

Lancashire Care NHS Foundation Trust

Community-based mental health services for adults of working age

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	Burnley and Pendle Spoke team	BB10 1LU
RW5HQ	Sceptre Point	Hyndburn, Ribble Valley and Rossendale community mental health team	BB5 5DE
RW5HQ	Sceptre Point	Chorley and South Ribble Spoke team	PR6 OHW
RW5HQ	Sceptre Point	Central Lancashire community rehabilitation Team	PR7 IPS

Summary of findings

RW5HQ	Sceptre Point	Early intervention team - Morecambe	LA4 5QG
RW5HQ	Sceptre Point	Blackpool complex care Team	FY3 9HR
RW5HQ	Sceptre Point	Early intervention team - Blackpool	FY3 9HR

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 the community-based services for adults of working age as good because:

- There were safe working practices; staff worked to keep themselves and patients safe. Staff worked within the trust's lone worker policy. Staff had manageable caseloads. Incidents were reported appropriately and lessons were learnt.
- The community mental health teams were effective in providing multidisciplinary, evidence based care. Staff completed care plans to a good standard and patients received regular formal reviews of their care. Staff ensured patients received physical health checks with easy read physical health monitoring tools.
- Patients told us that staff were caring and we observed staff treating patients with kindness, dignity, respect and compassion. Staff took the time to listen to patients and to understand their needs. There were service user development workers within the social inclusion teams to promote self-help groups and user involvement initiatives.
- There was improved responsiveness and staff joint working when patients were in transition from children and adolescent mental health services to adult mental health services. A recent audit confirmed these improvements. Patients requiring long term rehabilitation received appropriate intensive support. There was good interagency working including with other teams, crisis teams, primary care and acute mental health hospitals. Social inclusion teams worked to ensure people's holistic needs were met and worked with hard to reach groups in innovative ways to promote mental well-being.
- There were improved governance arrangements to oversee the community mental health teams. The team was well-led by experienced and committed managers. Morale was improved following most

changes being implemented from the community service review. Managers reviewed individual and team performance. There was improvements to supervision, training and appraisal rates from the last inspection.

However

- The arrangements for adhering to the requirements of the Mental Health Act when patients were on a community treatment order needed improvement. This was because many patients on a community treatment order were not routinely given information about their rights or informed of their rights to an independent mental health advocate verbally.
- Patients had not exercised their rights to appeal and we could not be assured that this was an informed choice. Robust systems were not in place to ensure that certain patients were automatically referred to the tribunal or that the corresponding legal authority to administer medication to community treatment order patients were kept with the medicine chart and reviewed by nurses administering medication, leading to incidents of staff giving medication without legal authorisation.
- Staff did not always consider the consent status and scope of parental responsibility when patients came into the service at the age of 16.
- There were delays in patients accessing a bed in Blackpool and staff had to manage patients' risks in the community until a bed became available.
- While staff were completing comprehensive risk assessments in most cases, there was a small number of patient risk records, which had not been reviewed recently.
- Staff were not always recording whether patients had been given copies of their care plan.
- The results of all audits were not always fully disseminated to community mental health staff.

Summary of findings

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

Are services safe?

We rated the community-based services for adults of working age as good for safe because:

- The buildings in which staff worked and patients were seen were well maintained.
- Staff completed comprehensive risk assessments and ensured these were regularly reviewed in most cases.
- Staff understood and worked within the trust's lone worker policy to keep themselves safe.
- Staff had manageable caseloads and there were sufficient staff to meet patients' needs.
- Incidents were reported appropriately and staff received support and debriefing.
- Staff completed mandatory training to ensure they were kept up-to-date.

However:

- We found a small number of patient risk assessments that had not been reviewed recently.
- Staff from the social inclusion team received basic information for patients referred from primary care and whilst working practices were adapted to manage risks, the recording of ongoing risks were not routinely reviewed.

Good



Are services effective?

We rated community-based services for adults of working age as requires improvement for effective because:

- Patients on a community treatment order were not routinely given information about their rights verbally and in writing when the community treatment order commenced or at regular intervals.
- Patients on a community treatment order had not been informed of their rights to an independent mental health advocate.
- Patients had not exercised their rights to appeal and we could not be assured that this was an informed choice.
- Systems were not in place to ensure that the corresponding legal authority to administer medication to community treatment order patients were kept with the medicine chart and reviewed by nurses administering medication.
- One community patient who lacked capacity appeared to receive medication without appropriate authorisation from a second opinion appointed doctor.

Requires improvement



Summary of findings

- Staff did not always consider the consent status and scope of parental responsibility when patients came into the service at the age of 16.

However:

- Care plans were of a good standard and were regularly reviewed.
- Patients received regular formal reviews of their care in line with the care programme approach.
- Staff ensured patients received physical health checks with easy read physical health monitoring tools.
- Teams were multidisciplinary including psychologists and specialist practitioners based in the teams' core community mental health team function.
- Staff received supervision and appraisal and felt well supported.

Are services caring?

We rated the community-based services for adults of working age as good for caring because:

- The feedback we received from patients was positive.
- We observed staff treating patients with kindness, dignity, respect and compassion. Staff took the time to listen to patients and to understand their needs.
- There were mechanisms to capture feedback from people who used the service.
- There were service user development workers within the social inclusion teams to promote self-help groups and user involvement initiatives.

However:

- Staff were not always clearly recording whether patients were routinely offered and received a copy of their care plan.

Good



Are services responsive to people's needs?

We rated the community-based services for adults of working age as good for responsive because:

- There was improved joint working when patients were in transition from children and adolescent mental health services to adult mental health services. The transition protocol was being reviewed by the trust and other relevant agencies. A recent audit confirmed these improvements.
- Patients had timely access to care and treatment with no waiting lists.

Good



Summary of findings

- Patients requiring long term rehabilitation received appropriate intensive support.
- There were systems to triage referrals based on the individual needs of people who used the service.
- There were good patient flows with access in and discharge out into primary care when patients did not require specialist secondary mental health services.
- Services were planned and delivered to meet people's needs in a person centred way, taking their individual needs into account.
- Social inclusion teams worked to ensure people's holistic needs were met and worked with hard to reach groups in innovative ways to promote mental well-being.
- The teams had access to interpretation services for patients who required this.
- Patients knew how to make a complaint and staff received several compliments.

However:

There were delays in patients accessing a bed in Blackpool and staff had to manage patients' risks in the community until a bed became available.

Are services well-led?

We rated the community-based services for adults of working age as good for well-led because:

- Staff understood the trust's vision and values.
- Each team was well-led by committed managers.
- Staff felt respected, valued and supported by their managers and their peers.
- Morale was improved following most changes being implemented from the community service review.
- Managers reviewed individual and team performance.

However:

- Staff were not always informed of audit results and the recommendations to embed service improvements and quality initiatives.

Good 

Summary of findings

Information about the service

Lancashire Care NHS Foundation Trust provides community mental health services to adults of a working age across Lancashire. The adult mental health teams work under three localities with their own governance arrangements:

- The Central Lancashire locality covers services in Preston, Chorley and South Ribble and West Lancashire.
- The North Lancashire locality covers services in Lancaster and Morecambe, Fylde and Wyre and Blackpool.
- The East Lancashire locality covers services in Blackburn, Hyndburn, Pendle, Rosendale and Burnley.

Community mental health services provided within each locality included

- complex care and treatment teams which included the community mental health teams assertive outreach function
- community rehabilitation teams
- community restart services
- early intervention teams.

We inspected the community mental health services for adults of working age during the comprehensive inspection of the trust in April 2015. We found that the community mental health services for adults of working

age required improvement overall. We rated this core service as requires improvement for responsive and well-led because the trust did not have appropriate arrangements to transition children and young people into adult services and also because the trust did not have appropriate measures in place to monitor and address key performance indicators, staff training uptake and appraisal rates. Following the April 2015 inspection, we therefore issued one requirement notice, which related to safe care as there was a lack of arrangements around the transition of patients between child and adolescent mental health services and community mental health services for adults of working age. We rated the safe, effective and caring domains as good.

The trust provided an action plan telling us how they would improve the transition arrangements including action to introduce a new protocol and auditing arrangements. We therefore found there were improved arrangements for managing the transition from children and adolescent mental health services to adult mental health services. We also found that there were improvements to the shortfalls we found last time against the well-led key question because there were more visible governance arrangements and improved performance in relation to key performance indicators, staff training rates and appraisals.

Our inspection team

Our inspection team was led by:

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

Head of Inspection: Nicholas Smith, Care Quality Commission

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

The team that inspected this core service comprised three CQC inspectors and two specialist advisors (consisting of a mental health nurse and a senior social work manager).

Why we carried out this inspection

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

also checked to find out whether Lancashire Care NHS Foundation Trust had made improvements to their community mental health services for adults of working age since our last inspection of the trust in April 2015.

Summary of findings

When we last inspected the trust in April 2015, we rated community mental health services for adults of working age as requires improvement overall. We rated the service as good for safe, effective and caring key questions, and responsive and well-led were rated as requires improvement.

Following the inspection in April 2015, we told the trust that it must take the following actions to improve community mental health services for adults of working age:

- The trust must ensure that there is a protocol for the transfer of young people from CAMHS services to adult mental health services and that this is fully adhered to by staff to ensure the health, safety and welfare of service users.

As a result, we issued the trust with one requirement notice.

This related to:

- Regulation 12 Safe Care and treatment.

On this inspection, we found improvements had been made. There were improved joint working arrangements when patients were in transition from children and adolescent mental health services to adult mental health services. The transition protocol was being reviewed by the trust and other relevant agencies. A recent audit confirmed these improvements.

How we carried out this inspection

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

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

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

The inspection took place across a range of the community-based mental health services for adults of working age. We sample community mental health services as part of our comprehensive inspection process. We therefore visited seven community mental health teams for adults of working age. The teams we visited were:

Two community mental health teams providing care coordination, community mental health team and assertive outreach functions. These were:

- Hyndburn, Ribble Valley and Rossendale community mental health team
- Blackpool complex care team

Two community restart inclusion services providing social integration, education, employment and user development support. These were:

- Burnley and Pendle restart spoke team
- Chorley and South Ribble restart spoke team

One community rehabilitation team providing longer term rehabilitation in the community to patients with severe and enduring mental illness.

- Central Lancashire community rehabilitation team

Two early intervention teams, which work with people experiencing their first episode of psychosis. These were:

- Early intervention team - Morecambe
- Early intervention team - Blackpool

During this inspection:

- We spoke with 22 patients who used the service and three carers.
- We spoke with the managers for each of the teams.
- We spoke with 50 members of staff from a range of disciplines and roles. This included 19 members of staff who attended three focus groups held within the team offices. Staff we spoke with included doctors, nurses, psychologists, occupational therapists and support, time and recovery workers.
- We looked at 30 care records.

Summary of findings

- We looked in detail at Mental Health Act records relating to nine patients on community treatment orders and asked for statistics about adherence to the Mental Health Act for 145 patients on a community treatment order.
- We accompanied staff on 12 visits and observed how they provided care and treatment to people in their own home or at the team bases.
- We looked at the environments and equipment where the teams were based.
- We looked at the arrangements for the management of medicines.
- We looked at records about the management of the service including policies, minutes of meetings and results of audits.

What people who use the provider's services say

We spoke with 22 patients and three carers. Patients gave largely positive comments stating that staff were very caring and treated them with dignity and respect.

Patients receiving social inclusion support from staff within the restart teams were appreciative of the support they received to improve their mental well-being, get active and increase their confidence. A common theme from the patients about the restart team was that staff had been exceptionally helpful and supportive, much more than any other services patients had accessed.

Carers we spoke with individually were complimentary of the care patients had received. For example, one carer reported seeing a big improvement in their relative's condition since receiving support from the community mental health teams.

Patients commented that staff were very flexible and arranged appointments at times that suited them.

Patients stated that staff were punctual and phoned to explain any delay. None of the patients we spoke with had any concerns nor had any of these patients raised a formal recent complaint. Two patients did state that when their care coordinator left or changed jobs, there was a delay in allocating a new care coordinator and they were not always kept informed until a new named worker was identified.

People had an opportunity to comment on the services they received on comment cards prior to the inspection. We did not receive any comment cards from patients receiving support from the community mental health teams. During the inspection period, we received one letter from a relative who stated that the community mental health team supporting their mother provided wonderful care to a high standard. They went on to state that they do not feel they would have coped without the support of staff from the community mental health team.

Good practice

- The restart teams worked to ensure people's holistic needs were met, promoted social inclusion and worked with hard to reach groups in innovative ways to promote mental well-being. For example, the restart team had developed a football league called the inclusion league which was developed in conjunction with Lancashire Football Association. Following a small settlement of people displaced from Syria, staff from the recovery service had established links and invited people to attend this local league football team to promote well-being and encourage participation and awareness of services available.
- The trust had a pilot scheme providing clinical pharmacy technician input into the west Lancashire community mental health team in order to support medicines optimisation, improve patient care, and ensuring cost effective use of medication.

Summary of findings

Areas for improvement

Action the provider **MUST** take to improve

- The trust must ensure that patients on a community treatment order are provided with information on their rights verbally and in writing.
- The trust must ensure that patients on a community treatment order are provided with information on their right to an Independent Mental Health Advocate.
- The trust must ensure that care and treatment is provided in accordance with Part 4 of the Mental Health Act by ensuring that treatment for a mental disorder for relevant patients on a community treatment order was properly authorised under a CTO11 certificate, CTO12 certificate or under urgent procedures.
- The trust must ensure that systems are in place to enable community mental health team staff to check when administering medication for mental disorder to a patient on a community treatment order, to include legal certificates on medicine charts.

Action the provider **SHOULD** take to improve

- The trust should ensure that the consistency of risk recording and evidencing patient's being given copies of their care plan is improved.

- The trust should ensure that relevant professional community mental health staff are properly informed and trained in their responsibilities when working with patients on a community treatment order.
- The trust should ensure that any periodic audit of adherence to the Mental Health Act includes checking whether community patients were informed of their rights and that the consent to treatment rules are adhered to.
- The trust should ensure that community staff properly consider and record the competence and scope of parental responsibility when patients under 16 years of age transition from child and adolescent mental health services into the community mental health teams and address other shortfalls identified in the external audit of the transition arrangements.
- The trust should ensure that the results of all audits are disseminated to community mental health staff to help them continuously improve and work within best practice guidelines.

Lancashire Care NHS Foundation Trust

Community-based mental health services for adults of working age

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Burnley and Pendle Spoke team	Sceptre Point
Hyndburn, Ribble Valley and Rossendale community mental health team	Sceptre Point
Chorley and South Ribble Spoke team	Sceptre Point
Central Lancashire community rehabilitation team	Sceptre Point
Early intervention team - Morecambe	Sceptre Point
Blackpool complex care team	Sceptre Point
Early intervention team - Blackpool	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.

We looked in detail at Mental Health Act records relating to nine patients on community treatment orders and asked for statistics about adherence to the Mental Health Act for 145 patients on a community treatment order. We found:

- Staff could request an assessment under the Mental Health Act for people in the community and this would generally be coordinated quickly. However, there were delays in patients from Blackpool being admitted due to the lack of an available bed. This meant that community mental health staff supported patients at home even when it was agreed they needed to be in hospital.

Detailed findings

- We found shortfalls in community patients being given information on their rights whilst on a community treatment order both when the community treatment order was first started and at regular intervals.
- We found shortfalls in community patients being given information about their right to receive support from an independent mental health advocacy service whilst on a community treatment order.
- Many patients on a community treatment order had not exercised their rights to appeal and, because many patients were not informed verbally of their rights or of their right to advocacy support, we could not be assured that this was an informed choice.
- Trust staff had a duty to refer certain patients to have an independent mental health tribunal to review the appropriateness of remaining on a community treatment order where patients had not applied themselves. The trust told us that there were 39 patients on a community treatment order who were eligible for an automatic referral to a tribunal and of these 28 patients were referred within the statutory timeframe. Eight patients were referred but outside the statutory timeframes and three had not been referred.
- The second opinion appointed doctor certificate was not kept with the medication card for patients on a community treatment order. Three patients on a community treatment order had received medication which was not authorised. For example, in one case, the patient lacked capacity to consent, a second opinion appointed doctor had been requested but had not authorised the treatment regime and doctors had not used urgent authorisation.
- The trust carried out an audit of community treatment orders but the scope of the audit checked whether appropriate arrangements and consultation had taken place prior to patients being placed on a community treatment order. This did not identify the shortfalls in providing patients with their rights, medication authorisation and referrals to tribunals.

However we also found:

- Records showed that the community treatment order application paperwork was in place, the mandatory and discretionary conditions considered were clearly recorded, renewals occurred appropriately and the conditions of the community treatment order were monitored.

Mental Capacity Act and Deprivation of Liberty Safeguards

Overall we found staff were adhering to the requirements of the Mental Capacity Act. Staff made sure health decisions were made based on mental capacity assessments, or in the best interest of the person.

- There was a record and monitoring of mental capacity and consent, when significant decisions were made. For example, when people needed to be brought into hospital, or when there were concerns that patients were making unwise choices such as financial decisions.
- Staff contributed to best interest considerations where necessary.
- Staff had a clear understanding of their responsibilities in undertaking mental capacity assessments, when they were the principle decision maker.
- The electronic system used by staff to record patient's treatment had clear section to record and retain records in relation to Mental Capacity Act such as advance decisions and best interest decisions.

However:

- Staff did not always consider the consent status and scope of parental responsibility when patients came into the service at the age of 16.

Are services safe?

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

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

Our findings

Safe and clean environment

Staff within the community mental health teams provided care mostly in patients' own homes. If there were any concerns about staff safety, staff would see patients in pairs or arranged to see patients in safer alternative venues, such as using interview rooms in team offices. Patients would also be asked occasionally to attend the team locations for routine reasons including for assessment, to attend a care programme approach review or to see the consultant psychiatrist.

The team offices used to see patients were clean with welcoming reception areas and well equipped interview rooms. Reception areas were also appropriately designed to ensure the safety of reception staff. Reception and permanent staff controlled access to other parts of the building through unlocking doors and escorting people through the building. Interview rooms were either equipped with alarm systems or staff wore personal alarms.

There were appropriate checks in place to ensure that the buildings were well maintained. For example, the East Lancashire restart team premises was last used as a mental health day centre. The building had showers which were routinely checked to prevent legionella. The buildings in which staff worked and patients were seen were well maintained with appropriate health and safety checks.

Teams had systems for visitors to sign in and out of the building. This ensured that staff were aware who was in the building for fire safety. The teams had regular fire tests to test that the fire alarms were working properly and fire drills to practice evacuating the building. The time taken to evacuate the building was not always recorded on some of the records we saw.

Medication was not stored or dispensed from team offices. Patients would receive their own medication from the GP and store it in their homes. The exception was the Hyndburn, Ribble Valley and Rossendale community

mental health team where patients would collect supplies of clozapine. The clozapine stocks were not stored in team offices and were dispensed by pharmacists working from the same building at The Mount.

Safe staffing

The community mental health teams each had a team manager and a number of community psychiatric nurses and support workers. Most teams had a range of social workers and allied health professionals working as part of the multidisciplinary teams. The review team was overseen by a nurse looking at the assessment into the review team and an occupational therapist. The recovery team was made up of support time recovery workers and inclusion workers – there was a service manager and deputy managers who were professionally qualified.

Some teams had higher staffing levels because they covered a wider geographical area or due to higher caseloads and acuity of patients based on clustering data. For example the Blackpool complex care team community mental health team employed 9.6 whole time equivalent nurses and 11.8 whole time equivalent other support care staff whilst the Hyndburn, Ribble Valley and Rossendale community mental health team had 5 whole time equivalent nurses and 5 whole time equivalent support workers.

Overall the community mental health teams for adults had a vacancy rate of 12.5%. Actual staffing levels within teams were usually within the expected staffing levels. Where there were vacancies, managers were working to address these with plans to recruit staff. There were no agency and bank staff used in the three months prior to our inspection.

The teams with the highest staff vacancy rate was the Blackpool complex care team with a vacancy rate of 38% as stated by the trust data. However, when we spoke with the manager of this team they confirmed that they did not have any vacancies currently although 1.6 whole time equivalent nurses had been seconded to work on a temporary basis in the inpatient wards at the Harbour. Despite staffing levels being very slightly lower than the established levels in some teams, we did not hear from staff or patients that it impacted on people waiting to be assessed or allocated to a named worker.

Are services safe?

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There were low levels of sickness across most teams with an average sickness rate at 4.6%. The exceptions were Central Lancashire restart team with an average sickness level of 7% and the Blackpool complex care team with an average sickness of 8%. We discussed the sickness levels with the team manager who explained there were no current staff off sick and sickness absence did not significantly affect patient care. The absence levels of the central Lancashire restart team related to a small number of Lancashire Care staff and was disproportionately affected because it did not include staff from the other partner agency.

Staff received mandatory training and were up-to-date as required. Mandatory training included moving and handling, conflict resolution, equality and diversity, basic life support, health and safety, infection control, adult and children's safeguarding, fire safety, information governance and prevent training which was training for staff to be aware of the need to prevent people from being drawn into terrorism.

The initial data from the trust prior to the inspection showed that there was mandatory training uptake of 83% across the adult mental health directorate which covered the community mental health teams for adults and the early intervention service. This showed that most teams maintained good uptake of mandatory training compliance rates with many showing 100% compliance rates in many mandatory training courses. There were only a small number of shortfalls in mandatory training uptake levels. A small number of training courses for some teams were showing below 75% uptake rates. These were manual handling and conflict resolution for the Blackpool complex care team at 50% and manual handling of 55% for the Restart team in Burnley. Staff in community mental health teams would not routinely move patients in their everyday work so the impact of some staff not being up-to-date on manual handling was minimal.

We discussed the training uptake levels with team managers and were assured that uptake rates had improved since this data and also where there were gaps, staff were booked on future courses to maintain and improve the uptake rates. When we spoke with staff, we did not identify deficits in staff understanding as a result of lower uptake in mandatory training levels.

Staff reported having manageable caseloads which enabled them to monitor patients to provide safe and

effective care. For example, staff were managing a caseload of below 35 cases at any one time. The core community mental health teams did not have formal caseload weighting tools; team managers used Health of the Nation Outcome Scales clustering data to evaluate case mix within teams in addition to individual caseload reviews by team managers.

The early intervention teams had developed a caseload weighting tool provide an overview of both care coordinators caseload and that of the service. This was used in supervision to consider workload, but also to consider pressures within teams and services, the management of sickness and business continuity, being able to prioritise the resource on need or severity.

Staff told us and records confirmed that caseloads were managed in supervision and reviewed regularly. Staff received regular supervision. This included management and clinical supervision. For example 100% of the staff within the Blackpool complex care team had received regular clinical supervision. Eighty per cent of staff within the Hyndburn, Ribble Valle and Rossendale community mental health team had received clinical supervision with the shortfall due to staff sickness.

Managers and service managers received monthly reporting information, which helped them to oversee the levels of activity within the team such as new referrals, appointments, open cases and quantitative data on whether the capacity of the team could meet the demands placed upon them.

Assessing and managing risk to patients and staff

Referrals into secondary community mental health services were screened primarily by staff from the single point of access team. We have reported on the single point of access function when we looked at mental health crisis services and health based places of safety. The community mental health teams had a system to assess the information on each person and determine which member of staff was allocated to undertake a formal assessment.

Staff undertook comprehensive risk assessments at initial referral and updated them when necessary. Most of the risk assessments were kept up-to-date and were of a good standard to enable any staff member to understand the risks presented for each patient. On four out 30 of files, risk assessments had not been updated for some time. We

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brought these to the attention of the relevant managers. We did not see significant changes in these patients' risk profile or presentation but risk assessments should be routinely reviewed at least annually.

Risks assessments were routinely reviewed at least annually during a care programme approach review or sooner if there were significant changes in patients' risks. Patients we spoke with confirmed they knew who to contact in a crisis and their care plans were clear in relation to what to do in a crisis.

Patients' physical health was monitored and checked initially and on an ongoing basis. The electronic recording system had an at a glance dashboard showing the latest physical health checks and whether the information was in expected or healthy ranges or outside of these with required action. Staff ensured that patients had a comprehensive physical health check at least annually as part of the care programme approach reviews. There was evidence of appropriate liaison with GPs and other health professionals where people had an identified health need that required monitoring. An audit carried out in March 2016 to check whether patients were screened for six key physical health problems and where clinically indicated, directly provided with, or referred onwards to other services for interventions for each identified problem showed 92% compliance amongst a sample of 36 records.

Patients received regular checks to make sure that any medication they received was not causing adverse effects; especially when people were first put on medication such as clozapine which requires regular blood checks.

Safeguarding matters were considered as part of the initial referral, assessment and on an ongoing basis through the risk assessments. Staff were trained in safeguarding matters and had a good understanding of how to raise a safeguarding alert. However, in the community mental health teams the social work input was not integrated and, where this was the case, staff informed us that they were not involved in the full safeguarding process because this was passed to the staff in the local authority to investigate. We saw that staff had taken appropriate action when they became aware of a significant safeguarding matter. For example, we saw an example of an alert being made following concerns about financial abuse of a patient by a family member.

Lone working procedures were well established across the teams. All members of staff were provided with mobile phones and signed in and out of the buildings. The trust had a lone working policy in place. Staff were following this at each location we visited. Staff at each location signed out and ensured the service had information on their appointments. Support time recovery worker staff at the East Lancashire restart team used an electronic signing in and out system following each appointment.

Checks on staff whereabouts were carried out by a member of staff allocated including the duty worker or an administrative member of staff acting as a shift coordinator. If there were identified safety risks, or if the person was not known to the service, they would ensure two members of staff attended the appointment. Staff within the teams had a well-known specific phrase that could be texted or telephoned to alert colleagues if they were in danger.

The pharmacy team were proactive in developing approaches to support medicines optimisation in community mental health teams. The trust had completed a pilot study providing clinical pharmacy technician input into the Blackpool team for the first six months of 2016. The technician supported improved recording of patients' current medication and allergy status and identified where additional monitoring needed to be completed for example, for patients prescribed clozapine or lithium promoting safe prescribing practices

Non-medical prescribing formed part of the role of the pharmacists working with community teams in Preston, Blackpool, Blackburn and Burnley. For example, the pharmacist prescriber in Blackpool held clinics in response to referrals from psychiatrists to review prescribing for patients who were taking clozapine, patients prescribed several medicines and patients who had complex physical health problems. The pharmacist also visited patients in their own homes to provide information to support people to better understand the medicines they were taking. This work had not yet been evaluated. Pharmacy staff had developed a business case and key performance indicators to show how pharmacist technicians supported medicines optimisation in community mental health teams.

A recent audit of clozapine carried out across the trust in May 2016 identified the need for improved recording of smoking status due to the effects smoking has on patient's plasma levels. It also recommended that physical health

Are services safe?

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

and side effect monitoring was improved and clearly documented for patients prescribed clozapine. The audit recognised that the number of patients initiated on clozapine in the community was low. This was due to pressures on inpatient services and the lack of community initiation services across Lancashire.

In the East Lancashire restart team, patients were seen by support time recovery workers from the Richmond Fellowship. Staff received basic information for patients referred from primary care and working practices were adapted to manage risks. However, the recording of ongoing risks were not routinely reviewed. For example, one person was identified as presenting with particular risks when first referred in and had been seen by the service on an ongoing basis. There had been no risk incidents and the patient's current risk profile was not reviewed to indicate that there had been no incidents. Managers in the restart team recognised the need for improved risk recording.

Track record on safety

We looked at the incidents data reported by the trust. The trust was required to report serious incidents to the Strategic Executive Information System. The trust reported 118 incidents to this system between 2 April 2015 and 27 March 2016. Of these, 23 incidents related to community mental health services for adults of working age. There were 12 incidents still open on the system. The oldest ongoing incident was dated April 2015 and was regarding a death in custody. These included incidents of expected and unexpected deaths of people receiving services from community mental health teams.

We analysed the data about the 35 significant adverse events in relation to community mental health teams in the period 2 April 2015 to 27 March 2016. Eighty eight per cent (31 incidents) were unexpected or avoidable death or severe harm of one or more patients, staff or members of the public which mainly involved suicide or serious self harm of patients. There were two incidents that prevented, or threatened to prevent, the trust's ability to continue to deliver healthcare services, including data loss, or property damage and one incident of the loss of confidence in the service, adverse media coverage or public concern about healthcare or an organisation and one incident that had not yet been categorised.

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

There was no other significant concerning information highlighted that involved the community mental health services we visited. This was corroborated through the data provided by the trust and by managers in the teams who confirmed that there had not been any significant safety incidents recently.

Reporting incidents and learning from when things go wrong

Staff knew how to raise safety incidents and the types of incidents to report. Incidents were inputted onto the trust's incident recording system. Staff were aware of the need to report the deaths of patients in receipt of community mental health services even when they had not had contact immediately prior to the patient's death.

Incidents and patient alerts were discussed in team meetings, team huddles, complex case meetings and at individual staff supervision to ensure lessons were learnt were properly disseminated.

Staff received feedback and debriefing from incidents within the trust usually from their line manager. Staff who had attended coroner's inquests felt supported by their line managers and wider team members.

Duty of Candour

There had been no significant incidents that met the harm threshold identified in the duty of candour regulations within the community mental health teams for adults. Staff were aware of the need to say sorry if necessary.

The trust's incident reporting system had been updated to prompt staff to identify and report on incidents that met the duty of candour threshold. Staff received information about incidents, lessons learnt and duty of candour from team information boards and regular newsletters.

Managers of the community mental health teams for adults told us that there had not been any recent incidents that met the harm threshold identified in the duty of candour regulations. Managers looked to resolve problems at a local level and carry out an incident review if there had been actual or potential harm to the patient.

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

Assessments and care plans contained up to date, personalised information to support staff to deliver appropriate care and treatment pathway.

Staff worked with GP services as part of the shared care protocols to ensure people received relevant medication and physical health checks.

Patients had a named worker, a written plan of care which outlined the care they would receive and had regular reviews of care. This meant that patients were receiving care under the framework of the care programme approach. Reviews of care were occurring at least annually as required under the care programme approach. This was confirmed by the records we saw and trust data that showed that 99% of patients had received a care programme review in the last 12 months for the period September 2015 to August 2016.

We looked at 30 care records of patients receiving community mental health services; records were stored electronically. Patients had an appropriate assessment which included a risk assessment and an assessment of patients' mental health, their current health needs, and their wider circumstances including their family, employment and financial circumstances. The assessment included discussions about patients' physical and psychological needs and preferences. A written care plan was then developed with the patient to meet their identified needs. The care plans we looked at were regularly reviewed, centred on the needs of the individual patient and demonstrated knowledge of current, evidence-based practice. Care and intervention plans recorded were of a good standard

Care plans were recovery focused as they included patient's strengths, patient identified needs, holistic care and support systems in line with recovery approaches. Observations of care showed that staff clearly recognised the importance of care that met patient needs with the aim to promote well-being, encourage social inclusion and prevent hospital admission.

Best practice in treatment and care

We found evidence which demonstrated staff implemented best practice guidance within their everyday clinical practice. For example, staff were following guidance on

suicide prevention and integrated best practice into their risk assessments. Staff within the early intervention teams were working within National Institute for Health and Care Excellence to promote patient understanding and engagement on first presentation of psychosis. Staff had developed practical guides to treatment pathways for patients within early intervention services which had been published as good practice on the National Institute of Health and Care Excellence website.

The National Institute of Health and Care Excellence quality standard relating to medication aimed to ensure that clozapine was offered to adults with schizophrenia who had not responded adequately to treatment with at least two antipsychotic drugs. The early intervention team audited the use of clozapine within the service as concerns were being raised by the medical team around initiating this medication, which requires high levels of monitoring. The audit recognised that there was limited services in place to initiate clozapine, with community initiation occurring only on a ward in Blackburn and inpatient initiation not always being a realistic option due to the pressure on beds. This audit led to a waiting list being set up for those that required clozapine initiation so that the need could be monitored.

The teams used the Health of the Nation Outcome Scale, a widely used outcome measure of health and social functioning of people with severe mental ill health. Staff assigned service users prescribed clusters in relation to their diagnosis and functioning and reviewed these to track any overall changes in patients' needs. Team managers received a dashboard showing overview cluster information, which included the total number of patients in each cluster type and showed a comparison with similar teams across Lancashire Care. For example the data showed that the Blackpool complex care teams had higher numbers of patients clustered with greater identified needs such as ongoing psychosis with high symptoms and disability and enduring non-psychotic disorders which were disabling. The data also showed whether patients had improved their emotional, social and psychological well-being and psychological disturbance by looking at the factor change between first cluster assessment and last cluster assessment, for last three months. The dashboard showed that there had been a 13% improvement in the factor relating to severe disturbance.

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The Canadian Occupational Performance Measure was used with patients who were assessed by occupational therapists for their level of occupational need and to measure the outcomes of occupational therapy. This was an internationally standardised outcome measure that measured a patient's self-reported experience of occupational performance and satisfaction.

Staff provided interventions to assist patients to manage their mental health distress such as anxiety management, psychological interventions, medication awareness and relapse prevention work. The teams also provided a range of activities and therapeutic interventions to patients to support their recovery including through support time recovery workers who assisted patients with practical issues such as attending the job centre, benefits office or signposting and seeking independent advice. Staff within the restart teams helped patients engage in the community. Staff offered a range of short term interventions including dialectical behavioural therapy and cognitive behavioural therapy as well as formal initial psychology input through psychologists based in the teams. Staff carried out reviews of medication to optimise patients' medical treatment and help patients recover from their mental distress.

Once a patient had been accepted into the services, patients received home visits from a named care coordinator or key worker so that they were seen regularly by the same team members. Patients commented favourably on the continuity of care they received.

Patient's physical health needs were considered alongside their mental health needs. This included monitoring symptoms and alerting the general practitioner or encouraging or making referrals to the appropriate health care professionals. Patients received proactive physical health checks.

The teams had carried out local audits to improve practice. This was most evident in the early intervention teams where there were detailed clinical audits on in relation to clinical record keeping, reviewing the use of clozapine, community treatment orders, and carer's assessments. Other audits that had occurred across other teams included handwashing audit, appointment and patients not attending appointments audit, referral numbers and

wait time audit, and a driving and mental illness audit to look at whether staff were considering and addressing the risks for individual patients with severe and enduring mental illness holding a driving licence.

None of the community mental health teams we visited had applied for accreditation of their service through the Royal College of Psychiatrists' (RCP) recently introduced community mental health team accreditation scheme, which aims to work with teams to assure and improve the quality of community mental health services.

Skilled staff to deliver care

The core community mental health teams consisted of staff from a range of mental health disciplines which included psychiatrists, community psychiatric nursing staff, occupational therapists, psychologists, advanced nurse practitioners, support, time and recovery workers medical secretaries and administration staff. Social workers were also attached to the teams but these were employed and line managed separately.

The community restart team were managed by nurses and social workers but the social inclusion, employment, housing and user development work was carried out by support time recovery workers. The community rehabilitation team was managed by occupational therapy who directly oversaw the work of the support, time and recovery workers providing rehabilitation and reablement.

The nursing staff were experienced band 6 staff. As well as mandatory training, staff could also access specialist training including cognitive behavioural therapy skills, behavioural family therapy training, specialist training to work with people with personality disorder on mindfulness, specialist training by pharmacy colleagues on management of side effects, clozapine training, lithium training. Staff from the early intervention team the service had supported training to develop staff to deliver services in order to meet the National Institute of Health and Care Excellence quality standard for first episode psychosis.

Figures showed that most staff within the teams we visited had an annual appraisal in the last year. For example, 100% of the central Lancashire rehabilitation team and 77% of staff in the Blackpool complex care team had received an appraisal. Staff confirmed that they had received an

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appraisal. Staff felt supported and were aware of took responsibility for their personal and professional development. Staff were committed to providing high quality community care, which met patients' needs.

Multidisciplinary and inter-agency team work

Teams worked together to plan ongoing care and treatment in a timely way through the multidisciplinary meetings. Care was coordinated between teams and services from referral into the service via the single point of access teams through to acceptance into community mental health teams and discharge or transition to another service such as back to the patients' GP. Where possible, the professional holding the care coordination role was determined by patients' needs. For example, if patients needed support with medication concordance they would be seen by a community psychiatric nurse, if their needs were related to daily living tasks, they would be seen by an occupational therapist. Whilst social workers were line managed by and employed by the local authority, staff reported that the multidisciplinary working continued with relevant social work input. When there were social care needs, packages of social care identified or safeguarding matters, social work staff took the lead in considering these.

Staff from across professional groups attended multidisciplinary meetings to collaboratively manage referrals, risks, treatment and appropriate care pathways options. We observed very good multidisciplinary working in the teams during multidisciplinary meetings and handover. Patients under the restart and review teams were also retained on the caseload of the community mental health teams who continued to carry out the care coordination role. Staff with care coordination roles had access to a weekly team information meeting and weekly multidisciplinary clinical discussion meeting where they are able to discuss complex cases with the multidisciplinary team.

Staff within the core community mental health teams operated shared care with GPs and primary care services. The teams linked in with the inpatient services for people who had been admitted to hospital.

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

Staff could request an assessment under the Mental Health Act for people in the community and this would generally be coordinated quickly by an approved mental health

professional. However there were delays in patients from Blackpool being admitted due to the lack of an available bed. This meant that community mental health staff supported patients at home even when it was agreed they needed to be in hospital. This would also include involving the crisis and home treatment team staff to provide more intensive or regular contact.

We looked in detail at Mental Health Act records relating to nine patients on community treatment orders and asked for statistics about adherence to the Mental Health Act for 145 patients on a community treatment order. The records for the nine community treatment orders related to two teams we visited. In the rest of the teams we visited, none of the patients were on a community treatment order.

Records showed that the community treatment order application paperwork was in place, the mandatory and discretionary conditions were clearly recorded, renewals occurred appropriately and the conditions of the community treatment order were monitored.

We found shortfalls in the recording whether community patients have been given information on their rights and informing community patients about their right to receive support from an independent mental health advocacy service whilst on a community treatment order. For example in the Blackpool team, we looked at five out of nine of the records which failed to show that the patient had been informed of their rights in writing and verbally as required by the Mental Health Act.

Figures from the trust showed that 62% of patients (90 out of 145 patients) did not have a record to state their rights on a community treatment order were explained verbally when the community treatment order was initiated. Only 15% of relevant patients (14 out of 96 relevant patients) had their rights on a community treatment order explained verbally on an ongoing basis, for example, at key events such as community treatment order renewal or medicines authorisation as evidenced by the trust's Mental Health Act systems. This meant that we could not be assured that patients on a community treatment order were routinely given information about their rights verbally and in writing when the community treatment order commenced or at regular intervals.

The trust told us that the same percentages of patients had not received a verbal explanation of their rights to receive support from an independent mental health advocate

Are services effective?

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whilst on a community treatment order – so 62% of patients had not had a verbal explanation of their right to advocacy support when the order commenced and 85% of relevant patients had not had a verbal explanation of their right to advocacy support on an ongoing basis when they reached key events such as when the order was renewed.

On the nine records we looked at, there was no clearly recorded evidence that patients had exercised their rights to appeal to either the hospital managers or the first tier tribunal. As records did not clearly evidence whether patients were informed of their rights, we were not assured that patients not exercising their right to appeal was an informed choice.

Trust staff had a duty to refer certain patients to have an independent mental health tribunal to review the appropriateness of remaining on a community treatment order where patients had not applied themselves. The trust told us that there were 39 patients on a community treatment order who were eligible for an automatic referral to a tribunal and of these 28 patients were referred within the statutory timeframe. Eight patients were referred but outside the statutory timeframes and three had not been referred.

There are particular rules about consent to treatment for patients on a community treatment order. In most circumstances, after a month, the patient needs to consent or, if they lack capacity to consent, treatment needs to be authorised by a second opinion appointed doctor arranged by the Care Quality Commission. The Mental Health Act requires that a legal form is completed to show these decisions and the Mental Health Act Code of Practice states that the form should be kept with the medicine chart. This was to ensure that staff and patients knew that the medication was legally authorised when the medication was given. The appropriate legal consent form (CTO11) or second opinion appointed doctor certificate (CTO12) was not routinely kept with the medication cards when patients were on a community treatment order. Systems were not in place for staff to check the medicines prescribed against the corresponding legal authority to administer medication when patients were subject to a community treatment order.

In one case, records showed that one patient on a community treatment order lacked capacity to consent, a second opinion appointed doctor had been requested to

authorise the treatment plan. The request for a second opinion appointed doctor had been made in April but there was no clear record of the second opinion appointed doctor decision or that the second opinion appointed doctor had made any contact. The continuing treatment was not authorised under urgent procedures whilst awaiting the second opinion appointed doctor decision. This meant that one community patient who lacked capacity appeared to receive medication without it being authorised. Following our inspection we asked the trust to check whether there were other similar incidents and they told us that seven patients on a community treatment order had received medication which was not legally authorised.

Mental Health Act training had been determined as essential for a small number of staff within each team. The trust provided figures for the uptake of training for the Mental Health Act for staff and this showed that there was low uptake. For example, in the Blackpool complex care team three staff had been determined to require Mental Health Act training but only one member of staff was up-to-date. The manager in the service also recognised that the Mental Health Act training provided was generic and did not equip staff to understand their responsibilities in supporting patients on a community treatment order.

Good practice in applying the Mental Capacity Act

Overall, we found staff were adhering to the requirements of the Mental Capacity Act. Staff made sure health decisions were made based on mental capacity assessments, or in the best interest of the person.

There was a record and monitoring of mental capacity and consent, when significant decisions were made. For example, when people needed to be brought into hospital, or when there were concerns that patients were making unwise choices such as financial decisions. Staff contributed to best interest considerations where necessary.

Staff had a clear understanding of their responsibilities in undertaking mental capacity assessments, when they were the principle decision maker. Staff could tell us about occasions where formal best interest meetings were held where this was necessary due to type of decision involved. For example, in one team a best interest meeting was held when a patient kept on being taken to the emergency department of the local hospital for repeated infections.

Are services effective?

Requires improvement 

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When we looked at records relating to patients transitioning from children and adolescent services, on two records there were no clear records about the consent status and scope of parental responsibility when patients came into the service prior to the age of 16 during the transition discussions between staff from the trust and the child and adolescent mental health services (which was provided by a different NHS trust). We spoke with the manager of the relevant team and they accepted that there were shortfalls in the recording of the consent status and

scope of parental responsibility when patients transitioned into the service at the age of 16. The manager understood the need to ensure that staff recording in this area improved and would raise this shortfall at the team meeting and at supervision.

The electronic system used by staff to record patients' treatment had a clear section to record and retain records in relation to the Mental Capacity Act, such as advance decisions and best interest decisions.

Are services caring?

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

Our findings

Kindness, dignity, respect and support

We spoke with 22 patients and three carers. Patients gave largely positive comments stating that staff were very caring and treated them with dignity and respect. The only less positive comments we received were from two patients out of 22 who stated that when their care coordinator left or changed jobs, there was a delay in allocating a new care coordinator and they were not always kept informed until a new named worker was identified.

Patients receiving social inclusion support from staff within the restart teams were appreciative of the support they received to improve their mental well-being, get active and increase their confidence. A common theme from the patients about the restart team was that staff had been exceptionally helpful and supportive, much more than any other services patients had accessed.

Patients commented that staff were very flexible and arranged appointments at times that suited them. Patients stated that staff were punctual and phoned to explain any unavoidable delay. None of the patients we spoke with had any concerns nor had any of these patients raised a formal recent complaint.

People had an opportunity to comment on the services they received on comment cards prior to the inspection. We did not receive any comment cards from patients receiving support from the community mental health teams.

We observed staff providing care and treatment to patients including staff within the community rehabilitation team supporting a patient to overcome significant anxiety and ongoing monitoring of patients in the community by community psychiatric nurses and support time and recovery workers. Staff showed caring and compassionate attitudes through all of the interventions we observed. Staff helped patients to reflect on their strengths and the progress they had made in their own recovery goals.

Staff we spoke with had a good understanding of their caseload and were able to identify and talk through the ongoing support they provided to patients. Staff spoke respectfully about patients and their relatives at all times. Staff had a good understanding of confidentiality and asked patients explicitly about what information patients were happy to disclose to other people, including their

relatives and third parties. However, in one team, we did see that the team were supporting a father and son and the records did not have the information sharing explicitly recorded.

The involvement of people in the care that they receive

Patients told us that they were involved in planning their care and had opportunities to discuss their preferences to inform the support and care they received. Staff formulated care plans with patients; in some teams staff used computer tablets during home visits to complete care plans with patients and show patients the completed care plan on the screen.

Patients were able to decide who to involve in their care and decisions about their care, and to what extent. Family, friends and advocates were involved as appropriate and according to the person's wishes. Records showed that people had received a review of their care on at least an annual basis under the care programme approach and had been involved in this review of care.

Whilst most patients told us that they were provided with copies of their care plans, it was not always recorded in their care records whether a copy had been given to, or declined by, the patient. Seven out of the 30 records we looked at did not clearly record that the patient had received a copy of their care plan.

We observed a small number of clinical meetings between staff and patients using the services of the community mental health teams. Consultations were carried out in a participative manner with patients asked to reflect on their progress and recovery. Staff ensured patients' physical health issues were promoted within the meetings.

There were service user involvement initiatives to facilitate patients to comment on services and develop user led community mental health groups, including the employment of service user development workers, service users involved in interviewing community staff and other initiatives that took into account the populations that the community mental health teams worked within. For example, the service user development workers promoted well-being initiatives and were reaching out to different communities.

Are services caring?

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

Patients were asked about their experiences of receiving community mental health services by the trust. We saw suggestion and comments were encouraged with posters and cards displayed in reception areas. However, staff were not always aware of the results of recent surveys.

The Care Quality Commission carries out an annual survey of community mental health patients by sending a questionnaire to patients receiving community mental health services in the trust. At the start of 2015, a questionnaire was sent to 850 patients who received community mental health services at Lancashire Care NHS Foundation Trust. We asked people to answer questions about different aspects of receiving mental health care and treatment in the community. Responses were received from 216 patients who received community mental health services from the trust.

There were no significant issues of concern from the results of the last survey published in October 2015. The trust scored better than expected in one question, which was patients reporting that staff have an understanding how their mental health needs affect other areas of their life. The trust scored about the same as other mental health NHS trusts for all of the other questions including questions on having a written plan of care, staff listening and treating patients with dignity and respect, patients being aware of who to contact in a crisis, and patients

being given enough time to discuss their needs and treatment. In summary, the most recent survey showed that most respondents were happy with the community mental health services they were receiving.

Some teams had carried out audits of service user and carer involvement. For example, the early intervention teams carried out an audit of carer involvement in August 2015. There were positive findings including carers' assessments completed in 94% of cases, with carers' strengths and views discussed in 83% of these. Where appropriate, there were discussions about information sharing with the carer in 80% of cases. The audit recognised the need for better information sharing with GPs about carers' needs, improved welcome packs and better recording of information sharing discussions.

The trust had a participatory action service user research team, called PAR Excellence. They had developed a research project looking at shared decision making and had started to develop a shared decision making resource that included a library of service users sharing their experiences of meeting recovery goals. It was hoped that the findings of the project would influence the shared decision making approach, further resource development and use of service user experiences across community mental health teams once the research was completed in early 2017.

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 community mental health teams accepted referrals from the single point of access teams, inpatient wards, and other trust services and via local GPs. Staff we spoke with stated they had good relations and communication with the single point of access services and crisis services in their area. Patients could not refer themselves directly to the community mental health teams and needed to be referred by professional staff such as a GP or by the ward staff. There were systems to triage referrals based on the individual needs of people who used the service. New referrals were triaged by a duty worker each day to check whether they needed to be seen urgently or accepted as a routine referral. The initial assessment evaluated patient's needs and the care and treatment options available to them. Most patients were assessed within three weeks from referral with more urgent patients being seen much sooner. For example, 72% of patients referred into the Blackpool complex care team were assessed within three weeks of the referral.

Patients had timely access to care and treatment with no significant waiting lists. The trust and the teams monitored referrals that were unallocated, especially those that remained so after two weeks. The data provided by the trust showed a much improved picture in managing referrals and allocating a care coordinator. When we visited in April 2015 there were 243 patients awaiting a care coordinator across the early intervention teams this had reduced to 24 patients across all the early intervention teams in August 2016, with a consistent reduction being sustained for the last 11 months. The Blackpool complex care team and the Hyndburn, Ribble Valley and Rossendale team had 15 patients each awaiting allocation of a care coordinator at the time of the inspection in September 2016.

The early intervention teams had a standard of two weeks from referral to treatment and the key performance indicator stated that this target should be reached in at least 50% of cases. Figures provided showed they were exceeding this target for the last six months with an average of 74%; the highest percentage in any given month was in June 2016 with 87% and the lowest was 62% in February 2016.

Staff could respond promptly if there was a sudden deterioration in a patient's mental health, either directly or

through contact with staff from crisis teams. Staff explained that they could be flexible with patient contact times to meet patients' needs; patients confirmed this. Patients received timely access to a consultant psychiatrist at short notice if they required specialist medical assessment or input. Patients confirmed that they did not have to wait to see a psychiatrist when required.

Patients told us staff were punctual and they had not experienced cancelled groups or appointments. Staff attempted to engage people who missed appointments, mainly by phone calls and letters. If there was no contact without an explanation, staff would carry out a proactive home visit and, where appropriate, request that the police carry out a welfare call. If patients were discharged as they no longer accessed the service, the patient's GP and the referrer would be informed.

Staff within the community mental health teams had good links with the crisis services and acute wards to make sure that people who used services were admitted to and discharged from hospital when clinically appropriate. There were occasional incidents of miscommunication with patients discharged without care coordinators being fully involved. Aftercare support was agreed and patients were followed up within seven days. The data from the trust showed that staff were exceeding the 95% target for carrying out follow-ups within 7 days of discharge from hospital, with eight out of twelve months from September 2015 to August 2016 showing 100% adherence and an overall rate of 97%. There were good patient flows with access in and discharge out into primary care when patients did not require specialist secondary mental health services.

The assertive outreach function was incorporated into the duties of staff within the complex care teams. The early intervention service had a protocol for managing disengagement. Patients were not discharged solely for disengaging or failing to keep a fixed number of appointments.

Staff made reasonable efforts to stay in touch with patients work at developing a relationship that enabled increased engagement. As part of the assessment, staff discussed with patients and carers to agree what action to take and the risk management plan in the event of patients disengaging early or over the longer term. There were clear processes for the planned transfer of care when patients under the early intervention services required secondary

Are services responsive to people's needs?

Good 

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

services after three years or required transfer to primary care. Patients requiring long term rehabilitation received appropriate intensive support from the community rehabilitation teams.

Staff at the Blackpool complex care team worked with a significant proportion of temporary visitors and holiday makers to the town. Staff liaised with the patient's home mental health services and ensured they received appropriate care and treatment directly or through liaison.

There were delays in patients accessing a bed in Blackpool and staff had to manage patients' risks in the community until a bed became available.

When we inspected in April 2015, we issued a requirement notice, which related to safe care due to the lack of proper arrangements around the transition of patients between child and adolescent mental health services and community mental health services for adults of working age.

The trust provided an action plan telling us how they would improve the arrangements including action to introduce a new protocol and auditing arrangements. On this inspection, we found there were improved arrangements for managing the transition from children and adolescent mental health services to adult mental health services. There was improved joint working when patients were in transition from children and adolescent mental health services to adult mental health services. We case tracked patients who had been transferred from children and adolescent mental health services into adult services and saw that there was appropriate liaison between the two services. We looked in-depth at two patients' files where transition had started or had occurred since June 2016 and these showed that joint care coordination occurred and appropriate communication between the two services. In one case, records did not clearly state why the patient was not involved in the transition meetings, although the patient's mother attended.

The transition protocol was being reviewed by the trust together with other relevant agencies. The transition protocol included standards expected on involving young people and families, collaborative working between services, shared planning, effective communication and information sharing. Monthly transition meetings were beginning to be convened in each locality, with attendance from identified leads in order to discuss young people who

have been identified for transition. We saw that teams had identified leads. For example, there was a community psychiatric nurse in the Blackpool complex care team who had received training on children and adolescent mental health and they carried the caseload of transitioned patients.

The trust commissioned an external review to seek assurance over the improvements to the transition arrangements between children and adolescent mental health services to adult mental health services. The review was carried out by an NHS internal audit team external to the trust, in the summer of 2016.

The review considered the effectiveness and awareness of the transition protocol by both front line staff and service users. The review analysed seven service users who were due for transition from children and adolescent and adult mental health services to determine staff awareness and application of the new protocol. The audit team also devised a questionnaire to capture a sample of young people's views on their transition but the results of this were not yet available.

The audit confirmed that transfer of care documents were available in six out of seven files, evidenced discussion with the transition lead in all but one case and where it was agreed that transition was appropriate a joint meeting was held in 100% of cases. This meant that improvements had been made with significant assurance given to the board by the reviewing team. The report did highlight some shortfalls and made five recommendations. Out of seven care records, only one had fully documented discussions with the young person and their family on the proposed transition. It was not clear from the records if consent to share information had been gained from the young people and their families. There were also recommendations on developing an inpatient transition protocol and changes to the transfer of care document to provide improved accountability. The trust accepted the recommendations and senior managers were working to address the shortfalls.

The facilities promote recovery, comfort, dignity and confidentiality

Staff in the community mental health teams provided a range of flexible support to patients dependent on their needs. This included telephone contact and face to face visits with people in their own homes, at team bases or at other venues as appropriate. Patients commented that

Are services responsive to people's needs?

Good 

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

staff were very flexible and arranged appointments at times that suited them. Patients stated that staff were punctual and phoned to explain any unavoidable delay. Some patients utilised text message contact with staff from the community mental health staff where this was appropriate, for example for appointment reminders and depot medication prompts.

Staff saw patients in buildings that were well maintained, clean and had appropriate furniture. Rooms were available for individual consultations. Information leaflets were available in reception areas, which provided a full range of information on Mental Health conditions, services, treatment options and wider social support and well-being services.

Care plans showed that staff considered patients' holistic needs and did not just treat their mental distress or illness. For example, care plans showed staff supporting patients with major changes and life events, money and benefits issues, family dynamics and education and volunteering. This was particularly evident with the recovery and rehabilitation teams. The East Lancashire restart team had a housing worker integrated within the team to keep patients in their homes through supporting them to pay their rent or mortgage, manage the upkeep of their home, keep within any housing agreement and other housing related support.

Meeting the needs of all people who use the service

The team premises were accessible to patients with physical disabilities, with level or ramped access into the buildings and accessible toilet facilities. Parking included designated parking bays adjacent to or very near to buildings so that patients with limited mobility did not have to walk far to be seen. Interview rooms were available on the ground floor.

Staff respected people's diversity and human rights. Staff made good attempts to meet individual patient needs including cultural, language and physical needs. For example, on a home visit we saw staff using pictures to discuss recovery objectives for one patient with reading difficulties. Interpreters were available to staff if required when patients' first language was not English. Patients' individual needs were taken into account and respected as demonstrated by the content of the care plans and our observations between staff and patients.

The restart teams had developed links with the local community groups to signpost recovery and promote social inclusion to patients. These included reaching out to south Asian communities. Social inclusion teams worked to ensure people's holistic needs were met and worked with hard to reach groups in innovative ways to promote mental well-being. For example, the restart team had developed a football league called the inclusion league which was developed in conjunction with Lancashire football association. This helped to engage people in their local communities and get involved in sport. Following a small settlement of people displaced from Syria, staff from the recovery service had established links and invited people to attend this local league football team to promote well-being and encourage participation and awareness of services available. The restart team were also working with a charity working with south Asian women to try and reduce their dependency on primary care services and approach secondary mental health services.

Listening to and learning from complaints

The community mental health teams across Lancashire had received 587 compliments during the last 12 months, which had been recorded formally at trust headquarters. The Burnley and Pendle restart team received the most with 79 compliments, followed by the Hyndburn, Ribbles Valley and Rossendale community mental health team with 51 compliments.

Lancashire's community mental health teams had received 242 complaints from patients from 1 April 2015 to 31 March 2016. These included complaints against 41 different teams or sub teams which included complex care teams, the improved access to psychological therapies service, and single point of access and hospital liaison functions. Of these complaints, the improved access to psychological therapies received 52 complaints. Fifty two out of 242 complaints were upheld and 81 were partially upheld. One complaint had not been resolved and had been referred to the health service ombudsman and was still being considered by the ombudsman at the time of our inspection

The team with the most complaints were the complex care and treatment teams with 133 complaints. The Blackpool complex care team had received 16 complaints. Out of 242 complaints, 46% (112) related to communication problems. Of these types of complaints, 25% were upheld and 54% were partially upheld.

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Where complaints had been raised, we saw that the trust had worked to resolve these complaints.

Complaints and concerns that people had raised were discussed at team meetings. We found evidence to show that managers had taken timely action in response to complaints they had received. For example, there was one case where a change in care coordinator was accepted due to a breakdown in the patient staff relationship. Complaints were well managed.

We spoke with 22 patients. None of these had any concerns nor had any of these patients raised a formal complaint. Two patients did state that when their care coordinator left or changed jobs, there was a delay in allocating a new care

coordinator and they were not always kept informed until a new named worker was identified. Patients told us that they would be happy to ask their care coordinator for information about complaints if they were not happy with any aspect of the service they received. Patients knew how to raise concerns and were given written information about making complaints as part of an information pack. Information on complaints and the patient advice and liaison service were also available in reception areas.

Staff were aware of the trust's complaints procedure and where it could be accessed. Staff were committed to resolving complaints and preventing complaints from occurring.

Are services well-led?

Good 

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

Our findings

Vision and values

Lancashire Care NHS Foundation Trust had the following vision:

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

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

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

The trust expected all staff to show these values by:

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

The trust's vision and values were clearly displayed throughout the reception and team offices of the community mental health teams. This helped patients to understand the care they should expect when receiving community mental health services. Patients commented on the positive care they had received from compassionate, caring staff which was in line with the trust's values.

Staff understood the trust's vision and values. The vision and values were visually represented as a rainbow which helped promote staff awareness. Discussions with staff in groups and individually showed that staff showed commitment to providing high quality patient-centred care.

However, on occasions, care could not always be delivered in the right place as prescribed in the trust's vision. This was due to pressure on inpatient mental health beds leading to delays in patients being admitted or by being treated out of area. For example, one patient we spoke with was admitted to four separate hospitals, including three out of area hospitals, due to the lack of an available local bed.

Good governance

Teams had clearly written standard operating procedures that prescribed how the team would operate and identified expectations on staff when communicating internally with other teams and externally to other health services such as primary care. The standard operating procedures had key performance indicators. For example, the procedures for the community mental health teams included allocation of a named worker within one day of transfer/referral, face-to-face contact within two weeks of transfer/referral, outcome of request for input to be communicated to the original referrer within five working days, all service users having a care plan and risk management plan and all service users having as a minimum an annual review of their care programme approach care plan. Team managers had dashboards and data, which showed how the staff within the teams were meeting these key performance indicators.

The trust had a well-established experts by experience programme that contributed to ensuring service users had a voice in terms of influencing the running of services through the governance arrangements. Experts by experience members had meaningful influence on the running of all the community mental health teams through their involvement in the community mental health redesign. Experts by experience commented on all the new standard operating procedures under the community mental health redesign, as members for the clinical and operational oversight group. Experts by experience had also been involved in developing recommendations around excellent care planning and priorities for focus following our community mental health survey results. These include the development of a new approach to giving the public information about the trust's services (and particularly the role of crisis teams), and a service user charter. Experts by experience members were working to develop a local experts by experience group in each area

Performance data about the teams were displayed on team information boards. Performance was discussed during a team 'huddle' meeting and monthly team meetings.

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Managers had good oversight of their team performance and data was readily available to understand whether staff were meeting the standards expected of them including number of contacts, care plan reviews, seven day follow ups and care programme reviews annually.

There was improved quality of data collated on the performance of the community mental health teams compared to when we last inspected. In one team we visited, the dashboard used by managers to oversee the work of individual staff had not pulled through one piece of data accurately from the electronic patient recording system. We were therefore concerned that the data which managers relied upon to manage staff performance may not always be accurate. On the day of the inspection, the manager agreed to look into this to see if this was an isolated incident or a wider problem and agreed to take appropriate action.

The early intervention team managers produced an operational delivery report that was discussed in team meetings which clearly evidenced that team performance and data was discussed to drive up standards. The early intervention team meetings also clearly showed that policies and audits were discussed to improve patient care and individual staff practice. In other teams staff felt that they were asked to produce data but did not receive any details of analysed data back from managers or at team meetings. In addition, staff were not always informed of audit results and the recommendations to embed service improvements and quality initiatives. For example, staff were not cited on the team's friends and family test results or on recent audits such as medicines audits on the use of clozapine.

Team managers told us that they felt well supported by their line managers and had sufficient autonomy to manage teams effectively. Managers were able to submit risks to locality and network risk registers. The impact on bed reductions on community mental health teams and capacity issues within the Blackburn and Darwen and Fylde and Wyre community mental health teams were on the network risk registers. This was a much improved position from when we last inspected in April 2015 when there were many more teams on the risk register for capacity issues as well as the risks associated with the overall impact of the community services review that was occurring at that time.

Leadership, morale and staff engagement

When we last visited the trust, the community mental health services were undergoing a community service review, which led to uncertainty and lower morale. The review was largely completed and changes to teams had been implemented. We did not hear any significant concerns about the changes in terms of staff engagement, support or structures. Morale was improved following most changes being implemented from the community service review.

Each team was well-led by committed managers. Managers reviewed individual and team performance. For the teams we visited, there were no staff on formal suspension or formal supervised practice. Across all of the trust's community mental health services, there were five staff on formal suspension or formal supervised practice between April 2015 and March 2016.

Staff felt respected, valued and supported by their managers and their peers. Staff told us that teams worked well together. Staff felt they were well managed locally with an appropriate level of support and challenge. Team managers felt supported by service managers. Teams were well managed to support staff to deliver good quality of care. Staff told us that they could raise concerns without fear of victimisation and were confident that local managers would take their concerns seriously.

Commitment to quality improvement and innovation

The early intervention service had developed a visual representation of the early intervention service clinical pathway. This was developed through collaboration with the staff and patients to understand best practice approaches and how treatment could be delivered in accordance with the National Institute for Health and Care Excellence guidelines and quality standards. This had been published on the National Institute for Health and Care Excellence website. This helped guide staff on providing holistic care and treatment to patients experiencing a first episode of psychosis.

None of the community mental health teams we visited had applied for accreditation of their service through the Royal College of Psychiatrists' (RCP) recently introduced community mental health team accreditation scheme which aimed to work with teams to assure and improve the quality of community mental health services.

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The community restart team in central Lancashire were shortlisted in the Nursing in Mental Health category within the Nursing Times Awards 2016 in recognition of their philosophy of moving away from traditional day centre models to a social inclusion model that helped people with

mental health problems develop and maintain supportive networks with other people in their local communities to promote their recovery, and sustain that recovery more effectively.

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

Treatment of disease, disorder or injury

Regulation

Regulation 9 HSCA (RA) Regulations 2014 Person-centred care

Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Person Centre Care

Registered Location: Sceptre Point

The trust were not always providing person centre care to patients on a community treatment order in breach of Reg 9 (1) (a), (3) (g) and (6).

How the regulation was not being met:

- Patients on a community treatment order were not provided with information they would reasonably expect as they were not getting information on their rights as required under s132A of the Mental Health Act
- Patients on a community treatment order were not provided with given information on their right to an Independent Mental Health Advocate as required under s.130D of the Mental Health Act as a qualifying patient;
- Patients were not always automatically referred to a mental health tribunal in the prescribed statutory time periods.
- Care and treatment was not provided in accordance with Part 4 of the Mental Health Act. There were seven community patients without legal authorisation of their treatment plan.
- Systems were not in place to include legal certificates on medicine charts for community mental health team staff to check when administering medication for mental disorder to a patient on a community treatment order.