a screening tool.

The screening of referrals was discussed at weekly huddle meetings before progressing onto the multidisciplinary team discussion. Here, the referral was accepted and placed on a waiting list using a waiting list scoring tool, allocated to a specific professional or rejected and individual referrers informed. The teams monitored patients on their waiting list and where any increase in risk was detected, they responded by allocating patients or by completing a home visit accordingly.

All teams were trained in safeguarding adults level one and figures identified all teams were above 94% compliance. Training in safeguarding vulnerable adults at level two was mandatory for staff. Figures in the Lancaster and Morecambe team showed only 20% of staff were up-to-date with this training and with the other two teams were 80% compliance and above. All three teams were 100% compliant with staff trained in safeguarding children level one and level two was 93% compliant in the Chorley and South Ribble team and 100% in the other teams. All staff we spoke with in each service were able to tell us how they would make a safeguarding alert. Care records and electronic reporting systems contained evidence that safeguarding concerns had been referred to the local authority. We also saw that safeguarding was considered during discussions between staff, patients, carers and care workers and on referral of patients into the service. On the initial visit, staff provided patients with a pictorial and written information sheet about abuse. This was to inform patients about what abuse was and what to do if they were being abused.

All teams we visited followed and understood the trust lone working policy and local procedures. All staff carried a work mobile telephone. They understood their responsibilities to update the information board with their whereabouts and telephone the office after home visits. The teams had personal contact details and car registration numbers of staff should there be a need to escalate. Buddy systems were in place, with an identified person to monitor staff members' whereabouts each day.

A blue light indicator on an electronic system highlighted known violence from a patient or anyone living with them if they were previously known to services.

Track record on safety

None of the three teams had reported a serious incident requiring investigation over the twelve months leading up to the inspection.

Are services safe?

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

Reporting incidents and learning from when things go wrong

Staff we spoke with knew how to report incidents on the electronic risk management system used by the trust. Staff were able to describe what incidents should be reported. Information we reviewed identified all three teams were reporting incidents. During the last 12 months, August 2015 to August 2016 the West Lancashire team reported 9 incidents, Chorley and South Ribble team 23 and Lancaster and Morecambe team 21.

Incidents were graded by severity on a scale of one to five. We saw that staff reported incidents for example, in relation to safeguarding, assaults, unexplained injuries, record keeping errors, patients that did not attend their appointments, failure of follow up arrangements, self-harm and patient deaths.

The learning disability team managers had access to place items onto the risk register. Records we reviewed identified these were being reviewed and the severity and impact were considered. Action plans were in place to address the potential reported risks.

Staff received feedback from investigations and incidents via trust emails, governance meetings and team meetings when lessons learnt were shared. Staff received debriefing after serious events and staff told us that their own teams also provided support to them. Staff accessed clinical supervision as an additional means of support where needed.

Duty of candour

Staff understood the principles of the duty of candour. They received information about the duty of candour from team information boards and newsletters. The trust quality accounts for 2015 and 2016 also referred to the duty of candour and this was available on the trust website. The trust's policy was based on the principles of openness, transparency, honesty and genuine communication. The trust informed us their incident reporting system had been updated to report on compliance with the duty of candour. Compliance was reported to the quality and safety sub-committee and commissioners. The trust indicated in their December 2015 integrated quality and performance report that they have had no duty of candour breaches between April and December 2015.

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 examined 19 care records within the three teams. We saw initial assessments and risk assessments had been completed following referral and various assessments included communication assessments, physical and functional assessments, dysphagia assessments and sensory assessments. We found some support plans (easy read) were in place, one patient had a dentist passport produced and some patients had a crisis contingency plan.

We checked five care records at the Chorley and Ribble team. Three of the five records did not contain a care plan. However these records contained easy read support plans, risk assessments, dental passports, sensory assessments and recorded specific input from the health professional. Staff told us one of the care plans could have been stored in the patients old file. The manager confirmed that a care records audit had been completed and an action plan had been produced to identify where there were any gaps and actions to take. All patients and carers reported that they had a copy of their care plan.

One patient on a community treatment order had a care plan in place and this had been reviewed. The other teams we visited had care plans in place that were up to date, personalised, holistic and recovery focused.

The trust had a transition protocol in place for children who were under their local child and adolescent mental health service. Six months before a child was 18 years old, a referral into the learning disability service was made and both teams would meet to discuss. In Lancaster and Morecambe team, a children's nurse had been commissioned to oversee the transition of care into the community adult learning disability team.

All of the learning disability teams had paper records. These were stored securely and available to the team at the location they were stored. Teams had access to a computerised system where completed crisis plans were stored. This allowed other teams to access information when patients were in crisis.

Lancaster and Morecambe team told us how they had monthly meetings with the memory service to discuss any referrals, as their service was electronic.

Best practice in treatment and care

The trust was involved in a quality improvement programme-prescribing audit for the prescribing observatory for mental health. A re-audit in 2015 had taken place for 59 patients over five community teams. Staff reviewed and audited antipsychotic prescribing for patients known to the learning disability teams. These audits allow the trust to benchmark themselves against other participating trusts and to implement improvements from the findings. The trust highlighted themselves as a red indicator in the summary provided to us with no explanation given about their findings. Standard three that the trust were assessed as action required in relation to the side effects of antipsychotic medication and should be reviewed at least once a year. This review should include assessment for the presence of intracardiac electrophysiology a test to look at how well the hearts electrical signals are working, and screening for the four aspects of the metabolic syndrome: obesity, hypertension, impaired glucose tolerance and dyslipidaemia. There were no clear dates for the action plan implementation from the audit. This meant that potentially patients may be at risk if the action plan was not implemented.

The trust had put plans in place to meet the needs of people with a learning disability due to be discharged from hospital as part of the Transforming Care Agenda. This included plans for additional resources and clozapine monitoring.

The Lancaster and Morecambe team provided examples of how they had implemented best practice in the prevention of unnecessary admissions of patients to acute adult mental health wards. They had worked closely with the local authority and clinical commissioning groups to provide the necessary support for the patient at times of crisis. The teams did not have access to any dedicated learning disability acute beds within their trust.

Most of the community learning disabilities teams were able to provide some psychological therapies for patients who were unable to access generic services. How these were delivered was dependent on commissioning arrangements in each team. Staff had been trained in positive behavioural support to support patients with challenging behaviour.

In five out of the eight community teams psychology was a commissioned post and the other three teams without a commissioned service had some provision provided on a

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.

sessional basis. The West Lancashire team had three sessional psychology sessions available; speech and language therapy was not commissioned however, referrals were made into an acute trust. We saw there was a draft service specification in progress to address the inequities of team provision and patient access to services within the trust.

West Lancashire team had information displayed on the staff information board to inform staff of the applicable National Institute for Health and Care Excellence guidance in relation to the service they were providing.

Support for housing, employment and benefits were provided by the local authority teams in each area. The community teams had good links and referral pathways into these teams.

Staff gathered patients' medical history during the assessment process and continued to monitor their physical health needs. Staff liaised closely with GPs, carers and support staff to facilitate physical health checks for patients with their local GPs. Staff informed us that they would support services to complete the patients' hospital passports if needed. Lancashire Care NHS Foundation Trust had developed a health needs checklist that was provided in an easy read format. These indicated if patients had a health action plan as well as any court appointed deputy who would manage their health needs. Part of the checklist addressed how patients were able to communicate that they were in pain, lifestyle choices that may affect their health, assistance with eating and drinking as well as addressing if patients had a functional assessment and a positive behavioural support plan.

Learning disability community teams had implemented a screening programme to reduce inequalities in the NHS screening programmes for people with a learning disability. NHS England awarded the trust a contract to deliver this program in November 2015. Learning disability team staff provided training to NHS screening providers, support staff and carers of people with a learning disability and learning disability self-advocates. The screening programme focused on five areas: breast, bowel and cervical cancer, diabetic eye screening and abdominal aortic aneurism screening. Although the screening programme implementation was, over a short period of six months, this had raised awareness among staff and individuals and a document provided an analysis of the programme. It also

addressed the importance of the application and understanding of the Mental Capacity Act and best interest decisions when supporting patients to attend a screening appointment.

Skilled staff to deliver care

The national specification guidance for community learning disability teams recommends that there needs to be a range of staff skills commissioned and recruited as part of community health infrastructures. This includes staff from the following professional groups: clinical psychologists, learning disability nurses, occupational therapists, physiotherapists, psychiatrists and speech and language therapists.

Services across Lancashire were commissioned differently and some teams employed staff on a sessional basis. Lancaster and Morecambe team had a dedicated consultant nurse who reviewed medication for existing patients but was unable to prescribe for any new patients referred. The trust had identified the gap in the psychiatry commissioning arrangements within their trust risk register.

The West Lancashire team did not have speech and language therapy or occupational therapy commissioned. The team reported they were able to refer into services to access these.

Many of the staff within the teams were qualified and had access to additional training in positive behavioural support. Lancaster and Morecambe had received dementia training with the local memory assessment clinic. The manager in the Chorley and South Ribble team told us that some staff had completed sensory processing training.

New staff received the trust corporate induction and were then supported within the teams. Staff informed us they received regular supervision and attended team meetings as well as weekly intake meetings. The Lancaster and Morecambe team and Chorley and South Ribble team had regular nurse meetings.

The appraisal rate for non-medical staff in the community teams we visited was, West Lancashire 100%, Chorley and South Ribble 72% and Lancaster and Morecambe was 84%.

The supervision rates for staff having received managerial supervision in the three teams was 100%. Staff confirmed they received supervision every four to six weeks. Staff could access managerial and clinical supervision in various formats including reflective practice and peer supervision.

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.

Clinical psychologists, speech and language therapists and occupational therapists received two-monthly supervision from senior staff from the same discipline. Poor staff performance was addressed in supervision.

Multi-disciplinary and inter-agency team work

Multidisciplinary and inter-agency working was good. We observed one multidisciplinary team meeting (huddle) and reviewed minutes of these. We saw that staff spoke to each other in a respectful way and that each member of the team had the opportunity to contribute to the meeting. All of the teams had weekly meetings and Chorley and South Ribble team had monthly nurse waiting list meetings. These meetings provided staff with the opportunity to share information and to manage the teams effectively.

The team managers informed us of the working links to crisis teams. The West Lancashire team advised us that the crisis team would accept only patients with a learning disability and mental health diagnosis. Patients without a mental health diagnosis would have to present at A&E or the emergency duty team within the local authority would respond to the crisis. This team reported good working links with the mental health team. The manager told us that their team would respond to patients who were going into crisis as soon as they were able. They arranged support by producing positive behavioural plans and arrangements were made at weekends with local authority staff to support patients. They would also convene a meeting to prevent any admission of a patient with multi-disciplinary and other agencies involved.

The Lancaster and Morecambe team met monthly with the memory service and implemented their joint working pathway in dementia as a multidisciplinary team. All teams had good links into the local authority and made referrals into the social work teams.

The West Lancashire team co worked with the adults at risk team from another hospital trust to deliver learning disability awareness to hospital staff and work collaboratively with other nurses. The physiotherapist from this team hosted community clinics at the local learning disability day service.

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

Training in the Mental Health Act was mandatory for staff in the community learning disabilities teams. Figures provided by the trust indicated that West Lancashire team

were 75% compliant, Chorley and South Ribble were only 10% compliant and Lancaster and Morecambe were 0%. Staff commented that further training was needed to implement and understand the Mental Health Act due to the transforming care agenda.

There was limited use of the Mental Health Act within the community learning disability teams. The community teams were aware of whom to contact if a Mental Health Act assessment was needed. There were some patients on community treatment orders. The teams worked jointly with the mental health community teams who usually oversaw these. We reviewed the record of one patient who was on a community treatment order at the Chorley and South Ribble team. All of the necessary forms, reports and care plan reviews had been completed as well as documented information about providing a patient with their rights.

The trust had raised an issue on their risk register around no recall beds being available for patients whose community treatment order identified recall beds. There were no recall beds locally in the trust. The trust identified that this issue would potentially cause the delayed discharge of patients under the transforming care agenda.

Legal advice on implementation of the Mental Health Act and the Code of Practice was available throughout the trust.

One record we looked at in the Chorley and South Ribble team had a responsible clinician's assessment for the capacity to consent to treatment. This was signed and up to date.

Access to advocacy was available and some patients had appointed advocates. Staff were able to access independent mental health advocates to support patients in understanding their rights under the Mental Health Act where needed.

Good practice in applying the Mental Capacity Act

There was a policy on the Mental Capacity Act and the Deprivation of Liberty Safeguards, which staff were aware of and could refer to. Staff received mandatory training, level one and two in the application of the Mental Capacity Act. None of the teams were below 75% for level one training. However, two of the teams were below 75% for level 2 training these were Chorley and South Ribble and Lancaster and Morecambe both with 47% of staff trained.

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 within the learning disability teams had received some additional training in relation to learning disability patients accessing health screening and the need for staff to consider the application of the Mental Capacity Act where patients lacked capacity to consent.

Staff had a clear understanding of the Mental Capacity Act for patients who had an impaired capacity and capacity to consent. An easy read document was produced to assist patients in consenting to their care and treatment. Staff provided patients with assistance and easy read information to make a specific decision themselves before they were assumed to lack capacity.

Patients were supported to make decisions where appropriate and when they lacked capacity, decisions were made in their best interests. We saw evidence of good practice in the care and treatment records that reflected the appropriate use of the Mental Capacity Act in relation to patients' capacity to consent to treatment and best interest decisions.

The trust had an identified person who staff could contact to discuss any issues in relation to the application of the Mental Capacity Act.

Are services caring?

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

Our findings

Kindness, dignity, respect and support

We observed seven direct contacts with patients and/or carers across the three services. Staff attitudes and behaviours were compassionate, sensitive, respectful and caring. One carer stated the community learning disability team had been involved in producing a positive behavioural plan and had enlisted the wider multidisciplinary team to help improve their care and treatment.

One carer commented that they are lovely staff, caring, and have an individual approach 'work with you' 'they are part of your team, can turn to them any time'.

Staff understood the needs of individual patients and actively referred individuals to the speech and language teams to help with communication. Adaptations and improving how they communicated more widely with patients was also addressed. Carers told us that there was good interagency working and occupational therapists worked alongside the physiotherapists, speech, and language staff.

Patients and carers confirmed that staff were helpful respectful, polite and caring.

The involvement of people in the care that they receive

Patients and carers reported that they were fully involved. All reported that they had a copy of their care plan and were given lots of information as well as information about how to make a complaint.

We saw that carers were actively involved in their relative's care. The community learning disability teams provided support as well as information to carers on how to access a carer's assessment.

We attended a health in action group specific to only the Lancaster and Morecambe team where six patients attended. The patients' overall care plans included attendance at this group. Patients were fully involved in making decisions about the group and arrangements for speakers to attend the meetings were planned. During our visit, we observed a speaker who talked about hate crimes. All of the patients were positive about the group. They commented that attendance at this group provided opportunities for them to discuss any issues they had and felt confident to tell group members and staff if there were any problems. The aim of the group was to encourage independence by accessing different resources in the community and to learn new skills as well as providing health and wellbeing awareness.

The Lancaster and Morecambe team also had a co design experience based project for patients. People provided feedback about services and their feedback made improvements and changes to services.

Information about advocacy services was available in the teams we visited. Access to advocacy was available and some patients had appointed advocates.

We reviewed information about how patients gave feedback about the care they received. All the teams we visited completed the friends and family test with patients, and their comments were posted on the team information boards.

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

All of the teams had an eligibility criteria that stated, patients must have a significantly reduced ability to understand new or complex information and to learn new skills (impaired intelligence) with:

- A reduced ability to cope independently (impaired social functioning) which started before adulthood (age 18) with a lasting effect on development.
- Be registered with a GP within the area the teams were based.
- Have a health or behaviour need that cannot be managed by mainstream health services with reasonable adjustments.

The services accepted self-referrals and from anyone else. Where individual patients did not meet the criteria for accessing the learning disability teams, they were signposted to the most appropriate service for their needs.

Urgent referrals into the teams were prioritised by risk and the teams were able to respond on the day of referral or within 24 hours. Access to duty psychiatric cover was also available out of hours.

The teams had referral to treatment times for patients to be seen within 18 week for specific disciplines. These included speech and language therapy, occupational therapy and physiotherapy. The teams we visited did not have any patients exceeding these waiting times in August 2016. The trust performance managers as well as commissioners monitored these monthly. There were no patients waiting over 18 weeks for referral to treatment times for speech and language treatment, occupational therapy and physiotherapy where the service was commissioned.

All teams reported good working links with the mental health teams, where patients had a learning disability and mental health diagnosis. Joint assessments were completed and these patients could access the crisis teams out of hours. The duty psychiatrist responded to patients in crisis out of hours and the behavioural management team could be accessed. Patients in crisis would need to access accident and emergency departments or the emergency duty teams provided by the local authorities.

The teams we visited were responsive to new and existing patients being referred into the teams. All of the teams had

a weekly intake meeting where patients were discussed. These meetings addressed the reasons for individual referrals and provided summary information they had about the patients being referred. We reviewed West Lancashire intake minutes these identified where psychiatry input was needed and this was allocated to psychiatry. Patients were allocated to specific disciplines dependant on their needs. Patients being discharged or closed from the service were also discussed at these meetings as well as in clinical supervision. Information was sent to the carers, referrers, GPs and patients when they were discharged. They were provided with contact details of the team should they need further support.

Staff were aware of the transforming care agenda and worked closely with other services to facilitate discharge of patients back into their own community.

If patients could not be seen immediately, further information was gathered from the referrer to assess the risks. Where the risks had been deemed high the teams were able to respond by undertaking a home visit to further assess. All of the teams we visited described how they were responsive to patients in crisis. Where necessary staff arranged services over the weekend period and completed positive behavioural plans. All of the teams reported how they would seek additional support for individuals in crisis to prevent any acute admissions of patients into a psychiatric bed.

The teams mostly saw patients in their own homes. Where patients did not attend their appointments then they were offered a further three appointments before being discharged from their service. The teams were proactive in re-engaging with patients where they had missed appointments and letters and telephone calls were made to re-engage.

Staff told us that appointments were only cancelled on rare occasions, for example in emergencies and during unanticipated staff sickness. On the rare occasion appointments were cancelled, these were discussed within the team to try to reallocate within the teams and arrange an appointment as soon as possible. Appointments ran to time where possible and if there were any delays then staff would contact the individuals to inform them of this.

A new draft standard operating procedure and a service user access protocol had been produced and was awaiting ratification by the trust.

Are services responsive to people's needs?

Good 

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

The facilities promote recovery, comfort, dignity and confidentiality

One of the three teams visited saw patients on their premises. The West Lancashire team had 11 interview rooms with adequate soundproofing. There were no clinic rooms at the community teams we visited. Information was readily available in the reception waiting area informing patients and carers about how to make a complaint or raise a concern as well as information about local services and treatments.

Meeting the needs of all people who use the service

Staff provided patients and their carers with a comprehensive information pack, some of which was easy read material. The pack included information about customer care, consent, comments compliments and complaints, how to get a carers assessment, keeping their health information private, access to medical records and information about them and what to do if they were being abused. Staff signed to confirm the patient had received this.

Accessible information and leaflets were available in other languages spoken by people who use the services. All the teams had access to interpreters and/or signers.

The West Lancashire team had adjustments for patients requiring disabled access as well as access to toilet facilities. There was a lift fitted in the community base as well as ramps to the entrance of the building.

All of the teams we visited had access to easy read material available for patients. Teams had also developed their own resources to meet the needs of individual patients. These included the use of pictorial assessment forms, health action plans and health needs assessments that had been developed to aid communication and understanding. The

trust had copies of the Department of Health information sheets/brief guides for people with a learning disability. One example of this was a guide on consent and these were provided to all patients on acceptance to the service.

Listening to and learning from concerns and complaints

Staff provided patients and or their carers on referral with a compliment, comment and complaint form. This was a standardised form and was not adapted for patients with a learning disability apart from three faces to indicate if it was a complaint, compliment or comment. The form was aimed at the patient's carer or staff member completing this on their behalf. The trust customer care department managed all of the complaints. The form stated that staff would be able to provide support to help individual patients complete the complaint form and this could be done by telephone. Staff informed us that if patients raised any concerns or complaints they would discuss this with them or their carers initially to try to rectify their concerns.

Staff were aware of how to handle complaints and were aware that the trust customer complaints department managed these. Staff received feedback from complaints, compliments and comments via their team meetings.

- The learning disability community service teams received 10 complaints.
- One complaint was still on hold, two complaints were withdrawn, three were not upheld, four partially upheld.
- No complaints were referred to the Parliamentary and Health Service Ombudsman.

The learning disability community teams in Lancashire received 61 compliments during the last 12 months. Of these West Lancashire team received one compliment, Chorley and South Ribble received six, and Lancaster and Morecambe received one.

Are services well-led?

Good 

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

Our findings

Vision and values

Lancashire Care NHS Foundation Trust's vision was to provide high quality care, in the right place, at the right time, every time. The vision was underpinned by the trust values of compassion - offer it, integrity - show it, respect - earn it, excellence - reach for it, accountability - accept it and team work - share it.

Staff were aware of the vision and values and information was available on the staff intranet, team information boards and within the trust yearly review document 2015 to 16.

Staff we spoke with were passionate about providing respectful and compassionate care to all patients. The teams we visited all worked well together and had regular team meetings. We saw good teamwork and managers support their staff well. There were clear team objectives and their annual appraisals reflected the trust values. Most of the staff were positive about the teams they worked in commenting that teams were supportive of each other. Staff knew who their senior managers were in the trust and managers could be approached.

Good governance

Effective governance systems were in place to support the delivery of learning disability services. They ensured staff were kept updated about the trust vision and direction. All teams had weekly huddle meetings and information from the trust clinical business meetings were shared with the teams by the service managers. Information was also shared monthly from team level up to the business meeting governance unit.

Overall, there were fluctuating rates of compliance with core mandatory training as noted in the report earlier. Each team had a training matrix showing the levels of compliance with mandatory training and the managers oversaw this. Information was also inputted centrally by the trust and some of the figures did not marry with the team's mandatory training figures. The inaccuracies of the quality data submitted to the academy regarding compliance had been highlighted on the trust risk register.

The appraisal rates for non-medical staff in West Lancashire team was 100%, Chorley and South Ribble were 72% and Lancaster and Morecambe had 84% of their staff appraised. The supervision rates for the three teams were 100%.

Staff maximised their time on providing direct care where possible. All of the teams had administrative support allocated. However, two of the teams reported there being a shortage of administrative staff at Chorley and South Ribble and Lancaster and Morecambe team. The Lancaster and Morecambe had reported this via their risk register. This meant that staff within the teams had to cover aspects of the administrative role by inputting performance related data. This has affected staff time by them having to answer telephones and complete their own admin.

The teams reported incidents and learning from these incidents were discussed. Safety alerts were displayed on the team information boards. Management meetings were also available for staff to review. The team information boards had learning from complaints and patient feedback detailed 'you said we did'.

All teams had staff members identified as 'champions' in safeguarding and staff were aware of the processes in place of what and who to report to.

The provider used key performance indicators (dashboards) to monitor waiting times, access to treatment, referral to treatment times, contacts, assessments, care plans and discharges to gauge the performance of the teams. Where these indicators were affected by staff recruitment or sickness managers had been proactive in raising these on the learning disability trust risk register.

The learning disability team managers had access to place items onto the risk register of which there were 38 at the point of our inspection. Records we reviewed identified these were being reviewed and the severity and impact were considered. Action plans were in place to address the potential risks.

Leadership, morale and staff engagement

The average sickness rates for the three teams from 1 October 2015 to 30 September 2016 were 3.6%. The national average for sickness was 4.4% for the NHS.

Staff informed us they were fully aware of the whistle-blowing process in the trust and had access to policies and procedures. Staff were able to raise concerns without fear of victimisation. There were no reports of bullying and harassment in any of the teams we visited.

Of the staff we spoke with staff morale was good and staff reported job satisfaction in the teams we visited. Staff felt

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.

able to raise issues with their managers, they were listened to, and they provided mutual support to their team members. Staff within all of the teams reported their concerns about the transforming care agenda and how this had affected their workload and management of their roles as care coordinator for patients being moved into community placements.

Staff had received a communication document from the trust. This indicated and acknowledged some of the challenges the learning disability community teams were facing in Lancashire due to the full implementation of transforming care agenda. This communication document updated staff about what the trust were doing or planning to do in the future. The issues reported on:

- addressing increased waiting times for nursing referrals
- addressing learning disability consultant psychiatry capacity
- partnership working with another trust
- employment of strategic leads for learning disability and autism
- transfer to specialist community services business unit
- understanding future demand for services
- knowledge and skills to understand processes around legal frameworks to understand working with people with offending histories, or those subject to conditional discharges, guardianship orders and community treatment orders.

Staff were open and transparent and were aware of the duty of candour to explain and apologise to patients when something goes wrong.

Staff were able to give feedback on the needs of the service, service development and the transforming care agenda. We reviewed a communication document, which confirmed this.

Commitment to quality improvement and innovation

The learning disability teams were committed to address issues regarding the increased discharges of people from long-stay hospitals who require psychotropic medication and to review the increasing concerns about the inappropriate use of psychotropic medications with people with learning disabilities. A pharmacist had been allocated to help the trust understand the anticipated future demand and ensure that all services were able to develop to meet this need.

The Lancaster and Morecambe team had implemented an evidence based co design project to make improvements to their services by using service user feedback to shape the service.

The Chorley and South Ribble team had introduced an innovation known as work space walks. This was to encourage team members to spend time away from their desks and take a short walk together to improve health and wellbeing and thinking space.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Treatment of disease, disorder or injury

Regulation

Regulation 18 HSCA (RA) Regulations 2014 Staffing
Essential training for the teams we visited was not at a sufficient level in relation to the Mental Health Act level two training, Mental Capacity Act level two and prevent training.

This was in breach of Regulation 18 (2) (a)