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	Morecambe Community Mental Health Teams	LA4 5QG
RW5HQ	Sceptre Point	Lancashire and Morecambe Single Point of Access	LA4 5QG
RW5HQ	Sceptre Point	North Lancashire In-reach Team	LA1 3JT
RW5HQ	Sceptre Point	East Lancashire Community Rehabilitation Team	BB4 6NW

Summary of findings

RW5HQ	Sceptre Point	Central and East Lancashire Community Rehabilitation Gateway Team	BB4 6NW
RW5HQ	Sceptre Point	Preston West Strand Clinical Care and Complex Treatment Team	PR1 8UY
RW5HQ	Sceptre Point	Preston West Strand Single Point of Access Team	PR1 8UY
RW5HQ	Sceptre Point	Blackpool Early Intervention Team	FY2 0JW
RW5HQ	Sceptre Point	Wyre Community Mental Health Team	FY7 6AH
RW5HQ	Sceptre Point	Wyre Single Point of Access	FY7 6AH

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	Requires improvement 
Are services safe?	**Good** 
Are services effective?	**Good** 
Are services caring?	**Good** 
Are services responsive?	**Requires improvement** 
Are services well-led?	**Requires improvement** 

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 gave the overall rating for community-based services as requires improvement because:

- The number of staff that had not completed mandatory training was below expected levels. This had the potential to put people who use the service and staff members at risk.
- There were concerns expressed by staff and reflected in the services risk register over the capacity of teams.
- We identified concerns over the transition of young people from CAMHS. The trust had a protocol in place however this was not being followed consistently and was out of date.
- We identified concerns over the ability of services to manage young people when they transfer from CAMHS at the age of 16. The trust recognised these issues. Actions had been agreed and a CQUIN target was associated the delivery of the action plan.

However:

- Services were being delivered in line with adherence to the Mental Health Act 1983, the Code of Practice and the Mental Capacity Act 2005. Capacity was being assessed on admission and was reviewed as required. Appropriate risk assessments and paperwork was in place for individuals on community treatment orders. Staff displayed a good knowledge of both the MHA and MCA. However the level of staff training on these areas was below expected standards.
- Systems were in place to monitor and manage risk. Escalation procedures for urgent referrals were in place. Assessments were carried out in a timely manner, reviewed and reflected in care plans. Safeguarding was embedded within the service. Staff displayed a good understanding of their roles and responsibilities in this regard.
- Feedback from people who use the service was positive. We observed people who use the service being treated in a respectful manner and with a caring and empathetic approach. We saw evidence of involvement in their care and decisions over treatment. Where families and / or carers were involved their opinions and views were also reflected. However it was not clear that people who use the service were routinely offered a copy of their care plan.
- Processes were in place to monitor performance. Regular governance meetings were held and performance data was on display in teams. Teams used a Quality SEEL tool to assess performance and generate improvement. However there were no KPIs in place for the single point of access services. We were told these were being developed.

Summary of findings

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

Are services safe?

Good

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

- Comprehensive risk assessments were in place and were regularly reviewed.
- There were good processes in place to support the identification and reporting of safeguarding concerns.
- There was a lone worker policy in place that staff understood and adhered to.
- Staff received feedback from incidents and investigations and adjusted working practices.
- Buildings accessed by people who used the service were well maintained and fit for purpose.

However

- The number of staff who completed mandatory training was below expected standards. This had the potential to put people who use the service and staff at risk.
- Reception staff had not all completed conflict resolution training.

Are services effective?

Good

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

- Pre-admission and ongoing assessments were in place in each record we reviewed. The assessments were of a good standard and there was evidence of regular reviews.
- Care plans were in place and were reviewed
- Services were meeting CPA targets
- There was evidence in care plans that physical health care was being monitored and that annual checks were occurring.
- Staff followed NICE Guidance and there was a programme of audit to support this.
- Teams were multi-disciplinary in nature and staff had access to relevant professions.
- Staff received supervision. However in some cases this was six weekly.
- People who use the service had access to psychological therapies within community teams. However there were waiting lists in place.
- Practise was in line with the Mental Health Act and Mental Capacity Act. However not all staff had received training.

However

Summary of findings

- Staff told us that they received annual appraisals but this was not reflected in data provided by the trust. Only 59% of non-clinical staff had a performance appraisal in the last 12 months.

Are services caring?

Good

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

- The feedback we received from people who used the service was positive. People who used the service and their carers reported they were happy with the service they received. One individual had not had a positive experience and was going through the complaints procedure.
- Staff treated people who used the service with kindness, dignity, respect and compassion. Staff took the time to listen to individuals and to understand their needs. People who use the service were given space and encouragement to express their opinions. These were listened too and acted upon by staff.
- Carers we spoke to felt they were involved in decisions around treatment and care. Carers we spoke to felt supported.
- There were mechanisms in place to capture feedback from people who used the service. The findings from feedback were discussed and considered by teams.

However

- It was not clear the people who used the service were routinely offered a copy of their care plan.

Are services responsive to people's needs?

Requires improvement

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

- There was evidence that the transition from CAMHS to adult mental health services was not working effectively. The transition protocol was not being followed consistently and was out of date.
- We identified concerns over the ability of services to manage young people when they transfer from CAMHS at the age of 16. The trust recognised these issues. Actions had been agreed and a CQUIN target was associated the delivery of the action plan.
- At present there are no KPIs in place specific to single point of access services. However these were being developed.

However

Summary of findings

- The services had processes in place to identify and escalate urgent referrals.
- The SPoA teams were seeing 86% of referrals within their target timescale.
- Buildings were clean and well maintained.
- The service had access to translation services including face to face translation.
- Processes were in place to engage with individuals who found it difficult to engage with mental health services

Are services well-led?

Requires improvement 

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

- There were concerns over team capacity on the services risk register. These were also raised by staff in Morecambe CMHT, Lancashire and Morecambe SPoA, Preston West Strand CCTT and Wyre CMHT. This meant that staff were not able to maximise their time and engage effectively with professional development.
- Mandatory training compliance in some teams did not meet the trust target.
- Supervision sessions in some teams were not happening with regular frequency.
- There was no automated monitoring tool or reports for referral to assessment or treatment within CMHTs and CCTTs.
- A lack of clarity about the future configuration of community services had created a high number of temporary/acting up team leadership positions and caused a level of insecurity amongst team members.

However

- Staff were aware of the trust's vision and values
- There were monthly governance meetings and evidence of ongoing monitoring of performance.
- Staff felt supported at a local level.
- There was evidence that change had been initiated following adverse incidents.
- The service had undertaken engagement with staff over the service redesign. However not all staff felt involved.

Summary of findings

Information about the service

Lancashire Care NHS Foundation Trust provides community adult mental health services to adults of a working age across Lancashire.

The adult mental health network is split into three localities. 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. Each locality has its own governance arrangements.

Community services provided within each locality include single point of access, community mental health teams and complex care and treatment teams (CCTTs). Assertive outreach functions are built into the CCTTs.

There are also community rehabilitation and restart services as well as services that work with people living in supported housing. The service also provides Improving Access to Psychological Therapies (IAPT) in the east, central and north (excluding Blackpool) localities.

One of the teams we visited, the Blackpool early intervention service has strong operational links with the adult mental health network but organisationally it is based within the children and families network.

Our inspection team

Our inspection team was led by:

Chair: Peter Molyneux, Chair, South West London and St George's Mental Health NHS Trust

Head of Inspection: Jenny Wilkes, Care Quality Commission

Team Leader: Sharon Marston, Care Quality Commission

The team which inspected this core service comprised three CQC inspectors, a Mental Health Act reviewer and four specialist advisors consisting of two mental health nurses, a social worker and an occupational therapist.

Why we carried out this inspection

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

How we carried out this inspection

To 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.

As part of the inspection we carried out announced visits too:

Morecambe community mental health team (CMHT)

Lancashire and Morecambe single point of access service (SPoA)

North Lancashire in-reach team

East Lancashire community rehabilitation team including the gateway service

Preston West Strand CMHT

Summary of findings

Preston West Strand SPoA

Blackpool early intervention service (EIS)

Wyre CMHT

Wyre SPoA

During this inspection we:

- spoke with 14 people who used the service, three of whom we visited in their homes
- met with 48 members of staff from a range of disciplines and roles
- spoke with three carers or relatives.
- reviewed 16 care records of which we case tracked six.
- observed seven clinical engagements including two CPA reviews.
- attended one handover meeting and one daily team huddle.
- reviewed management records and minutes of team and locality meetings

What people who use the provider's services say

During this inspection we spoke with 14 people who use services and three carers or relatives. We also observed seven clinical engagements.

The majority of feedback from people who use services on their experience was positive. People who use services were complimentary towards staff and considered them to be caring and empathetic. Our observations of staff interaction with people who use the service were positive. Staff engaged with people who used service in a respectful manner and provided space for them to express their opinions. Carers that we spoke to were also very positive about the service they had received.

Although one person who used the service that we spoke to was unhappy with his care. He had submitted a complaint and been supported to do so. He was awaiting a response at the time of the inspection.

Good practice

Areas for improvement

Action the provider MUST take to improve
Actions the provider MUST take:

- The trust must ensure that there is a protocol in place 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.

Action the provider SHOULD take to improve
Actions the provider SHOULD take:

- The trust should ensure that all staff receives mandatory training line with trust policy including training on the Mental Health Act and Mental Capacity Act.
- The trust should ensure that people who use the service are offered copies of their care plans and that this is recorded.
- The trust should ensure the full implementation of actions detailed in the CAMHS Transition CQUIN. This will ensure that the adult mental health service is able to meet the needs of young people transferred from CAMHS at the age of 16.
- The trust should ensure ongoing consultation and feedback around the community services review. This will help address uncertainty within teams and staffing groups.
- The trust should ensure that annual appraisals take place for staff including non-clinical staff. This will support existing supervision arrangements to ensure staff are appropriately supported and are able to develop professionally.
- The trust should ensure that appropriate KPIs are developed for single point of access services. This will help ensure that the service is running effectively.

Summary of findings

- The trust should review caseloads for each team to ensure that staffing consistently meets need and staff rotas factor in time for training and personal development.

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
Morecambe Community Mental Health Team	Sceptre Point
Lancashire and Morecambe Single Point of Access	Sceptre Point
North Lancashire In-reach Team	Sceptre Point
East Lancashire Community Rehabilitation Team	Sceptre Point
Central and East Lancashire Community Rehabilitation Gateway Team	Sceptre Point
Preston West Strand Clinical Care and Complex Treatment Team	Sceptre Point
Preston West Strand Single Point of Access Team	Sceptre Point
Blackpool Early Intervention Team	Sceptre Point
Wyre Community Mental Health Team	Sceptre Point
Wyre Single Point of Access	Sceptre Point

Detailed findings

Mental Health Act responsibilities

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

Staff we spoke to understood their responsibilities with regards to the Mental Health Act (MHA). The teams we visited delivered care in line with the MHA and the MHA Code of Practice. Appropriate risk assessments and care plans were in place for patients subject to a community treatment order (CTO).

Training on the MHA was not mandatory for all staff. Compliance with training was varied across the service. Across CCTTs only 37% of staff identified as requiring level two training had received it. Staff had access to advice and support from within the trust.

Mental Capacity Act and Deprivation of Liberty Safeguards

Staff we spoke to understood their responsibilities under the Mental Capacity Act (MCA) and were able to articulate key principles. Care records we reviewed showed that capacity had been considered during the assessment process and recorded appropriately. Staff had access to advice and support from within the trust. However compliance with training around the MCA and Deprivation of Liberty Safeguards (DoLS) was varied across the service. Across the CCTTs 87% of staff had completed level one training. Only 47% had completed level two training.

Good

Are services safe?

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

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

Summary of findings

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

- Comprehensive risk assessments were in place and were regularly reviewed.
- There were good processes in place to support the identification and reporting of safeguarding concerns.
- There was a lone worker policy in place that staff understood and adhered to.
- Staff received feedback from incidents and investigations and adjusted working practices.
- Buildings accessed by people who used the service were well maintained and fit for purpose.

However

- The number of staff who completed mandatory training was below expected standards. This had the potential to put people who use the service and staff at risk.
- Reception staff had not all completed conflict resolution training.

Our findings

Safe environment

People who used the service were seen by staff in six of the eight team bases we visited. Of the other two teams, one team rarely saw individuals at their base and the other team did not see people who used the service at their base in Ridgelea House at all. People who used this service were seen in their supported accommodation. With the exception of Ridgelea House, which was on the trust's estates risk register, all the buildings were well maintained and clean. Interview rooms had alarms fitted and appeared fit for purpose.

We spoke to administration staff at the Preston West Strand site. The site hosts a complex care and treatment team (CCTT) and a single point of access team (SPoA). The building is accessed by people who use the service.

Administration staff in the building had been placed on a rota to man the reception. Staff told us that they sometimes felt vulnerable when dealing with individuals who may be aggressive or emotional. Staff told us they had not received training to support them in this role. Mandatory training records provided by the trust identified that none of the ten administration staff based in the building had completed conflict resolution training although it was identified as a required need. We also spoke to one staff member who was a designated fire warden. However they had not received the required training.

Staff from the teams we visited also saw individuals in their own homes and in other community settings.

We checked the clinic rooms at the teams we visited. They all had the necessary equipment needed to see individuals within the community. We checked and found that equipment was maintained and checked on a regular basis.

Safe staffing

We looked at the staffing levels of each team we visited in order to ensure that they met the needs of people who use the service. Of the teams we visited, staff raised concerns about staffing in Preston CCTT, Morecambe SPoA and the Wyre community mental health team CMHT. These concerns related to not having enough staff and being unable able to recruit to vacancies quickly. This increased caseload size and in some cases caused waiting lists, meaning that some staff only had time to see the most vulnerable individuals. Similar staffing concerns were identified on the team's network risk register about Blackpool, Lancaster and Morecambe CCTTs.

There was also a lack of clarity about future plans for community services that caused staff to feel insecure about their existing roles. Many of the teams we visited were being managed by people on a temporary and/or interim basis. Many of these concerns had been raised with the adult mental health network managers and were included on the network's risk register.

Care coordination was provided by staff in CMHTs and CCTTs. The rehabilitation teams did not care coordinate the

Good

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individuals they worked with, but instead liaised with their care coordinators in CMHTs and CCTTs as appropriate. SPoAs did not carry caseloads for the purpose of care coordination.

The trust monitored caseloads, across and within teams, using payment by results cluster information. However, the network risk register included actions to review the caseloads of some teams. The majority of the teams we had caseload data for appeared to have caseloads set below the Department of health policy implementation CMHT guidance of 35. However staff expressed concerns that the acuity levels and complexity of people who used the service were much higher than it had been. Some care coordinators had caseloads over 35 and data supplied for the Wyre CCTT and Preston CCTT indicated that average caseloads would be around 40 for some team members. In the Wyre community team, the team manager and deputy were carrying large caseloads in order to increase team capacity and reduce waiting lists. Changes to the location of some trust inpatient beds also impacted on community teams, as staff spent more time travelling to see individuals on their caseload.

Information provided by the trust showed that there were variable levels of compliance with mandatory training. The trust has a target of 85% compliance with its mandatory training programme. However this was not being met in all areas. For example in Wyre CMHT conflict resolution was 59%, fire safety 65%, infection control 59%, manual handling 31% and basic life support 19%. In the Lancashire and Morecambe CCTT conflict resolution training was 44%, infection control was 40% and basic life support was 28%. In the Preston CCTT conflict resolution training was at 83%, fire safety 63%, manual handling 63% and basic life support 59%

Actions were being put into place to increase mandatory training compliance and ensure six-weekly supervision. However some teams had allocated protected time for training and personal development.

Concerns were also raised by staff struggling to keep on top of updating care plans and they said they would have liked more time to plan proactively rather than deal with things reactively as was the case at the time of our visit. One member of staff said that they 'had no head space to think'.

These concerns had been reported to senior managers, and we noted (from reviewing network risk registers and meeting minutes) that actions were being taken in order to address capacity problems.

Assessing and managing risk to people who use the service and staff

People who used the service had a risk assessment in place which was recorded on the trust's electronic care records system. A risk management plan was produced and updated in response to patient's presentation, or at every 12 months as part of a review. There was also a 'flag system' on the electronic records to highlight a risk which could be used during caseload allocation.

For example, an individual posing a risk to a female member of staff would be allocated to a male. Staff adhered to the trust's lone working policy. All teams recorded who they were visiting, and this was monitored. If the risk indicated it, staff would visit in pairs.

Staff working in SPoA teams also used the skills-based training on risk management (STORM) risk assessment tool in order to identify the risk of suicide and escalate urgent cases. However, we were told that no assessments for identifying risk of violence and aggression were made. The SPoA used a triage system based on risk in order to respond to referrals.

In the Blackpool early intervention service, risks were discussed and reviewed in their daily team meetings. Care coordinators also discussed risk and changes in presentation with colleagues from the crisis team.

We reviewed 16 care plans and found that they all had initial risk assessments completed. However, one record had an out of date risk assessment that had not been reviewed within an appropriate timeframe**.**

In order to respond to sudden deteriorations in the health of people who use the service, Morecambe SPoA had introduced urgent daily appointments. The Wyre CMHT had introduced additional appointments specifically for people who were at risk of relapsing; this meant they could provide more intensive support at a time when individuals needed it.

Safeguarding training was mandatory and community teams had appointed a staff member in each team to be

Good

Are services safe?

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their safeguarding champion. As of January 2015, 84% of staff across the adult mental health network had completed safeguarding adults training, and 89% had completed safeguarding children training.

The east Lancashire community rehabilitation teams were using their quality SEEL to identify additional training needs and would use protected learning time to address any identified requirements. The quality SEEL is a self-assessment tool covering safety, effectiveness, experience and leadership. They also included safeguarding concerns as part of their daily handover meetings. The SPoA at Preston West Strand, also used their quality SEEL to identify a need for further safeguarding information. Services had identified the need for, and began delivering specific training to improve staff knowledge and awareness around risks such as child exploitation, female genital mutilation and forced marriage. Morecambe SPoA and east Lancashire rehabilitation team worked collaboratively with their local authorities around safeguarding. Overall, staff demonstrated that they understood the trust's safeguarding policy and knew who to contact if they needed additional help, advice or support.

Track record in safety

In the 12 months from December 2013, there had been 57 reported serious incidents in community teams.

We reviewed information supplied by the trust and identified that manager and post incident reviews had been completed into serious incidents. We reviewed one post incident review which had been completed following a serious incident and found specific recommendations for both community teams to improve their practice, and considerations for how lessons could be learnt from a corporate perspective. The incident concerned a homicide and learning around engagement and communication had been embedded

Reporting incidents and learning from when things go wrong

Staff at LCFT used a web based risk management system called Datix, and reported all incidents on this system. The policy of the trust was to report all incidents within 24 hours. An incident policy had been ratified by the trust in May 2015, and outlines procedures, roles and responsibilities with regard to incident reporting and management.

Of the staff we spoke to, it was clear they knew how to report incidents and what their roles and responsibilities were with regard to this. They demonstrated an open and transparent approach to discussing incidents and the impact this has had on their working practices.

The trust used green light/blue light safety alerts which were shared with staff via emails; these were used to disseminate learning from incidents across the trust. Team leaders also told us that they used their team meetings to share information and learning from incident reviews. Where staff had been directly involved in an incident, additional support could be provided.

Are services effective?

Good

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

Summary of findings

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

- Pre-admission and on-going assessments were in place in each record we reviewed. The assessments were of a good standard and there was evidence of regular reviews.
- Care plans were in place and were reviewed
- Services were meeting CPA targets
- There was evidence in care plans that physical health care was being monitored and that annual checks were occurring.
- Staff followed NICE Guidance and there was a programme of audit to support this.
- Teams were multi-disciplinary in nature and staff had access to relevant professions.
- Staff received supervision. However in some cases this was six weekly.
- People who use the service had access to psychological therapies within community teams. However there were waiting lists in place.
- Practise was in line with the Mental Health Act and Mental Capacity Act. However not all staff had received training.

However

- Staff told us that they received annual appraisals but this was not reflected in data provided by the trust. Only 59% of non-clinical staff had a performance appraisal in the last 12 months.

Our findings

Assessment of needs and planning of care

We reviewed 16 care records across the service. Each contained a completed assessment although the assessment tool was not consistent across services. Some services utilised the health and social needs assessment whilst others did not. For instance the single point of access (SPoA) service at Preston West Strand (central Lancashire) used an assessment based on mental state examination.

Care plans were in place in all of the records we reviewed. Care coordination rested within the community mental health teams (CMHT) / complex care and treatment teams (CCTT) teams and care plans were developed under the care programme approach framework. There was evidence that the person who used the service and where appropriate carers and advocates were involved. With the exception of one record the care plans had been reviewed regularly.

Access to community services was through the SPoAs. Individuals were given an assessment prior to referral on to the appropriate service. They were not offered a copy of the assessment. Where SPoA services in Morecambe and Wyre had delivered brief interventions this was captured in a separate care plan (referred to as a management plan). Interventions delivered by the rehab and in-reach teams were also captured on a separate care plan.

All the information needed to deliver care was stored on the trust's electronic care records system. This was accessible to staff. However some staff told us that on occasion the system was slow and some said they found it difficult to navigate. Training on the electronic care records system was available to staff. In addition the electronic system was not shared with children and adolescent mental health services (CAMHS). This meant that when a young person transferred from CAMHS into adult services staff found it difficult to access all the required and relevant information. This issue had been acknowledged by the CAMHS – adult mental health transition group and a solution was being sought.

Best practice in treatment and care

Clinicians demonstrated a good knowledge of THE National Institute for Health and Care Excellence (NICE) Guidance. This was supported and monitored by the pharmacy department who conducted audits to ensure compliance. This included participation in the Prescribing Observatory for Mental Health UK to benchmark practice against national guidance and other comparable trusts.

The service was able to offer psychological therapies as recommended by NICE. However staff acknowledged difficulty in accessing dialectical behaviour therapy. The CCTT and CMHTs were able to refer individuals to Increasing access to psychological therapies services but also had psychology available within their teams. However there were waiting times in place for these services which varied from team to team and from location to location. For example at the time of inspection the psychologist in

Are services effective?

Good

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

Morecambe CMHT told us that there was a waiting list of between two and three months although this was being addressed by the employment of a trainee. Staff in the Early Intervention Service (EIS) told us that there was a waiting list of up to 18 weeks for cognitive behavioural therapy and 10 weeks for family intervention therapy. The SPoAs and rehabilitation teams accessed psychological therapies through Increasing access to psychological therapies services.

People who used the service within CMHTs and CCTTs services received support around employment, housing and benefits from Support time and recovery workers or via referral to an appropriate agency (for example Social Inclusion, Help Direct, Citizens Advice Bureau) . We saw care plans that evidenced these referrals taking place. We visited the north Lancashire in-reach team and the east Lancashire community rehab team. These services work direct with individuals to support them in accommodation and in day to day living within the community.

Physical healthcare was considered on initial assessment and managed in collaboration with GPs. We reviewed 16 case notes of which 12 had an annual physical health assessment in place. Staff had access to specialist services both within the trust and externally within primary care. Shared care protocols were in place with GPs to support the management of individuals being prescribed lithium or antipsychotic medication.

Services within the adult mental health network measured outcomes by payment by result cluster type. The recovery star was in place in some teams. However this was not consistent across the services. The north Lancashire in-reach team and the community rehabilitation teams also utilised the Camberwell assessment of need tool. The Blackpool EIS also utilised the questionnaire about process of recovery tool. Occupational therapy (OT) outcomes were captured using the Model of human occupation screening tool.

There was a programme of audit in place which included audits against NICE Guidance. This was supplemented by local audits such as case note audits and OT audits. We also spoke to doctors who had been involved in audits as part of their continuing personal development. However not all staff were engaged or aware of the audits taking place and it was unclear how findings and recommendations were fed back.

Skilled staff to deliver care

Teams were multi-disciplinary in nature and staff had access to OT, psychology and psychiatry although in some cases there were waiting lists in place. Social workers were also integrated into the teams and pharmacy support was available.

Staff were appropriately experienced and qualified for their role. Some of the staff we spoke to had accessed specialist training around cognitive behavioural therapy and psychosocial interventions. Staff had also accessed training on issues such as honour based abuse, forced marriage and female genital mutilation.

There was an identified gap in training around the management of young adults aged 16 to 18. This was relevant because within Lancashire Care trust transition from CAMHS to adult mental health services happens at the age of 16. Training is now being delivered in line with the review of the CAMHS- adult mental health transition and the associated commission for quality and innovation targets.

Staff that we spoke to had received an induction with the exception of one locum doctor. It was unclear why an induction had not been provided in that case. All staff we spoke to confirmed that they received supervision. Frequency was variable depending upon the staffing role but occurred at least every six weeks. Supervision was in either a 1:1 or group setting and covered both clinical and managerial issues.

There were systems and documentation in place to support the annual appraisal and personal development of staff. We spoke to 48 staff. Only two told us they had not received an appraisal in the last 12 months. However figures provided by the trust showed that across the CMHT, CCTT, SPoA and rehabilitation services only 60.43% of staff had an up-to-date personal development review (PDR).

The supervision and appraisal of administrative and non-medical staff occurred outside of the community team line management. Figures provided by the Trust showed that 59% of non-medical staff had received an appraisal over the past 12 months. We spoke to five members of the administration staff and four of these had an appraisal within the last 12 months and were receiving regular supervision.

Are services effective?

Good

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

The trust had a policy in place to address poor staff performance. We spoke to two team managers who between them were managing three staff members on the performance framework. They told us they had been supported in doing so by the trust Human Resources department.

Multi-disciplinary and inter-agency team work

The teams operated within an MDT framework and we observed a collaborative approach to care and treatment. Staff were also able to call clinical solutions meetings when they were required. These brought together relevant staff and management to discuss a particular case and treatment options. For instance we saw evidence of clinical solutions meetings being held to address referrals that had not been accepted.

We observed one handover meeting. The meeting was planned and well structured. Each individual who had been referred or who was receiving care was discussed. These discussions were effective and comprehensive covering areas such as risk, changes in presentation and safeguarding concerns. Urgent referrals were identified and allocated. Decisions were taken collectively and each staff member was able to contribute.

We observed two CPA reviews. These were held in line with best practice. All relevant disciplines attended. People were encouraged to participate and given the opportunity to express their views. The trust had a key performance indicator (KPI) target for 95% for CPA review occurring within 12 months. The trust had met this target in each of the last three reporting quarters. The trust had a KPI target for seven day CPA follow ups of 95%. The trust had met this target in each of the last three reporting quarters.

We saw an example of collaborative working between the Wyre CCTT and the East Lancashire rehabilitation team. A care home within their locality closed with four days notice. The teams were able to work together and found new placements within the area.

Adherence to the MHA and the MHA Code of Practice

Staff had access to training on the Mental Health Act (MHA) although it was not mandatory training for all teams or roles. Staff we spoke to showed a good understanding of the MHA and its application. Updates were circulated by the trust. However MHA training figures for CCTTs provided by the trust showed variable compliance. Only 37% of staff identified as needing MHA Level 2 training had received training.

Where relevant the teams provided care and treatment in accordance with the MHA and the MHA Code of Practice.

In the care records that we reviewed we found appropriate risk assessments and care plans in relation to Community Treatment Order (CTOs). Paperwork was completed appropriately and care plans reflected relevant elements of the CTO.

Staff had access to advice and support from within the trust.

Good practice in applying the MCA

Staff had access to training on the Mental Capacity Act (MCA). Staff we spoke to showed a good understanding of the MCA and its application. Updates were circulated by the trust. However MCA training figures for CCTTs provided by the trust showed variable compliance. 87% of staff identified as requiring MCA Level 1 training had received training. Only 47% of staff identified as requiring MCA Level 2 training had received training.

Staff were able to articulate the principles of the MCA. Staff were aware of where to go for support and advice about the MCA and DoLS within the trust.

In the care records we reviewed we found that capacity has been considered during the assessment process and recorded. Where they were in place capacity assessments had been completed appropriately.

Staff had access to advice and support from within the trust.

Good

Are services caring?

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

Summary of findings

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

- The feedback we received from people who used the service was positive. People who used the service and their carers reported they were happy with the service they received. One individual had not had a positive experience and was going through the complaints procedure.
- Staff treated people who used the service with kindness, dignity, respect and compassion. Staff took the time to listen to individuals and to understand their needs. People who use the service were given space and encouragement to express their opinions. These were listened too and acted upon by staff.
- Carers we spoke to felt they were involved in decisions around treatment and care. Carers we spoke to felt supported.
- There were mechanisms in place to capture feedback from people who used the service. The findings from feedback were discussed and considered by teams.

However

- It was not clear the people who used the service were routinely offered a copy of their care plan.

Our findings

Kindness, dignity, respect and support

We observed five consultations during the inspection. Staff engaged with individuals in a respectful and dignified manner. People who used the service were treated with compassion and understanding. We witnessed meaningful two-way conversations between staff and people using the service during appointments. People were involved in decisions about their care and treatment. Staff we talked to individually spoke respectfully about individuals on their caseload.

We spoke to 14 people who use services users during the inspection. One person we spoke to was not satisfied with the level of care that he was receiving. He had submitted a complaint and was awaiting the outcome. Overall people told us they were happy with the service they received and reported that staff treated them with respect and were responsive to their needs.

The trust had information governance policies available for staff. Staff we spoke to showed an understanding of issues around confidentiality. We were asked for appropriate identification prior to reviewing individual medical records.

The involvement of people in the care they receive

People who use the service and carers we spoke with told us that they were involved in decisions about their care. The care records we reviewed demonstrated this. However it was not always clear whether a copy of the care plan had been offered to individuals. We spoke to 14 people who used the service of whom only six had a copy of their care plan.

We spoke to three carers during our inspection. Carers stated that they felt involved in care and were involved in decisions around treatment as appropriate. Carers were positive about the service they received. One carer had a carers plan in place and two carers were scheduled for a carers assessment.

Advocacy services were available in all three regions of the trust. Staff were aware of how to access these services and we saw promotional material in some premises. Individuals we spoke with were aware of advocacy services and felt comfortable asking their care coordinator for additional details if required.

None of those we spoke with were actively engaged in making decisions about the service. However we spoke to one recently appointed staff member who stated a person who used services had been part of his interview panel.

Services within the adult mental health directorate have utilised the friends and family test (FFT) since January 2015. Results of the FFT were displayed on team information boards and discussed in team meetings. The East Lancashire in-reach and east Lancashire community rehabilitation teams also utilised the express your experience – achieve change together tool. We saw team meeting records that showed that staff analysed and discussed the findings of these surveys.

Are services responsive to people's needs?

Requires improvement

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

Summary of findings

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

- There was evidence that the transition from CAMHS to adult mental health services was not working effectively. The transition protocol was not being followed consistently and was out of date.
- We identified concerns over the ability of services to manage young people when they transfer from CAMHS at the age of 16. The trust recognised these issues. Actions had been agreed and a CQUIN target was associated the delivery of the action plan.
- At present there are no KPIs in place specific to single point of access services. However these were being developed.

However

- The services had processes in place to identify and escalate urgent referrals.
- The SPoA teams were seeing 86% of referrals within their target timescale.
- Buildings were clean and well maintained.
- The service had access to translation services including face to face translation.
- Processes were in place to engage with individuals who found it difficult to engage with mental health services

Our findings

Access and discharge

Teams accessed inpatient beds through the crisis service in their locality. Staff spoke about increased difficulties in accessing beds as a result of a reduction in bed numbers. However teams were taking steps to manage this. For example the Wyre CCTT carried out a patient flow exercise. As a result they have introduced a system of relapse appointments which meant they could see individuals who required intensive support more frequently. This has reduced the number of referrals to the crisis team and reduced the number of in-patient admissions

Each single point of access team (SPoA) had procedures in place to see urgent referrals within 24 hours. In the Lancashire and Morecambe SPoA the team has three urgent referral appointments each day. This was in response to a previous serious untoward incident (SUI). Community mental health teams (CMHT) and Complex care and treatment teams (CCTT) had procedures in place to identify and accelerate urgent referrals.

There is a 10 day KPI for referral to assessment for routine cases. Data provided by the trust for the east Lancashire locality covering September to December 2014 showed that the SPoAs in the region were 86% compliant with this.

The majority of staff we spoke with stated they had good links with crisis services in their area. However there were some concerns raised regarding access within the north Lancashire region. A team manager expressed the concern that the focus of the crisis team was to help move people on from inpatient beds which reduced their capacity to work with community teams. We spoke to one person who used the service within the same region who stated that he did not find the crisis team to be helpful.

Teams had processes in place to engage with people who are reluctant to engage with mental health services. Assertive outreach teams were incorporated into CCTTs. The Early intervention service had a specific protocol for managing disengagement.

We were told there were concerns over the transfer of individuals from child and adolescent mental health services (CAMHS). Within Lancashire Care the transition from CAMHS to adult mental health services occurs at the age of 16. When we reviewed the transfer protocol we found that it was out of date and not always followed. We found evidence that the transition was not working effectively and that adult mental health services were not always able to meet need.

We case tracked six transfers from CAMHS to adult mental health. In three of these cases the existing transition protocol was followed. However in three cases the transition protocol was not properly followed.

We spoke to service level management regarding this issue. They told us that the trust had identified that the transition pathway was not effective. As a result a review of the transition pathway was undertaken. A pilot project was launched in the central Lancashire locality and then rolled out to the other two localities. CQUIN performance targets

Are services responsive to people's needs?

Requires improvement

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

were built into the review. Steering groups had been established in each locality to oversee the implementation of actions. These included the delivery of appropriate training, the development of a new referral process, the identification of young people's champions in each team and the implementation of mechanisms to capture feedback. We reviewed the action trackers for each locality. Training had either been delivered or was scheduled. Central and north localities had initiated work with the IT department to gain access to CAMHS electronic care records. This was not possible in the east Lancashire locality as CAMHS services in the area are not provided by the trust. All other actions had been completed.

Guidance was also produced for teams on the management of 16 – 18 years olds. When we reviewed the operational policies for CMHT and SPoA teams provided by the trust they did not make reference to either the guidance or the transition protocol. These policies are due for review later this year. We were told they would be rewritten in line with the on-going community services review and incorporate relevant reference to young people.

In two of the cases we reviewed the individual was unable to effectively engage in the adult mental health community services due to a diagnosis of autism. The eligibility criteria for adult mental health community services excludes those with developmental disorders including those on the autistic disorder spectrum. This meant that if an individual on the autistic disorder spectrum had an IQ level that excluded them from learning disability services there was no clear pathway for them to follow.

The facilities promote recovery, comfort, dignity and confidentiality

Buildings that people who used the service visited well maintained, clean and had appropriate furniture. Rooms were available for individual consultations. Clinic rooms were kept clean and tidy. Clinic rooms were appropriately equipped and equipment was checked regularly.

Information leaflets on services were available and staff were able to access them as required. However a full range of information was not available in every reception and waiting area. The east Lancashire in-reach team had a welcome pack that had been developed collaboratively with those using the service.

Meeting the needs of all people who use the service

Buildings where people who use the service might have visited had disabled access. Consultation rooms were available on the ground floor. Staff told us that they would visit individuals in the community if this was preferred.

Teams had access to translation services when they were required. This included face to face translation and the ability to have information translated into other languages.

Listening to and learning from complaints

Total number of complaints in last 12 months: 117

Total number of complaints upheld: 15

Total number of complaints referred to the Ombudsman in last 12 months: 2

Total number of complaints upheld by Ombudsman in last 12 months: 0

We spoke to 14 people who use the service. Six told us that they knew how to complain. One individual had submitted a complaint and was awaiting the outcome. Eight people who use the service told us that they were not aware of the formal procedure but would be happy to ask their care coordinator for information.

Staff we spoke with were aware of the trust's complaints procedure and where it could be accessed. Staff were aware of PALS and local advocacy services.

Feedback on complaints was given through team meetings. We saw evidence of this in team meeting minutes. Where it was deemed appropriate recommendations of complaint investigations could also be shared through green and blue light emails. However we spoke to one locum consultant who had not received feedback from complaints he had been involved in.

Are services well-led?

Requires improvement

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

Summary of findings

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

- There were concerns over team capacity on the services risk register. These were also raised by staff in Morecambe CMHT, Lancashire and Morecambe SPoA, Preston West Strand CCTT and Wyre CMHT. This meant that staff were not able to maximise their time and engage effectively with professional development.
- Mandatory training compliance in some teams did not meet the trust target.
- Supervision sessions in some teams were not happening with regular frequency.
- There was no automated monitoring tool or reports for referral to assessment or treatment within CMHTs and CCTTs.
- A lack of clarity about the future configuration of community services had created a high number of temporary/acting up team leadership positions and caused a level of insecurity amongst team members.

However

- Staff were aware of the trust's vision and values
- There were monthly governance meetings and evidence of on-going monitoring of performance.
- Staff felt supported at a local level.
- There was evidence that change had been initiated following adverse incidents.
- The service had undertaken engagement with staff over the service redesign. However not all staff felt involved.

Our findings

Vision and values

Staff we asked were aware of the trust's vision and values. These were also displayed in sites that we visited.

Staff were aware of senior management. There is a weekly trust update circulated by email. Staff can email senior management directly through the intranet using the Dear Derek facility. However senior management had not visited every team and some staff felt there was a disconnect between service and board level.

Good governance

There were monthly governance meetings held in each locality. Minutes we reviewed showed that performance, adverse incidents and complaints were discussed.

The trust had a centralised data warehouse available via the intranet. Teams were expected to produce their own performance reports. We saw performance data displayed on team information boards. We witnessed performance being discussed during a team daily 'huddle' meeting. Performance was also discussed within monthly team meetings. Performance against KPIs was monitored in locality governance meetings. However not all services had KPIs in place. There were no KPIs directly related to the SPoA teams. However we were told these were being developed.

The trust provided data on waiting times from referral to assessment for SPoA teams. There was no automated monitoring tool for performance against referral to assessment targets for CMHT and CCTT teams. Reporting was by exception only. The trust has only recently began monitoring referral to treatment within CMHTs and there were no routine or automated reports.

Teams also managed their own quality SEELs which covered performance across the areas of quality, safety, experience and leadership. The quality SEEL is a self-assessment tool covering safety, effectiveness, experience and leadership. These were reviewed monthly and displayed within staffing areas.

Network risk registers captured concerns over capacity within community teams. Some staff told us that they struggled to keep on top of their workload and were not able to work as proactively as they wanted. Actions were being taken to address these issues.

Caseloads were with Department of health guidance but a number of staff told us that capacity issues meant it was difficult to complete mandatory training and conduct monthly supervision. Actions were in place to increase

Are services well-led?

Requires improvement

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.

training compliance and protect at least six weekly supervision sessions. Only two staff we spoke with had not had an appraisal within the last 12 months. However data provided by the trust did not reflect this.

Staff used the electronic Datix system to report adverse incidents. All the staff we spoke with were aware of the system and how to access it. Staff we spoke with were aware of the trusts complaints procedure. Minutes of team meetings showed that the results of serious untoward incidents (SUIs) and complaints were fed back to the team.

There was evidence that change had occurred following SUIs. For instance Morecambe CMHT had made changes to their appointment system to better respond to urgent referrals. The Blackpool EIS had developed a new engagement procedure following a serious of adverse incidents and an SUI.

We spoke with three staff members who had been involved in SUI reviews. Two of the staff stated they had been supported through the process. One staff member did not feel they had been supported through the process. We spoke to one locum consultant who stated he had not been given feedback on complaints that had been submitted.

There were good systems in place in relation to safeguarding. Teams had identified safeguarding champions. Safeguarding was discussed in the clinical engagements and team meetings we observed.

There was adherence to the MHA and MCA. Procedures were followed appropriately.

Team managers were able to submit risks to locality and network risk registers.

Staff were aware of the whistleblowing process. Staff we spoke with felt that there was an honest and open culture within the teams and that they could raise concerns without fear of victimisation. However one staff member we spoke to told us they would go directly to the CQC

Leadership, morale and staff engagement

There were no bullying or harassment cases active at the time of the inspection. Staff told us that colleagues were supportive and that teams worked well together. Morale was generally high. However there was some concern relating to the ongoing community services review which had created some uncertainty. Staff felt that they delivered a good quality of care

Many of the teams we visited were being managed by people on a temporary and/or interim basis. However staff told us they felt supported within their own team and by their team managers. Staff felt services were well managed locally. Team managers we spoke to said they felt supported by service managers. There were opportunities for managers to access appreciative leadership courses

The adult mental health community services are currently undergoing a review. There was a lack of clarity amongst staff about future plans and insecurity about their existing roles. However, although not all staff felt they had been involved in the process we saw evidence of attempts to engage with the workforce. Some staff gave us examples of how they had contributed to the review. Workshops with clinicians and professionals had taken place in November 2014, December 2014 and January 2015. The trust had a database of stakeholder feedback in place. The deputy network director had commenced a programme to visit each team to discuss the proposed new model. A briefing sheet for staff had been developed but had not been circulated at the time of the inspection. This was due to be circulated in May 2015.

Commitment to quality improvement and innovation

Adult mental health services are engaged with the Prescribing Observatory for Mental Health. This includes audit and quality improvement.

The trust's Early intervention service had developed an 'Early intervention service workers guide to psychosocial interventions and cognitive behavioural therapy informed case management for psychosis.' A number of trusts have expressed an interest in purchasing this.

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	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment We found that the transfer of young people to adult mental health services was not working effectively. There was no current protocol for staff to follow and inconsistency in practice. This is a breach of Regulation 12 (2) (i) The provider must ensure that there is a protocol in place for the transfer of young people from CAMHS to adult mental health services and that this is fully adhered to be staff to ensure the health, safety and welfare of service users.

This section is primarily information for the provider

Enforcement actions

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.