Rethink Carers Lancashire

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Newsletter
August 2019

c/o Rethink Mental Illness, Paul's House, Tower Street, TA14BH

Meeting Friday August 23rd, Brindle Community Hall, 10.15 – 3 pm.

LEARN HOW TO SAVE A LIFE IN JUST TWO HOURS!

The morning session will be a bit different, in that we have a training session from the British Heart Foundation's 'Heart Start' team to learn how to keep someone alive until professional help arrives. Some of us are of a generation where this knowing this could be crucial, and of course some psychiatric drugs can increase heart problems. Not something we want to think about, but it's better to be prepared if we can.

In the afternoon we'll be welcoming Matthew Ling, Advanced Mental Health Pharmacist for Lancashire Care Trust, to discuss the current situation with psychiatric medication and answer any questions we have. If you have any questions for Matthew, please send them in beforehand, preferably by Monday August 19th. **PLEASE NOTE THAT THE AFTERNOON SESSION WILL START PROMPTLY AT 1 O'CLOCK**

Lunch will be as at the last meeting, either meat and potato pie or cheese pie, £5 to include all teas, coffees, biscuits, etc. £1 for those who don't want the lunch.

ORDERS FOR LUNCH TO BE SENT BY **MONDAY AUGUST 19TH**, PLEASE.

Don't forget the monthly Accrington meetings, 6 -8 pm at Elmfield Hall, open to any carers who can get there: **on August 14th we have Richard Atherton, Services Manager for social care in East Lancashire, who will be helping us understand the way care needs are being assessed and the process for deciding how much people should contribute to their care costs.**

MESSAGE TO ALL OUR CARER MEMBERS: YOU DESERVE THIS!

Book your place NOW at our FREE tea party, Friday October 4th, 2 -4 pm, Brindle Village Hall

Delicious sandwiches and cakes, good company, light-hearted insight into what we've been doing for the last 10 years

NEWS FROM LANCASHIRE CARE NHS TRUST

With the appointment of Caroline Donovan as Chief Executive, there's a lot of change in the Trust, and several new appointments to the most senior management posts, with some newly appointed staff not yet in place. This has meant that some of the initiatives we were expecting seem to have been put on hold – e.g. the in-patient booklet, training on information-sharing with informal carers (although this *is* being progressed by Lancashire County Council), the Recovery College.

We have written to Caroline to introduce ourselves but haven't yet had a reply – of course she has a massive task to address all the issues raised in the reports outlined below but we hope to establish a good relationship in due course.

We've had a very positive response from Russell Patton, who has taken a similar role to that of Sue Moore (who left the Trust unexpectedly in May and couldn't attend our Brindle meeting as planned). Russell has just joined the Trust as Executive Director of Operations and has agreed to come to our meeting in late October/November, date to be arranged.

CQC REPORT

Published:23 May 2018 England's Chief Inspector of Hospitals has told Lancashire Care NHS Foundation Trust that it must make improvements following an inspection by the Care Quality Commission.

Overall rating for this trust: **Requires improvement**
Are services safe? **Requires improvement**
Are services effective? **Requires improvement**
Are services caring? **Good**
Are services responsive? **Good**
Are services well-led? **Requires improvement**

The rating for forensic inpatient and secure wards remained unchanged at Good.

Dr Paul Lelliott the Deputy Chief Inspector of Hospitals (and lead for mental health), said:**"It is disappointing to report that our overall rating for Lancashire Care NHS Foundation Trust has declined since our last inspection. The trust has been under pressure notably in mental health crisis services and the child and adolescent mental health wards. The board and senior management team did not have sufficient oversight of staff supervision; particularly in some core services, where rates of ongoing appraisal and supervision were too low and have not improved since our last inspection. However, patients and carers have told us that staff were compassionate, committed and interested in them as individuals. Inspectors could see that staff ensured that patients' cultural, religious and dietary needs were being met and services were equipped to meet the needs of patients with physical disabilities. "Encouragingly there were areas where the trust had improved such as community health inpatient services, but the trust needs to address those areas where we have identified the need for improvement. We will continue to monitor the service closely and return at some time in the future to check on progress."**

You can read this report in full at. https://www.cqc.org.uk/sites/default/files/new_reports/AAAH1218.pdf

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REPORT ON CRISIS SERVICES

On behalf of all partners, including NHS, local authority, voluntary and charitable sector, police and other emergency services, the Healthier Lancashire and South Cumbria Integrated Care System (ICS) decided to commission an independent review of urgent mental health services. This is because it was clear that no single organisation could provide a solution on its own.

The review aimed to develop future plans for mental health services for the 1.7million people in Lancashire and South Cumbria and look for ways to support Lancashire Care NHS Foundation Trust, and other mental health providers across the region, to enhance the quality of services for people with mental health conditions.

Northumberland, Tyne and Wear NHS Foundation Trust, as a provider of high performing mental health services, was commissioned to independently lead the review with additional input and oversight from senior clinicians independent of both Trusts. **An online summary of this review, outlining the commitments made by all stakeholders, is attached with this newsletter. Ask for a hard copy if you'd like one. Full report (with a lot of interesting analysis of Trust services) at www.healthierlsc.co.uk/MentalHealth**

The Trust's website has an interesting section which is really for staff but in the public domain. The Chief Executive has made a couple of short videos to outline progress and answer questions – go to https://www.lancashirecare.nhs.uk/a-chat-with-caroline

Our May meeting: we were pleased to welcome Charlotte Hammond, (Head of Service-Learning Disabilities, Autism and Mental Health, Lancashire County Council) who gave us some very frank answers to what she described as the 'difficult' questions sent in by group members. Here's what she said:

1. What are current plans for integrating clinical and social care into a comprehensive package for the service user? Care Act assessments are no longer managed by the NHS Trust (LCFT) and Lancashire County Council's social services are much clearer about their remit. At the moment there is no agreement about a shared electronic and recording system but a standard operating policy is being developed. LCC has a review team specifically to review social care packages once a year. Multi-disciplinary mental health teams should include social workers; these teams should hold care planning meetings covering both health and social care aspects. There have been good developments with Direct Payments and Personal Budgets. **(See next page)**

2. What is happening about carer support contracts and plans for respite care? The contract for carer support was out to tender and has now been given to nCompass / Carers Link. Carers can request their Carer assessments to be done by a Social Worker. The contract for respite care will go out to tender by September; Charlotte suggested our Rethink group could have input into the spec for this. What is currently done is traditional and doesn't always meet the needs for those we care for.

3. What are the criteria for contacting Mental Health Services when a suicide disclosure is made? There is a lot of uncertainty at what stage to contact the services as there is often a negative response when trying to make a referral. The assessment team have an approach that seems to question why a referral is being made. It would be good to have clear thresholds and criteria to inform when carers and/or third sector organisations should be making a referral. Such matters should be raised with the GP or CMHT, it would not normally go to Social Services unless specific social care factors were involved. Triggers for suicide are very individual, and a full understanding of the situation is needed. An enhanced crisis service is currently being developed. Following a suicide, the Safeguarding Adults Board would manage a review. Queries were raised about how much weight would be given to the carer's opinion, and the point at which Social Services would start contacting health services.

4. Can you explain the role of Social Care Support Officers (SCSO)? (with particular reference to their function re Care Act assessments) These vary according to the service, but in mental health the SCSO is more likely to be carrying out a review and only in straightforward instances doing an initial Care Act assessment. This applies also to older adult services for people eligible under the Care Act and where additional support is needed for those living in their own home. SCSOs are not qualified / registered professionals and wouldn't be expected to undertake very complex cases independently; they should ask for support if an assessment turns out to be more complicated than expected. A Care Act assessment might result in an offer of Direct Payments, domicilliary care, daytime opportunities or carer respite; there is more flexibility in commissioning an agency than carers thought, in that it would be possible to go outside the LCC list of approved providers where needs cannot be met by agencies on the list, as the council has a statutory obligation to provide appropriate care.

5. How can you ensure that inpatients have a Care Act assessment as part of the discharge plans, to make sure that the social aspect of care is in place in time for discharge and they will not be left several months without essential components of their recovery? Multi-disciplinary teams have been very medical, with Social Workers brought in at the end of the process; this has resulted in too many patients staying in hospital for too long. Social Workers are expected to be independent enough to challenge medical proposals, especially where an informal patient may have no clear reason to be there, social workers are expected to highlight the rights of people using services. Who is telling the social care staff that someone is in hospital? Part of the CMHT remit is to involve the Social Worker. There are few waiting lists for in-patient Care Act assessments, so these should be started as soon as someone reaches the point where details of discharge need to be worked out. The most support is needed when someone goes into crisis or leaves hospital. In secure care Social Workers are employed by the hospital rather than – as for community Social Workers - by the council. LCFT is recruiting a significant number of staff to ensure that discharges are not delayed and that any gaps left by social workers focussing on statutory work are appropriately filled. The issue of stress (leading to absence through illness) amongst Care Coordinators was mentioned, the local authority sickness record is significant though is markedly improving.

6.How can carers keep up with the frequent restructuring of services and redeploying of staff? Is this happening at the moment? There have been no major changes to LCC staffing since May 2018 when mental health Social Workers were brought back under LCC management, but it is recognised that there should have been better communication of the changes. A website (jointly between health and social care) setting out the system would be a good idea. In terms of who can be a Care Coordinator, Social Workers can't take responsibility for medication, so anyone on Clozaril or depots will have to have a Care Coordinator who is a qualified nurse. LCFT is still sorting this out.

INTEGRATING CLINICAL AND SOCIAL CARE INTO A COMPREHENSIVE PACKAGE FOR THE SERVICE USER

There are now moves towards a joint consultation (LCC and LCFT) with service user and carer groups about bringing together the CPA (clinical) process and Care Act (social care) assessments/planning. These were always supposed to be integrated but in practice have always leaned in one direction or the other. As soon as we have a date for the consultation with our group we'll let you know.

You'll find the Rethink webpage about CPA (= Care Programme Approach) at https://www.rethink.org/advice-and-information/living-with-mental-illness/treatment-and-support/care-programme-approach-cpa/

The **CARE PROGRAMME APPROACH** is a package of care that is used by secondary mental health services (e.g. Community Mental Health Teams, High Intensity Teams, Crisis Teams, Early Intervention Teams. The individual will have a care plan and someone to coordinate care if under CPA. All care plans must include a crisis plan. CPA aims to support mental health recovery by helping someone understand their strengths, goals, support needs, and difficulties. The Care Programme Approach should be available to someone who has a wide range of needs from different services or is thought to be a high risk.
health professionals should think about the following things when deciding if help is needed under CPA:

- Severe mental illness, including personality disorder which isn't managed well.
- Risks or possible risks such as self-harm, suicide attempts, harming other people including breaking the law, a history of needing urgent help, not wanting support or treatment, and vulnerability such as financial difficulties or abuse. This could be financial, physical or emotional abuse.
- Severe distress now or in the past.
- Problems working with mental health services now or in the past.
- Learning disability or drug or alcohol misuse as well as a mental illness.
- Services from a number of agencies, such as housing, physical care, criminal justice or voluntary agencies.
- Recently been detained under the Mental Health Act 1983 or detained at the moment. (Also known as being sectioned.)
- Recently been put in touch with the Crisis Team or getting their help at the moment.
- Needing a lot of support from carers.
- Caring for a child or an adult.
- Disadvantage or difficulties because of parenting responsibilities, physical health problems or disability, housing problems, problems finding or staying in work, mental illness significantly affecting day-to-day life, and immigration status, language difficulties, sexuality or gender issues because of ethnicity.

Under the CPA people should get a care coordinator and a care plan. A care coordinator is the person who will coordinate and monitor care. The name of the care coordinator and the care needed should be written into the care plan. The care coordinator won't necessarily be the person who provides the support, this may be another professional such as a therapist. Care coordinators can be social workers, community psychiatric nurses (CPNs) or occupational therapists (OTs). There should be regular contact with the care coordinator, who should work with other health professionals to assess needs, write a care plan which shows how the NHS and other services will meet needs, and regularly review care plans with the individual to check progress.

In our area now many service users are being taken off CPA and passed to the care of the GP. There are also issues about carers not being informed or consulted about care plans even when they are providing all the care and there are no issues of their relative refusing to consent to information being shared. We wonder how risk assessments can be done without seeking information from the person who knows the service user best.

GET IN TOUCH IF YOU HAVE CONCERNS ABOUT HOW YOUR RELATIVE IS EXPERIENCING THE CPA.