Lancashire Care NHS Foundation Trust

Evidence appendix

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This evidence appendix provides the supporting evidence that enabled us to come to our judgements of the quality of service provided by this trust. It is based on a combination of information provided to us by the trust, nationally available data, what we found when we inspected, and information given to us from patients, the public and other organisations. For a summary of our inspection findings, see the inspection report for this trust.

Facts and data about this trust

The trust had 26 active locations registered with the CQC (on 18 January 2018).

Registered location	Organisation ID	Local authority
Ashton Health Centre	RW5NN	Lancashire
Bacup Primary Health Centre	RW5CC	Lancashire
Bamber Bridge Clinic	RW5RJ	Lancashire
Barbara Castle Way Health Centre	RW5RG	Blackburn with Darwen
Burnley General Hospital	RW5CA	Lancashire
Chorley and South Ribble Hospital	RW5DA	Lancashire
Clitheroe Hospital	RW5QM	Lancashire
Darwen Health Centre	RW5RC	Blackburn with Darwen
Dental Care Calderstones Hospital	RW5Y5	Lancashire
Garstang Road Preston Learning Disability Supported Living Scheme	RW5EP	Lancashire
Guild Lodge	RW5ED	Lancashire
HMP Liverpool	RW5FY	Liverpool
Longridge Hospital	RW5AQ	Lancashire
Mental Health Decision Unit North, Blackpool	RW5X1	Blackpool

Victoria Hospital		
Minerva Centre	RW5RP	Lancashire
Oak House Dental Care	RW5Y4	Lancashire
Ormskirk Hospital	RW5FA	Lancashire
Ringway Dental Care	RW5Y7	Lancashire
Royal Blackburn Hospital	RW5AA	Blackburn with Darwen
Royal Preston Hospital	RW5EE	Lancashire
Sceptre Point	RW5HQ	Lancashire
St Peters Primary Healthcare Centre	RW5CV	Lancashire
The Cove	RW5LY	Lancashire
The Harbour	RW5KM	Lancashire
The Orchard	RW5MQ	Lancashire
Yarnspinners Primary Healthcare Centre	RW5XX	Lancashire

The trust had 555 inpatient beds across 40 wards, 18 of which were children's mental health beds. The trust also had 4621 outpatient clinics a week and 5630 community clinics a week within 650 locations across Lancashire in a range of settings.

Total number of inpatient beds	555
Total number of inpatient wards	40
Total number of day case beds	0
Total number of children's beds (MH setting)	18
Total number of children's beds (CHS setting)	0
Total number of outpatient clinics a week	4621
Total number of community clinics a week	5630

The trust noted that these totals include:

- Inpatient beds: 26 inpatient beds at HMP Liverpool
- Inpatient wards: HMP Liverpool ward
- Outpatient clinics: dental clinics
- Community clinics: Mental Health clinics

Is this organisation well-led?

The trust board had the appropriate range of skills, knowledge and experience to perform its role. The board was led by the chief executive who had been in post since 2009 and the chair who was appointed in June 2016. The board had 13 directors which included six non-executive and five executive directors in addition to the chief executive and chair. The executive directors included a director of nursing, a chief operating officer, chief financial officer, director of human resources and a medical director.

The trust had a senior leadership team in place with the appropriate range of skills, knowledge and experience. The non-executive directors had diverse backgrounds within the nursing, legal and financial professions in addition to the housing, voluntarily and private and public business sectors up to board level.

The board had currently no black, minority ethnic members and consisted of seven women and six men.

	BME	Women
Executive	0	3
Non-executive	0	4
Total	0	7

A non-executive director had responsibility for the oversight of the associate hospital managers. The group did not completely reflect the diversity of the patient population, although there was a good gender and age mix amongst the current group. The equality and diversity lead had been involved in recent recruitment campaigns and posts had been advertised within local community groups in addition to more traditional routes to improve the diversity within the group.

The trust had a child and adolescent mental health medical lead and the trust's learning disability transformation lead was the trust's lead for learning disability and autism.

The board meeting and a quality committee we attended were well planned, attended and chaired. The trust had four committees which reported directly to the board which were: quality committee, audit committee, finance and performance committee and a nominations remuneration committee. Each committee lead presented the board with a comprehensive up to date progress report. This was linked to the key priorities of the committee and identified challenges faced and plans in place to address these. Detailed data sets and supporting evidence was available within the reports to provide assurance to the board.

The chair invited each non-executive director to present on their area of expertise to the board. The board assurance framework was reviewed by the board at each meeting.

Medicines optimisation was integrated into the board assurance framework and risks were kept under review. The new chief pharmacist (appointed October 2017) had reviewed the trust's medicines optimisation strategy. Medicines optimisation updates were provided to the board through the annual report outlining governance arrangements, key achievements and areas for development.

The board had a comprehensive understanding of the key priorities and challenges faced by the trust and progress made against these. There was consistency among all board members regarding the priorities and challenges the trust faced which was further evidenced through the interviews and focus groups we held. Members of the board demonstrated collective accountability, transparency and integrity within the meetings. We observed board members providing respectful, appropriate challenge to other members when clarity or further assurance was sought regarding a particular issue.

Fit and proper person checks were in place. Providers are required to ensure they take proper steps to ensure that their directors (both executive and non-executive), or equivalent, are fit and proper for the role. Directors must be of good character, physically and mentally fit, have the necessary qualifications, skills and experience for the role. The trust had two policies: recruitment and selection guidance and the recruitment and selection policy which set out the main principles the trust had adopted for the recruitment, selection and appointment to posts including the fit and proper persons test for the appointment of directors.

We reviewed the personnel records of the 12 directors in the trust in line with the fit and proper person requirements. We found the trust was meeting these requirements with the exception of occupational health screening which were not present in three of the files.

Members of the trust board undertook a visit to a clinical team each month called, 'good practice visits'. Membership included executive directors or their deputies, non-executive directors, governors and clinical commissioning group team members. Feedback from visits was shared within teams and themes from the visits were discussed at the board meeting. Board members also participated in a programme of 'quality assurance visits' with commissioners to seek assurance of quality and undertook reactive visits where concerns were identified.

Staff we spoke with in the core services we visited and focus groups we held provided mixed feedback in relation to the visibility of the senior management team. Whilst some staff reported members of the senior leadership team were visible and approachable, others stated this was not their experience. In the 2016 NHS staff survey, the trust scored slightly higher than similar trusts as they had in 2015 for the 'support from immediate managers' staff reported they received, but they scored seven percent lower for 'reporting good communication between senior management and staff at 28%. This was three percent lower than the 31% reported in 2015.

When senior leadership vacancies arose the recruitment team reviewed capacity and capability needs. Succession planning of non-executive directors was undertaken on an annual basis and reported through the nomination and remuneration committee. Each director's skills, expertise and background were recorded on a matrix which was aligned to the trust's strategic priorities. The trust used this to consider the skill mix and succession planning of the executive directors across the board.

The trust reviewed leadership capacity and capability on an ongoing basis. Since our last inspection, the trust had completed a programme to redesign their operational delivery model, and realign the four previous clinical networks into three networks to reflect the changes which were taking place in health and social care provision across Lancashire in line with the Lancashire and South Cumbria sustainability and transformation plan and the trust's strategic plan for 2017-22. Delivery of the trust's portfolio of services took place across three interdependent clinical networks which were: mental health, community and wellbeing and children and young people (up to age 25 including both mental and community health provision).

Each network was operationally led by a clinical director and a head of operations. They were supported by a head of nursing, allied health professional lead, psychology lead and deputy head of operations. Corporate support services provided a range of business partners to the network management teams including finance, human resources and quality governance.

Networks were divided into localities, and each locality was led by a care group manager who operationally managed the matrons and service managers.

The trust had reviewed leadership capacity and capability to support the implementation of the new operational delivery model. As a result of this review, the trust had restructured this level of line management with the appointment of lead nurses within the three networks to strengthen the clinical leadership provided to the matrons and staff within the networks.

There was some confusion expressed by service managers, lead nurses and matrons within the focus groups we held regarding their own roles and the roles of each other within the new structure. The in- patient matrons had recently started to work two clinical shifts a week on the wards they were responsible for and the ward managers worked three per week. The director of nursing reported this decision had been made to strengthen the senior clinical presence on the wards and to support safe staffing numbers. However; there was concern expressed from matrons and ward managers that this impacted on their ability to undertake some aspects of their roles such as ensuring appraisals and team meetings took place which they felt had a negative impact on staff teams.

Leadership development opportunities were available, including opportunities for staff below team manager level. Succession planning was in place throughout the trust. The trust had a leadership and talent management strategy which was incorporated within their three year 'people plan' which was developed in 2016. The people plan had been developed in conjunction with the King's Fund and was focused on the following six domains:

1. Ensuring People have a clear shared vision and shared values

2. Ensuring people have clear plans objectives and outcomes

3. Managing people effectively so they feel supported with improved Health and well being

4. Providing learning development and training for all people

5. Ensuring people are working well in teams

6. Developing people leaders and people managers.

This was supported by the trust's Quality Academy which was also set up in 2016 to provide a central hub to monitor and manage all aspects of staff training and development. The people plan was underpinned by an operational plan which included a detailed schedule of activities to successfully implement the strategy. Activities included the continued delivery of the, 'appreciative leadership' programme which had been attended by over 1,300 leaders since it was introduced in 2012. The trust had also provided a 'leading for high performance' course which over 160 staff had attended since August 2016.

A development programme called, 'rising stars' was established for staff at band 8a or below who were aspiring leaders to support their development.

However; staff groups we spoke with told us that although managers supported staff accessing developmental opportunities and training, this was not always achievable due to the staffing challenges faced within some clinical areas. Releasing staff to attend training and development courses was reported to be a particular challenge on the acute wards.

The trust worked with a local college to provide courses for band 1 to 4 unqualified staff to help them gain the academic qualifications needed to access degree level programmes such as nursing. In addition, the trust had an established nursing apprenticeship programme in place through partnership working with a local university.

Vision and strategy

The trust had a clear vision and set of values with quality and sustainability as the top priorities which was introduced in October 2015 after extensive engagement with key stakeholders and staff.

The trust's overarching vision was: 'High quality care, in the right place at the right time, every time'. This was underpinned by the following strategic objectives:

1 – Compassion: To provide high quality services

2 – Integrity: To deliver sustainable services that meet the needs of local people

3 – Teamwork: To become recognised for excellence

4 – Respect: To employ the best people

5 – Accountability: To provide financially sustainable services

6 – Excellence: To innovate and exploit technology to transform care

The trust had committed to three quality outcomes:

• People at the heart of everything we do

• Motivated, engaged and valued staff

• Always being the best we can be.

The trust's vision and values were captured on a single page visual presentation which incorporated script and animation to support accessibility. These were displayed throughout the trust and on the trust web site.

Staff at all levels within the trust demonstrated a good understanding of the values and vision of and were able to articulate how these linked to their work. The values were embedded within all levels of the trust from staff induction, the recruitment process, policies, appraisal system, board assurance framework and board meetings.

The pharmacy and medicines management operational plan set a clear vision with measurable goals for improving medicines optimisation across the trust, linked to the trust's common objectives. The trust participated in the 2017 NHS Benchmarking Pharmacy and Medicines Optimisation audit providing comparative data to support planning and implementation of changes relating to medicines optimisation.

The trust had a robust and realistic strategy for achieving the priorities and developing good quality, sustainable care. The trust aligned its strategy to local plans in the wider health and social care economy and had developed it with external stakeholders.

In 2015, NHS England worked with other national organisations to produce The Five Year Forward View, which was a national plan to improve health and care services across 44 geographical areas in England. The plan involved organisations working together across the geographical footprint to improve health and wellbeing outcomes for people as well as setting out how health and social care services would be delivered locally based upon local needs. This led to the trust working with partners from other NHS providers and commissioners, local government and the voluntary sector to develop the 'Lancashire and South Cumbria sustainability and transformation plan'.

The board of directors reviewed the trust's 2014-19 strategic plan to ensure it was aligned to the sustainability and transformation plan.

The key changes in the trust's 2017-22 strategic plan in relation to the trust's 2014-19 strategic plan are detailed below:

2014-19 Strategic Plan	2017-22 Strategic Plan
Competitive strategy	Collaborative strategy
Patient focused through a commercial approach	Patient focused through an integrated collaborative approach
Organisational sustainability	Sustainable services

The 2017-22 plan demonstrated the trust's commitment to working in collaboration with partners to deliver system wide transformation within the geographical footprint. Board members were able to describe how the plan now focussed on supporting partnership working with stakeholders to ensure the delivery of sustainable care which was responsive to the local populations needs.

This was reflected in the trust's refreshed strategic intent priorities which were to:

- be the prime provider of specialist, acute and community mental health services
- be the lead provider in delivering new models of integrated physical and mental health out of hospital services, and
- realise the benefits of our geographical footprint to deliver system wide sustainable infrastructure solutions and organisational vehicles for new models of care.

This was underpinned by a strategic planning framework which brought together the trusts vision, strategic priorities and risks, delivery programmes and governance arrangements.

Each board committee had a strategic plan which was aligned to support the implementation of the overarching strategic plan. The trust was delivering year 1 of the 2017-22 strategy which was underpinned by a set of annual shared objectives for 2017/18 and the following key enabler plans:

• Operational plan

• Quality plan

• People plan

• Estates plan

• Health informatics plan

Progress reports from each of the committees were presented to the board in advance of the board meetings where they were discussed and reviewed.

The people plan included a strategy for meeting the physical health needs of patients which was monitored through the quality and safety sub-committee which reported to the quality committee.

The board assurance framework identified key risks in relation to delivering the trust strategy and actions to mitigate these. This ensured the board members had good oversight of progress made and areas where further work was required to ensure the strategic priorities were met.

Staff, patients, carers and external partners had the opportunity to contribute to discussions about the strategy, especially where there were plans to change services. Local providers and people

who use services had been involved in developing the strategy. The trust had over 14,000 members which it consulted with in order to shape the future of its services to meet the needs of the people it served. Members received regular information about the trust including a quarterly magazine. Members were eligible to stand as a governor on the trust's Council of Governors and vote for other members to become governors. In this way, people with experience of the services were actively engaged in the planning and delivery of the services.

The trust's engagement strategy formed part of their people plan. It set out actions the trust were taking to ensure the public, patients, carers and other organisations were involved in improving service delivery. The trust proactively engaged with staff, patients, carers, public and external partners to provide opportunities for people to contribute to discussions and share their views about proposed changes to services including service re-design proposals. They also engaged with stakeholders and the public in discussions involving longer term strategic changes as detailed in the Lancashire and South Cumbria sustainability and transformation plan in addition to specific local work streams within the trust. This included engaging with people with lived experience as part of the perinatal service design and with the public through GP patient participation groups to understand their views on community services in Southport and Formby. The trust also engaged with the public and involved young people affected by the move to the new child and adolescent in-patient ward the Cove.

The trust supported the two vanguard areas of Morecambe Bay and the Fylde Coast which had been allocated funding from NHS England to develop new models for those sections of the population that had the highest health needs.

The trust had an equality and diversity lead contact within the estates department to ensure the protected characteristics of the population were considered in any planned service changes. All proposed plans were subject to an equality impact assessment which identified the potential impact of the change on patients and staff in relation to the protected characteristics.

Culture

In the 2016 NHS Staff Survey the trust had better results than other similar trusts for, 'recognition and value of staff by managers and the organisation', 'staff motivation at work', 'support from immediate managers', 'effective team working' and the 'percentage of staff experiencing harassment, bullying or abuse from staff' in the last 12 months.

In the 2016 NHS Staff Survey the trust had better results than other similar trusts in 12 key areas:

Key finding	Trust score	Similar trusts average
KF15. % satisfied with the opportunities for flexible working patterns	59%	58%
KF16. % working extra hours	68%	71%
KF4. Staff motivation at work	3.98	3.94
KF7. % able to contribute towards improvements at work	74%	74%
KF8. Staff satisfaction with level of responsibility and involvement	3.92	3.90
KF9. Effective team working	4.00	3.87
KF5. Recognition and value of staff by managers and the organisation	3.59	3.55
KF10. Support from immediate managers	3.94	3.88
KF2. Staff satisfaction with the quality of work and care they are able to deliver	3.93	3.89
KF24. % reporting most recent experience of violence	95%	88%

KF25. % experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months	23%	28%
KF26. % experiencing harassment, bullying or abuse from staff in last 12 months	17%	21%

In the 2016 NHS Staff Survey: the trust had worse results than other similar trusts in 10 key areas

Key finding	Trust score	Similar trusts average
KF11. % appraised in last 12 months	87%	92%
KF12. Quality of appraisals	3.10	3.02
KF13. Quality of non-mandatory training, learning or development	4.02	4.08
KF28. % witnessing potentially harmful errors, near misses or incidents in last month	25%	24%
KF29. % reporting errors, near misses or incidents witnessed in last month	91%	93%
KF17. % feeling unwell due to work related stress in last 12 months	44%	39%
KF18. % attending work in last 3 months despite feeling unwell because they felt pressure	58%	55%
KF1. Staff recommendation of the organisation as a place to work or receive treatment	3.61	3.71
KF6. % reporting good communication between senior management and staff	28%	35%
KF23. % experiencing physical violence from staff in last 12 months	3%	2%

Commissioners reported the culture within the trust at board level and strategically to be good.

Staff we spoke with in the five core services we inspected and the focus groups we ran, told us they felt supported by their local managers and overall, staff felt respected and valued by the organisation. However; within the child and adolescent in patient ward, staff morale was low and they reported feeling disconnected from the organisation.

The trust's strategy, vision and values underpinned a culture which was patient centred. At each board meeting, a patient or carer and member of staff were invited to attend the board and talk about their story. This could be a story regarding a patient's/carers own experience of the care and treatment provided by the trust or a story from a member of staff regarding the care they provided to patients.

The trust had developed a coaching network which was underpinned by a values based framework. Twenty one staff had been identified as cultural ambassadors for the trust.

The trust recognised staff success in a number of ways. The trust held an annual staff 'amazing care award' which members of the public could vote for via the trust's web site. Over 350 staff had attended the staff awards ceremony in 2017. Recognition of individual, team and trust achievements were reported through the Quality Matters e-bulletin which the director of nursing sent to all staff each month, the trust's website and quality account.

The trust worked appropriately with trade unions who were established within the trust and raised issues on behalf of staff. They attended weekly staff induction sessions to discuss their role with new staff members. They also explained how they were represented on the policy group which was led by the director of human resources. They were currently involved in reviewing the absence policy which they described as being 'punitive' compared to the old policy which they reported to have been more supportive of staff.

Managers addressed poor staff performance where needed. The trust had relevant policies and procedures in place in relation to managing poor staff performance. The director of human resources told us that where possible, managers would strive to place staff on alternative duties as opposed to suspending them pending the outcome of any disciplinary procedure. In the 12 months up to 21/08/2017, 27 staff had been suspended within the trust and eight had been placed on alternative duties. The grades of staff ranged from band 1 to band 8d. We reviewed six completed disciplinary staff records which demonstrated that trust policies and procedures were followed with appropriate actions and outcomes recorded.

However; senior staff in some of the focus groups we held reported that performance issues in relation to bank staff were not always effectively managed and they were not clear about how these were being managed across the trust. They gave us examples of where they had reported an issue with a bank member of staff who had worked in their clinical area, to find the staff member was then working within another clinical area and they would not be made aware there was a performance issue with the member of staff. They felt this could compromise patient care.

The trust had appointed a freedom to speak up guardian shortly after the publication of the Francis report review in February 2015. The review was set up in response to evidence that NHS organisations did not appropriately react to the concerns raised by staff, including the maltreatment of those speaking up. The role of the freedom to speak up guardian is to foster a culture of safety and learning in which NHS staff can raise concerns. The trust's freedom to speak up guardian was supported in their role by a cohort of 24 freedom to speak up champions. The freedom to speak up guardian was part of a regional network of guardians and attended national conferences to support them within their role. Over the past 12 months, they had received 122 concerns from staff. Ninety two of these had been raised through the 'Dear David' initiative which enabled staff to raise any concerns they had quickly and anonymously directly with the chair of the trust. Seven were raised via CQC and the remaining 23 were raised directly to the freedom to speak up guardian. Common themes from the concerns raised included:

- staffing
- management culture and conduct
- workplace moves and changes
- working hours and flexible working and the
- impact of the network re-design.

The freedom to speak up guardian reported directly to the director of nursing and submitted quarterly reports to the quality committee in addition to an annual report to the audit committee. All concerns received were reviewed by the director of nursing who determined an appropriate course of action, which ranged from seeking assurance from services to the commissioning of an investigation.

Staff at all levels of the organisation understood the role of the freedom to speak up guardian. They were aware of the trusts whistleblowing policy and how to raise concerns. Staff felt able to raise concerns without fear of retribution although some staff within the acute and psychiatric

wards reported that they did not raise concerns as they were not confident this would lead to change.

The trust took appropriate learning and action as a result of concerns raised. All concerns were acknowledged within 48 hours and staff who provided their name also received an email with a full response in relation to the issue they had raised. Feedback to staff was shared through the Quality Matters e-bulletin which was circulated to staff on a monthly basis. This comprised an overview of the types of issues escalated and what had been done to resolve them so that staff were aware of the resultant actions.

One matron explained how the chief operating officer had visited the Cove in response to concerns raised regarding delays in damaged windows being replaced. They told us that following the visit, the chief operating officer had ensured that the work was completed.

The trust applied duty of candour appropriately. The trusts associate director of safety and quality governance was the duty of candour lead for the trust. The trust's 'Being Open' policy took into account the statutory duty of candour requirements. This set out the process staff needed to follow including reporting through the electronic incident reporting system. This included a three day review form which required the reviewing manager to confirm they had informed the patient or other relevant person and the date and name of the person completing it.

All Level 4 and Level 5 incidents were reviewed daily as part of a conference call chaired by the duty of candour lead. These were reviewed to determine further actions such as triggering a serious incident investigation. In the 12 months up to August 2017, the trust had reported 91 incidents which met the duty of candour requirements.

We reviewed five serious incident investigations which evidenced the trust applied duty of candour appropriately and followed their 'Being Open' policy in relation to these incidents.

Compliance was tracked through the monthly quality surveillance reports and reported to the quality and safety sub-committee and commissioners.

The trust had an equality and diversity lead for the trust. Feedback from union representatives was positive in relation to the work the lead had done to promote the equality agenda within the trust.

The workforce race equality standard requires NHS trusts to demonstrate progress against nine indicators of workforce equality. The trust had an overarching workforce race equality standard in conjunction with an equality and diversity statement of intent for 2015-20 which was linked with the trust's strategy, vision and values.

This identified four specific goals for each year which networks were required to focus on. These were:

2015/16 Goal 2 Improved patient access and experience

2016/17 Goal 4 Inclusive leadership at all levels

2017/18 Goal 1 Better health outcomes for all

2018/19 Goal 3 Empowered, engaged and well-supported staff

The trust aimed to review progress against all four goals in 2019/20.

The quality and safety and people sub-committees provided the quality committee with assurance against progress in meeting the goals and also served as the escalation point for risks identified by the director of human resource and the networks.

The trust had networks in place to promote the diversity of staff. The trust had increased the number of equality and diversity champions to 96 within the trust from the 60 it had during our last inspection.

The staff survey results for 2016 showed the trust was similar to other trusts in relation to, 'staff felt equality and diversity were promoted in their day to day work and when looking at opportunities for career progression'.

The trust had also won the NHS England Diversity and Inclusion Partner award for 2016/17.

The trust faced significant on-going challenges recruiting and retaining both nursing and medical staff. In July 2017 the overall vacancy rate for the trust was 22%. In December 2017, this had reduced to 13% with the vacancy rates for each network being:

Mental health: 13%

Community and wellbeing: 11%

Children and young people: 11%

Support services: 22%.

The trust had a number of actions detailed on the board assurance framework to improve staff recruitment, retention and reduce the use of bank and agency staff. These included a rolling recruitment programme, replacing leavers in a more timely way by extending the notice period for band 5 and 6 employees to allow for recruitment to take place and reducing the recruitment time process. The trust worked with partnership organisations to support building the future workforce which included the introduction of nurse associates and apprenticeship roles across the networks.

There was support for pharmacy staff role development. The trust was developing the role of pharmacist technicians in community mental health teams to support delivery of the physical health care agenda, clozapine safety and good medicines optimisation. Similarly, a business case was being prepared following a pilot of pharmacist enhanced non-medical prescriber support to the acute admission wards for improving medicines reconciliation and discharge and to support medical and nursing staffing.

The trust had a workplace planning group and a staffing for quality and safety group in place. These groups provided coordination on the overall strategies for improving staffing and mitigating risks which were incorporated into an action plan which was reviewed monthly. The staffing for quality and safety group reported to the quality and safety subcommittee which reported to the board through the quality committee. This ensured the board had oversight of any staffing issues within the trust.

The trust used the Hurst Tool for calculating staffing across inpatient services and the deputy director of nursing and heads of nursing were involved in national work to further develop this tool for specific areas of specialist care and for community services to enable greater analysis of acuity and activity and more accurate calculations of staffing levels across all areas.

E-rostering had been implemented on the wards which was supported by the safe care system which compared staffing levels with the actual care needs of patients on a shift by shift basis. The safe care system produced reports which showed any staffing deficits in red.

The trust had defined a number of early indicators called 'red flags' which identified where staffing levels may not be adequate. These included: incidents relating to violence and aggression, less than two qualified staff on shift, staff unable to facilitate leave and missed observations around physical health.

There was an escalation process for staff to report 'red flags'. There had been a decrease in the number of 'red flags' staff had reported from 177 in August 2017 to 84 in October 2017.

As at 31 July 2017 the trust overall sickness rate was at 6.5%. This had increased to seven percent in December 2017 which was higher than the trust target of 4.5%. The overall rates for each network for December 2017 were as follows:

- Mental health: 9%
- Community and wellbeing: 8%
- Children and young people: 6%
- Support services: 3%.

Staff sickness rates had been escalated on the trust's board assurance framework with actions identified to reduce these. A high sickness absence rate within the medicines management team had prompted review of, and increased focus on staff health and wellbeing supported by the trust's health and well-being team. This had improved sickness absence to less than four percent (end Q3).

The trust was a Mindful Employer and had a Health and Wellbeing programme in place which was supported by 195 Health and Wellbeing Champions across all networks. The trust worked in partnership with external organisations to promote access to physical activities for staff to improve health and wellbeing in addition to in-house activities.

Staff had access to support for their own physical and emotional health needs through occupational health.

Definition

Substantive – All filled allocated and funded posts.
Establishment – All posts allocated and funded (e.g. substantive + vacancies).

Substantive staff figures			**Trust target**
Total number of substantive staff	At 31/07/2017	6709	N/A
Total number of substantive staff leavers	01/08/2016–31/07/2017	881	N/A
Average WTE* leavers over 12 months (%)	01/08/2016–31/07/2017	12%	10%
Vacancies and sickness			
Total vacancies overall (excluding seconded staff)	At 31/07/2017	1408.5	N/A
Total vacancies overall (%)	At 31/07/2017	22%	5%
Total permanent staff sickness overall (%)	At 31 July 2017	6.5%	4.5%
	01/08/2016 – 31/07/2017	6.3%	4.5%
Establishment and vacancy (nurses and care assistants)			
Establishment levels qualified nurses (WTE*)	At 31/07/2017	2330.8	N/A
Establishment levels nursing assistants (WTE*)	At 31/07/2017	1381.7	N/A

Number of vacancies, qualified nurses (WTE*)	At 31/07/2017	399.1	N/A
Number of vacancies nursing assistants (WTE*)	At 31/07/2017	161.0	N/A
Qualified nurse vacancy rate	At 31/07/2017	17%	5%
Nursing assistant vacancy rate	At 31/07/2017	12%	5%
Bank and agency Use			
Shifts bank staff filled to cover sickness, absence or vacancies (qualified nurses)	01/08/2016 – 31/07/2017	14,495 (57%)	N/A
Shifts filled by agency staff to cover sickness, absence or vacancies (Qualified Nurses)	01/08/2016 – 31/07/2017	4,469 (18%)	N/A
Shifts NOT filled by bank or agency staff where there is sickness, absence or vacancies (Qualified Nurses)	01/08/2016 – 31/07/2017	4,384 (17%)	N/A
Shifts filled by bank staff to cover sickness, absence or vacancies (Nursing Assistants)	01/08/2016 – 31/07/2017	31,495 (42%)	N/A
Shifts filled by agency staff to cover sickness, absence or vacancies (Nursing Assistants)	01/08/2016 – 31/07/2017	2,282 (3%)	N/A
Shifts NOT filled by bank or agency staff where there is sickness, absence or vacancies (Nursing Assistants)	01/08/2016 – 31/07/2017	3327 (4%)	N/A

*Whole Time Equivalent

The trusts training targets operated on an annual basis and the figures reported relate to the current financial year at the time of reporting (1 April 2017 to 31 March 2018). The trust wide training compliance reported for this financial year was 52% against the trust target of 85%. Of the training courses listed 15 were below the trust target and of those, 12 were below 75%.

Key:

Below CQC 75%	Between 75% & trust target	**Trust target and above**

Training course	Trustwide mandatory/ statutory training total %
Mental Capacity Act Level 1 (Clinical)	**99%**
Mental Capacity Act Level 1 (Admin)	**85%**
Safeguarding Vulnerable Adults Level 1	83%
Safeguarding Children Level 3	83%
Safeguarding Children Level 2	76%
Equality & Diversity	71%
Infection Control (Admin)	71%
Manual Handling Level 1	63%
Fire Safety	57%
Infection Control (Clinical)	55%
Health & Safety	52%
Safeguarding Children Level 1	45%
Information Governance	42%
Manual Handling Level 3	41%
Manual Handling Level 2	40%

Conflict Resolution	37%
Resuscitation (Basic Life Support)	27%
Immediate Life Support (ILS)	25%
Total	**46%**

The overall completion rates for core services ranged between 40% (Prisons and CHS – Sexual health) and 74% (CHS – Community health inpatient services).

The overall mandatory training compliance reported for this inspection was lower than the 72% reported at the last inspection, however the figures may not be directly comparable due to timing of the reports within the financial year; the end of year compliance figure for the period between 1 April 2016 and 31 March 2017 was 93%.

An up-date on compliance with mandatory training was presented to the board in February 2018 by the chair of the quality committee. This showed the overall compliance rate was above the trust target of 85% however: performance remained below target in:

• basic life support (79%)

• intermediate life support (78%)

The following essential skills subjects were also below the 85% target:

• prevent (49%)

• Mental Capacity Act level 2 (43%)

• Mental Health Act level 2 (45%)

• violence reduction (61%)

• safeguarding adults level 2 (46%)

Essential training was mandatory for specific job roles.

These findings were similar to findings we reported during our last inspection. This meant the trust had not ensured that all staff had received the training required specific to their role. The director of nursing reported that releasing staff from some clinical areas to attend face to face training continued to be difficult due to the on-going staffing challenge the trust faced. Low levels of compliance with training had been escalated on to trust's board assurance framework. Each network had a recovery plan.

In the 2016 staff survey results, the trust scored lower than the average score (92%) of similar trusts with 87% for the percentage of staff reporting they had received an appraisal. They also scored lower for the quality of appraisals.

The trust's target rate for appraisal compliance was 85%. As at 31 March 2017, the overall appraisal rates for non-medical staff was 33%.

None of the 16 core services achieved the trust's appraisal rate. The core services with the highest appraisal rates were Community Dental (80%) and Community Health Inpatient Services (79%).

Appraisal rates presented to the board in February 2018 reported the following compliance rates within the three networks: Mental health: 32%, community and wellbeing: 65%, children and young people: 62%. Support services were at 57% which meant the overall trust compliance rate was 49%.

Poor compliance with appraisal rates had been escalated onto the board assurance framework. Specific actions to improve engagement with appraisals had been introduced organisationally. These included:

- making clear the organisational priorities to all staff and their role in helping the trust to achieve its goals
- staff access to corporately planned education, training and professional development could only be gained through the appraisal structure
- a review of team sizes to ensure managers had appropriately sized teams
- training and development to ensure managers had and maintained the skills and understanding required for regular reviews with their staff.
- scheduled internal auditors focussing on the quality of the appraisal process in order to identify any areas for improvement to ensure staff have a positive experience of appraisals.

Core Service	Total number of permanent non-medical staff requiring an appraisal	Total number of permanent non-medical staff who have had an appraisal	% of non-medical staff who have had an appraisal
CHS - Community Dental	113	90	80%
CHS - Community Health Inpatient Services	28	22	79%
CHS - Community health services for adults	1013	562	55%
CHS - Community health services for children, young people and families	669	322	48%
MH - Community-based mental health services for older people.	303	140	46%
MH - Community mental health services for people with learning disabilities or autism	261	108	41%
Trust - Support Services	719	269	37%
Admin/Management/Other	722	256	35%
MH - Community-based mental health services for adults of working age.	422	121	29%
MH - Mental health crisis services and health-based places of safety.	174	27	16%
CHS - Sexual Health	34	4	12%
MH - Specialist community mental health services for children and young people	264	29	11%
MH - Acute wards for adults of working age	733	75	10%
MH - Forensic inpatient/secure wards.	334	17	5%
Prisons	278	9	3%
MH - Wards for older people with mental health problems.	208	2	1%
Total	6275	2053	33%

As at 31 March 2017, the overall appraisal rates for medical staff was 78%.

Four of the 12 core services with medical staff achieved the trust's appraisal rate. The core services, which achieved the trust's appraisal target, were 'Community health services for adults' with 100%, 'Admin/Management/Other' with 100%, 'Community-based mental health services for older people' with 90% and 'Community-based mental health services for adults of working age' with 86%. The rate of appraisal compliance for medical staff reported during this inspection is lower than the 96% reported at the last inspection as of May 2016.

Core Service	Total number of permanent medical staff requiring an appraisal within the last 12 months	Total number of permanent medical staff who have had an appraisal in the last 12 months	% appraisals
CHS - Community health services for adults	3	3	100%
Admin/Management/Other	1	1	100%
MH - Community-based mental health services for older people.	30	27	90%
MH - Community-based mental health services for adults of working age.	51	44	86%
MH - Specialist community mental health services for children and young people	15	12	80%
MH - Forensic inpatient/secure wards.	14	11	79%
MH - Wards for older people with mental health problems.	9	7	78%
Prisons	2	1	50%
MH - Community mental health services for people with learning disabilities or autism	2	1	50%
CHS - Sexual Health	5	2	40%
CHS - Community Health Inpatient Services	6	0	0%
Trust - Support Services	1	0	0%
Total	139	109	78%

Trust policy required all clinical staff to engage in quarterly supervision as a minimum. This could be on an individual basis or in facilitated peer groups. The trust had introduced optional supervision passports for all staff in 2016 although they did not have a standard supervision recording system and therefore could not provide consistent or full data in respect of supervision compliance. Team managers recorded and monitored compliance within their teams which was reported to the quality and safety sub-committee via network managers. This meant the board were reliant upon managers reporting accurate compliance rates for their teams and clinical networks. Although this provided reassurance to the board, it did not provide assurance due to the absence of supporting evidence.

The trust's target rate for clinical supervision was based on the number of sessions delivered, 125 teams had a target rate of 100% and 40 teams had a target rate of 95%. As of 24 August 2017,

the overall clinical supervision compliance rate was 71%. This data had been manually collected by the trust between 14 August 2017 and 24 August 2017.

Caveat: there is no standard measure for clinical supervision and trusts collect the data in different ways, it is important to understand the data they provide.

None of the 13 core services achieved their clinical supervision target. 'Community health services for children, young people and families' and 'Specialist community mental health services for children and young people' had clinical supervision rates of 98%, against a target rate of 100%. Other teams had target rates of either 100 or 95%. Not all of the other core services achieved the 95% target.

Core Service	Number of formal supervision sessions required for staff group	Number of actual formal supervision sessions received by staff group	Clinical supervision rate (%)
CHS - Community health services for children, young people and families	5054	4942	98%
MH - Specialist community mental health services for children and young people	657	641	98%
CHS - Sexual Health	60	56	93%
MH - Child and adolescent mental health wards.	616	556	90%
MH - Community-based mental health services for older people.	1861	1311.3	70%
CHS - Community health services for adults	1532	1038	68%
MH - Forensic inpatient/secure wards.	1204	771	64%
MH - Community mental health services for people with learning disabilities or autism	2577	1641	64%
CHS - Community Health Inpatient Services	336	207	62%
MH - Acute wards for adults of working age	973.8	580.9	60%
MH - Community-based mental health services for adults of working age.	2230	858.9	39%
MH - Wards for older people with mental health problems.	602	150	25%
MH - Mental health crisis services and health-based places of safety.	212	0	0%
TOTAL	17914.8	12753.1	71%

Governance

The trust had effective structures, systems and processes in place to support the delivery of its strategy. The trust had last commissioned an external independent review of its governance arrangements in July 2016.The review provided assurance to the board that there was a clear connectivity at network level up to board level.

The trust had four committees which reported directly to the board, three of which had sub-committees which were:

- Quality committee: quality and safety sub-committee, people sub-committee and mental health legislation sub-committee
- Audit committee: corporate governance and compliance sub-committee
- Finance and performance committee: business development and delivery sub-committee, Finance sub-committee and infrastructure sub-committee
- Nominations remuneration committee.

Non-executive and executive directors were clear about their areas of responsibility. The trust had a council of governors who provided a link between the communities the trust served and the board of directors. The governors met monthly and reported they met regularly with the chair of the board. They understood their role in terms of holding the non- executive members of the board to account. The non-executive directors were also invited by the chair to attend informal sessions with the council of governors to promote networking and provide an opportunity for governors to challenge the non-executives about the trust's performance or areas of concern. They also provided feedback to the non-executive directors as part of the annual appraisal process.

We attended both a board and quality committee meeting and reviewed a range of minutes from the board and sub-committee meetings. Papers to inform the meeting were circulated in good time and contained clear, relevant information in relation to the meetings.

Each of the sub-committees had specific sub groups/committees which linked into them to support the delivery of the trust's strategy. The structure from the board to the sub groups/committees was displayed on a single sheet which provided a clear overview of the board's overarching governance structure.

Since our last inspection, the trust had completed a programme to redesign their operational delivery model, and realign the four previous clinical networks into three networks to reflect the changes which were taking place in health and social care provision across Lancashire in line with the Lancashire and South Cumbria sustainability and transformation plan and the trust's strategic plan for 2017-22. Delivery of the trust's portfolio of services took place across three interdependent clinical networks which were: mental health, community and wellbeing and children and young people (up to age 25 including both mental and community health provision).

Each network was operationally led by a clinical director and a head of operations. They were supported by a head of nursing, allied health professional lead, psychology lead and deputy head of operations. Corporate support services provided a range of business partners to the network management teams including finance, human resources and quality governance.

Networks were divided into localities, and each locality was led by a care group manager who operationally managed the matrons and service managers.

The trust had recently restructured this level of line management with the appointment of lead nurses within the three networks who were responsible for providing clinical leadership to the matrons and staff within the networks.

For each of the three networks, the management structure from service manager/lead nurse level to the board was displayed on a flow chart within a single sheet. This provided a clear visual overview of the management structure for each network and enabled staff to see how their teams fit into the overarching trust governance structure.

There were standardised templates for each of the governance meetings from this level up to the board which included a number of quality issues such as staffing, safeguarding, incidents, complaints, infection control issues and learning from incidents. There was consistency in the

quality of the minutes from the various meetings and clear links within these to the boards' strategic objectives and values.

However; there was some confusion expressed by service managers, lead nurses and matrons within the focus groups we held regarding their own roles and the roles of each other within the new structure. The in- patient matrons had recently started to work two clinical shifts a week on the wards they were responsible for and the ward managers worked three per week. The director of nursing reported this decision had been made to strengthen the senior clinical presence on the wards and to support safe staffing numbers. However; some matrons reported through the focus group we held and in the core services we visited, that this had led to them feeling disempowered and that their voice was not always heard in the organisation. Some described how the lead nurses and care group managers had different priorities and expectations from them which could cause confusion.

The matrons described an emerging structure across the wards and teams to support the quality agenda. They had implemented a standardised meeting structure and agenda across some services and described this as, 'work in progress'.

At team level in some of the core services we visited, there was inconsistency in the quality, recording and frequency of team meetings which took place. This meant that managers could not be assured that governance arrangements were fully embedded within these teams.

Appropriate governance arrangements were in place in relation to medicines management. The medicines safety group, chaired by a full time medicines safety officer, focussed on all aspects of trust medicines safety, including incident reporting and review. Network reporting to the medicines safety group had improved and the trust's medicines safety dashboard was being developed to provide greater assurance with regard to medicines safety. The chief pharmacist was the trust's controlled drugs accountable officer and the required controlled drugs quarterly reports were submitted to the local intelligence network.

Appropriate governance arrangements were in place in relation to Mental Health Act administration and compliance. There was an executive and non-executive lead appointed at the trust which ensured that the Mental Health Act was given appropriate oversight at board level. Each of the networks had a Mental Health Law governance group, which fed into the mental health law sub-committee chaired by the director of nursing. The sub-committee provided reports to the quality committee, which reported directly to the board on Mental Health Act work-streams, issues and risks.

There were a number of multi-agency policies and protocols in place which were developed in partnership with other organisations to ensure collaborative working. This included the local acute trusts to meet the physical care needs of detained patients.

There was representation from partners on Mental Health Act working groups and committees, including approved mental health professionals, local authorities, police and ambulance services. Mental Health Act data was used to identify Mental Health Act issues and risks which were actioned in partnership with other organisations where appropriate.

The Mental Health Act administration team had robust Mental Health Act systems and processes in place to monitor compliance the legislation and Code of Practice 2015. There was a standard operating procedure in place to cover all processes. When there was a change to Mental Health Act legislation or updates to case law, staff were informed. Mental Health Act related polices were up to date and in line with the Code of Practice 2015 and there was a robust process for developing and ratifying Mental Health Act related policies. A daily Mental Health Act overview was provided to all ward managers to ensure that they were kept aware of the administrative

requirements of the Mental Health Act and the time frames within which all actions had to be completed.

Mental Health Act reports included issues around assessment and application for detention, breaches in section 136, adherence to the Code of Practice requirements and compliance with audit and training. However, they did not include datasets on repeat admissions data, black and minority ethnic representation against local population groups and causes of detention.

The trust worked with three local authorities and had section 75 agreements in place with two of them. The local authorities provided the approved mental health professional service. These services were well resourced and staff had previously reported they felt supported in their roles.

The trust had a section 12 register in place.

The trust had effective systems in place to manage and respond to complaints. The trust was asked to comment on their targets for responding to complaints and current performance against these targets for the last 12 months.

	In Days	Current Performance
What is your internal target for responding to* complaints?	3 working days	99%
What is your target for completing a complaint?	25 working days: completion date is agreed with the complainant	58%
If you have a slightly longer target for complex complaints please indicate what that is here	-	-

* Responding to defined as initial contact made, not necessarily resolving issue but more than a confirmation of receipt

**Completing defined as closing the complaint, having been resolved or decided no further action can be taken

	Total	Date range
Number of complaints resolved without formal process* in the last 12 months**	0	1 August 2016 – 31 July 2017
Number of complaints referred to the ombudsmen (PHSO) in the last 12 months	15	1 August 2016 – 31 July 2017

**Without formal process defined as a complaint that has been resolved without a formal complaint being made. For example PALS resolved or via mediation/meetings/other actions

We reviewed five closed formal complaints which the trust had received in line with the trust's complaints policy and procedures criteria for managing complaints. All the complainants had been initially responded to within three working days. The complaints had been investigated appropriately and resolved where applicable in line with trust policy. The investigator had maintained contact with the complainant in addition to formally writing to them with the outcome of the investigation which included any actions the trust had taken or intended taking in response to the outcome of the complaint.

This trust received 8792 compliments during the last 12 months from 1 August 2016 to 31 July 2017. This was higher than the 2,981 reported at the last inspection. 'Adults Community' had the highest number of compliments with 24%, followed by 'Community health services for adults' with 20% and 'Community Dental' with 11%.

The trust worked in partnership with over 32 different statutory and non-statutory organisations to promote good patient care. This was in line with the national Five Year Forward View initiative, which involved organisations working together across the geographical footprint to improve health and wellbeing outcomes for people as well as setting out how health and social care services would be delivered locally based upon local needs.

Initiatives included:

- the development of a crisis house in the community which was delivered by a third sector organisation with referrals managed via the trust's crisis home treatment team
- promoting the health, wellbeing and improving outcomes for individuals and communities through the establishment of an integrated community wellbeing service with the local authority and
- a formal partnership with a wildlife trust called 'My Place' which aimed to empower young people, encouraging them to take action in their local greenspaces that will have a positive impact upon their own mental health

The trust also worked with partners from other NHS providers and commissioners, local government and the voluntary sector to develop the 'Lancashire and South Cumbria sustainability and transformation plan'.

The trust provided Mental Health Act support to a local acute trust and there was a service level agreement in place for the delivery of liaison psychiatry services.

Management of risk, issues and performance

The trust had systems in place to identify learning from incidents, complaints and safeguarding alerts and make improvements. The trust used an electronic system for reporting incidents which any member of staff could access. The trust incident management policy had clear timescales for reporting incidents which staff were aware of. All incidents were required to be reported within 24 hours. Incidents were graded in severity from one to five. For incidents graded level four or five, managers were required to complete an initial investigation within 72 hours. All incidents graded below four were investigated locally within seven days. Staff were aware of their roles and responsibilities in relation to reporting incidents and the escalation process they were required to follow. Since our last inspection, the trust had up dated the incident reporting system to include a new process which ensured staff received feedback on incidents they had reported.

In September 2016, the trust established a dedicated Investigations and Learning Team to undertake all serious incident investigations including safeguarding and deaths within the trust. The team consists of eight investigations and learning specialists reporting to the head of investigations and learning along with administrative support. The team was independent of clinical services and aimed to produce impartial and transparent investigation reports with the objective of improving the quality of investigations. The team had produced a leaflet for people affected by a serious incident that explained the process and had procedures in place to ensure that everyone involved in a serious incident investigation received a copy of the final anonymised report. The team provided post-investigation debriefings for the clinical team and for people who used services, their carers and families.

The trust had a monthly serious incident learning review panel which was established in April 2017. This was attended by non-executive and executive directors, clinical directors and commissioners. The purpose of the panel was to review a selection of serious incident reports, recommendations and action plans to test, share and challenge learning. Safeguarding also had a lessons learnt group and produced seven minute bulletins with concise learning points.

The trust used a range of ways to share learning across the organisation which included:

- Dare to share/time to shine events
- Up-dates to the electronic incident reporting form to include a lessons learnt section for completion by the reviewer
- Team dashboards created for use at team level to facilitate discussion about team level incidents
- Thematic reviews presented at the quality and safety sub-committee
- Use of safety alerts to share lessons learnt from incidents.

However: staff on some wards and in the focus groups we held told us that learning across teams and the clinical networks was not consistent and always embedded in practice.

The trust had identified pharmacy and medical leads accountable for the delivery of POMH-UK (Prescribing Observatory for Mental Health) benchmarking audits of prescribing against national standards. The trust's Greenlight e-bulletin was used to disseminate learning from incidents with a recent example highlighting the neuroleptic malignant syndrome following a serious incident at the trust, where the symptoms were not promptly recognised.

The trust had been recently been rated as having, 'good levels of openness and transparency', ranking 23rd out of 230 NHS trusts in NHS Improvement's learning from mistakes league which demonstrated the trust's open culture to learning from incidents.

Providers must report all serious incidents to the Strategic Executive Information System (STEIS) within two working days of identifying an incident.

Between 1 August 2016 and 31 July 2017, the trust reported 98 STEIS incidents. The most common type of incident was 'Apparent/actual/suspected self-inflicted harm' with 55. Twenty-one of the 98 incidents occurred in mental health crisis services and health-based places of safety.

Never events are serious incidents that are entirely preventable as guidance, or safety recommendations providing strong systematic protective barriers, are available at a national level, and should have been implemented by all healthcare providers. Lancashire Care NHS Foundation Trust reported no never events during this reporting period.

We asked the trust to provide us with the number of serious incidents from the same period on their incident reporting system. The number of the most severe incidents (93) was broadly comparable with the number the trust reported to STEIS. From the trust's serious incident information, there were three unexpected deaths, two of these occurred in acute wards for adults of working age and one occurred in 'community health inpatient services'.

Type of incident reported on STEIS	**Abuse/alleged abuse of adult patient by staff**	**Apparent/actual/suspected self-inflicted harm**	**Disruptive/ aggressive/ violent behaviour**	**Medication incident meeting SI criteria**	**Slips/trips/falls meeting SI criteria**	**Unauthorised absence meeting SI criteria**	**Pressure ulcer meeting SI criteria**	**Commissioning incident meeting SI**	**Confidential information**	**Sub-optimal care of the deteriorating patient**	**Total**

Mental health crisis services and health-based places of safety.		20						1			21
Community-based mental health services for adults of working age.		14					1	1			16
Prisons		6			2			7			15
Not included in SIRI data/ core service unknown		8		1			2		2		13
Community health services for adults		1		1			8		1		11
Acute wards for adults of working age		2	1	2				1	1		7
Forensic inpatient/secure wards.		1	1			2		1			5
Other										3	3
Community health services for children, young people and families									2		2
Community-based mental health services for older people.		2									2
Community Health Inpatient Services										1	1
Specialist community mental health services for children and young people		1									1
Wards for older people with mental health problems.	1										1
Total	1	55	2	4	2	2	11	11	9	1	

Providers are encouraged to report patient safety incidents to the National Reporting and Learning System (NRLS) at least once a month. They do not report staff incidents, health and safety incidents or security incidents to NRLS.

The highest reporting categories of incidents reported to the NRLS for this trust for the period 1 August 2016 to 31 July 2017 were ‘self-harming behaviour’, ‘disruptive, aggressive behaviour’ and ‘patient accident’. These three categories accounted for 5949 of the 11224 incidents reported. Self-harming behaviour accounted for 78 of the 108 deaths reported.

Ninety one percent of the total incidents reported were classed as no harm (76%) or low harm (15%).

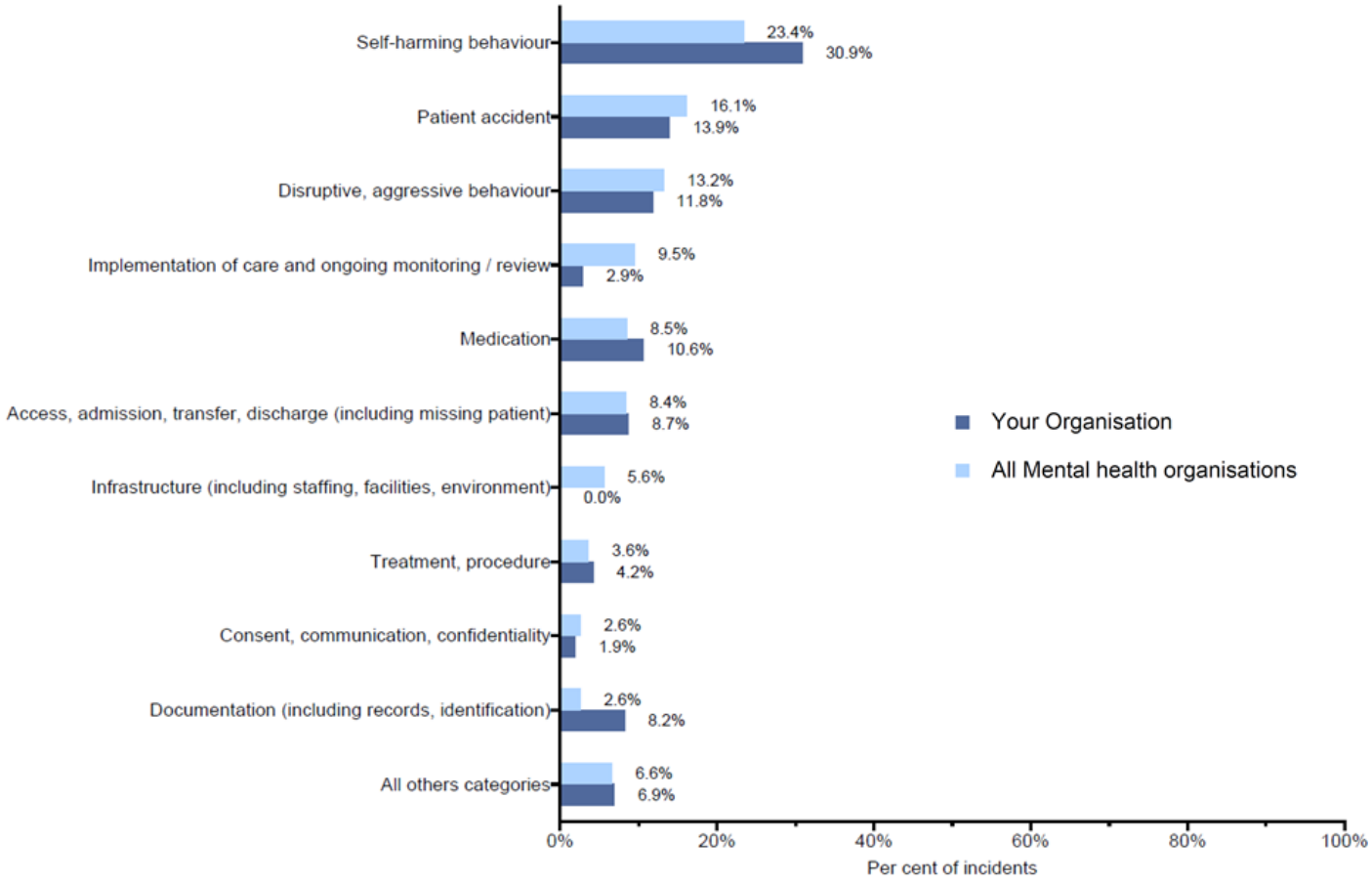
Incident type	No harm	Low harm	Moderate	Severe	Death	Total
Self-harming behaviour	2181	806	231	34	78	3330
Disruptive, aggressive behaviour (includes patient-to-patient)	1090	197	79	6	2	1374
Patient accident	800	346	74	12	13	1245
Access, admission, transfer, discharge (including missing patient)	1073	46	50	3		1172

Medication	1069	37	37	6		1149
Documentation (including electronic & paper records, identification and drug charts)	996	2	2		1	1001
Other	300	166	130	16	14	626
Treatment, procedure	462	12	27	8		509
Implementation of care and ongoing monitoring / review	34	83	101	48		266
Consent, communication, confidentiality	227	1	1			229
Infrastructure (including staffing, facilities, environment)	183	4	6	1		194
Clinical assessment (including diagnosis, scans, tests, assessments)	53	1	1			55
Patient abuse (by staff / third party)	45	3		1		49
Medical device / equipment	12	1				13
Infection Control Incident	3	3	5	1		12
Total	**8528**	**1708**	**744**	**136**	**108**	

According to the latest six-monthly National Patient Safety Agency Organisational Report (1 October 2016 to 31 March 2017), the trust was in the middle 50% of reporters nationally for similar trusts.

Self-harming behaviour, medication and documentation (including records, identification) accounted for a higher proportion of the total number of incidents reported compared to similar

trusts.



Organisations that report more incidents usually have a better and more effective safety culture than trusts that report fewer incidents. A trust performing well would report a greater number of incidents over time but fewer of them would be higher severity incidents (those involving moderate or severe harm or death).

Lancashire Care NHS Trust reported more incidents from 1 August 2016 to 31 July 2017 compared with the previous 12 months. The overall number of incidents was slightly higher with increases in the number incidents classified as 'No harm', 'Low', 'Severe' and 'Death' reported. The largest proportional increase was the increase in reported incidents relating to a Death, which increased from 11 to 108.

Level of harm	**1 August 2015 – 31 July 2016**	**1 August 2016 – 31 July 2017 (most recent)**
No harm	8340	8528
Low	1577	1708
Moderate	808	744
Severe	46	136
Death	11	108
Total incidents	**10782**	**11224**

Lancashire Care NHS Trust submitted details of eight classes of external reviews which commenced or were published in the last 12 months.

These reviews included Quality Visits by Commissioners

- Coroners Inquests

- Trust commissioned independent review of a complaint/incident
- PHSO reviews of complaints
- CQC Mental Health Act Monitoring Visits
- CQC Focused Review (Appreciative Inquiry) into use of MHA
- PPO reviews into deaths in custody alongside NHS England Clinical Reviews
- Trust commissioned independent reviews of services/projects

The trust reported that 'All reviews are coordinated by the Safety and Quality Governance Department. This ensures reports are received, factually checked and action plans developed where appropriate. The reports are used to provide assurance and inform areas for quality improvement. Where appropriate, actions are tracked through the electronic risk management system to provide oversight and reporting of progress.'

A theme emerging from many of the above reviews reflects the demand on services, in particular mental health inpatient services which is compounded by staffing challenges.

A number of reviews covering the healthcare services at HMP Liverpool identified challenges with quality and safety. A comprehensive improvement plan was developed in response to these visits and an internal quality assurance visit.'

Arrangements were in place for identifying, recording and managing risks, issues and mitigating actions were identified. The trust board had sight of the most significant risks and mitigating actions were clear. The trust provided its board assurance framework which was reviewed at each board meeting. This detailed risks scoring and gaps in the risk controls that affect strategic ambitions.

Within the board assurance framework, any risk which scored 15 or higher according to the Risk Rating Matrix was classified as 'Significant'. There were five cases with a current risk score of 15 or higher. Two of these risks related to strategic ambition 4 'to employ the best people'.

Key:

Signficant (15-20)	High (8-12)	Moderate 3-6	Low (1-2)

Network/Support Service	Objective	Objective Measure	Deadline	Draft Q1 Position	Link to BAF strategic objective no.
Mental Health Network	To demonstrate compliance in relation to all aspects of Mental Health Law	Formulation and delivery on a transformation plan that is compliant with our contract, competitive in terms of other providers and reflects high quality, evidence based, safe care for our service users.	Q4		1
Mental Health Network	To demonstrate compliance in relation to all aspects of Mental Health Law	Formulation and delivery on a transformation plan that is compliant with our contract, competitive in terms of other providers and reflects high quality, evidence based, safe care for our service users.	Q4		2

Mental Health Network	Staffing at all times is at a level that allows safe and effective care	Sickness absence ≤ 4.5% Mandatory and essential training completion >85% 80% staff in post against establishment by Q4 Return to Work interviews at ≥ 90% PDR completion (and supervision) ≥ 95% 100% of HCSW staff to have achieved care certificate	Q4		4
Nursing & Quality Directorate	To develop the Quality Academy to better support Operational Service Quality	Increase on 16/17 levels of Staff Survey engagement score. Staff Friends and Family Test. Staff Retention Levels Core and Essential Skills Compliance Rising Maintain or Improvement on LDA outcomes /performance 100% utilisation of Apprenticeship Levy	Q4		4
Mental Health Network	To deliver services in budget and to achieve all CIPs	Financial Activity: CIP target of £4.497m delivered with budget balanced or in surplus by year end Reduction of over-expenditure of £3.4m	Q4		5

- The trust has provided documents detailing their highest profile risks in support services, Children and young person's wellbeing and Community and wellbeing services. As with the Board assurance framework risks scoring 15 or higher were classified as 'Significant'. There were 27 cases with a current risk score of 15 or higher.
- The majority (20) of the highest profile risks related to the support services network.
- Across all of the networks, 10 of the risks related to strategic ambition 4 'To employ the best people'.

Staff were able to escalate concerns to the network risk register via the matrons or service managers. There was a clear process for escalation of risks from networks to the trusts risk register via the committees. The concerns staff, stakeholders and union representatives discussed with us through interviews, focus groups and in the core services we inspected were captured on the network and corporate risk register where appropriate.

The trust was rated in year 2016 as having "good levels of openness and transparency", ranking 23rd out of 230 NHS Trusts in NHS Improvement's Learning from Mistakes League.

There was a robust audit programme in place to monitor compliance against trust policies and best practice guidance which was managed through the trust's audit committee governance structure with oversight from the board. If an audit did not show 80% compliance during a re-audit, then a deep drive was undertaken by the medical director, head of audit and the head of quality improvement to explore what support may need to be provided within clinical areas to ensure compliance which resulted in an action plan being developed. Actions from the plan were tracked through the quality and safety sub-committee. Audits remained on the programme until 80% compliance was achieved.

There were plans in place for emergencies. The trust had detailed business continuity management plans including a major incident plan and associated polices to ensure services

could respond effectively in the event of an emergency situation or major incident which could impact on service delivery. This included situations such as flooding, bomb scares and pandemics.

Where cost improvements were taking place, the trust had effective systems in place to ensure they did not compromise patient care. The trust has a significant cost improvement programme totalling £15.1m for 2017/18 and was confident in delivering this. Each network had developed a cost improvement plan which had been co-produced with staff. Each cost improvement plan proposal was subject to a quality and equality impact assessment which considered the impact on patient care, protected characteristics and sustainability. With the exception of some matrons, all staff we spoke to from ward level to board told us that the trust placed quality before finance. This was also reflected in the discussions we had with stakeholders.

Board members were able to provide examples of where the board had rejected cost improvement proposals due to the negative impact this would have had on quality.

NHS Improvement's single oversight framework currently segments the trust into category two for finance and use of resources. The framework identifies four segments. Segment one reflects providers with the strongest financial performance. Segment four reflects providers with the worst performance.

	Historical data		Projections	
Financial Metrics	Previous financial year (2 years ago)	Last financial year (2016/17)	This financial year 2017/18	Next financial year (2018/19)
Income	£344,011	£344,012	£336,958	£333,167
Surplus	-£3,635	-£1,018	£2,271	£2,943
Full costs	£347,646	£345,030	£334,688	£330,224
Budget	-£3,044	-£1,379	£2,167	£2,943

Although the trust was underperforming against its 2017/18 financial plan, it had submitted a recovery plan to NHSI that had clear milestones and deliverables that enabled the trust and NHSI to monitor performance against the recovery trajectory. NHSI reported no concerns in the way that financial risks were managed or reported within the trust or with the accountability for financial governance arrangements.

The trust finance team was applying for towards excellence accreditation which was endorsed by NHS Improvement.

Information Management

The Information Governance Toolkit is an online system which enables organisations to complete a self-assessment against information governance policies and standards. NHS organisations are required to complete this each year. Information governance is the system an organisation uses to ensure that personal and corporate information is handled safely. The trust had completed the Information Governance Toolkit assessment in March 2017 and scored 80% which was 'satisfactory'.

The trust had a separate senior information risk owner and a Caldicott guardian who was the medical director. In addition, there was a data quality lead in place who co-ordinated monitoring and actions across the networks with the support of the network designated data quality leads.

The trust had assessed policies and procedures against the European Union General Data Protection Regulation which will apply from 25 May 2018, when it supersedes the UK Data Protection Act 1998. Board members had received assurance through the finance and performance committee and were confident they would meet the new regulations.

The board received holistic information on quality and sustainability. The trust had a system of quality surveillance to monitor and facilitate team to board assurance on quality and safety. The trust had 'board balance score cards' for each clinical network which provided data on a range of key performance indicators such as staffing, training compliance, incidents reported, safeguarding alerts, appraisal rates and complaints/compliments. Information on the score cards could be broken down to each team. The teams used 'quality dashboards' which provided them with information on key performance and quality indicators specific to their team. Teams also used an electronic outcome measures tool which monitored safety, effectiveness, experience and leadership known as SEEL. This consisted of data collected from a variety of sources and measured 16 quality outcomes. Information regarding the outcome of the SEEL audit was displayed in each clinical area on their team information board, which was visible and accessible to visitors. The matrons told us they used team information to analyse trends and issues with the ward managers.

Clinical directors of each network provided quality surveillance reports to the board via the quality and safety sub-committee and quality committee. These were aggregated and embedded in the integrated quality and performance report which was reviewed by the board. The board and senior staff expressed confidence in the quality of the data they received and welcomed challenge. This was evident in the board meeting and quality subcommittee we attended.

The trust had a programme of projects to improve information management systems within the trust. The board had recently approved a business case for a new Electronic Patient Record system across all clinical services. In addition, they had plans in place to roll out the Electronic Prescribing and Medicines Administration system which they had implemented in 2016 on the in-patient wards to community teams this year.

The trust had also launched a new quality improvement software system at the 2017 Quality Improvement Conference called Life QI. The trust intended using the tool to record all quality improvement activity which would allow staff and the board to see the totality of improvement work taking place.

The board and senior staff expressed confidence in the quality of the data and welcomed challenge. This was evident in the board meeting we attended.

However: the board acknowledged that information management systems could be improved which was reported on network registers and the board assurance framework. These risks were regularly reviewed by the sub committees, committees and board.

The trust had information governance systems in place including the confidentiality of patient records. Trust-wide, compliance with information governance training was 94% in December 2017.

The trust had a good track record of submitting notifications to external bodies as required. Board members and senior executives had a transparent and open culture when reporting notifications.

The trust had not reported any data security breaches. A recent internal cyber security audit the trust carried out provided 'significant assurance'.

Engagement

The trust had a structured and systematic approach to engaging with people who use services, those close to them and their representatives.

The trust's engagement strategy and plan formed part of the trust's people plan. The engagement plan set out detailed actions which identified how the public, patients, carers and other organisations were involved in improving service delivery. The delivery of the people plan was managed by the people plan delivery group and monitored through the people sub-committee with progress reported to the board via the quality committee.

The trust's engagement strategy included a stakeholder engagement plan which defined how the trust identified key partners to work with. The trust was actively engaged in collaborative work with over 32 external partners. This included partnership working with other NHS providers and commissioners, local government and the voluntary sector to develop the 'Lancashire and South Cumbria Sustainability and Transformation Plan'.

The trust received feedback from carers through joint work with the local authority as the lead for the Lancashire wide carer's strategy.

The trust's council of governors sought feedback from people within the community in a number of ways which they feedback to the board. A patient or carer was invited to attend the board meetings each month to talk about their story.

The trusts inclusivity and diversity team proactively engaged and sought feedback from under-represented members of the public through a variety of forums. They engaged with a number of steering groups and organisations to share learning and gain an insight into people's lived experience. Examples included: Deafway, the North West Visual Impaired Forum, Accrington Blind Society, Lancashire Deaf Rights Group, One Voice Blackburn and LGBT Lancashire.

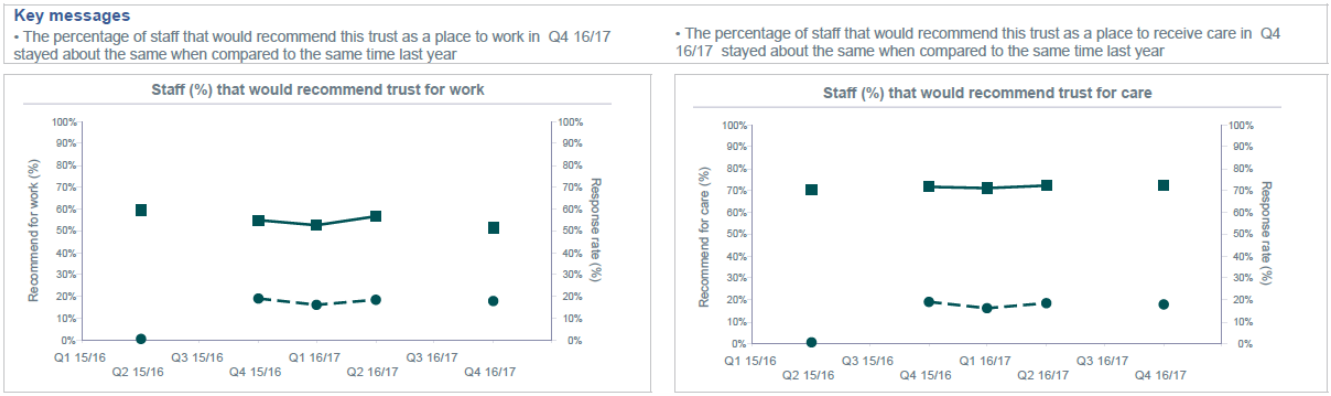
The trust issued a quarterly newsletter, 'Voice News' for patients, people who had used services and carers. This provided updates on the trust vision and strategy, publicised opportunities for involvement and asked for people's opinions and feedback. The trust's internet page had details of the number of ways people could provide feedback to the trust or become involved in a number of initiatives.

The Patient Friends and Family Test asks patients whether they would recommend the services they have used based on their experiences of care and treatment.

The trust scored between 89% and 92% and generally scored similar to or slightly better than the England average for patients recommending it as a place to receive care across the six months in the period June 2017 to November 2017. September 2017 saw the highest percentage of patients who would recommend the trust as a place to receive care with 92%.

The trust was similar to or slightly better than the England average in terms of the percentage of patients who would not recommend the trust as a place to receive care across the six months.

	Trust wide responses				England averages (excluding independent providers)	
Month	Total eligible	Total responses	% that would recommend	% that would not recommend	England average recommend	England average not recommend
June 2017	29,124	224	90%	3%	88%	4%
July 2017	28,953	270	91%	2%	89%	4%
August 2017	28,734	264	91%	3%	88%	5%
September 2017	28,106	250	92%	3%	89%	4%
October 2017	29,500	359	89%	5%	86%	6%



November 2017	29,232	221	91%	2%	87%	5%

The trust had a number of established methods to promote engagement and communication with staff across the trust. These ranged from board member visits to clinical areas, newsletters, staff engagement events and e-bulletins.

The Staff Friends and Family Test asks staff members whether they would recommend the trust as a place to receive care and also as a place to work.

The trust stayed about the same over the last six quarters in terms of staff recommending the trust as a place to receive care. The proportion of staff recommending the trust as a place to work also stayed about the same, with slightly higher scores in Q2 15/16 and 16/17. Q2 15/16 had a very low response rate, the other quarters all had a similar response rate.

There is no reliable data to enable comparison with other individual trusts or all trusts in England.

The staff survey was conducted between October and November 2016. The survey was distributed to 1250 staff and was completed by 442 members of staff giving the Trust an overall response rate of 35.9%.

The 2014 staff engagement score was 3.62 and increased to 3.87 in 2015 which was one of the highest among all NHS organisations who participated. For 2016 the staff engagement score reduced slightly to 3.8.

The trust had established relationships and engaged well with external stakeholders including clinical commissioning groups, NHS Improvement and NHS England.

Learning, continuous improvement and innovation

The trust had a robust governance structure in place to support and drive quality improvement within the trust. The trust had a quality plan 2017/18 which had been co-produced with staff. The plan included a quality led strategy which was aligned to the delivery of the trust's three quality outcomes. Each network had a quality improvement plan with clear timescales for completion.

The trust had implemented a quality improvement framework methodology which was led by a central quality improvement team. The methodology included a menu of tools which staff could access to support them in quality improvement work. The team facilitated a number of learning programmes for staff to support them to use the tools and new methodology.

All quality improvement programmes were captured on the trust's life quality improvement system which staff could access. Progress against the programmes was reported through the quality committee to the board.

The trust had a robust audit programme in place to monitor compliance against trust policies and best practice guidance which was managed through the trust's audit committee governance structure with oversight from the board. The trust actively sought to participate in national improvement and innovation projects including clinical research studies. Over the past year, the trust had completed over 40 audits which included all the national clinical audits which it was eligible to participate in. The trust used information from audits and key performance indicator metrics to identify trends and area's which required further investigation or improvement. This included deep dives where re-audits did not indicate sufficient progress had been made or key performance indicators showed a negative trajectory.

The trust was committed to research and had recently partnered with another trust to host a dedicated clinical research facility.

Individual staff members and teams had been recognised by external organisations and received awards for improvement work. This included:

- Professor Hussain was awarded the Clinical Research Role Model of the Year award at the North West Coast Research and Innovation Awards 2017. The award was for dedication to addressing inequalities in access to health care and clinical insightfulness as a research leader committed to addressing mental health inequalities in the UK. His research into depression and self-harm which disproportionately affects low income British South Asian women was particularly highlighted as having a powerful impact.

- The trust won the 2017 Healthcare Financial Management Association Innovation Award in recognition of its work in reshaping its mental health services.

- The trust's equality and diversity lead was nominated for an NDA Positive Role Model award

- The trust had completed the NHS Employer's Diversity and Inclusion 2016/17 Partnership Programme and graduated on to the 2017/18 Alumni Programme

- The trust was invited to deliver a presentation on the impact of storytelling on culture and inclusion, at the Global Equality and Diversity Conference in November 2017

- The trust had developed a programme of face-to-face and electronic medicines management training to support the clinical development of the pharmacist workforce which won the college of mental health pharmacy presentation award 2017.

- The trust had been shortlisted in three categories for the HSJ Value in Healthcare Awards 2018. These were in the:

    - 'Mental Health' category for its work in enhancing acute mental health care pathways

    - 'Improving the value of NHS support services' category for the work it has done to improve patient safety through the development of its team of specialised serious incident investigators and

    - Training and Development' category for the work the pharmacy team have done in developing an in-house virtual learning community for mental health pharmacists.

NHS trusts can take part in accreditation schemes that recognise services' compliance with standards of best practice. Accreditation usually lasts for a fixed time, after which the service must be reviewed.

The table below shows services across the trust awarded an accreditation (trust-wide only) and the relevant dates.

Accreditation scheme	Service accredited	Comments and Date of accreditation / review
Baby Friendly Initiative	LCFT Child & Family Health Service Health Visitors Wellbeing Prevention & Early Health Services Lancashire	April 2016 September 2016
LGBT Quality Mark Award	Pan-Lancashire CaSH	July 2016
Quality Network for Community CAMHS: Eating Disorder Services	EDS (CAMHS)	
Dementia Action Alliance: Dementia Wards	Dementia Wards	
NHS Library Quality Assurance Framework (LQAF)	Library Services	-
Quality Network for Inpatient CAMHS (QNIC)	The Junction The Platform (both now moved to The Cove)	
ECT Accreditation Scheme (ECTAS)	Royal Blackburn Hospital Royal Preston Hospital	
Quality Network for Forensic Mental Health Services	Low Secure Unit Medium Secure Unit	February 2017

The trust had effective systems in place to identify and learn from unanticipated deaths. The trust recorded all deaths of patients in mental health services on the electronic incident reporting system, all community inpatient deaths, all offender healthcare deaths and all community health deaths where there was a possible connection to healthcare services. The associate director of safety and quality governance (or deputy) hosted a daily incident review conference call where all deaths were reviewed and further actions were commissioned such as serious incident investigations. The medical director chaired a weekly serious incident review panel which undertook a further review of all deaths. The trust also had a monthly serious incident learning panel which was chaired by a non-executive director and attended by commissioners which reviewed deaths. The trust also participated in the sudden unexpected death in childhood and the learning disabilities mortality review Programme.

The trust had a dedicated investigations and learning team who undertook all serious incident investigations including deaths. We looked at five reports of death investigations which the team had completed. The reports followed a root cause analysis methodology, were of a good standard and were in line with trust policy.

Community health services

Community health inpatient services

Facts and data about this service

Information about the sites, which offer community inpatient services at this trust, is shown below:

Location site name	Team/ward/satellite name	Patient group	Number of clinics per month	Geographical area served
Longridge Community Hospital	Longridge Ward	Mixed	-	-

***Data relating to the number of clinics per month and the geographical area served was not provided**

The Longridge Community hospital is situated in the town of Longridge, eight miles from the city of Preston.

Longridge ward is a 15 bedded nurse led inpatient unit that provides step up, step down and end of life care. The unit is open 24 hours a day and medical cover is provided by GPs based at the two surgeries in Longridge.

Out of hours medical cover is provided by the Preston out of hour's service. Admission criteria were that patients must be registered with a Longridge GP. Their condition must be such that treatment at home is not appropriate or that post-surgical or medical care, rehabilitation or end of life care is required.

On occasion patients out of area would be admitted only if there was a plan of care already in place with the placing trust.

The community hospital also hosts clinic rooms for outpatient services. A large physiotherapy facility and kitchen assessment facility are available on the ground floor to enable rehabilitation to progress.

During the inspection, we visited the ward over two days. We spoke with 12 staff, five patients and reviewed five sets of health care records.

Is the service safe?

Mandatory training

The trust set a target of 85% for completion of mandatory training and their overall training compliance was 65% against this target.

A breakdown of compliance for mandatory courses for the year to date (at July 2017) for the period between 1 April 2017 and 31 March 2018, for medical/dental and nursing staff in community inpatient services is shown below:

Key:

Below CQC 75%	Between 75% & trust target	**Trust target and above**

Training course	This core service (staff trained/staff eligible)	Trust target %	Trust wide mandatory/ statutory training total %
Equality & Diversity	**300% (3/1)**	85%	108%
Safeguarding Children Level 2	**233% (7/3)**	85%	93%
Health & Safety	**200% (4/2)**	85%	100%
Fire Safety	**89% (24/27)**	85%	91%
Infection Control (Clinical)	**89% (24/27)**	85%	89%
Information Governance	56% (15/27)	85%	95%
Conflict Resolution	50% (1/2)	85%	83%
Manual Handling Level 3	35% (6/17)	85%	60%
Resuscitation (Basic Life Support)	7% (2/27)	85%	78%
Infection Control (Admin)	None eligible	85%	246%
Manual Handling Level 1	None eligible	85%	96%
Manual Handling Level 2	None eligible	85%	75%
Immediate Life Support (ILS)	None eligible	85%	73%
Safeguarding Children Level 1	None eligible	85%	106%
Safeguarding Children Level 3	None eligible	85%	96%
Core Service Average	65%		

The overall completion rate for staff at the service, at the time of the inspection, was 90%. All healthcare support workers had completed the basic life support module and registered nurses had completed their intermediate life support module.

Safeguarding

A safeguarding referral is a request from a member of the public or a professional to the local authority or the police to intervene to support or protect a child or vulnerable adult from abuse. Commonly recognised forms of abuse include: physical, emotional, financial, sexual, neglect and institutional.

Each authority has its own guidelines as to how to investigate and progress a safeguarding referral. Generally, if a concern is raised regarding a child or vulnerable adult, the organisation will work to ensure the safety of the person and an assessment of the concerns will also be conducted to determine whether an external referral to Children's Services, Adult Services or the police should take place.

At the last inspection staff were compliant with safeguarding training. This was still the case for this inspection.

Staff demonstrated understanding of safeguarding processes and how to escalate and report concerns.

The service made 10 safeguarding referrals between 1 August 2016 and 30 April 2017, all concerning adults. Data for this core service was not provided for May 2017 to July 2017.

There was a link safeguarding nurse on the ward who acted as a link and support for staff when needed. Staff knew who the trust's safeguarding lead was and knew how to contact them if needed.

We saw policies and procedures were up to date and displayed on the information boards for easy access.

Referrals		
Adults	Children	Total referrals
10	0	0

Overall there was no general trend in referrals with no referrals between October and December 2016 and between one and three referrals in other months. March 2017 had the highest number of referrals with three adult referrals.

Cleanliness, infection control and hygiene

Patient led assessments of the care environment (PLACE) are self-assessments which are undertaken by teams of NHS and private/independent health care providers, and include at least 50 per cent members of the public (known as patient assessors). They focus on the environment in which care is provided, as well as supporting non-clinical services such as cleanliness, food, hydration, and the extent to which the provision of care with privacy and dignity is supported and whether the premises are equipped to meet the needs of people with dementia against a specified range of criteria.

The 2017 PLACE score for the Longridge Community Hospital at which this core service is based scored similar to or slightly better than average for cleanliness; condition, appearance and maintenance; dementia friendly; and disability.

Site Name	Core Service(s) provided	Cleanliness	Condition Appearance and maintenance	Dementia Friendly	Disability
Longridge Community Hospital	Community Inpatients CHS - Community health services for adults	99.0%	95.5%	85.2%	87.2%
Trust Overall	-	**98.0%**	**94.0%**	**75.5%**	**76.5%**
England Average	-	**98.0%**	**95.2%**	**84.8%**	**86.3%**

We saw cleaning schedules and rotas for domestic and nursing staff were completed and signed by the staff that had completed the cleaning. A healthcare support worker was allocated each day to be the overall person responsible for the cleaning of clinical equipment and areas.

There was adequate access to hand gels and handwashing sinks in clinical areas and also at the point of care.

Staff washed their hands in line with the World Health Organisation's "Five Moments of Hand Hygiene" guidance between personal care activities with patients and utilised the hand sanitiser where appropriate.

Clinical staff arms were "bare below the elbows" in line with guidance from the Department of Health (2008) and wore uniforms in line with trust policy. Staff wore appropriate personal protective equipment when treating patients.

We reviewed equipment such as blood pressure monitors, hoists, scales and walking aids. All the items were visibly clean and displayed green "I am clean" stickers with the date of cleaning to items to identify those which had been cleaned and were ready for use.

The service undertook regular infection prevention and control audits. The most recent audit was undertaken in November 2017 and showed a 90% compliance with the standards. This resulted in a number of recommendations. Action plans had been made and were completed at the time of the inspection.

Curtains providing privacy around patient beds appeared visibly clean throughout the service. Curtains displayed the date of replacement which was all within the replacement dates and in good condition.

Staff managed clinical waste in line with trust guidance. Waste bins were appropriately colour coded for the appropriate waste disposal method and we noted bins routinely emptied by domestic staff during our inspection. Nursing staff correctly labelled and secured sharps bins. Staff did not overfill any of the sharps bins.

Domestic staff told us and we saw documentation to demonstrate rooms being deep cleaned where appropriate in line with the service's policies.

Environment and equipment

The service had 15 beds, two four bedded bays, two sets of two bedded bays and three single rooms. Each bay was single sex and there were no single sex breeches.

All areas were visibly clean, bright and well maintained.

Resuscitation equipment was available and the service carried out daily checks to confirm it was fit for purpose. The equipment was tagged with tamper proof seals so equipment could not be removed or tampered with between checks.

The service had sufficient storage for essential equipment and cleaning storage areas staff had ensured consumables, including pulp items, were stored off the floor in line with national guidance.

We saw oxygen cylinders were stored appropriately on the ward with a further eight stored on site. A monitor was used to inform when a cylinder was nearing empty. These were replaced in blocks of four so there was no possibility of running out of oxygen cylinders.

In April 2017 the service undertook a mock fire evacuation lead by the fire service which gave staff the opportunity to use patient slides and review how patients should be evacuated.

Assessing and responding to patient risk

The service had arrangements in place to assess and respond to patient risk. Nursing records included nursing staff carrying out risk assessments to identify patients who were at risk of pressure sores, falls and malnutrition.

Staff used the national early warning score (NEWS) to identify deteriorating patients. NEWS is a nationally standardised assessment of illness severity and determines the need for escalation based on a range of patient observations.

We looked at the use of NEWS during our review of patient records. The notes showed staff had documented care appropriately. Staff told us if there was a deterioration of a patient's condition they would report it immediately to the nurse in charge. When speaking with senior nursing staff they would immediately report this to the GP.

The service also had a protocol for the deteriorating patient which directed them to make a 999 call if the situation required this. Staff were clear about this action and had undertaken it on a number of occasions. We saw the protocol which supported these actions.

A ward safety huddle record sheet was used at each nurse handover. Information was shared within the huddle to raise any risks, patient deterioration, admissions and planned discharges.

The notes for the daily huddle also included the screening of all medical inpatients for Methicillin resistant Staphylococcus aureus bacteraemia (MRSA) within 24 hours of admission. We saw 13 of the 15 patients had a negative MRSA test and two patients were awaiting their results.

We reviewed two do not attempt cardio pulmonary resuscitation (DNACPR) records. Medical staff had completed them appropriately, evidenced discussions with family and signed and dated them.

Healthcare support workers undertook the bedside emergency assessment course for healthcare staff (BEACH), which helped improve their response to deteriorating patients.

Staffing

Staff fill rates compare the proportion of planned hours worked by staff (Nursing, Midwifery and Care Staff) to actual hours worked by staff (day and night). Mental health trusts are required to submit a monthly safer staffing report and undertake a six-monthly safe staffing review by the director of nursing. This is to monitor and in turn ensure staffing levels for patient safety. Hence, an average 70% fill rate in January 2016 for nursing staff during the day means; In January, 70% of the planned working hours for daytime nursing staff were actually 'filled'.

The below table covers staff fill rates for registered nurses and care staff during August, September, and October 2017.

Key

> 125%	< 90%

Day		Night		Day		Night		Day		Night	
Nurses	Care staff	Nurses	Care staff	Nurses	Care staff	Nurses	Care staff	Nurses	Care staff	Nurses	Care staff
August 2017				September 2017				October 2017			

(A3218) Longridge Hospital	105%	95%	100%	102%	102%	**90%**	95%	98%	107%	109%	98%	102%

Total numbers – Planned vs Actual

Team	Month (specify Date)	Staffing Group	Planned Staff WTE	Actual Staff
Longridge Ward	**August**	Registered Nurses	1612	1662
		Care Staff	1860	1809
	September	Registered Nurses	1612	1599
		Care Staff	1860	1725
	October	Registered Nurses	1679	1901
		Care Staff	3025	3847
Core service total	**August – October**		**11648**	**12543**

The service continued to use an electronic safe staffing tool which determined the numbers and levels of staff required to provide safe care.

We saw staff rotas which showed two registered nurses for the early, late and night shifts and three healthcare support workers for the early shift and two healthcare support workers for the late shift and night cover.

The service used a flow chart for escalating staffing shortages. We saw this flowchart showed what staff should do if there was a sudden shortfall in staffing. There were three levels of actions which were yellow, amber and red rated. This showed the action needed, timescales and who should be informed of the shortages.

There were occasions when additional staff were needed to ensure safe care but this was mainly covered by the service's substantive staff.

There were six healthcare support workers continuing to work on six month temporary contracts. This issue was due to be resolved in the very near future. Staff we spoke with did not feel insecure and were very happy continuing to work for the service.

Between August 2016 and July 2017, the trust reported an overall vacancy rate of 14% in the service.

Staff group	Total number of substantive staff (at 31 July 2017)	Total % vacancies overall (12 months - excluding seconded staff)
Nursing and Midwifery Registered	13.6	11%
Additional Clinical Services	14.6	14%
Medical and Dental	1.3	34%
Other	0.5	23%
Core service total	30.0	14%

Between August 2016 and July 2017, the trust reported an overall turnover rate of 8% in community inpatient services.

Staff group	Total number of substantive staff (at 31 July 2017)	Total number of substantive staff leavers in the last 12 months	Total % of staff leavers in the last 12 months
Nursing and Midwifery Registered	17	2	14%
Additional Clinical Services	18	1	7%
Medical and Dental	6	0	0%
Other	1	0	0%
Core service total	42	3	8%

Between August 2016 and July 2017, the trust reported an overall sickness rate of 10% in community inpatient services.

Staff group	Total available permanent staff days	Total % permanent staff sickness overall
Nursing and Midwifery Registered	4625.3	16%
Additional Clinical Services	4645.1	6%
Medical and Dental	306.9	0%
Other	352.9	0%
Core service total	9930.2	10%

Between 1 August 2016 and 31 July 2017, Lancashire Care NHS Trust Foundation Trust reported an overall bank and agency usage rate of 91% for qualified nursing staff within this core service.

The service had two full time qualified nursing vacancies which had been advertised. Staff worked together to ensure the service used bank staff as little as possible. There had been no agency staff used for the last six months.

Total Number of Shifts available	Total Shifts Filled by Bank Staff	% Usage of Bank Staff	Total shifts Filled by Agency Staff	% Usage Agency Staff	Total shifts NOT filled by Bank Staff	Total shifts NOT filled by Agency Staff
297	261	88%	10	3%	57	19%

Between 1 August 2016 and 31 July 2017, Lancashire Care NHS Trust reported an overall bank and agency usage rate of 93% for healthcare assistants within this core service. There are concerns raised with the data quality as the number of shifts filled and unfilled by bank and agency staff exceeds the total number of available shifts, as specified by the trust.

Some staff had chosen to work long day shifts (12 hours) which they preferred to do. The duty rota was managed to support those staff wanting shorter days. Staff told us this worked well and took into account their personal circumstances. They told us this made for a more settled workforce.

Total Number of Shifts available	Total Shifts Filled by Bank Staff	% Usage of Bank Staff	Total shifts Filled by Agency Staff	% Usage Agency Staff	Total shifts NOT filled by Bank Staff	Total shifts NOT filled by Agency Staff
373	327	88%	18	5%	52	14%

There were no medical locums used for this service.

Two local GPs services provided Monday to Friday medical cover and out of hours cover was provided by a local 'out of hours service'. For those patients admitted from an out of area trust, care was provided by one of the local GP services. This was provided by a service level agreement which was monitored by the trust.

Quality of records

We reviewed five sets of nursing and medical records. Records we reviewed were comprehensive, legible, dated and signed.

Patient records were paper based and included a range of risk assessments and care plans that were to be completed on admission and reviewed throughout a patient's stay. All patients had an individualised care plan that had been reviewed and updated.

Medical records were stored securely in a locked room.

We saw individual care plans were used for the care and support for the dying person.

The service carried out regular record keeping audits. An audit undertaken in December 2017 showed from a total of 30 standards audited, 28 were 100% compliant. Actions plans for improvement were identified such as recording the occupation of the patient and the name and designation of the person making the entry needs to be completed.

Medicines

Medicines management within the service met trust and national guidance. This included the secure storage of medicines as well as in the ordering, administration and destruction of controlled drugs (prescription drugs controlled under the misuse of drugs legislation). Controlled drugs were administered by two members of staff and in all ward stocks matched documentation. This meant there were effective systems in place to ensure the safe managements of controlled drugs.

We saw and records showed that patients received the right medication at the right dose at the right time.

Patient's medication was stored in individual locked cabinets by their bedside.

Anticipatory medicines were prescribed and administered appropriately. Anticipatory medicines include what medication a patient might need to manage symptoms likely to occur during their last days of life.

Medicines that required storage at temperatures below eight degrees centigrade were appropriately stored in fridges on the ward. We saw fridge temperatures were regularly checked and recorded.

A rheumatology pharmacist visited the service twice a week and provided advice to nursing staff and GPs. Medications were reviewed by the pharmacist and the GP

There was a weekly top up system provided which ensured the ward stock was kept up to date

The pharmacist undertook regular audit of mediations such as missed doses and medication reconciliation. Any discrepancies would be dealt with by the pharmacist at the time of the incidence.

We saw staff wore red tabards when carrying out medication rounds. This ensured that other staff and patients did not disturb them so patients received their medication in an effective and safe way.

Safety performance

The NHS Safety Thermometer allows teams to measure harm and the proportion of patients that are 'harm free' during their working day. For example, at shift handover or during ward rounds. This is not limited to hospital; patients can experience harm at any point in a care pathway and the NHS Safety Thermometer helps teams in a wide range of settings, from acute wards to a patient's own home, to measure, assess, learn and improve the safety of the care they provide. Safety Thermometer data should also not be used for attribution of causation as the tool is patient focussed.

The safety thermometer display board informed staff, patients and their relatives the service had eight months of harm free care.

The service had no patients with a urinary catheter infection.

We saw data which demonstrated the service had experienced no falls for over eight months although one patient had a fall on the evening of the inspection in January 2018.

Incident reporting, learning and improvement

Trusts are required to report serious incidents to Strategic Executive Information System (STEIS). These include 'never events' (serious patient safety incidents that are wholly preventable).

In accordance with the Serious Incident Framework 2015, the trust reported one serious incident (SI) in community inpatient services, which met the reporting criteria, set by NHS England between, August 2016 and July 2017. This incident was categorised as Sub-optimal care of the deteriorating patient meeting SI criteria.

Incident Type	Number of Incidents
Sub-optimal care of the deteriorating patient	1
Core Service Total	**1**

Between 1 August 2016 and 31 July 2017, trust staff in this core service reported one serious incident.

This incident did not involve the unexpected death of a patient.

This incident was classified as 'other'.

The number of the most severe incidents recorded by the trust incident reporting system is comparable with that reported to Strategic Executive Information System (STEIS). This gives us more confidence in the validity of the data.

Incident Type	Number of Incidents
Other	1
Core Service Total	**1**

Incidents were recorded and documented using an electronic incident reporting system to capture data on incidents or near misses. Staff could clearly demonstrate how to use the system, and identified types of incidents that should be recorded; they understood what constituted an incident.

Between January 2017 and December 2017, there were 85 incidents reported. These were rated as 52 causing no harm, six moderate harm, 12 low harm, one severe harm and 14 deaths. Staff reported all expected deaths as an incident.

Staff we spoke with told us how they would report an incident and these would be discussed at daily handover meetings.

Incidents, complaints and lessons learnt were discussed at monthly team meetings.

Staff were aware of the duty of candour and what this meant. The duty of candour is a legal duty on hospital trusts to inform and apologise to patients if there have been mistakes in their care that have led to significant harm. The duty of candour aims to help patients receive accurate truthful information from health providers.

Is the service effective?

Evidence-based care and treatment

The service used national and best practice guidelines to care and treat patients. For example: an action plan for improving end of life care had been developed to improve care and treatment for people at the end of their life.

Patient's records demonstrated good care plans were in place and we saw staff used a dementia assessment tool to assist staff in identifying the level of care a patient needed.

The service worked closely with the acute frailty team which was based on national evidence. This included the process of triaging patients in to the service, inclusion and exclusion criteria to ensure the appropriate patient was transferred to the service prior to discharge into the community or back to their home.

Nutrition and hydration

The patient records we checked included all appropriate assessments for nutritional intake which highlighted those at risk of malnutrition and we saw that these were reviewed at appropriate intervals. We found the service using food and fluid balance charts where appropriate and updating them routinely.

Nursing staff completed the malnutrition universal screening tool to assess and record patients' nutrition and hydration needs. Nursing staff had completed the malnutrition universal screening tool in all the care records we observed.

Nurses who carried out hourly comfort rounds on their patients included nutrition and hydration monitoring. For example, nurses checked patients had fluids within easy reach and that they had been offered food appropriate to their dietary needs.

Staff we spoke with confirmed that adjustments were made to accommodate people's needs, religious and cultural beliefs.

Patients had access to a jug of fresh water by their bedside and we saw nursing staff assisting patients to drink throughout the day.

The trust used a "red tray" system to identify patients who needed additional support to eat their meals.

Patients we spoke with said staff gave them choices of food and snacks. Patients told us the food was excellent quality and there was plenty of choice.

The service promoted "protected mealtimes." During lunch and evening meal times all non-urgent activity on the ward stopped so that nurses and healthcare workers could help with the meal service and also provide extra assistance for those patients that needed it.

Pain relief

There was access to a range of medications for pain relief, this included patient controlled analgesia.

Pain relief was managed on an individual basis, and was regularly monitored. Pain scores were routinely collected and recorded by nursing staff during observation rounds. We also observed this information being discussed at nurse handovers.

We observed nursing staff asking patients about their pain level. All the patients we spoke with said that staff managed their pain well and one patient told us "nurses are always asking me if I am in any pain."

Patient outcomes

The service had participated in clinical audits as part of the trust's clinical audit programme, the audits related to Waterlow risk assessments and care of dying adults.

Audit	Audit Scope	Audit Type	Date Completed	Key Actions following the audit
Waterlow risk assessments (85%)	Community and Wellbeing Network (Integrated Neighbourhood Teams in District Nursing, Inpatients at Longridge Community Hospital and Treatment rooms)	Clinical (Lancashire Care Foundation Trust (LCFT) Guidelines for the Prevention and Management of Pressure Ulceration (May 2013))	01/07/2017	Requirement for Waterlow risk assessment completion at initial visit to be reinforced. Content of personalised care plan to be reinforced.
Care of dying adults (79%)	Community and Wellbeing Network (Integrated Neighbourhood Teams in District Nursing, Inpatients at Longridge Community Hospitals)	Clinical (NICE QS 144 Care of dying adults in the last days of life, March 2017)	01/07/2017	Hydration tool kit to be shared with all staff to support knowledge and evidence base when assessing and planning care/ advice for patients who are at end of life.

The service participated in the National Hip Fracture audit and the National Parkinson's audit which looked at outcomes for patients. At the time of the inspection there were no results.

Competent staff

The trust's measure of clinical supervision data is sessions delivered. Between 1 August 2016 and 31 July 2017 the average clinical supervision rate for non-medical staff was 62% against the trust's target of 100%.

Team	Clinical Supervision Target	Clinical Supervision Delivered	Clinical supervision rate (%)
Longridge Ward	100%	207	62%
Core Service Total	100%	207	62%

Between 1 April 2016 and 31 March 2017, 79% of permanent non-medical staff within the community inpatient services core service had received an appraisal compared to the trust target of 85%.

On the inspection we found that between April 2017 and December 2017 all nursing staff received clinical supervision every three months.

Healthcare support workers were supported in developing their skills and two healthcare support workers were attending an information session on how to enrol on an associate practitioners (Band 3) course. This would enable them to expand their knowledge and expand their skills. These courses would be funded from the services charitable funds.

Student nurses we spoke with had received an induction to the unit and were being mentored using specific competencies. One student nurse was completing an assessment (direct observation of nursing activity) whilst we were visiting the service. They told us their stay on the

ward had been very good and helped to understand what happens to the patient once they have been discharged from an acute hospital.

Total number of permanent non-medical staff requiring an appraisal	Total number of permanent non-medical staff who have had an appraisal	% appraisals
28	22	79%

The service had links nurses for a variety of areas such as tissue viability; infection control and prevention, end of life care and falls prevention. These link nurses provided support and expert advice to other staff.

The specialist palliative care team provided training and support to staff when needed.

Multidisciplinary working

Weekly multidisciplinary meetings took place with physiotherapists, occupational therapists and nursing staff. The pharmacist would attend every two weeks.

Patient weekly review information was collated by healthcare support workers prior to the weekly multidisciplinary meeting which was used to discuss patient's progress relating to their personal care, mobility, kitchen skills, nutrition and falls. This was used by the occupational therapy staff as an aide to discuss the patient's likelihood of discharge home or into a community setting.

The physiotherapist and occupational therapist developed a task sheet for healthcare support workers to use when preparing patients for their discharge home. They would undertake activities such as practicing bed transfers, mobility practices, basic exercises and washing and dressing. This would then give the team a good understanding of the patient's preparedness for discharge.

The service was supported by regular contact with its local hospice who would give guidance and training to staff when needed.

The physiotherapists worked 16 hours a week at the service visiting the ward on a Monday, Thursday and Friday.

District nurses told us the standard of referral information was very good, staff at the service were approachable.

Health promotion

We saw posters displayed across the service about access to cessation smoking services and to information about alcohol consumption.

We saw admission forms included offering nicotine replacement therapy and alcohol services.

Occupational therapists had access to kitchenettes to support patients in regaining their independence in making hot drinks and snacks before discharge.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The trust told us that five Deprivation of Liberty Safeguard (DoLS) applications were made to the Local Authority 1 August 2016 and 31 July 2017 of which three were pertinent to community inpatient services. The trust told us that a direct notification had been made for each of the applications approved.
- The greatest number of DoLS applications made in a single month was two, April 2017.

Number of DoLS applications made by month													
	Aug 16	Sep 16	Oct 16	Nov 16	Dec 16	Jan 17	Feb 17	Mar 17	Apr 17	May 17	Jun 17	Jul 17	Total
Applications made	0	0	0	0	0	0	1	2	0	0	0	0	**3**
Applications approved	0	0	0	0	0	0	1	2	0	0	0	0	**3**

Staff followed the trust Mental Capacity and Deprivation of Liberty Safeguards Operational Procedure. Staff we spoke with had a clear insight on how to assess patients' capacity to make decisions about their care. Staff training relating to the Mental Capacity Act, and Deprivation of Liberty Safeguards, was attended by staff at the service.

Is the service caring?

Compassionate care

- The 2017 PLACE score for privacy, dignity and wellbeing at Longridge Community Hospital was 78.2% which was worse when compared to other similar trusts for privacy, dignity and wellbeing.

Site Name	Core Service(s) provided	Privacy, Dignity and Wellbeing
Longridge Community Hospital	Community Inpatients CHS - Community health services for adults	78.2%
Trust Overall		87.6%
England Average (Mental Health and Learning Disability)		90.6%

A feedback survey undertaken in December 2017 by the service showed the 13 patients who responded felt their privacy had been maintained, staff were kind and considerate and all would recommend the service to their relatives.

All of the patients we spoke with said staff had treated them with compassion and kindness. For example one patient said, “The nursing staff are excellent. They’ve been very patient and spent as much time with me as I needed.”

We saw evidence of the genuine rapport between staff and patients.

Emotional support

Due to the locality of the service the chaplaincy service provided multi-faith spiritual care on demand.

We observed staff speaking with patients in a quiet and professional manner.

Understanding and involvement of patients and those close to them

All relatives we spoke with understood the care their loved ones were receiving. One relative said “we have been here before and know exactly what to expect”.

One patient said they had been admitted from another hospital and felt staff had explained the reason for admission clearly. They said, “I’ve been given a good explanation of my condition and I think they’ve done a great job of keeping me up to date’.

We saw a carers display board included information for relatives and significant others such as: Dementia Buddies, Carers link, Guardian Angels, useful telephone numbers.

We saw documentation and relatives told us, a medication reminder chart was used to help them remember which medications needed to be taken when patients were discharged home.

Is the service responsive?

Planning and delivering services which meet people's needs

The service provided inpatient services for patients registered with two GP practices in Longridge. The service was used as a step up facility, rehabilitation and step down care for end of life care.

Physiotherapists, occupational therapists nursing staff and community nurses provided an acute frailty team that provided intensive therapy to patients over the age of 75. This service was provided to patients admitted to the service whose medical needs meant they were likely to be discharged within 72 hours

Mixed Sex Breaches are defined by CQC as a breach of same sex accommodation, as defined by the NHS Confederation definition. Also included is the need to provide gender sensitive care, which promotes privacy and dignity, applicable to all ages.

The service reported no mixed sex breaches during the 12-month period from 1 August 2016 and 31 July 2017.

Meeting the needs of people

In collaboration with the staff and the acute frailty team, patients with social and mobility needs received rapid care that reduced the need for an inpatient ward admission and meant patients were discharged safely to community teams.

Nurses carried out hourly ward rounds in each bay to ensure patients were constantly monitored for changing needs and enabled nurses to escalate care to other multidisciplinary teams if needed. These enabled staff to meet individual needs and ensure discharge planning was individualised.

The service followed the National Institute for Heath and Care Excellence quality standard for the care are of dying adults in the last days of life. The team had prepared an information board that detailed how they provided care in line with quality standard. The service provided advanced care planning and coordinated care with each patient's family and the trust end of life care team.

The service's charitable funds were used to develop activities programmes to stimulate patients and encourage them to socialise. These included art therapy and music events. The service had refurbished the day room and we saw staff encourage patients to get out of bed and to enjoy light exercise. Charitable funds were also used to buy a drinks machine, garden furniture, holistic therapies and daily newspapers.

We saw a number of activities available to patients throughout the week such as: card making, movie afternoons and the use of tablet computers. Staff helped some patients to use the tablet computers. This tablet computer included videos of differing types of exercise, jigsaws and other activities which were person centred.

Where possible end of life care patients were cared for in one of the three side rooms.

Staff told us they had recently discharged a patient home who was receiving end of life care so that they may die at home. Staff had worked in collaboration with the end of life team to achieve this.

There was access to the service via a lift for those people living with a disability.

Staff could access the use of a translator if needed but due to the low numbers of patients who did not speak English as a first language in the area this was not often needed.

Access to the right care at the right time

The largest ethnic minority group within the trust catchment area is Asian/Asian British with 7% of the population.

	Ethnic group	Percentage of catchment population (if known)
First largest	White	91%
Second largest	Asian/Asian British	7%
Third largest	Mixed Race	1%
Fourth largest	Black/Black British	0.4%

The trust provided information on 20 services the longest waiting times to access them over the past 12 months, none of these services related to community inpatient services.

The trust provided information regarding average bed occupancies between 1 July 2017 and 31 December 2017; the mean bed occupancy rate was 83%. At the last inspection, over the period 1 November 2015 to 30 April 2016 the mean occupancy was 90%,

Team	Average bed occupancy (Range)
Longridge Ward	71% - 94%

The trust provided information for average length of stay for the period 1 January 2017 and 31 December 2017 which was 21 days. This ranged from one day to 115 days.

From the information provided at the time of the previous inspection, the average length of stay was 20 days.

Team	Average length of stay in days (Range)
Longridge Ward	16 - 27

Between 1 August 2016 and 31 July 2017 there were no delayed discharges within this core service. This amounts to 0% of the total discharges (219).

Total Discharges	Total Delayed Discharged	% Delayed Discharges
219	0	0%

Learning from complaints and concerns

The service received 3 complaints during the 12 months between 1 August 2016 and 31 July 2017 and had received no complaints between July 2017 and January 2018.

Details of the trust complaints policy was on display in all clinical areas and wards and quality and performance boards encouraged patients to raise any concerns with the ward manager or nurse in charge. Learning from complaints would be discussed at the weekly team meeting.

Ward	Type of complaint reported	Total
Longridge Community Hospital	Communications (1) Patient Care including Nutrition/Hydration (1) BLANK (1)	3
Total		**3**

The service received 52 compliments during the 12 months between 1 August 2016 and 31 July 2017.

Is the service well-led?

Leadership

The service was part of the Adult Community and Well Being Services Division.

We observed ward managers working alongside nursing staff providing support and guidance where necessary. We saw close team work and an appreciation of one another's contribution to the overall care of patients.

Staff had access to personal development opportunities and included: appreciative leadership for senior nursing staff, end of life courses and national falls conferences.

Nursing leadership had been improved with a development programme for band six nurses. This led to greater senior nurse presence on the wards.

Vision and strategy

The trust had a vision to provide 'to provide high quality care, in the right place at the right time every time'.

The community and wellbeing business plan for 2018-19 included the further development of the frailty service which sees the increase of frailty beds on the Longridge ward. The increase will be realised in 2018 by increasing the number of beds used for frailty patients from three to ten. At the last inspection we found staff were unsure of the future of the service. At this inspection we found staff were clear about the direction of the service. Whilst the frailty service had further embedding, staff on the ward were clear about their roles.

Further work is necessary to take full advantage of the expertise, professionalism and commitment of the current ward staff in order to realise the full potential of the service.

Culture

Nursing staff said they felt supported and able to speak up if they had concerns. All staff reported that the service was a lovely place to work, and helped each other to ensure that patients received the 'best care and treatment'.

One member of staff told us 'I can't believe how lucky I am to work on such a great ward' and said 'we have time to stop and talk with the patients and get to know them better'.

Governance

Staff had a good understanding of the governance processes. .

Risks, incidents, complaints, compliments, quality of care and staffing were regular items on the monthly team meetings. Any issues were passed to the senior management team for their information and action.

There were three risks on the risk register; all had been reviewed at regular intervals. For example there were no standard operating procedures for admission to the ward. The standard operating procedure had been developed and was being reviewed by the local GP services prior to ratification.

Regular governance meetings took place with the two local GP services.

Management of risk, issues and performance

Weekly team meetings took place at the service. Agenda items included performance and governance such as: admissions, training, Mental Capacity Act/Deprivation of Liberty Safeguards, discharge planning, staffing and clinical supervision. Patient safety issues were also included such as: incidents, pharmacy issues, falls, moving and handling and risk assessment.

Gaps in training and insufficient therapy staff were issues needed to be addressed in the last inspection. These had been actioned and all staff had received their mandatory training. Access and joint working with therapy staff had improved and there were more formal documented meetings that ensured a more cohesive approach to patient care.

Information management

Information needed to deliver effective care and treatment was available to staff in a timely and accessible way via paper patient records and the staff intranet.

The staff used protocols and guidelines to care for their patients which were paper based but could also be accessed on the intranet. We saw policies and guidelines displayed on boards near the nurse's station.

Engagement

Staff told us they would take part in daily and weekly team meetings. Staff valued these meetings as they felt comfortable to ask questions and bring their ideas for discussion at these meetings.

Staff told us they were most proud about how the teams worked and communicated well together as a team.

The service displayed the latest results of their participation in the 'you said, we did' scheme operated by the trust. For example, staff had introduced a daily meeting between the nurse in charge and the catering team to ensure patients had a choice of appropriate food. This had led to a further option of meals every week rather every two weeks.

Patients and relatives often gave monies towards the purchasing of equipment and training courses for staff to show their appreciation of the high quality care that had been received.

Learning, continuous improvement and innovation

NHS Trusts are able to participate in a number of accreditation schemes whereby the services they provide are reviewed and a decision is made whether or not to award the service with an accreditation. A service will be accredited if they are able to demonstrate that they meet a certain standard of best practice in the given area. An accreditation usually carries an end date (or review date) whereby the service will need to be re-assessed in order to continue to be accredited.

The service had not been awarded an accreditation. However, at the last inspection the establishment of a ward based blood monitoring service was still waiting agreement. This was now in place and staff had the equipment and expertise to carry out this function.

The blood test shows how fast the blood clots in patients receiving oral blood thinning therapy was working which will result in a more effective way managing patients suffering a blood clot.

Mental health services

Acute wards for adults of working age and psychiatric intensive care units

Facts and data about this service

Location site name	Ward name	Number of beds	Patient group (male, female, mixed)
Pendleview Unit	Darwen Ward (male treatment)	19	Male
Pendleview Unit	Hyndburn (female treatment)	20	Female
Pendleview Unit	Ribble (male assessment)	12	Male
Pendleview Unit	Calder Ward (PICU Male)	6	Male
Scarisbrick Unit, Ormskirk Hospital	Scarisbrick Unit	20	Mixed
Scarisbrick Unit, Ormskirk Hospital	Lathom Suite	4	Male
The Harbour	Byron Ward	8	Female
The Harbour	Churchill Ward	18	Male
The Harbour	Keats	8	Male
The Harbour	Orwell Ward	18	Male
The Harbour	Shakespeare Ward	18	Female
The Harbour	Stevenson Ward	18	Female
The Orchard	The Orchard	18	Mixed
Victoria Unit, Burnley	Dunsop Ward (female treatment)	16 treatment beds, 4 assessment beds	Female
Victoria Unit, Burnley	Stockbeck (Female PICU)	6	Female
Victoria Unit, Burnley	Edisford Ward(female Assessment	14	Female
Victoria Unit, Burnley	Hodder Ward(Male treatment	21	Male

Is the service safe?

Safe and clean care environments

Safety of the ward layout

All wards complied with guidance on eliminating mixed sex accommodation. Fifteen of the 17 wards were single sex facilities. The Scarisbrick inpatient unit and the Orchard were both mixed sex wards. There were separate sleeping areas for males and females. Members of one gender did not need to pass the bedrooms of members of the opposite gender to access bathing facilities. Separate male and female only lounges were available.

Over the 12 month period from 1 August 2016 to 31 July 2017 there were no mixed sex accommodation breaches.

There were ligature risks on 17 wards within this core service. The trust had undertaken recent (from 10 August 2016 onwards) ligature risk assessments at 17 locations.

One of the wards presented a high level of ligature risk due to General ward fixtures and fittings and 15 wards presented a lower risk due to General ward fixtures and fittings.

All wards had an annual ligature risk assessment in place. A ligature is a place to which patients intent on harming themselves might tie something to strangle themselves. At our last inspection we found that the ligature risk assessments were not readily available on the ward. At this inspection all ward managers were able to access electronic copies of the risk assessment but hard copies were not available on all wards.

In general ligature risk assessments were comprehensive and staff had a good knowledge of the ligature points on their wards and the associated risks. However wards based at Burnley had a suspended ceiling. This had not been captured on the ligature risk assessment. Staff we spoke with told us that the risk was managed through individual patient assessment and the use of observations. The wards based at Burnley were due to move to new premises later in the year. At our last inspection we told the trust that they must remove the risk from a suspended ceiling at Stock Beck psychiatric intensive care unit. The trust informed us in their action plan that due to the planned move to new premises they would take steps to mitigate the risks rather than remove the ceiling. At this inspection we found that steps had been taken to remove or lower furniture and fittings that could be used to access the ceiling. However work to weigh down the ceiling had not yet taken place.

Layouts of some wards meant that staff were not able to observe all parts of the ward. This was managed by the use of convex mirrors, Closed circuit television and staff observations. Staff we spoke with demonstrated a good knowledge of the ward environment and were aware of the risks presented by blind spots. Wards had an identified safety and security nurse on each shift. They were responsible for completing regular environmental checks. Staff had access to personal alarms. Staff we spoke with knew how to activate the alarms and how to respond. Not all wards had nurse call systems in patient bedrooms. Staff managed this risk through individual risk assessment and observation levels.

Maintenance, cleanliness and infection control

All locations scored similar to the England average for cleanliness. Burnley General and Ormskirk and District General Hospital scored worse than the England average for condition appearance and maintenance these two locations also had much lower percentages in comparison to the England and trust average for dementia friendly and disability.

Site name	Core service(s) provided	Cleanliness	Condition appearance and maintenance	Dementia friendly	Disability
Burnley General MH	MH - Acute wards for adults of working age CHS - Dental CHS - adults	97.33%	85.24%	59.92%	65.48%
Ormskirk and General Hospital	MH - Community services for people with learning disabilities or autism MH - Acute wards for adults of working age	97.15%	85.75%	58.22%	65.28%
The Harbour	CHS - adults MH - Wards for older people with mental health problems. MH - Acute wards for adults of working age	99.12%	97.29%	88.99%	88.30%
The Orchard	MH - Acute wards for adults of working age	97.95%	94.88%	76.29%	88.03%
Trust overall		97.98%	94.02%	75.52%	76.54%
England average (Mental health and learning disabilities)		98.0%	95.2%	84.8%	86.3%

Wards were clean and well maintained. Equipment, furniture and décor were generally in a good condition. Cleaning records we reviewed were up to date and demonstrated that the ward environment was cleaned regularly. We observed domestic staff cleaning ward areas during our inspection. Domestic staff we spoke we spoke with told us they were supported in their role and adequately resourced. Wards adhered to infection control principles to try to help prevent the spread of infection. There were hand gel dispensers on entry to the wards which staff and visitors were prompted to use. Infection control information was displayed around the wards. Staff had access to personal protective equipment. We observed staff following good infection control practice during our visit. Support was available from a trust infection control team.

Seclusion room

There were seclusion rooms at each location. At the Harbour there were seclusion rooms attached to Keats and Byron psychiatric intensive care units. These facilities were used by the other wards at the location if required. At Burnley General Hospital there was a seclusion room available on Stock Beck psychiatric intensive care unit. This facility was used by the psychiatric intensive care unit and the three other wards based at the location. At the Royal Blackburn Hospital there was a seclusion room available on Calder psychiatric intensive care unit. This facility was also utilised by the other wards based at the location. There was a seclusion room attached to Lathom Suite psychiatric unit at Ormskirk Hospital. Patients on Scarisbrick inpatient ward could access the facility if required. There was an extra care area and a seclusion room at the Orchard.

Seclusion rooms allowed for staff observation of patients. Appropriate two way communication systems were in place. This enabled patients and staff to interact. Patients had access to toilet and washing facilities. However not all the seclusion rooms had showering facilities directly attached. Patients using the seclusion room on Stock Beck accessed shower facilities external to the seclusion room but off the main ward.

Access to the seclusion rooms varied in each location. Staff were able to escort patients to seclusion rooms at the Harbour, Ormskirk Hospital and the Orchard without having to enter public areas or access a different floor in the building. However at Burnley General Hospital the seclusion room was based on the ground floor. Edisford and Hodder ward were located on the first floor. This meant that should a patient on one of those wards require seclusion they had to be brought down to the ground floor using the buildings lift. Patients from Edisford or Hodder ward requiring seclusion would also need to pass a public area to access the psychiatric intensive care unit. The same applied to patients on Dunsop ward although the ward was based on the ground floor. There was a procedure in place to support this. This included the use of control and restraint teams if required to escort the patient. Staff went ahead to clear public areas in order to protect the privacy of clients being transferred to seclusion.

There were similar issues at the Royal Blackburn Hospital. The seclusion room was based on Calder psychiatric intensive care unit on the ground floor. This meant that patients on Darwen, Hyndburn and Ribble ward who required seclusion had to be escorted through a lift and several double doors to access the facility. There was a procedure in place to support this. This included the use of control and restraint teams if required to escort the patient. Staff went ahead to clear public areas in order to protect the privacy of clients being transferred to seclusion.

Clinic room and equipment

Clinic rooms were well maintained, tidy and appropriately equipped. Staff had access to a range of equipment for monitoring patients' physical health. This included blood pressure monitors, thermometers and scales. However clinic rooms on Hyndburn, Ribble, Darwen and Calder wards did not have an examination couch. Where patients required a physical health examination this took place in the patients' bedroom. On Darwen and Hodder wards the layout of the clinic room meant that it was possible to view inside from a window in the door. There were no blinds fitted to provide for patient privacy. Staff told us that they hung paper towels up when the room was in use.

Resuscitation equipment including automated external defibrillators and oxygen were available in all clinical areas. Equipment in clinic rooms was subject to regular checks and maintenance. Staff monitored the temperature of clinic rooms as well as fridges that were used to store medication. Where emergency drugs were in place they were checked regularly and were up to date and easily accessible.

Safe staffing

Nursing staff

Definition

Substantive – All filled allocated and funded posts.
Establishment – All posts allocated and funded (e.g. substantive + vacancies).

Substantive staff figures	Trust target

Total number of substantive staff	At 31 July 2017	662	N/A
Total number of substantive staff leavers	August 2016- 31 July 2017	50	N/A
Average WTE* leavers over 12 months (%)	August 2016- 31 July 2017	7.8%	10%
Vacancies and sickness			
Total vacancies overall (excluding seconded staff)	At 31 July 2017	96.9	N/A
Total vacancies overall (%)	At 31 July 2017	14%	5%
Total permanent staff sickness overall (%)	Most recent month (At 31 July 2017)	9%	4.5%
	1 August 2016- 31 July 2017	9%	4.5%
Establishment and vacancy (nurses and care assistants)			
Establishment levels qualified nurses (WTE*)	At 31 July 2017	301.7	N/A
Establishment levels nursing assistants (WTE*)	At 31 July 2017	283.6	N/A
Number of vacancies, qualified nurses (WTE*)	At 31 July 2017	63.1	N/A
Number of WTE vacancies nursing assistants	At 31 July 2017	10.5	N/A
Qualified nurse vacancy rate	At 31 July 2017	21%	5%
Nursing assistant vacancy rate	At 31 July 2017	4%	5%
Bank and agency Use			
Shifts bank staff filled to cover sickness, absence or vacancies (qualified nurses)	August 2016- 31 July 2017	3169	N/A
Shifts filled by agency staff to cover sickness, absence or vacancies (Qualified Nurses)	August 2016- 31 July 2017	846	N/A
Shifts NOT filled by bank or agency staff where there is sickness, absence or vacancies (Qualified Nurses)	August 2016- 31 July 2017	2031	N/A
Shifts filled by bank staff to cover sickness, absence or vacancies (Nursing Assistants)	August 2016- 31 July 2017	13,178	N/A
Shifts filled by agency staff to cover sickness, absence or vacancies (Nursing Assistants)	August 2016- 31 July 2017	1407	N/A
Shifts NOT filled by bank or agency staff where there is sickness, absence or vacancies (Nursing Assistants)	August 2016- 31 July 2017	1635	N/A

*Whole-time Equivalent

This core service reported an overall vacancy rate of 21% for registered nurses at 31 July 2017.

The vacancy rate for registered nurses was lower than the 26% reported at the last inspection (April 2016).

This core service reported an overall vacancy rate of 4% for Nursing assistants[1] at 31 July 2017.

The vacancy rate for registered nursing assistants was lower than the 6% reported at the last inspection (April 2016).

[1] 'Nursing assistants' include the following staff roles; nursing assistants, health care assistants, support workers, assistant practitioners and other support staff.

This core service has reported a vacancy rate for all staff of 14% as of 31 July 2017. This was similar to the rate (13%) reported at the last inspection (15 July 2016).

Vacancy rates decreased over the 12 months reported, vacancy rates were at 22% in August 2016 and lowered to 14% in July 2017.

	Registered nurses			Nursing Assistants*			Overall staff figures		
Ward/Team	Vacancies	Establishment	Vacancy rate (%)	Vacancies	Establishment	Vacancy rate (%)	Vacancies	Establishment	Vacancy rate (%)
AMH Locality Mangt (25-65)	0.0	0.0	0%	-	-	-	1.3	2.0	67%
Harbour The Hub (25-65)	0.0	3.0	0%	-	-	-	1.0	10.0	10%
STEP 5 Mangt	0.0	0	0%	-	-	-	0.7	0.7	100%
Lathom Suite Ward (25-65)	2.4	11.4	21%	0.2	12.2	2%	2.6	23.6	11%
Scarisbrick MH Inpatients (25-65)	0.2	17.7	1%	0	11.53	0%	0.2	29.8	1%
Admin Central Lancs (25-65)	0	0	0%	-	-	-	3.5	33.9	10%
Harbour - OT AMH (25-65)	0	0	0%	0.0	12.8	0%	1.0	18.6	5%
Admin Harbour (25-65)	0	0	0%	-	-	-	5.4	31.1	17%
Harbour - General (25-65)	0.6	12.6	5%	-	-	-	5.9	22.1	27%
Harbour - Keats Ward (25-65)	2.2	17.0	13%	1.3	19.1	7%	3.4	36.1	9%
Harbour - Byron Ward (25-65)	5.3	17.3	31%	0.0	19.1	0%	5.3	36.4	15%
Harbour - Orwell Ward (25-65)	0.0	17.0	0%	0.3	19.1	1%	0.3	36.1	1%
Harbour - Churchill Ward (25-65)	1.6	17.0	9%	0.7	19.1	3%	2.2	36.1	6%
Harbour - Stevenson Ward (25-	0.0	17.0	0%	0.6	19.1	3%	0.6	36.1	2%

65)									
Harbour - Shakespeare Ward (25-65)	6.0	17.0	35%	0.0	19.1	0%	6.0	36.1	17%
Dunsop Mental Health Inpatients (25-65)	2.8	16.7	17%	1.1	14.6	8%	4.0	31.3	13%
Edisford Assessment Ward (25-65)	9.3	21.8	43%	3.3	13.0	25%	15.0	38.3	39%
PICU Stockbeck Mental Health Inpatients (25-65)	1.4	10.4	13%	0.0	15.3	0%	1.4	25.7	5%
PICU Calder Ward (25-65)	2.2	11.4	20%	1.3	15.3	8%	3.5	26.7	13%
Darwen Ward (25-65)	7.7	16.7	46%	0.0	14.6	0%	7.7	31.3	25%
Hyndburn Ward (25-65)	4.4	16.7	26%	0.0	14.6	0%	4.4	31.3	14%
Hodder Mental Health Inpatients (25-65)	5.4	16.7	32%	1.5	13.6	11%	7.0	30.3	23%
Inpatient Management East Lancs (25-65)	0.6	4.0	15%	-	-	-	0.6	4.4	14%
Ribble A Assessment Ward (25-65)	9.6	21.8	44%	0.3	13.0	2%	12.4	38.3	32%
Inpatient Management The Orchard North Lancs (25-65)	0.0	1.5	0%	-	-	-	0.0	2.0	0%
The Orchard Mental Health Inpatients (25-65)	1.4	16.8	8%	0	18.9	0%	1.4	35.7	4%

Core service total	63.1	301.7	21%	10.5	283.6	4%	96.9	683.6	14%
Trust total	399.1	2330.8	17%	161.0	1381.7	12%	1408.5	6483.8	22%

NB: All figures displayed are whole-time equivalents

* These figures include; nursing assistants, health care assistants, support workers, assistant practitioners and other support staff.

Between 1 August 2016 and 31 July 2017, bank staff filled 66% of shifts to cover sickness, absence or vacancy for qualified nurses.

Certain teams had shifts filled totalling more than the total available shifts, the data quality of this metric is therefore unreliable.

In the same period, agency staff covered 18% of shifts for qualified nurses. Forty two percent of shifts were unable to be filled by either bank or agency staff.

Ward/Team	Available shifts	Shifts filled by bank staff	Shifts filled by agency staff	Shifts NOT filled by bank or agency staff
The Orchard	137	87 (64%)	0 (0%)	18 (13%)
RIBBLE (Male Assessment)	300	271 (90%)	4 (1%)	391 (130%)
HODDER (Adult Male)	116	104 (90%)	3 (3%)	75 (65%)
HYNDBURN	153	73 (48%)	3 (2%)	35 (23%)
Darwen Ward - QPH - (Adult)	291	278 (96%)	0 (0%)	52 (18%)
Calder PICU – Blackburn	351	333 (95%)	3 (1%)	53 (15%)
SPA Blackburn with Darwen	3	0 (0%)	0 (0%)	0 (0%)
STOCK BECK	297	270 (91%)	0 (0%)	82 (28%)
EDISFORD (Female Assessment)	397	389 (98%)	2 (1%)	217 (55%)
DUNSOP	105	93 (89%)	1 (1%)	190 (181%)
Harbour – Shakespeare	363	162 (45%)	152 (42%)	92 (25%)
Harbour – Stevenson	356	127 (36%)	169 (47%)	158 (44%)
Harbour – Churchill	527	302 (57%)	124 (24%	196 (37%)
Harbour – Orwell	362	123 (34%)	98 (27%)	123 (34%)
Harbour – Byron	412	155 (38%)	182 (44%)	149 (36%)
Harbour – Keats	240	62 (26%)	90 (38%)	65 (27%)
Harbour – Matrons	2	2 (100%)	0 (0%)	0 (0%)

Scarisbrick Unit - W/Lancs (A)	233	182 (78%)	12 (5%)	88 (38%)
Lathom Suite - W/Lancs (A)	159	139 (87%)	3 (2%)	47 (30%)
Harbour The Hub	19	17 (89%)	0 (0%)	0(0%)
Core service total	4823	3169 (66%)	846 (18%)	2031 (42%)
Trust Total	25,229	14,495 (57%)	4,469 (18%)	4,384 (17%)

***Percentage of total shifts**

Between 1 August 2016 and 31 July 2017, 40% of shifts were filled by bank staff to cover sickness, absence or vacancy for nursing assistants.

In the same time period, agency staff covered 4% of shifts. Five percent of shifts were unable to be filled by either bank or agency staff.

Ward/Team	Available shifts	Shifts filled by bank staff	Shifts filled by agency staff	Shifts NOT filled by bank or agency staff
The Orchard	708	391 (55%)	1 (0%)	31 (4%)
RIBBLE (Male Assessment)	1392	1101 (79%)	54 (4%)	85 (6%)
HODDER (Adult Male)	1149	517 (45%)	72 (6%)	61 (5%)
HYNDBURN	2496	332 (13%)	12 (0%)	41 (2%)
Darwen Ward - QPH - (Adult)	1062	460 (43%)	22 (2%)	32 (3%)
Calder PICU – Blackburn	995	241 (24%)	29 (3%)	21 (2%)
STOCK BECK	3453	469 (14%)	47 (1%)	42 (1%)
EDISFORD (Female Assessment)	1130	901 (80%)	46 (4%)	68 (6%)
DUNSOP	2044	1149 (56%)	110 (5%)	116 (6%)
Harbour – Shakespeare	2674	1205 (45%)	119 (4%)	155 (6%)
Harbour – Stevenson	3134	1227 (39%)	161 (5%)	217 (7%)
Harbour – Churchill	1335	490 (37%)	70 (5%)	80 (6%)
Harbour – Orwell	1549	676 (44%)	115 (7%)	128 (8%)
2 Harbour - Orwell Ward Assessment	6	0 (0%)	0 (0%)	0 (0%)
Harbour – Byron	4521	1838 (41%)	333 (7%)	268 (6%)
Harbour – Keats	2327	348 (15%)	73 (3%)	71 (3%)
Scarisbrick Unit - W/Lancs (A)	1706	1031 (60%)	101 (6%)	118 (7%)

Lathom Suite - W/Lancs (A)	1109	780 (70%)	42 (4%)	101 (9%)
Harbour The Hub	24	22 (92%)	0 (0%)	0 (0%)
Core service total	32,814	13,178 (40%)	1407 (4%)	1635 (5%)
Trust Total	75,152	31,495 (42%)	2282 (3%)	3327 (4%)

***** Percentage of total shifts

This core service had 46 (7%) staff leavers between 1 August 2016 to 31 July 2017. Turnover was the same as the last inspection (15 July 2016)

Ward/Team	Substantive staff at 31 July 2017	Substantive staff Leavers (1 August 2016 to 31 July 2017)	Average % staff leavers
The Orchard Mental Health Inpatients (25-65)	42	5	10%
Inpatient Management The Orchard North Lancs (25-65)	3	0	0%
Inpatient Psychology (S)	13	4	30%
Ribble Ward (25-65)	26	2	8%
Inpatient Management East Lancs (25-65)	8	0	0%
Hodder Ward (25-65)	25	2	8%
Hyndburn Ward (25-65)	35	1	4%
Darwen Ward (25-65)	25	2	8%
PICU Calder Ward (25-65)	29	2	8%
Stock Beck Ward PICU (25-65)	31	1	4%
Edisford Ward (25-65)	26	1	3%
Dunsop Ward (25-65)	30	0	0%
OT Basics (25-65)	2	0	0%
Harbour - Shakespeare Ward (25-65)	38	2	6%
Harbour - Stevenson Ward (25-65)	37	1	3%
Harbour - Churchill Ward (25-65)	37	2	6%
Harbour - Orwell Ward (25-65)	39	3	8%
Harbour - Byron Ward (25-65)	35	2	7%

Harbour - Keats Ward (25-65)	33	0	0%
Harbour - General (25-65)	18	4	18%
Medics Harbour (65+)	7	1	14%
Admin Harbour (25-65)	31	9	28%
Harbour - OT (25-65)	20	1	5%
Scarisbrick Mental Health Inpatients (25-65)	32	0	0%
Lathom Suite Ward (25-65)	21	0	0%
Harbour The Hub (25-65)	11	0	0%
Admin Pendleview	-	0	0%
Inpatient Management Parkwood	-	0	0%
351x Healey Ward - Chorley (Adult)	-	1	200%
351x Inpatient Management - Chorley	-	0	0%
Core service total	654	46	7%
Trust Total	6709	881	13%

The sickness rate for this core service was 9% between 1 August 2016 to 31 July 2017. The most recent month's data 31 July 2017 showed a sickness rate of 9%. This was higher than the sickness rate of 6% reported at the last inspection in 15 July 2016.

Ward/Team	**Total % staff sickness (at latest month)**	**Ave % permanent staff sickness (over the past year)**
Test Beds Programme	0%	2%
Inpatient Programme	0%	0%
The Orchard Mental Health Inpatients (25-65)	16%	10%
Inpatient Management The Orchard North Lancs (25-65)	0%	1%
Medics Step 5 Central (25-65)	-	0%
Ribble A Assessment Ward (25-65)	7%	9%
Inpatient Management East Lancs (25-65)	5%	4%
Hodder Mental Health Inpatients (25-65)	4%	6%

Hyndburn Ward (25-65)	5%	9%
Darwen Ward (25-65)	7%	12%
PICU Calder Ward (25-65)	7%	9%
PICU Stockbeck Mental Health Inpatients (25-65)	6%	8%
Edisford Assessment Ward (25-65)	5%	6%
Dunsop Mental Health Inpatients (25-65)	7%	6%
Harbour - Shakespeare Ward (25-65)	5%	8%
Harbour - Stevenson Ward (25-65)	16%	14%
Harbour - Churchill Ward (25-65)	5%	6%
Harbour - Orwell Ward (25-65)	11%	8%
Harbour - Byron Ward (25-65)	21%	18%
Harbour - Keats Ward (25-65)	8%	10%
Harbour - General (25-65)	6%	6%
Admin Harbour (25-65)	4%	4%
Harbour - OT AMH (25-65)	10%	13%
Scarisbrick Mental Health Inpatients (25-65)	14%	7%
Lathom Suite Ward (25-65)	5%	9%
STEP 5 Management	0%	0%
Harbour The Hub (25-65)	7%	4%
Medics Step 5 North Lancs	0%	4%
Community Rehab Unit Moss View	-	0%
High Dependency Rehab Unit Moss View	-	0%
Admin Pendleview	-	28%
Medics Step 5 East Lancs	-	0%
Admin Parkwood	-	0%

351x Healey Ward - Chorley (Adult)	-	0%
351x Inpatient Mangement - Chorley	-	0%
Core service total	9%	9%
Trust Total	6%	6%

The below table covers staff fill rates for registered nurses and care staff during August 2017, September 2017 and October 2017. There a regularly less than 90% of nursing staff shifts filled than planned, across all 3 months and all wards except at the Orchard and Byron ward. Care staff appear to be compensating for the lack of nurses and more than 125% of care staff shifts were regularly filled.

Key:

> 125%	< 90%

Wards	Day		Night		Day		Night		Day		Night	
	Nurses	Care staff	Nurses	Care staff	Nurses	Care staff	Nurses	Care staff	Nurses	Care staff	Nurses	Care staff
	August 2017				September 2017				October 2017			
Calder (L3311) (L3314) Calder PICU - Blackburn KB	63.58%	243.01%	72.73%	196.74%	57.67%	252.87%	65.36%	208.98%	67.34%	265.36%	69.10%	234.16%
Darwen (L3313) (L3313) Darwen Ward - QPH - (Adul KB	51.65%	220.96%	85.12%	147.43%	51.59%	231.62%	76.58%	161.95%	79.49%	193.06%	82.26%	151.87%
HYNDBURN (was (L3312) HYNDBURN KB	60.22%	275.76%	92.16%	188.20%	66.33%	273.51%	83.55%	221.55%	74.91%	269.63%	87.32%	204.29%
EDISFORD (was H (L3311) HODDER (Adult Male) KB	57.68%	258.48%	77.35%	256.09%	67.02%	207.73%	70.71%	163.16%	80.39%	148.33%	92.52%	113.49%
DUNSOP (was Wa (L4722) DUNSOP KB	61.29%	233.96%	79.95%	199.71%	63.62%	273.45%	76.69%	209.71%	78.45%	271.08%	90.00%	236.73%

STOCK BECK (was (L4687) STOCK BECK KB	59.70%	321.87%	70.71%	241.97%	70.44%	290.95%	70.45%	235.48%	105.58%	293.36%	84.57%	256.82%
BYRON (L5096) - (L5096) Harbour - Byron KB/ZP	165.00%	254.79%	135.12%	338.78%	157.80%	239.46%	134.58%	293.65%	205.90%	247.97%	128.13%	297.34%
CHURCHILL (L509 (L5094) Harbour - Churchill KB/ZP	66.46%	93.91%	89.57%	109.41%	66.95%	96.39%	86.42%	95.21%	76.77%	100.10%	83.28%	119.23%
SHAKESPEARE (L5 (L5092) Harbour - Shakespeare KB/ZP	64.73%	165.43%	92.71%	154.04%	72.22%	160.27%	84.67%	141.48%	71.15%	152.40%	77.07%	143.94%
Calder (L2063) (L2063) Calder Ward - Guild Lodge CR	43.47%	161.67%	141.35%	194.06%	58.60%	129.46%	132.27%	142.76%	55.68%	134.81%	128.35%	144.00%
Scarisbrick (L7010 (L7010) Scarisbrick Unit - W/Lancs (KB	54.16%	219.09%	84.37%	238.71%	76.25%	196.42%	95.92%	235.48%	74.61%	187.50%	97.91%	226.54%
Lathom (L7020) (L7020) Lathom Suite - W/Lancs (A) KB	74.69%	240.66%	50.00%	251.69%	88.53%	208.42%	48.28%	255.87%	98.10%	145.16%	50.37%	225.00%
STEVENSON (L509(L5093) Harbour - Stevenson KB/ZP	68.78%	174.48%	90.79%	185.56%	72.04%	179.35%	86.80%	171.65%	80.43%	169.32%	80.31%	149.65%
KEATS (L5097) - w (L5097)	62.28%	223.67%	92.71%	265.63%	79.71%	228.69%	82.32%	265.16%	74.98%	206.40%	78.19%	229.17%

Harbour - Keats KB/ZP												
ORWELL (L5095) - (L5095) Harbour - Orwell KB/ZP	63.44%	142.05%	83.73%	158.06%	71.71%	118.14%	80.14%	119.42%	80.68%	125.27%	88.00%	127.75%
The Orchard Inpa (L0300) The Orchard KB	93.81%	107.88%	103.38%	115.65%	106.50%	105.95%	102.77%	117.68%	116.85%	122.50%	113.31%	156.46%

Wards operated different shift patterns. At the Harbour there was a three shift pattern. Shifts running from 7:30am until 3:30pm and from 12:30pm to 8:30pm ran on six staff, incorporating two qualified nurses and four healthcare assistants. The night shift from 8:00pm until 8:00am ran on five staff including two qualified nurses and three healthcare assistants. Wards based at the Scarisbrick inpatient unit, the Orchard, Burnley General Hospital and the Royal Blackburn Hospital operated a two shift model. Shifts ran from 7:30am until 7:45pm and from 7:15pm to 7:45am. Day shifts ran on two qualified staff and four healthcare assistants. Night shifts ran on two qualified staff and two healthcare assistants. Some staff were also working hybrid shift patterns to provide cover and appropriate staffing levels.

Although vacancy rates had reduced since our last inspection staff we spoke with told us that staffing levels remained challenging especially at times of high acuity on the ward. Staff we spoke with told us that shift establishments were not always met and this was confirmed by staffing rotas that we reviewed. Vacancy rates, especially amongst qualified nurses along with an increase in patient acuity increased demand on staffing capacity. It was recognised that this led to a reliance on bank and agency staff.

The trust had systems in place to monitor and manage staffing levels and to mitigate risk. Staffing levels were set using an electronic system. Ward managers were required to submit daily reports that recorded the planned and actual number of qualified and unqualified staff on shift. The reports also captured planned ward activity and scored patient acuity on a five point scale. The system allowed the service to adjust staffing levels in response to the needs of each ward. Wards were expected to pick up one enhanced observation from their existing establishment but were able to request extra staff for any further enhanced observations. An enhanced observation is when a patient requires constant observation by at least one staff member.

When staffing levels were low, wards in each location worked collaboratively to meet need. This included transferring staff between wards and providing mutual support. Ward managers and if required modern matrons also completed clinical shifts. Ward managers were supported by managers to utilise bank and agency staff where this was required. Ward managers sought to use regular bank and agency staff to promote continuity of care. Bank staff were block booked in advance where possible. Bank and agency staff received an induction onto the ward.

Each location had twice weekly meetings to review and plan staffing. Annual leave was planned in advance. The electronic staffing system generated red flags if planned or actual establishments were low. Red flags were escalated to the executive nursing team to review. The trust had a rolling programme of recruitment.

Staffing levels meant that whilst there was always one qualified member of staff on duty there were instances when that individual was the only qualified staff member on the shift. This meant that if they were involved in other duties, for example, medication rounds there may not be a qualified staff member in communal areas. Where shifts were low on qualified staff the trust increased the number of healthcare assistants to compensate. Patients we spoke with told us that although staffing was stretched staff were a visible presence on the ward. Fifty two of the 54 patients we asked told us they could access a staff member when they required it.

At our last inspection we told the trust that they should ensure staffing levels are sufficient to support the delivery of activities and leave. At this inspection both staff and patients reported that some planned leave and ward activities were postponed or rearranged due to staffing capacity. We spoke to 61 patients and asked 52 if they had experienced their leave or planned activities being postponed or rearranged. Twenty one of the 52 patients we asked told us that they had. We spoke to 71 staff and asked 58 if they were aware of leave or activities being postponed or rearranged. Twenty of the staff we asked told us that leave or activities had been postponed or rearranged. When this occurred staff offered patients an apology and worked to rearrange the planned activity.

Staff alarms were linked to other wards within each location. This meant that staff on wards were aware of incidents on other wards and could help respond. Staff were identified on each shift to respond to alarms.

Medical staff

Medical Locum data was provided however there were significant issues with the data quality and therefore it has not been included.

There were consultants and junior doctors who worked with each of the wards. Doctors attended multi-disciplinary meetings including patient reviews and met with patients one to one where requested. Out of hours, an on-call rota provided cover. Staff were able to access a psychiatrist in an emergency.

At the time of our inspection the trust was introducing a sectorization model for medical staffing. The model was being implemented at all services apart from those based at the Royal Blackburn hospital. The sectorization model meant that instead have having consultants allocated to either community or inpatient services the consultant was allocated to individual patients and followed them through services. Staff we spoke with acknowledged the system offered benefits for patient continuity but expressed concerns over the practical application. For example whilst there had previously been set times for ward rounds in which each patient was seen, multidisciplinary reviews now had to be scheduled with more than one doctor depending on who patients on the ward were allocated too. The new system had been introduced in the week we inspected and staff acknowledged it needed time to bed in before it could be assessed.

Mandatory and statutory training

The compliance for mandatory and statutory training courses at 31 July 2017 was 57%. Of the training courses listed 10 failed to achieve the trust target and of those, 10 failed to score above 75%.

The training compliance reported for this core service this financial year (1 April 2017 – 31 July 2017) was lower than the last financial year 86% (1 April 2016 to 31 March 2017).

Training compliance ranged between 16% and 85% for wards within this core service. Inpatient Management the Orchard North Lancs had a training compliance level of 16%.

Key:

Below CQC 75%	Between 75% & trust target	Trust target and above

Training course	This core service %	Trust target %	Trustwide mandatory training total %
Immediate Life Support (ILS)	25%	85%	25%
Manual Handling Level 3	26%	85%	41%
Resuscitation (Basic Life Support)	29%	85%	27%
Manual Handling Level 2	33%	85%	40%
Information Governance	43%	85%	42%
Conflict Resolution	44%	85%	37%
Safeguarding Children Level 3	53%	85%	83%
Safeguarding Children Level 1	56%	85%	45%
Infection Control (Clinical)	67%	85%	55%
Fire Safety	71%	85%	57%
Infection Control (Admin)	86%	85%	71%
Manual Handling Level 1	89%	85%	63%
Mental Capacity Act Level 1 (Admin)	95%	85%	85%
Safeguarding Children Level 2	100%	85%	76%
Health & Safety	102%	85%	52%
Safeguarding Vulnerable Adults Level 1	105%	85%	83%
Mental Capacity Act Level 1 (Clinical)	106%	85%	99%
Equality & Diversity	119%	85%	71%
Core Service Total %	57%	85%	52%

Training levels were low and under trust targets in July 2017. The trust provided refreshed data at the time of our inspection. This showed that training compliance had improved significantly and overall compliance had increased from 57% to 91%. The new breakdown for training courses was:

Immediate Life Support (ILS)	76%	**85%**
Manual Handling Level 3	Not provided	85%
Resuscitation (Basic Life Support)	80%	85%
Manual Handling Level 2	75%	85%
Information Governance	86%	85%
Conflict Resolution	95%	85%
Safeguarding Children Level 3	Not provided	85%
Safeguarding Children Level 1	96%	85%
Infection Control (Clinical)	94%	85%
Fire Safety	95%	85%
Infection Control (Admin)	96%	85%
Manual Handling Level 1	98%	85%
Mental Capacity Act Level 1 (Admin)	92%	85%
Safeguarding Children Level 2	90%	85%
Health & Safety	99%	85%
Safeguarding Vulnerable Adults Level 1	93%	85%
Mental Capacity Act Level 1 (Clinical)	94%	85%
Equality & Diversity	99%	85%
Core Service Total %	91%	85%

At our last inspection we issued the trust with a requirement notice under regulation 18 (staffing). This related to ensuring that staff had an appropriate level of training in basic life support and immediate life support. Training compliance for the two courses at this inspection was 80% (basic life support) and 76% (immediate life support). Staff rotas for each shift required the ward manager to identify staff who were compliant with basic and immediate life support training. This meant that the trust could be assured that there were sufficient numbers of trained staff on each shift.

In addition to the mandatory training programme the trust also provided specific staff groups with 'essential' training. Mandatory training applied to all staff regardless of role. Essential training was training required by medical and nursing staff. The training was mandatory for those staff groups.

Compliance with essential training was low. Overall compliance was 46%. None of the four courses deemed as essential training were above 75% compliant. The course breakdown was:

Mental Capacity Act level two – 44%

Mental Health Act – 58%

Violence reduction training – 67%

Safeguarding adults level two – 26%

Mandatory and essential training was delivered in both face to face and e-learning formats. Staff we spoke with told us it could be difficult to access some face to face training depending on where it was delivered or if their ward was understaffed on the day. Ward managers supported staff to complete training where they could and monitored compliance on a rolling basis.

Assessing and managing risk to patients and staff

Staff completed risk assessments of patients on admission. Additional enhanced risk assessments could be completed if the initial assessment indicated the need. Risk assessments were reviewed every seven days or in response to a change in circumstances. We reviewed 128 care records. All of the records had completed risk assessments in place. We found one risk assessment that was out of date. Risk assessments were comprehensive and of a good quality. A standard trust template was used across wards.

Staff completed risk management plans to manage and mitigate patient risk. Risk management plans included details about support patients needed to reduce their risks. Where patients had specific risk issues, for example physical health risks these were captured and planned for.

Staff completed physical health screens on admission and monitored patients physical health throughout their admission. Staff completed daily physical health observations and utilised the early warning score system to help identify concerns or deterioration in a patients physical health.

Staff monitored changes in the level of patients risk through one to one sessions, ward reviews, observations and assessment. Staff responded to changing risk in patients where these were identified. For example, we saw instances where patient's observation levels had been changed in response to their risk level and presentation. Staff discussed individual patient risk at the handover of each shift.

There was a trust observation policy to support staff. There were differing levels of observation in place for patients dependent upon their level of need. At our last inspection we told the trust that they should ensure consistent recording of observation of patients. On this inspection we reviewed observation records on ten wards. Records were complete and up to date. Staff we spoke with understood the observation policy and how it was applied. Qualified nursing staff were able to

increase observation levels if they believed a patient's risks had increased. However, only a doctor could authorise a reduction in a patient's level of observation.

Patients were not subject to routine searches. Staff searched patients on the basis of individual risk assessment. Patients were asked for consent prior to any search. If the patient refused, staff carried out a further risk assessment to determine the need to proceed with the search. Searches were recorded in patient notes and via the on-line incident reporting system. There was a trust policy to support staff in this process. Patient's belongings were recorded on admission.

There were restricted and contraband items identified on wards. These items were proportionate to the environment and service type. Patients were informed of these restrictions on admission and via ward information leaflets. Staff avoided implementing blanket restrictions and managed risks individually. Patients had mobile phones on the wards and there was access to the internet.

The trust had a no smoking policy. However we found that this was applied inconsistently across sites. Some wards were smoke free whilst others allowed smoking in courtyards and out-door areas. On wards at the Burnley site we smelt smoke whilst on the ward environment and observed two patients attempting to smoke inside. Staff intervened to prevent this. We discussed management of smoking with staff. They told us that the policy was difficult to enforce and that they did not always feel supported in trying to do so. Staff were encouraged to report all incidents of smoking via the on-line reporting system but acknowledged not all incidents were captured.

There was a nicotine management policy and supporting procedures for staff to follow. This included online brief advice training. Some wards had smoking cessation champions in place. Smoking cessation advice and nicotine replacement therapy was offered for patients who wished to give up smoking. We saw evidence of patients who were being supported to give up smoking.

There were notices advising informal patients of their right to leave on display on most of the wards we visited. However this was not consistent and signage was not always clear. Information was also contained in ward information packs. Informal patients we spoke with knew they were able to leave the ward at will. However we were informed by some patients that they had experienced a delay in being able to leave the ward whilst they waited for nursing staff to either unlock doors or note their planned absence. If nursing staff had concerns over an informal patient leaving the ward they were able to use nurse holding powers and seek a medical review.

Use of restrictive interventions

This core service had 2213 incidents of restraint and 399 incidents of seclusion between 1 August 2016 and 31 July 2017.
Over the 12 months, there was small fluctuations in the incidence of both restraint and seclusion in over the year.
The below table focuses on the last 12 months' worth of data: 1 August 2016 and 31 July 2017.

Ward name	Seclusions	Restraints	Of restraints, incidents of prone restraint	Rapid tranquilisations
Lathom Suite	32	58	0 (0%)	2 (3%)
Scarisbrick Unit	27	89	0 (0%)	8 (9%)
Byron Ward	57	499	3 (1%)	281 (56%)
Churchill Ward	12	58	0 (0%)	2 (3%)
Keats	108	147	0 (0%)	13 (9%)
Orwell Ward	15	32	0 (0%)	5 (16%)
Shakespeare Ward	7	219	0 (0%)	47 (21%)

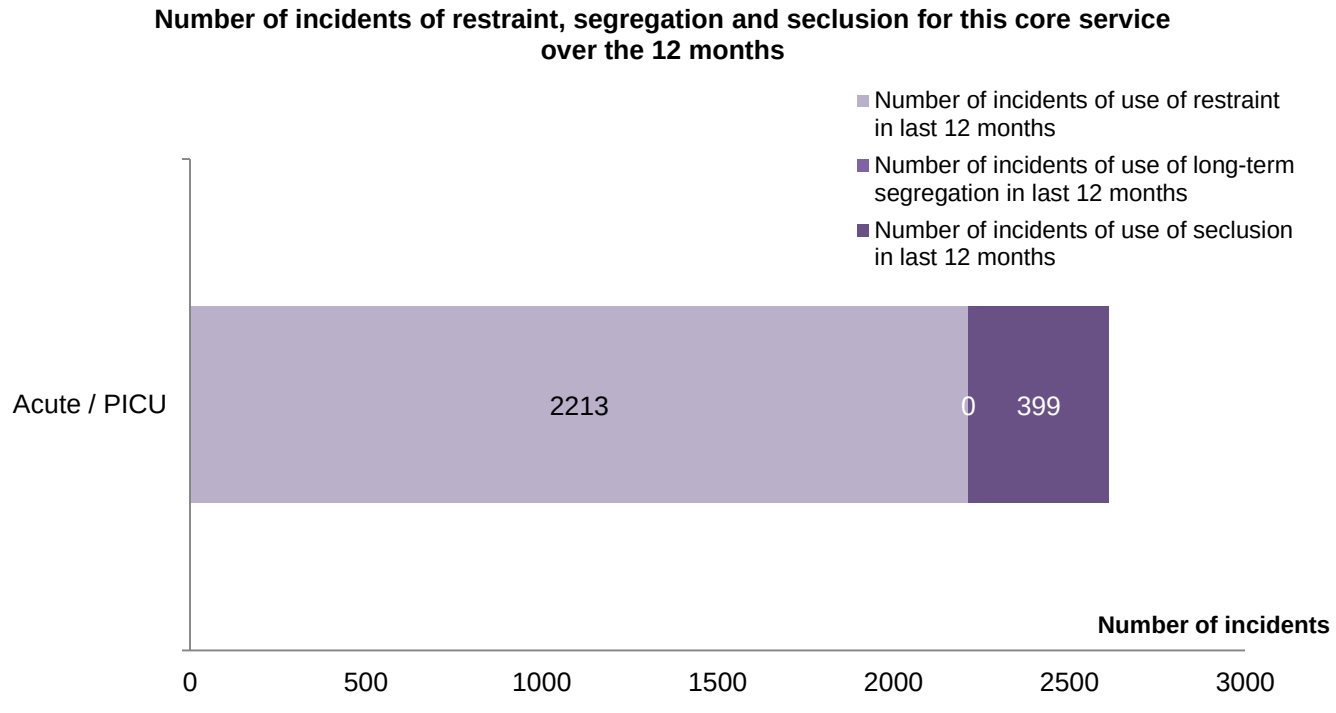
Stevenson Ward	17	227	0 (0%)	97 (43%)
Darwen Ward (male treatment)	6	27	0 (0%)	3 (11%)
Hyndburn (female treatment)	4	113	1 (1%)	45 (40%)
Ribble (male assessment)	9	59	0 (0%)	15 (25%)
Calder Ward (PICU Male)	21	95	0 (0%)	26 (27%)
Dunsop Ward (female treatment)	13	108	0 (0%)	13 (12%)
Stockbeck (Female PICU)	37	324	0 (0%)	176 (54%)
Edisford Ward(female Assessment	10	96	0 (0%)	23 (24%)
Hodder Ward(Male treatment	9	40	0 (0%)	7 (18%)
The Orchard	15	22	0 (0%)	4 (18%)
Core service total	399	2213	4 (<1%)	767 (35%)

There were four incidents of prone restraint which accounted for <1% of the restraint incidents. There were eight incidents of restraint in the previous year.

Over the 12 months, there were peaks in the use of restraint in June 2017, where there were a total of 244 incidents. In total there were 2213 incidents of restraint, in the previous year there were 1751 incidents of restraint. The trust was unable to supply information on the number of patients these incidents of restraint were used on.

Incidents resulting in rapid tranquilisation for this core services seem to have been fluctuated, with the highest numbers in April 2017 (108) and November 2016 (99). There were 767 incidences of rapid tranquilisation in the over the reporting period, compared to 515 incidences of rapid tranquilisation in the previous year.

There have been zero instances of mechanical restraint over the reporting period.



Over the 12 months, there was a peak in the use of seclusion in April 2017, where there were a total of 52 instances. In total there were 399 incidences of seclusion, in the previous year there was 316 incidences of seclusion reported in the previous year (1 August 2015- 31 July 2016). There were no incidents of long term segregation in this core service at the time of our inspection.

Staff received training in conflict resolution as part of their mandatory training. Compliance was 96%. Staff received training on violence reduction techniques as part of their essential training. Compliance was 67%. The trust had a violence reduction team that supported staff. This included the delivery of training, support around individual patients, reviewing the use of restraint and supporting staff and patients after incidents.

Staff attempted to use verbal de-escalation and diversionary tactics to manage patient agitation or aggression. Restraint was only used if non-physical de-escalation techniques had been unsuccessful. During our inspection we observed five occasions where staff had to respond to an agitated patient. In four of these instances staff managed the escalating behaviour in a calm, respectful manner and diffused the situation with verbal reassurance and supportive actions. However in one instance we observed a staff member using more aggressive vocabulary and body language. We raised this with the ward manager who agreed to discuss the issue with the patient and staff member.

When restraint was used this was recorded in patient notes and via the online incident reporting system. Incidents of restraint were reviewed by the violence reduction team who provided feedback and advice to staff.

Seclusion was used appropriately within the service. We reviewed eight seclusion records. The records were complete and up to date. The rationale for seclusion had been recorded and there was evidence of regular nursing and medical reviews. Periods of seclusion were not extended unnecessarily. Staff we spoke with understood the role of seclusion and when it should be used. There were extra care areas available on some wards where patients could be escorted to de-escalate without the need for seclusion.

Staff used rapid tranquilisation as a last resort. There was a policy in place to support its use when it was required. At our last inspection we found that patients were not consistently monitored post rapid tranquilisation. At this inspection we found that this continued to be an issue. We reviewed the records of 12 patients who had been administered medication for rapid tranquilisation. In five of these we found that observations had not been carried out in line with the trust policy. Observations had not been recorded as frequently as required and there were gaps in recording sheets. A rationale or explanation as to why the observation had not taken place was not captured.

Safeguarding

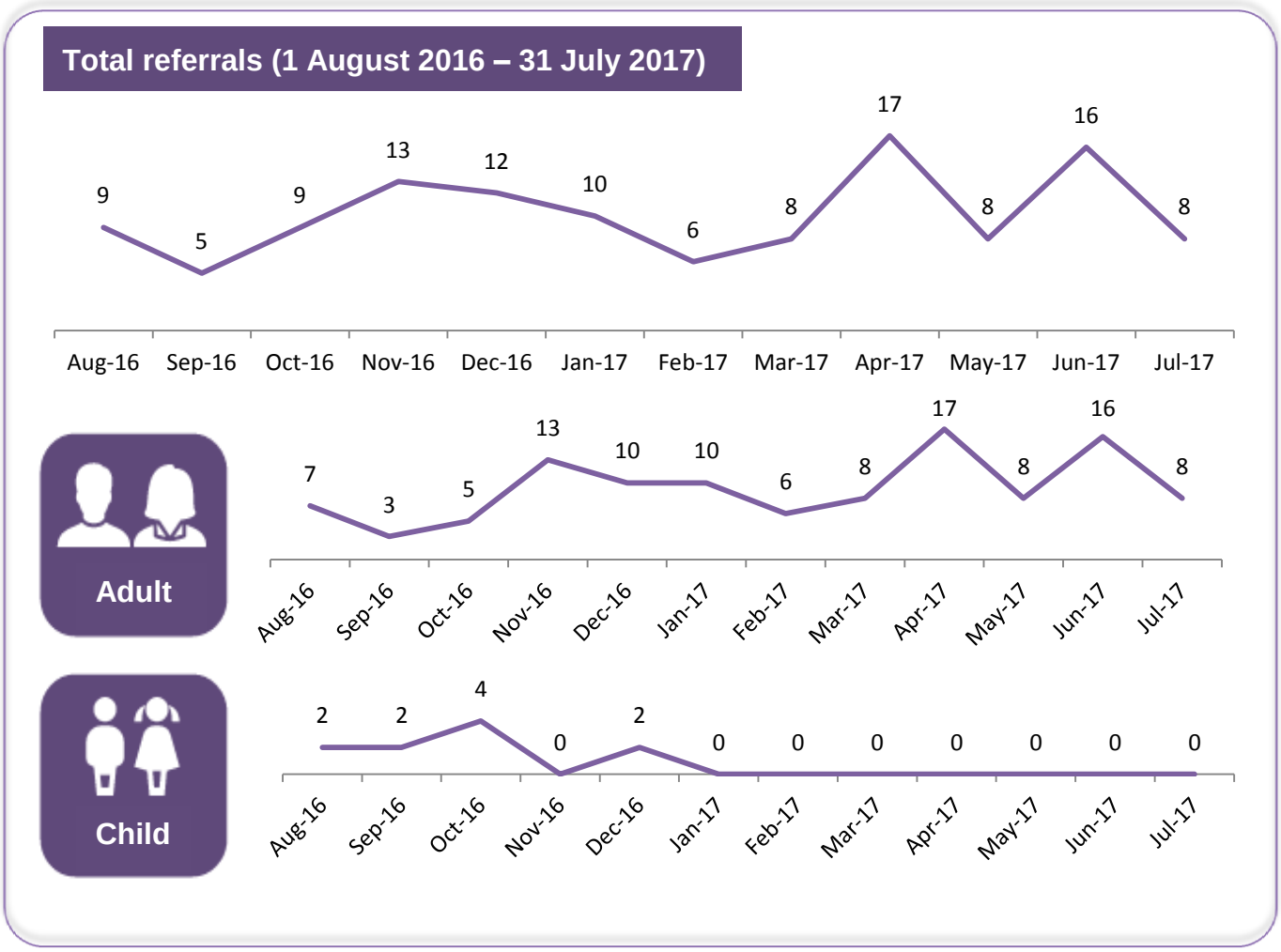
A safeguarding referral is a request from a member of the public or a professional to the local authority or the police to intervene to support or protect a child or vulnerable adult from abuse. Commonly recognised forms of abuse include: physical, emotional, financial, sexual, neglect and institutional.

Each authority has their own guidelines as to how to investigate and progress a safeguarding referral. Generally, if a concern is raised regarding a child or vulnerable adult, the organisation will work to ensure the safety of the person and an assessment of the concerns will also be conducted to determine whether an external referral to Children's Services, Adult Services or the police should take place.

This core service made 121 safeguarding referrals between August 2016 and July 2017, of which 111 concerned adults and 10 children.

Referrals		
Adults	Children	Total referrals
111	10	121

There were two peaks identified in adult referrals across the period in April 2017 and June 2017 with 17 and 16 respectively.



Lancashire Care NHS Foundation Trust has submitted details of zero serious case reviews commenced or published in the last 12 months (1 August 2016 and 31 July 2017) that relate to this core service.

Staff completed mandatory safeguarding training. Compliance rates were safeguarding adults level one 93%; safeguarding children level one 96%; safeguarding children level two 90%. A revised compliance figure for level three safeguarding children training was not provided. As of July 2017 compliance was 53%.

In addition to mandatory training medical and nursing staff also accessed essential training. Essential training included safeguarding adults level two. Compliance with the training was 26%.

Staff we spoke with demonstrated a good understanding of safeguarding. Staff were able to describe different types of abuse and knew how to identify individuals at risk. Staff were aware of how to raise safeguarding concerns and understood the procedures to do so. Records we reviewed demonstrated that safeguarding issues were being identified, reported and managed. There was evidence of liaison with police and local authorities. Staff were able to access support from the trusts central safeguarding team. There were safeguarding policies in place to support practice.

Arrangements were in place to support child visits. These took place off the ward. Where a risk assessment indicated the need, staff would supervise visits.

Staff access to essential information

Patient information was mainly stored electronically. Records kept in paper format included the recording of observations and seclusion records. Staff at the Harbour, Ormskirk hospital, Burnley General hospital and the Orchard also had access to the nerve centre. The nerve centre was displayed on a screen in the nurses' office. It showed up to date information on each patient including required observations and interventions. The system was being rolled out on wards at the Royal Blackburn site.

Information to deliver patient care was accessible to permanent and bank staff. However agency staff did not always have access to electronic care records. Agency staff could view basic patient information on the nerve centre. Staff we spoke with told us that they found the care records system easy to use and navigate.

Medicines management

The trust had procedures in place to help ensure staff followed good medicines management. We saw systems in place for the transporting, storage, dispensing, reconciliation and recording of medicines information. The trust used an electronic prescribing system which helped to reduce the risk of errors. The system flagged up prescribing that was outside of recommended guidance and included access to an on-line copy of the British National Formulary.

Administration records were captured on the electronic system including an electronic signature as well as time and date. We observed three medication rounds. Staff administered medication in line with trust policy and best practise. Appropriate checks were made to confirm the patient's identity and consent to treatment. T2 and T3 forms were in place. A T2 form is completed by a doctor and confirms that the patient understands the prescribing regime and has consented to it. A T3 form is used to record that a second opinion appointed doctor supports the use of medication that the patient has not consented too but that is deemed to be in their best interests.

Medicines were stored in locked cupboards inside clinic rooms. All medicines, including emergency drugs were in date.

The wards had input from pharmacists and dedicated pharmacy technicians who attended daily and inputted into ward rounds and multidisciplinary discussions where required. The pharmacists and staff reviewed the effect of patient's medication, including where they were on high dose antipsychotics. Pharmacy staff were available to assist staff and patients with any queries about medication.

Track record on safety

Providers must report all serious incidents to the Strategic Information Executive System (STEIS) within two working days of an incident being identified.

Between 1 August 2016 and 31 July 2017 there were seven STEIS incidents reported by this core service. Of the total number of incidents reported, the most common type of incident was *Apparent/actual/suspected self-inflicted harm* with seven. Two of the unexpected deaths were related to this core service.

A 'never event' is classified as a wholly preventable serious incident that should not happen if the available preventative measures are in place. This core service reported no never events during this reporting period.

We asked the trust to provide us with the number of serious incidents from the past 12 months. The number of the most severe incidents recorded by the trust incident reporting system was not comparable with STEIS. Eleven incidents in a serious incident requiring investigation and seven recorded within STEIS.

The number of serious incidents reported during this inspection was lower than the 10 reported at the last inspection (between 2 April 2015 and 27 March 2016)

	Type of incident reported on STEIS					
Number of incidents reported	Confidential information leak/information governance breach	Commissioning incident	Medication incident	Apparent /actual/suspected self-inflicted harm	Disruptive/ aggressive/ violent behaviour	Total
Blackpool Victoria Hospital	1	0	0	0	0	1
Byron Ward The Harbour Blackpool	0	0	1	0	0	1
Hyndburn Ward Pendleview RBH	0	0	0	1	0	1
Orwell Ward, The Harbour, Blackpool	0	0	1	0	0	1
Public Place	0	0	0	1	0	1
Scarisbrick Unit ODGH Ormskirk	0	0	0	0	1	1
Stockbeck Ward Burnley General Hospital	0	1	0	0	0	1
Total	**1**	**1**	**2**	**2**	**1**	**7**

Reporting incidents and learning from when things go wrong

The trust used an electronic incident reporting system to record incidents. Staff we spoke with knew what incidents to report and how to use the electronic system. Submitted incidents were reviewed by ward managers, modern matrons and within network governance meetings. Managers completed 72 hour reviews where required to identify immediate learning.

Ward managers and modern matrons we spoke to had been trained in root cause analysis in order to complete incident investigations. The trust had a range of measures to share and promote learning from incidents. This included blue light bulletins circulated via email, the 'pulse' newsletter; share the learning posters, shared learning events and a page on the trust intranet. Ward managers also discussed learning from incidents within team meetings, supervision and handovers. However staff we spoke with had differing experiences of receiving learning. Staff we spoke with did not always have time to read emails or the trust intranet. Agency staff did not always have access to these. Team meetings and supervision did not always happen regularly

depending on staffing capacity. Although staff were aware of learning from incidents that had occurred on their own ward or within their own location it was not clear there was effective sharing of learning across localities and from other services within the trust. Staff we spoke with were not able to discuss incidents or learning that had occurred outside of their locality.

There was a process to debrief staff and patients following an adverse incident. Debriefs could be led by ward managers, psychologists, members of the violence reduction team or staff trained as psychological first aiders. We saw examples of debriefs that had taken place following an incident and reflective practices that had occurred. However staff had not received debriefs after all relevant incidents. Where appropriate staff could be referred to occupational health and staff support services.

Ward managers were able to give examples of changes in practice that had occurred on their ward or within their location. However they were less certain about learning from other locations or services within the trust. This included changes in practice following a patient barricading themselves into a room, changes to safety glass following an incident of aggression and changes to documentation and paperwork.

Ward managers we spoke with were aware of duty of candour requirements. Duty of candour is a statutory requirement that ensures services are open and transparent with patients and carers. This includes informing patients about adverse incidents related to their care and treatment, providing support and offering an apology. Staff displayed an open and honest culture and understood their responsibilities to be open and transparent with people in relation to their care. The electronic incident reporting system included prompts around duty of candour.

The Chief Coroner's Office publishes the local coroners Reports to Prevent Future Deaths which all contain a summary of Schedule 5 recommendations, which had been made, by the local coroners with the intention of learning lessons from the cause of death and preventing deaths.

In the last two years, there have been no 'prevention of future death' reports sent to Lancashire Care NHS Foundation Trust in relation to this core service.

Is the service effective?

Assessment of needs and planning of care

We reviewed 128 care records. 126 records had a care plan in place. We found six care plans that were out of date. Care records we reviewed were generally of a good standard. Although there were instances of generic terminology we found that care records were personalised and holistic. Of the 126 records we found 11 that were not personalised, nine that were not holistic and 14 that were not considered to be recovery focused.

Staff completed physical health assessments on new admissions. This included an assessment of nutritional and dietary needs using the malnutrition universal screening tool. We found that 121 of the 128 care records we reviewed had a physical health assessment in place. In two records the patient had refused consent to the examination. Physical health assessments were of a good quality. They identified relevant interventions and specialist support that may be required. These were captured on patients care plans. Staff carried out ongoing monitoring of patients physical health. Staff completed observations using the national early warning score.

Best practice in treatment and care

This core service participated in five clinical audits as part of their clinical audit programme[1] August 2016– 31 July 2017.

Audit name	Audit scope	Audit type	Date completed	Key actions following the audit
Q4 Discharge Letters & Care Plans in Community Teams (Compliance 90%)	Adult and Older Adult Inpatient Wards	Clinical	31/03/2017	Results from the audit were shared across the network via Quality and Safety Meetings.
Q4 Nursing Management of Clozaril (Compliance 63%)	Community and Inpatient Localities and Wards	Clinical	31/03/2017	Re-audit added to 17/18 programme. Findings discussed with Assistant Medical Director. A process mapping day sharing the Clozapine Pathway ongoing. New monitoring forms in use.
4 Seclusion (Compliance 71%)	Inpatient wards on seclusion	Clinical	31/03/2017	Re-audit is placed on 18/19 programme. All findings were presented to Quality & Safety Committee/Governance Groups/PICU forum. A working group has been developed.
Re-Audit - Domestic Abuse (Compliance 53%)	Inpatients within Adult Mental Health and Service Users within Crisis Teams, A&E Liaison, Single Point of Access	Re-audit	31/03/2017	A steering group was formed to deveop a local action plan to address the issues from the findings. A question was included within the enhanced and standard risk assessment to remind staff and capture details around routine enquiry.

Re-Audit Personality Disorder (Compliance76%)	Adult Mental Health inpatients with stated diagnosis	Re-audit	31/03/2017	All due by October 2017.

Wards followed best practice and National Institute for Health and Care Excellence guidance in the delivery of care. Psychological therapies were available in line with the National Institute for Health and Care Excellence guidelines on psychosis and schizophrenia in adults (CG178). Psychologists were linked with wards and were able to offer one to one and group therapies. These included mindfulness, cognitive behavioural therapy, dialectical behavioural therapy, sleep hygiene and hearing voices groups. The level of psychological input varied from location to location. Some ward staff had received additional training in areas such as mindfulness and anger management to increase provision.

Staff carried out appropriate therapeutic drug and physical health monitoring. Staff completed regular physical health observations utilising the national early warning score. Staff used the Liverpool University neuroleptic side effect rating scale to measure and manage the side-effects of antipsychotic medications. Staff had access to phlebotomy services and electrocardiogram testing to assist in this.

Patients had access to good physical healthcare whilst on the ward. We saw strong management of patients with diabetes, respiratory illness and mobility issues. There was access to specialist services including podiatry, dietitians, physiotherapists and diabetes nurses. Care records we reviewed showed good communication between ward staff and other healthcare specialists.

Health and well-being workers visited each ward. They worked with patients to deliver activities and promote healthier lifestyles and diets. Smoking cessation advice and nicotine replacement therapy was available. Information about healthy living was available on wards.

Staff used recognised rating scales to assess and record severity and outcomes. Although outcome scales were in place they were not used consistently across all wards. We saw use of the health of the nation outcome scales and the model of human occupation screening tool on some wards. All wards used mental health clustering as an outcome measure. Mental health clustering groups patients together based on their diagnosis and severity of symptoms. Patients were reviewed on a regular basis and could move between clusters as their condition improves or worsens.

The acute and psychiatric intensive care wards participated in the five clinical audits detailed below as part of their clinical audit programme for 2016 and 2017. In addition ward staff completed local audits including clinic audits, medication audits, mattress audits, care record audits, Mental Health Act documentation audits and monthly quality reports.

Skilled staff to deliver care

Wards had access to a range of professionals. These included nurses, healthcare assistants, occupational therapists, health and well-being practitioners, recovery and restart workers, psychologists, consultant psychiatrists, pharmacists and Mental Health Act administrators. Staff were able to access other specialists within the trust including dietitians and physiotherapists. Staff were generally experienced and had the right skills to meet patient need. However there were a number of staff, including in management roles who were new to the post. Staff received specialist training outside of mandatory and essential training programmes. Staff we spoke to had attended additional training in psychosocial therapies, physical healthcare, dementia care and mentorship. Courses were advertised on the trust intranet and pulse newsletter. Training needs were identified through staff appraisal and personal development plans.

Staff did not receive training in learning disabilities. At the time of the inspection there were at least three patients with a mild learning disability being cared for on the wards. Staff sought support and advice from colleagues within the trust and from other learning disability services. Occupational therapists, psychologists and violence reduction practitioners worked with staff to develop appropriate care plans.

Staff received a corporate induction when they joined the trust and had a local induction onto wards. Bank and agency staff also received a local induction. Induction checklists and processes were in place. Induction paperwork we checked had been fully completed.

At our last inspection we told the trust they should ensure that local team meetings took place. At this inspection we found that team meetings were variable across the wards. This was due to staffing and capacity issues as it was difficult to get staff together whilst there were demands to care for patients. This meant that trust hadn't addressed our recommendation from our last inspection. Where team meetings had been cancelled or were not occurring ward managers attempted to keep staff informed with changes and updates by email, notices displayed within the staff office and personal conversations.

The trust had a policy and procedure for the management of poor staff performance and disciplinary issues. We spoke with ward managers who had managed poor performance. They felt that the process was clear and well structured. They were supported by the trust human resources team.

The trust's target rate for appraisal compliance is 85%. As at 31 March 2017, the overall appraisal rates for non-medical staff within this core service was 10%.

The rate of appraisal compliance for non-medical staff reported during this inspection was lower than the 14% reported at the last inspection (as at 29 June 2016).

Ward name	Total number of permanent non-medical staff requiring an appraisal	Total number of permanent non-medical staff who have had an appraisal	% appraisals
The Orchard Mental Health Inpatients (25-65)	42	0	0%
Mental Health Liaison Team (Lancaster) (25-65)	7	0	0%
Control Room Guild Lodge (S)	7	0	0%
Reception Guild Lodge (S)	1	1	100%
Inpatient Psychology (S)	12	3	25%
OT (S)	32	0	0%
Towneley Unit CSU (25-65)	11	0	0%
Hodder Mental Health Inpatients (25-65)	27	0	0%
Hyndburn Ward (25-65)	30	20	67%
Darwen Ward (25-65)	25	9	36%
PICU Calder Ward (25-65)	28	7	25%
Restart & Recovery Blackburn Inpatients (25-65)	17	0	0%
PICU Stockbeck Mental Health Inpatients (25-65)	30	0	0%
Edisford Assessment Ward (25-65)	28	1	4%

Dunsop Mental Health Inpatients (25-65)	27	0	0%
Community Rehab Team East (25-65)	10	5	50%
Clinical Treatment Team	19	1	5%
OT Basics (25-65)	3	0	0%
Restart & Recovery Burnley Inpatients (25-65)	8	1	13%
Personality Disorder Managed Clinical Network (MH)	12	7	58%
Psychosis Bipolar Network (MH)	13	0	0%
North Lancs Social Inclusion Service Cedar (25-65)	4	0	0%
North Lancs Social Inclusion Service Wyre (25-65)	1	0	0%
Mental Health Liaison Team (Fylde Coast) (25-65)	7	0	0%
Harbour - Shakespeare Ward (25-65)	32	0	0%
Harbour - Stevenson Ward (25-65)	30	1	3%
Harbour - Churchill Ward (25-65)	28	0	0%
Harbour - Orwell Ward (25-65)	34	0	0%
Harbour - Byron Ward (25-65)	33	0	0%
Harbour - Keats Ward (25-65)	34	0	0%
Harbour - General (25-65)	21	4	19%
Harbour - OT AMH (25-65)	21	8	38%
Harbour - OT OAMH (65+)	14	7	50%
Scarisbrick Mental Health Inpatients (25-65)	29	0	0%
Lathom Suite Ward (25-65)	19	0	0%
Harbour The Hub (25-65)	9	0	0%
351x Assessment Ward - Blackburn	20	0	0%
Core service total	725	75	10%
Trust wide	6007	1996	33%

The service undertook staff appraisals as part of a personal development review programme. At our last inspection we told the trust they should ensure that staff received annual appraisals. Appraisal compliance in the service in March 2017 was 10%. We requested updated appraisal compliance figures during our inspection. Data the trust provided showed that there were 554 active employees. This was a different figure to the data provided in March. Of those 393 (71%) had started a personal development review. However, of those only 154 (28%) had set objectives and only 112 (20%) had had a personal development review. We asked 49 staff about annual appraisals. Of those 31 told us that they had an annual appraisal in place. Ward managers and staff we spoke with acknowledged that appraisals could be difficult to undertake due to time and capacity issues. This meant that trust hadn't addressed our recommendation from our last inspection. Staff we spoke with told us that despite the lack of annual appraisals they felt supported in their role.

No information was provided by the trust in regards to appraisals for permanent medical staff for this core service.

Between 1 August 2016 and 31 July 2017 the average rate across all nine teams in this core service was 60% against a trust target of 100%.

Caveat: there is no standard measure for clinical supervision and trusts collect the data in different ways, it's important to understand the data they provide.

Ward name	Clinical supervision sessions required	Clinical supervision sessions delivered	Clinical supervision rate (%)
Byron Ward	54	0	0%
Calder Ward (PICU Male)	204	137	67%
Darwen Ward (male treatment)	284	203	71%
Dunsop Ward (female treatment)	0	101	0%
Edisford Ward(female Assessment	92	0	0%
Hodder Ward(Male treatment	1.75	2.85	163%
Hyndburn (female treatment)	204	137	67%
Orwell Ward	134	0	0%
Ribble (male assessment)	0	0	-
Core service total	973.75	580.85	60%
Trust Total	17914.8	12753.1	71%

We requested updated supervision compliance rates during our inspection. The trust submitted monthly compliance rates for November 2017 (50%), December 2017 (53%) and January 2018 (55%). However the trust stated that these figures only covered 78% of the service. This was because not all teams were recording supervision in the same way. This meant that the service could not be assured staff were receiving supervision. At our last inspection supervision compliance was 51%. We identified this as something the trust should improve.

Ward managers and staff we spoke with acknowledged that formal supervision was not occurring as regularly as it should. This was due to staffing pressures and capacity. Ward psychologists worked with staff and provided additional support. Staff we spoke with told us of group debriefs and reflective practice sessions that they considered to be a form of supervision. However these were not always recorded as such. Staff told us they felt supported in their role and were able to approach managers and colleagues for guidance and advice. This happened during informal conversations and within multidisciplinary meetings.

Multi-disciplinary and inter-agency team work

Staff held regular multidisciplinary meetings to discuss, review and care plan for the needs of patients. We observed four care reviews during our inspection. They were well attended and multidisciplinary in nature. There was good sharing of information and positive relationships between staff. Staff acknowledged that staffing pressures could impact upon personal attendance. Where staff members were unable to attend they provided relevant updates before the meeting and received copies of minutes detailing any actions allocated to them.

Care coordinators and relevant health professionals were invited to attend care programme approach review meetings. Staff maintained contact with care coordinators through telephone calls, emails and letters. Care coordinators were sent notes of meetings when they were unable to attend.

Handovers occurred in between all shifts. We observed three handovers during our inspection. Handovers were well managed and comprehensive. Each patient on the ward was discussed and updates were provided on individual and ward risks. Handovers we observed evidenced staff knowledge of patients as well as effective communication between staff on the two shifts.

Wards had good links with local community mental health teams, local authority safeguarding services and partner agencies.

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

Mental Health Act Level 1 was not provided by the trust in the routine provider information request from the CQC; however Mental Health Act Level 2 training was included. This is non-mandatory training and had a compliance rate of 11% (41 out of 694).

Staff received Mental Health Act training as part of their essential training programme. Overall compliance was 58%. This was an increase from 43% at our last inspection. Despite the low training compliance staff we spoke with were generally knowledgeable about the Mental Health Act and the code of practice. They were aware of their responsibilities under the act and delivered care in line with it. The trust had a Mental Health Act policy to support staff.

Mental Health Act documentation was up to date and complete. Staff had access to legal advice from the trust's Mental Health Act team and access to administrative support from Mental Health Act administrators who worked with each ward. The administrators scrutinised Mental Health Act to ensure that it had been completed properly and that detentions were legal. In addition the administrators provided oversight of the day to day implementation of the act within the service. They monitored patients' legal status, section renewal dates and confirmed that patients were regularly read their rights. They sent regular emails to ward staff with updates. These included alerts when a patients existing section was due to expire and reminders when patients were due to be read their rights.

We reviewed 128 care records. We found that staff explained patients' rights to them at regular intervals and in a way they could understand. Patients we spoke with were generally aware of their rights and understood them. T2 and T3 forms were in place and complete. Patients with capacity use a T2 form to consent to the medication they have been prescribed. Where a patient lacks capacity a T3 form is used to confirm that a second opinion appointed doctor has reviewed the patient's medication and is in agreement with it. We observed one medication round during our inspection. Staff checked medication and consent against the forms. We found evidence of informed consent in 118 of the 128 care records we reviewed.

Patients had access to Independent Mental Health Act advocacy services. These were advertised on wards. Staff knew how to refer patients to the service. Patients we spoke with were aware of the advocacy services available. Patients we spoke with who had used advocacy services were positive about their experience.

Not all of the wards we visited had notices advising informal patients that they could leave the ward. However informal patients we spoke with were aware of their rights. They acknowledged they needed to discuss this with a member of nursing staff and advise them of where they were going and when they planned to return. Staff also had to open the doors for patients.

Good practice in applying the Mental Capacity Act

As of 31 July 2017, Mental Capacity Act Level 1 (Admin) training had a compliance rate of 95% and Mental Capacity Act Level 1 (Clinical) had a compliance rate of 106%.

Mental Capacity Act Level 2 training was provided and was classed non-mandatory training. This had a compliance rate of 4% (18 out of 481)

Staff received Mental Capacity Act training as part of their essential training programme. Overall compliance was 92% for administrative staff and 94% for clinical staff. This was an increase from 78% at our last inspection. Staff we spoke with demonstrated a good knowledge of the act and its principles. Staff could seek support from the trust's central Mental Health Act team and there was a trust policy to provide guidance.

Staff assumed patient capacity unless there was reason to doubt this. Mental capacity was considered as part of the assessment process and where concerns over patient capacity were identified a mental capacity assessment was completed. We found evidence of capacity assessments in 55 of the records we reviewed. Assessments were generally of a comprehensive nature but were not always captured on the trust mental capacity assessment form. We found examples where assessments were captured in clinical notes.

We observed consideration of capacity in the multidisciplinary care reviews that we attended. We reviewed three best interest assessments that had been completed. These covered financial and accommodation issues. The best interest assessments were completed by appropriate individuals and were in line with the principles of the act. Patient views had been captured and there was carer involvement in two of the assessments.

The trust told us that one Deprivation of Liberty Safeguard (DoLS) application was made to the local authority for this core service between 1 August 2016 and 31 July 2017. This was made in March 2017.

The number of DoLS applications made during this inspection was lower than the seven reported at the last inspection (16 January 2015 and 11 February 2016)

Number of DoLS applications made by month

	Aug -16	Sep -16	Oct -16	Nov-16	Dec -16	Jan -17	Feb-17	Mar-17	April-17	May-17	Jun -17	Jul -17	Total
Applications made	0	0	0	0	0	0	0	1	0	0	0	0	1
Applications approved	0	0	0	0	0	0	0	1	0	0	0	0	1

Is the service caring?

Kindness, privacy, dignity, respect, compassion and support

Staff interactions and attitudes towards patients were caring and respectful. We observed staff interacting with patients in a friendly, supportive and calm manner. Our observations of the wards and patient review meetings showed that staff had a good knowledge of patients and their circumstances. Staff understood the individual needs of patients including their cultural, social and religious needs.

Staff respected patients' privacy and dignity. They knocked on bedroom doors before entering. Staff followed confidentiality protocols and did not discuss personal information about patients where this could be overheard by others.

During the inspection we observed staff respond to patients who were upset or distressed. In each case staff were supportive, prioritised the patient and discussed their concerns in a calm and constructive manner. We observed five incidents where staff had to manage agitated patients. In four of the incidents staff used appropriate language, body posture and de-escalation techniques to calm the patient. In one instance however we saw a staff member use more aggressive language and a less understanding approach.

Overall patient feedback on staff was positive. We spoke with 61 patients who were using the service and gathered feedback from four comment cards. Patients considered staff to be caring and compassionate. They felt staff helped them to understand their care and treatment and were interested in their well-being. Patients we spoke with gave examples of staff taking time to support and reassure them when they had concerns. We spoke with patients who described staff 'going the extra mile' to help meet their needs.

However not all feedback was positive. Seven patients we spoke with raised concerns over staff attitude. This included patients feeling that they were not being listened too or that staff were not respectful towards them.

The 2016 PLACE score for privacy, dignity and wellbeing at four core service location(s) scored comparable to similar organisations.

Four location(s) including three (75%) that scored worse when compared to other similar trusts for privacy, dignity and wellbeing.

Site name	Core service(s) provided	Privacy, dignity and wellbeing
Burnley General MH	MH - Acute wards for adults of working age CHS - Dental CHS - adults	76.32%
Ormskirk and General Hospital	MH - Community services for people with learning disabilities or autism MH - Acute wards for adults of working age	72.69%
The Harbour	CHS - adults MH - Wards for older people MH - Acute wards for adults of working age	94.59%
The Orchard	MH - Acute wards for adults of working age	87.10%

Trust overall	87.58%
England average (mental health and learning disabilities)	90.6%

The involvement of people in the care they receive

Staff orientated patients to the ward as part of the admission process. Patients were shown around the ward and introduced to other patients and staff. Wards had information and welcome leaflets available for patients. These included information on ward routine, facilities and activities as well as information on how to complain and advocacy services. The majority of patients we spoke with told us they had been orientated to the ward on admission and been provided with information. However one patient stated they had not been shown around the ward and three stated they had not been given information.

Staff involved patients in their care. Mental Health Act reviews carried out by the Care Quality Commission in this core service during the months preceding this inspection raised concerns that patients were not actively involved in their care planning. However, on this inspection we reviewed 128 care records and found that 116 captured patient's views. Patients we spoke with were generally positive about their care and their involvement in it. Only five of the 61 patients we spoke with told us that they didn't feel involved in their care. We observed four meetings in which care was reviewed with patients. Patients were active participants in discussions. Staff gave patients space to air their opinions and encouraged them to do so. In general patients we spoke with knew what was in their care plan. However it was not always clear whether they had been offered a copy. Records did not consistently indicate if the patient had been offered a copy of their care plan or record a rationale if this had been refused. We spoke with 61 patients and asked 55 if they had a copy of their care plan. Only 21 were clear that they had a copy of their care plan. However many patients told us that they either thought that they did or 'were not sure'.

Patients were able to give feedback on the service. However, not every ward was holding regular patient meetings. We reviewed the minutes of patient meetings on three of the wards we visited. They demonstrated that staff responded to patients concerns. Where wards were not consistently holding patient meetings we saw evidence that ad hoc meetings were being held in response to specific issues. Patient surveys were in place including the friends and family test. Some wards had 'you said, we did' boards on display. At the Harbour and the Orchard patients were able to attend patient groups held in patient cafes on site.

Patients were able to access advocacy services. Information on advocacy services and how to access them was available on the ward. This was in both poster and leaflet form. Advocacy services attended the wards on a weekly or as required basis to talk to patients. Staff we spoke with knew how to refer patients to advocacy services if they requested it. Patients we spoke with were aware of advocacy services available to them.

Patients had the opportunity to be involved in, and help influence, decisions about the service. For example patients could be part of interview panels for new staff. However none of the patients we spoke with had sat on an interview panel or were aware that this was available. There was a volunteer programme in place. At the Harbour some former patients had worked at the cafe on site.

Involvement of families and carers

Staff involved carers and families in patients care where this was appropriate and agreed with the patient. This included attendance at patient review meetings and being sent copies of correspondence and care plans. We spoke with three carers during the inspection. They were positive about staff and felt involved in their loved ones care. Staff maintained contact with family and carer members through phone calls and written correspondence. Carers we spoke with told

us they were able to ring the ward and speak to staff although staff were not always immediately available. At the Orchard a volunteer ran a weekly carers group.

Staff could refer carers to local care coordinators for carer assessment. The trust had been piloting the triangle of care model and completing baseline assessments. The Triangle of Care was a programme developed by the Princess Royal Trust for Carers and the National Mental Health Development Unit. It promotes a therapeutic alliance between the client, staff member and carer that promotes safety, supports recovery and sustains well-being. The concept of the triangle is used to illustrate carers as active partners within the care team. The process had not yet been fully implemented and early learning included the need to review staff training in relation to carers.

Carers were able to give feedback about the service. This included the friends and family test.

Is the service responsive?

Service Planning

Ward Moves

The trust was unable to provide the CQC with this information.

Moves at Night

The trust was unable to provide the CQC with this information.

Access and discharge

Bed management

The trust provided information regarding average bed occupancies for 17 wards in this core service between 1 August 2016 and 31 July 2017.

Ward name	Average bed occupancy range (1 August 2016 and 31 July 2017) (current inspection)
Darwen Ward (male treatment)	98.6% - 101.1%
Hyndburn (female treatment)	96.5% - 100.3%
Ribble (male assessment)	96.8%- 106.6%
Calder Ward (PICU Male)	99.4%- 105.4%
Scarisbrick Unit	96.3%- 102.5%
Lathom Suite	98.4%- 107.3%
Byron Ward	74.6%- 79.8%
Churchill Ward	98.6%- 103.1%
Keats	97.5%- 103.8%
Orwell Ward	95.2%- 110.9%
Shakespeare Ward	88.5%- 113.3%
Stevenson Ward	99.5%- 106.8%
The Orchard	98.5%- 109.9%
Dunsop Ward (female treatment)	98%- 103.7%
Stockbeck (Female PICU)	76.9%- 100.5%
Edisford Ward(female Assessment	52.4%- 93.1%
Hodder Ward(Male treatment	98.5%- 102.3%

The trust provided information for average length of stay for the period 1 August 2016 and 31 July 2017.

Ward name	Average length of stay range (1 August 2016 and 31 July 2017) (current inspection)
Darwen Ward (male treatment)	26.2-83.8
Hyndburn (female treatment)	25.8-94.6

Ribble (male assessment)	5.0-9.6
Calder Ward (PICU Male)	21.0-103.3
Scarisbrick Unit	14.3-47.7
Lathom Suite	9 – 74.5
Byron Ward	22.5-160.3
Churchill Ward	18.9 – 90.3
Keats	16.8 – 63.8
Orwell Ward	16.6- 78.4
Shakespeare Ward	22.0 – 102.7
Stevenson Ward	31.4 – 111.0
The Orchard	31.4- 94.5
Dunsop Ward (female treatment)	14.8- 68.6
Stockbeck (Female PICU)	18.4 – 110.0
Edisford Ward(female Assessment	3.9 – 6.5
Hodder Ward(Male treatment	38.1 – 96.9

This core service reported 158 out area placements between 01 August 2016 and 31 July 2017. As of 25 August 2017 this core service had 11 ongoing out of area placements.

There was one placement that lasted less than one day, and the placement that lasted the longest amounted to 294 days.

Number of out of area placements	Number moved to a different CQC Service	Range of lengths (completed placements)	Number of ongoing placements
158	104	0-294	11

This core service reported 246 readmissions within 28 days between 01 August 2016 and 31 July 2017. One hundred and ninety three of readmissions (78%) were readmissions to the same ward as discharge. Fifty nine readmissions were from Ribble Ward Blackburn

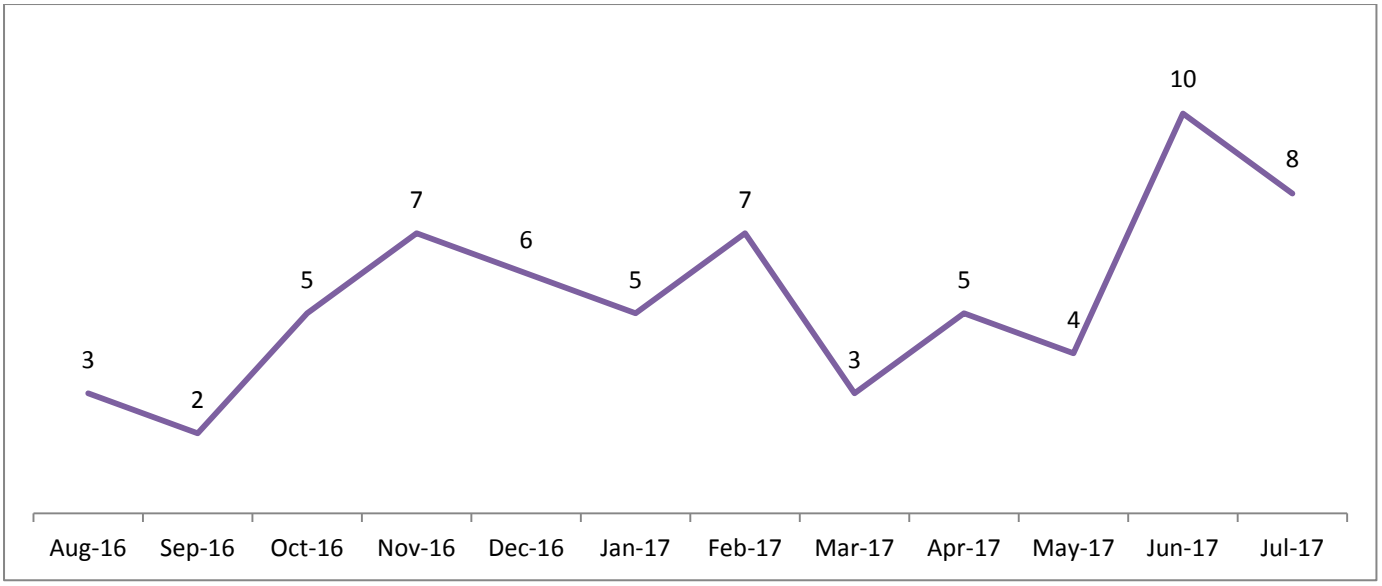
The average number of days between discharge and readmission was 11 days. There was one instance whereby a patient was readmitted on the same day as discharge. There were 13 instances where patients were readmitted the day after being discharged.

Number of readmissions (to any ward) within 28 days	Number of readmissions (to the same ward) within 28 days	% readmissions to the same ward	Range of days between discharge and readmission	Average days between discharge and readmission
246	193	78%	0-28	11

Discharge and transfers of care

Between 1 August 2016 and 31 July 2017 there were 2468 discharges within this core service. This amounts to 79% of the total discharges from the trust overall (3129). Of the 2468 discharges 38 were delayed.

The graph below shows the trend of delayed discharges across the 12 month period.



Team/ward/unit	Total discharges	Total delayed discharges	% of delayed discharges
Byron Ward The Harbour	9	4	44%
Calder Pendleview Unit Blackburn	4	0	0%
Churchill Ward The Harbour	101	5	5%
Darwen Pendleview Unit Blackburn	76	0	0%
Dunsop Ward Burnley General Hospital	119	0	0%
Female Assessment Ward Burnley General Hospital	553	0	0%
Hodder Ward Burnley General Hospital	106	2	2%
Hurstwood Hillview Blackburn	38	2	5%
Hyndburn Pendleview Unit Blackburn	104	4	4%
Keats Ward The Harbour	12	1	8%
Latham Suite Scarisbrick Unit Ormskirk General Hospital	8	0	0%
Orwell Ward The Harbour	139	4	3%
Ribble A Blackburn	560	0	0%
Scarisbrick Ward Ormskirk General Hospital	186	2	1%
Shakespeare Ward The Harbour	102	7	7%
Stevenson Ward the Harbour	113	3	3%
Stockbeck PICU Burnley General Hospital	11	1	9%
The Orchard Lancaster	133	3	2%
X CONTRACTED AMH VW - Acute	4	0	0%
Z OATS AMH VW - Acute	77	0	0%
Z OATS AMH VW - PICU	13	0	0%

This information was not provided by the trust, in the CQC routine provider information request.

Staff we spoke with told us that pressure on beds was high. This was reflected in bed occupancy figures. The service managed demand on beds through a central bed management hub. All requests for beds went through the hub. The bed management hub was led by clinical staff and had daily contact with modern matrons and wards. The hub collated information on bed

occupancy, planned discharges and patient leave. When patients were given leave of more than one night the multidisciplinary team identified the bed as ‘safe leave’ or ‘unsafe leave’ bed. If the bed was deemed as unsafe leave it was protected whilst the patient was on leave. If the bed was identified as a safe leave bed then the hub might explore utilising the bed for a new admission. A bed would be identified as a safe leave bed if the patient was settled and the leave was progressing well or if the patient was near discharge. Beds were identified as unsafe leave beds if for example it was the patients first period of leave or there was a likelihood of the patient returning early from the leave. Ward managers told us that when they asked for a bed to be protected this was respected.

The bed management hub prioritised admissions based on risk. Each patient’s current risks, circumstances and level of need were considered. Where a patient was identified as needing a priority admission this was actioned. Where ever possible patients were admitted to a ward within their own locality. However, if this was not possible they would be admitted to a ward within another part of the trust. Patients were also admitted to out of area services when an appropriate bed could not be found within the trust. The bed management hub was responsible for monitoring out of area patients and worked to repatriate them.

Ward managers were generally positive about the bed management hub and how it functioned. However some felt they had been pressured to accept patients in the past.

There were five psychiatric intensive care units within the trust including two female only units. There was a referral and transfer pathway in place between acute wards and the psychiatric intensive care units. Where there was not a psychiatric intensive care bed available within the trust a placement with an independent provider was secured. The patients return to the trust was facilitated when a bed became available. Where a ward had a patient awaiting admission to a psychiatric intensive care unit additional staff were provided to help manage the patients’ needs.

Staff began to consider patient discharge on admission and as part of the 72 hour care review meeting. Discharge plans were formulated with local community mental health teams and the patients care co-ordinator. Where a patient did not have contact with their local community mental health team the crisis team picked up this responsibility. Care plans we reviewed evidenced discharge planning. Discharge plans were discussed in patient reviews that we observed. At Burnley General hospital there was a band six practitioner dedicated to helping facilitate discharge. They worked with all four wards at the hospital.

The service held weekly delayed transfer of care meetings. The meeting reviewed all delayed discharges and worked with staff and partner agencies to facilitate discharge. The main cause of delayed discharges was a lack of suitable placements or community support for patients to move onto.

Facilities that promote comfort, dignity and privacy

- The 2016 PLACE score for ward food at the locations scored worse than similar trusts. There were four location(s) including three (75%) that scored worse when compared to other similar trusts for ward food.

Site name	Core service(s) provided	Ward food
Burnley General MH	MH - Acute wards for adults of working age CHS - Dental CHS - adults	87.53%
Ormskirk and General Hospital	MH - Community services for people with learning	85.03%

	disabilities or autism MH - Acute wards for adults of working age	
The Harbour	CHS - adults MH - Wards for older people MH - Acute wards for adults of working age	93.89%
The Orchard	MH - Acute wards for adults of working age	84.20%
Trust overall		90.97%
England average (mental health and learning disabilities)		91.5%

Not all patients had access to single occupancy bedrooms. At Burnley General hospital three wards (Dunsop, Edisford and Hodder) had shared dormitory bays. At the Scarisbrick inpatient unit there were two shared dormitory rooms accounting for eight beds. Sleeping bays within dormitories were portioned by walls. Staff regularly reviewed patients in shared dormitories and looked to transfer patients into single rooms based on need and risk. Patients we spoke with who were in dormitory rooms stated they would prefer single bed accommodation but did not raise specific concerns over the dormitory arrangements. The trust had acknowledged that dormitories were not appropriate for providing mental health care and were developing plans to remove their use. The three wards based at Burnley General hospital were due to relocate to new premises later in 2018. Patients were able to personalise their bedrooms. We saw bedrooms where patients had put up photographs and posters. Patients had secure storage facilities within their bedrooms and could also ask ward staff to store important or valuable items.

Staff and patients had access to a range of rooms on the ward to support treatment and care. However facilities varied from ward to ward and on some wards rooms were used for dual purposes. Patient lounges were available on all wards and there was access to hot and cold drinks as well as snacks. Wards had dining areas, shared spaces and access to laundry facilities.

Each ward had a facility that could be used for visiting. This included visits by family members and young children. Visiting facilities were booked in advance and staff risk assessed planned visits. Where required a staff member would observe the visit. Patients were able to make phone calls in private. This was either by using their mobile phone in their bedrooms or by accessing the ward phone.

Not all wards provided direct access to outside space. Hyndburn ward at the Royal Blackburn hospital and Edisford and Hodder wards at Burnley General hospital were located on the first floor of their buildings. Patients were granted section 17 leave to enable them to leave the ward and access outdoor space in the hospital grounds. Where section 17 leave was not appropriate for a patient they required a staff escort to access outside space. Staff and patients that we spoke with told us that the staff's ability to facilitate this could depend on staffing levels and ward acuity. Informal patients were able to leave the ward. This required staff to unlock the ward doors and provided an opportunity for staff to risk assess the patient prior to leaving. If informal patients presented high levels of risk staff reviewed their status as an informal patient and considered the need for a section. Wards located on the Burnley General hospital site were due to be relocated to new facilities in Chorley later in 2018. The new facilities included access to garden space.

Nursing staff, occupational therapists, restart and recovery teams and health and well-being workers provided activities to patients on the ward. Activities included arts and crafts, board games, quiz nights and walking groups. Activities were scheduled for seven days a week but there was a reduced provision at weekends. Activity schedules were on display on wards to inform patients of what was available. Wards had activity rooms or communal areas where activities could take place. There were also additional facilities off the ward in each location. These included larger group and activity rooms as well as access to gym facilities. Patients at the Harbour and the

Orchard had access to a patient café. However patients required either section 17 leave or escorted leave to access these facilities.

Staff and patients we spoke with told us that planned ward based activities normally took place but were occasionally cancelled due to staffing pressures or ward acuity. Patients we spoke with told us they enjoyed the activities that were offered.

Patients could keep their own mobile phones with them on the ward. If there were any concerns with this arrangement for individual patients, staff would risk assess this. Wards also had communal phones or a cordless portable phone that patients were also able to use if they required.

Patient we spoke with gave negative feedback on the food provided on the wards. Although some of the patients we spoke with felt the food was good or 'OK' several raised concerns over the variety, quality and quantity of food that was available. Patients had access to hot drinks and snacks on the ward. They were also able to order takeaways.

Patients' engagement with the wider community

Occupational therapists, restart and recovery teams and health and well-being workers were able to support patients in accessing education and work opportunities in the wider community. However the wards were for acutely unwell patients and so the main focus was on the delivery of current treatment. Staff supported patients to access the community through the use of leave and some wards offered walking groups and allotment sessions.

Staff supported and facilitated patient contact with family members and loved ones. This included booking visiting facilities, providing staff to supervise visits where this was required and booking interpreters to enable family to understand the content of the ward rounds. Carers were able to visit patients on the wards and patients also went on periods of home leave to spend time with their family and friends. There were arrangements in place to facilitate visits from children and young people. These were held off of the ward environment.

Meeting the needs of all people who use the service

The service was able to make adjustments for patients who required disabled access. Where wards or facilities were based on the first floor of a building there were lifts to enable access

Wards had a variety of information on display and available to patients. This included information on mental health, physical health, advocacy, local support services and ward activities. Information was available in poster and leaflet form. However the provision of information varied from ward to ward.

Staff had access to translation services. This included face to face and telephone translation. Language needs were identified through referral and assessment information. Staff told us translation services were generally responsive and of a good quality. We saw three instances where interpreters had been requested to attend ward rounds to support communication between staff and the patient and family members. On one ward staff were working with translation services to identify the appropriate dialect required for a patient of Kurdish descent. Information leaflets were not routinely displayed in other languages. However, staff were able to access translation services to have documents and patient information translated where required.

Food was available to meet specific needs. Patients could order food that met their religious or cultural requirements such as halal meat and vegetarian food. Patients had access to spiritual support. There was a trust inter faith team that supported staff and patients. We spoke to one patient who had been supported to attend services at the local place of worship for their religion.

Listening to and learning from concerns and complaints

Ward	Type of Complaint Reported	Total
Darwen Ward (male treatment)	Staffing numbers (4)	14
Dunsop Ward (female treatment)	Staff (5)	13
Edisford Ward(female Assessment	Access to treatment or drugs (2) Clinical Treatment (2) Communications (2)	11
Hodder Ward(Male treatment	Other (4)	9
Hyndburn (female treatment)	Staffing numbers (3)	8
Keats	Clinical treatment (2) Other (2)	7
Inpatient Management East Lancs (25-65)	Unknown (1)	1
Harbour - Shakespeare Ward (25-65)	Communications (1)	1
Lathom Suite	Admissions, discharges and transfers excluding delayed discharge due to absence of care package (1) Restraint (1)	2
OLD-Inpatients	Admissions, discharges and transfers excluding delayed discharge due to absence of care package (1)	5
OLD-Non Clinical	Admissions, discharges and transfers excluding delayed discharge due to absence of care package (4)	4
Orwell Ward	Access to treatment or drugs (4) Other (4)	16
Ribble (male assessment)	Clinical Treatment (4)	9
Scarisbrick Unit	Communications (2)	7
Shakespeare Ward	Other (4)	10
Stevenson Ward	Privacy, dignity and wellbeing (2) Other (2)	7
Stockbeck (Female PICU)	Other (3)	8
The Orchard	Communications (3) Other (3)	8
Unknown	Privacy, dignity and wellbeing (1)	1
Core service total	**Other (38)**	**141**

This core service received 141 complaints between 1 August 2016 and 31 July 2017.

This core service received 172 compliments during the last 12 months from 1 August 2016 and 31 July 2017 which accounted for 2% of all compliments received by the trust as a whole.

Patients we spoke with either knew how to complain or stated they would raise any concerns with staff. Information on how to complain was on display within wards in poster and leaflet form. Information on how to contact the Care Quality Commission was also on display. The majority of patients we spoke with told us they would feel comfortable raising concerns with staff. We spoke with four patients who told us they had made formal complaints. Three of the complaints were ongoing. One complaint had been resolved and the patient was happy with the outcome. Patients we spoke with also gave examples of where they had raised issues with staff without going through the formal complaints process. Patients were happy with the responses they had received. Some wards had 'you said we did' boards to illustrate changes that had been made.

Staff we spoke with were aware of the trust complaints process and could support patients to access the trust complaints team. There was a structure in place to investigate complaints and identify recommendations. Complaint investigations were fed back through service operational meetings, ward meetings and in supervision sessions. We spoke to one staff member who had been interviewed as part of a complaint investigation and who had received feedback on the outcome.

Is the service well led?

Leadership

Ward managers and modern matrons we spoke with were motivated and knowledgeable about their role, ward and patient base. Ward managers and modern matrons completed clinical shifts as part of their responsibilities. Whilst we found that this helped to address staffing pressures it meant that they had reduced time to deliver their managerial responsibilities. This was a contributing factor to the low level of compliance with supervision and appraisals within the service. In addition we found that wards did not have regular team meetings. Team meetings were scheduled but did not always take place. Where team meetings had been cancelled or were not occurring ward managers attempted to keep staff informed with changes and updates by email, notices displayed within the staff office and personal conversations.

Ward managers we spoke with were generally positive about the support they received from modern matrons. However some concerns were raised around the level of support offered in areas such as tackling smoking on the wards. Staff we spoke with were positive about their ward managers and considered them supportive and approachable. Ward staff were less certain about management above modern matron level. Staff could not consistently identify staff at senior level within the service or trust.

Ward managers had access to leadership and development courses. Ten of the ward managers we spoke with had attended leadership or managerial training. Ward managers could also complete root cause analysis training to enable them to complete incident and complaint investigations.

Ward managers and modern matrons that we spoke to demonstrated a good understanding of the challenges the service faced. They understood the pressures from issues such as staffing and worked collaboratively and with the trust to manage the risk. They were aware of areas that needed improving on their individual ward and had ideas on how to address these.

Vision and strategy

The trust had a vision and a set of values that had been developed with staff. The trust's vision was to provide 'high quality care, in the right place, at the right time, every time.'

The trust's values were:

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

Staff we spoke with were generally aware of the trust's vision and values. We saw that staff delivered care in line with the values.

Culture

Staff morale was generally positive despite the challenges they faced. Staff acknowledged that it could be difficult on the wards when acuity was high and/or staffing levels were stretched. Staff were positive about the team work that occurred within and across wards to help manage this. Staff were positive about their colleagues and felt there were good relationships within their multidisciplinary teams.

The majority of staff we spoke with felt respected, supported and valued by colleagues. Morale was lowest on wards located at the Burnley General hospital site. Although feedback from staff on these wards was still positive overall they felt frustrated by the environmental challenges they faced and difficulties in implementing the smoke free policy.

Staff were aware of whistle blowing policies and procedures. There was a local speak up guardian in place. Staff felt able to raise concerns without fear of victimisation. However, two staff told us they would not raise concerns because they felt that nothing would happen in response.

There were policies and procedures in place to support equality and diversity. Staff received training in equality and diversity. Training compliance was 99%. The trust had a process to equality impact assess new policies and procedures. Staff had access to black, minority and ethnic and lesbian, gay, bisexual and transgender staff support groups. However we spoke with one black, minority and ethnic staff member who felt incidents of patient racism had not been dealt with properly.

There were policies and procedures in place to manage poor staff performance and absence. Managers received support from the trust human resources team. There were clear processes to follow when adverse incidents or poor staff performance required suspension and investigation. Staff had access to occupational health and support services.

Between 1 August 2016 and 31 July 2017, there were 12 cases where staff had been either suspended, placed under supervision or were moved to a different ward. 10 staff had been suspended and two were classed as other.

The number of staff placed under supervision, suspended or moved ward during this inspection was better than those reported at the last inspection (23 between April 2015 and March 2016)

Caveat: Investigations into suspensions may be ongoing, or staff may be suspended, these should be noted.

Ward name	Type of supervision/ supervised practice
Stephenson Ward	Suspended
The Orchard	Suspended
Orwell Ward	Suspended
Psychology	Other
Byrom Ward	Suspended
The Orchard	Suspended
Scarisbrick Unit	Other
Lathom Suite	Suspended
Byron Ward	Suspended
Orwell Ward	Suspended
Orwell Ward	Suspended
Hilldale	Suspended

Governance

There were systems and processes in place to assess and monitor the quality of care delivery and the safety of the environment. Staff reported adverse incidents on an electronic system and incidents were reviewed by ward managers and modern matrons. There were processes in place to instigate investigations where required and senior staff trained in root cause analysis methodology. Staff completed a range of audits on the ward. These included audits of medication, clinic rooms, infection control practice and care records.

There were a range of forums to disseminate learning but it was not clear that staff were engaging with them. Ward managers worked clinical shifts as part of their responsibilities. This meant they had less time to perform managerial functions. This along with vacancies and staffing capacity meant that wards were not consistently able to deliver supervision, appraisals or hold team meetings. Where team meetings had been cancelled or were not occurring ward managers attempted to keep staff informed with changes and updates by email, notices displayed within the staff office and personal conversations. We found that the trust struggled to provide accurate and comprehensive figures around supervision and appraisal rates. This was due to inconsistency across wards in how these were recorded.

Ward managers had access to performance dashboards. These provided live performance data which could be discussed in team meetings and supervision sessions. The trust had centralised processes to manage and mitigate the risk from staffing pressures and demand for beds. There were commissioning for quality and innovation targets in place including around smoking cessation. Wards produced monthly and quarterly performance reports.

There was a service wide governance structure above the wards. Ward managers and modern matrons attended these meetings and fed back to ward staff. If team meetings were not scheduled this was done through email. Action plans developed from investigations and quality assurance processes were monitored at service level. The trust were aware of the challenges within the service. These included staff recruitment and the removal of dormitory accommodation. Plans were in place to address these concerns. There was an ongoing programme of staff recruitment.

There was a suite of policies and procedures to guide and support staff. Policies and procedures were in date and appropriate for use. There were process to equality impact assess new policies

and procedures. This meant that the trust and service policies and operational practises were not discriminatory.

There was inconsistency across wards in documentation and some processes. Wards were using different methods to report appraisal and supervision figures. This meant that the trust was not able to provide comprehensive compliance figures. Different teams used different supervision templates.

The trust have provided their board assurance framework, which details any risk scoring 12 or higher (those above) and gaps in the risk controls which impact upon strategic ambitions. There were no risks related to this core service and all mental health services at Burnley General Hospital.

Corporate risk register[2] (Internal use only - Remove before publication)

The trust has provided a document detailing their highest profile risks. Each of these has a current risk score of 15 or higher. The following relate to this core service and other services at the site.

Key:

High (15-20)	Moderate (8-15)	Low 3-6	Very Low (0-2)

Opened	ID	Description	Risk level (initial)	Risk score (current)	Risk level (target)	Link to BAF strategic objective no.	Last review date
26 April 2017	8554	Withdrawal of resuscitation service to mental health wards at BGH	15	15	4		Not given

Management of risk, issues and performance

There were risk registers in place at ward level. These fed into a mental health network risk register which in turn fed into the trust risk register. Staff were able to discuss and escalate any risk where necessary. Risks scored above 15 or higher were escalated to the trust register. Ward managers we spoke with were aware of risks associated with their ward or the wider service. Ward and service risk registers were reviewed within the governance structure. The service had business continuity plans in place in the event of an emergency or significant adverse event.

The mental health network risk register captured risks around staffing levels and delivering cost improvement plans to meet budget constraints.

Where cost improvement plans had been put forward, these included a quality impact assessment which reviewed the impact upon patient safety.

Information management

The trust had information management systems to collect data from wards about the service. This helped inform senior managers about the performance of the wards and where improvements

[2] Corporate risk register

were required. Staff had access to the equipment and technology necessary to undertake their role. They had access to computers and laptops to access patient records. The trust had recently introduced ipads for staff to use when carrying out physical observations. The equipment and system were new and staff acknowledged there had been technical problems whilst they were being introduced. Ward managers and senior staff had access to a performance dashboard that included relevant data on adverse incidents, complaints and safeguarding. There was an electronic reporting system that captured all adverse incidents and complaints. The system could run reports giving an overview of incidents and status.

However there were no consistent processes for the recording of supervision and appraisal. This meant that the trust could not provide accurate and comprehensive compliance figures.

There was a team of staff who could respond and support staff with any information technology issues. The trust were in the process of sourcing a new patient recording system and were looking at other systems they felt may be more able to meet their needs

Information governance systems included confidentiality of patient records. Records could only be accessed by staff with the appropriate authority from the trust by way of a personal log on and password. Paper records were kept secure and locked away when not in use.

The service submitted statutory notifications to external bodies where required. These included the Care Quality Commission, local authorities and the police.

Engagement

Staff, patients and carers had access to current information about the trust and the service. The trust had a website so people with access to the internet could find out information about the services provided. The trust could provide information in alternative formats. Staff had access to a trust intranet which provided current information relating to the trust. This included the latest news, training opportunities and shared learning. However it was not clear that staff regularly accessed these resources or had capacity to do so.

Patients and carers were able to give feedback on the service they received. This included completing the friends and family test. Results from these surveys were collated centrally and fed back to the service. Patients and carers could also feedback opinions through the complaints and compliments procedures. There were hearing feedback and patient experience teams at trust level that patients and carers could contact.

The trust ran a volunteer scheme which patients, carers and members of the public were able to access. Patients, carers and members of the public were able to become ‘members’ of the trust and apply to sit on the trust membership panel. The trust regularly consulted the membership panel on issues across the trust and within the adult acute and psychiatric intensive care units.

Learning, continuous improvement and innovation

NHS Trusts are able to participate in a number of accreditation schemes whereby the services they provide are reviewed and a decision is made whether or not to award the service with an accreditation. A service will be accredited if they are able to demonstrate that they meet a certain standard of best practice in the given area. An accreditation usually carries an end date (or review date) whereby the service will need to be re-assessed in order to continue to be accredited.

Acute mental health and psychiatric intensive care units were not accredited with any scheme.

Forensic inpatient/secure wards

Facts and data about this service

Location site name	Ward name	Number of beds	Patient group (male, female, mixed)
Guild Lodge	Calder	10	Male
Guild Lodge	Marshaw	10	Male
Guild Lodge	Fairoak	18	Male
Guild Lodge	Dutton	15	Male
Guild Lodge	Mallowdale	8	Male
Guild Lodge	Fellside East	8	Female
Guild Lodge	Fairsnape	8	Male
Guild Lodge	Greenside	12	Male
Guild Lodge	Fellside West	15	Male
Guild Lodge	Elmridge	9	Female
Guild Lodge	Forest Beck	8	Female
Guild Lodge	Bleasdale	9	Male
Guild Lodge	Whinfell	9	Male
Guild Lodge	Langden	15	Male
Guild Lodge	Hermitage	10	Male

Is the service safe?

Safety of the ward layout

The ward complied with guidance on eliminating mixed-sex accommodation. Over the 12 month period from 1 August 2016 to 31 July 2017 there were no mixed sex accommodation breaches. All wards were single sex accommodation only.

Staff undertook regular assessment of the ward environment. All fifteen wards within this core service have had a ligature risk assessment within the past year (1 August 2016- 31 July 2017). None of the wards presented a high level of ligature risk. The trust had taken actions in order to mitigate ligature risks, including changes to the estate, management through individual clinical risk assessment and care planning, and procedural checks. All wards had access to ligature cutters and the availability of these was checked daily.

The layout of the some wards did not allow staff to fully observe all parts of the ward. However, this was mitigated by use of risk assessments, mirrors, regular checks and good relational security arrangements.

Environmental risks were raised and triaged in order of urgency, staff told us that repairs requiring urgent attention were dealt with quickly; the company responsible for this were, on the whole, easy to contact and responsive. Two wards had metal wall lockers located in a bathroom, the ligature risks associated with these were mitigated by restricting access and ensuring high risk patients did not use these areas alone. One ward manager was looking into the removal of these lockers to a different area.
Safety and security nurses were allocated on a daily basis to ensure the environment was safe and secure. They were designated by the nurse-in-charge to carry out hourly checks on patients' movements, the environment and sign patients in and out, documenting clothing descriptions and keeping accurate records. They noted the free time status of individual patients undertook sharps checks, cutlery checks and co-ordinated with occupational therapy staff about patients and staff movements for groups. They also ensured that visitors were safely escorted and had sufficient support whilst on the ward environment.

There was evidence of physical security arrangements in all the wards and units. Staff collected keys and personal alarms from the reception area, and the wards were entered via an airlock off the reception area. Visitors were not given alarms although were escorted whilst in the ward environments. Patients also had access to an alarm system and patient alarms were evident in all ward areas including bedrooms. These alarms were checked regularly to ensure they were in working order. There were procedures and checks to ensure that the alarms and keys were safely managed.

Keys were issued from the main reception area; these keys were not universal to all wards. Individual wards response teams were coordinated to ensure access in case support was necessary. Some wards had limited key access to the seclusion rooms, not all staff carried the seclusion room key which could cause difficulty in access to seclusion when a patient may be disturbed, and a new digital key system was under consideration across the hospital site. A trial was scheduled on the Fellside wards to commence in April 2018.

Relational security is the knowledge and understanding staff have of a patient and of the environment, and the translation of that information into appropriate responses and care. Relational security was discussed in supervision, staff meetings and training sessions; posters were visible in all staff areas relating to the See Think Act 2nd Edition, Royal College of Psychiatrists. Physical security was evident in the grounds of the hospital with fencing and roof lines complying with national specifications. Perimeter checks were undertaken to ensure maintenance of the perimeter fence. There was procedural security support available to staff and a designated security lead with responsibility for security across the hospital site.

Maintenance, cleanliness and infection control

All ward areas were clean and kept in good condition. All areas were well maintained. Cleaning records were kept and demonstrated that wards were cleaned regularly. Patients and staff told us that the wards were always clean and that staff and patients also took responsibility in maintaining cleanliness standards on a daily basis when the cleaning staff were off duty.

The ward staff ensured they followed the local infection control policies and had the equipment necessary to support this. They had support from a dedicated infection prevention and control team who provided specialist advice for all staff employed by the trust and who promoted infection prevention practices to minimise the risk of infections being spread. This team monitored clinical practices and levels of infections to minimise risk of patients picking up infections, provided advice for patients with infections and advice for staff if there are outbreaks of infections. Staff received regular education and training on infection prevention and control.

For the most recent Patient-led assessments of the care environment (PLACE) assessment 2017 the location scored worse than the similar trusts for 'dementia friendly' and 'disability' aspects of the environment.

Site name	Cleanliness	Condition appearance and maintenance	Dementia friendly	Disability
Guild Park Lodge	97.86%	95.98%	69.49%	67.42%
Trust overall	97.98%	94.02%	75.52%	76.54%
England average (Mental health and learning disabilities)	98.0%	95.2%	84.8%	86.3%

Seclusion rooms

The seclusion rooms did not have any apparent safety hazards and had robust environments such as reinforced windows and doors with natural light. The seclusion rooms allowed for communication with the patient via an intercom system and had a clock visible to the patient. They had limited furnishings, including a single bed, pillow, mattress and blanket, controlled lighting and doors which open outwards. All the seclusion rooms had externally controlled heating where staff were able to monitor the room temperature. Any blind spots had alternate viewing panels and mirrors where required. There was access to food and drink for patients in seclusion.

All medium and low secure wards had seclusion rooms. There were two patients subject to long term segregation in the seclusion rooms at the time of the inspection.

All wards had areas designated to be quiet/high dependency areas for patients requiring an area with less stimulation. Staff were aware of the Mental Health Act Code of practice relating to the definition of seclusion. Patients had freedom of movement from these areas and were supported to return to the ward area when requested.

Clinic room and equipment

The wards had fully equipped clinic rooms; resuscitation equipment and emergency drugs were accessible in case of emergency. There was an established quality checking system to ensure stock balances and expiry date rotation. However, we found two instances where these checks had not been undertaken, which were rectified on the day.

There was a schedule in place for electrical testing and calibrating medical equipment. Fridge and room temperatures were checked daily. Most non-refrigerated medicines must be stored at less than 25°C to ensure they remain effective. Two clinic rooms exceeded this recommended

temperature on a regular basis although standalone air conditioning equipment was evident this was not always effective.

Staff were trained in infection control precautions including hand-hygiene and sharps management. Hand washing facilities and antibacterial hand gel were available for staff use. The equipment and premises were cleaned in line with local policies, adequate personal and protective equipment was available to staff, and all staff were offered appropriate immunisation. Laboratory specimens were handled and stored in line with local policy.

Safe staffing

Nursing staff

Definition

Substantive – All filled allocated and funded posts.
Establishment – All posts allocated and funded (e.g. substantive + vacancies).

Substantive staff figures			**Trust target**
Total number of substantive staff	At 31 July 2017	430	N/A
Total number of substantive staff leavers	August 2016- 31 July 2017	38	N/A
Average WTE* leavers over 12 months (%)	August 2016- 31 July 2017	8.8%	10%
Vacancies and sickness			
Total vacancies overall (excluding seconded staff)	At 31 July 2017	67.52	N/A
Total vacancies overall (%)	At 31 July 2017	14.5%	5%
Total permanent staff sickness overall (%)	Most recent month (At 31 July 2017)	8.4%	4.5%
	1 August 2016- 31 July 2017	7.8%	4.5%
Establishment and vacancy (nurses and care assistants)			
Establishment levels qualified nurses (WTE*)	At 31 July 2017	167.97	N/A
Establishment levels nursing assistants (WTE*)	At 31 July 2017	237.33	N/A
Number of vacancies, qualified nurses (WTE*)	At 31 July 2017	40.22	N/A
Number of vacancies nursing assistants (WTE*)	At 31 July 2017	13.70	N/A
Qualified nurse vacancy rate	At 31 July 2017	23.9%	5%
Nursing assistant vacancy rate	At 31 July 2017	5.8%	5%
Bank and agency Use			
Shifts bank staff filled to cover sickness, absence or vacancies (qualified nurses)	August 2016- 31 July 2017	1205 (43%)	N/A
Shifts filled by agency staff to cover sickness, absence or vacancies (Qualified Nurses)	August 2016- 31 July 2017	290 (10%)	N/A
Shifts NOT filled by bank or agency staff where there is sickness, absence or vacancies (Qualified Nurses)	August 2016- 31 July 2017	604 (22%)	N/A

Shifts filled by bank staff to cover sickness, absence or vacancies (Nursing Assistants)	August 2016- 31 July 2017	3508 (18%)	N/A
Shifts filled by agency staff to cover sickness, absence or vacancies (Nursing Assistants)	August 2016- 31 July 2017	209 (1%)	N/A
Shifts NOT filled by bank or agency staff where there is sickness, absence or vacancies (Nursing Assistants)	August 2016- 31 July 2017	580 (3%)	N/A

*Whole-time Equivalent

This core service reported an overall vacancy rate of 24% for registered nurses at 31 July 2017. The vacancy rate for registered nurses was higher than the 15% reported at the last inspection (April 2016).

This core service reported an overall vacancy rate of 6% for nursing assistants[3] at 31 July 2017. The vacancy rate for registered nursing assistants was lower than the 8% reported at the last inspection (April 2016).

This core service has reported a vacancy rate for all staff of 14% as of 31 July 2017. This was higher than the rate (9%) reported at the last inspection (15 July 2016).

	Registered nurses			Health care assistants			Overall staff figures		
Ward/ Team	Vacancies	Establishment	Vacancy rate (%)	Vacancies	Establishment	Vacancy rate (%)	Vacancies	Establishment	Vacancy rate (%)
Mangt Secure Services	0.0	7.9	0%	0	0	0%	0.0	9.9	0%
Specialist Services Mangt	1.0	1.0	100%	0	0	0%	2.0	6.0	33%
Control Room Guild Lodge	0	0	0%	2.8	8.8	32%	2.8	8.8	32%
Reception Guild Lodge	0	0	0%	0	0	0%	0.0	1.0	0%
Secure Services Medics	4	4	100%	0	0	0%	12.5	23.9	52%
Inpatient Psychology	0	0	0%	0.0	0.0	0.0%	1.3	11.1	12%
OT	0	0	0%	0.0	11.9	0%	0.0	30.5	0%
Fairsnape Ward	3.1	13.0	24%	7.1	19.0	37%	10.2	32.0	32%
Greenside Ward	3.1	11.0	28%	0.0	13.0	0%	3.1	24.0	13%
Calder Ward	4.1	12.0	34%	0.0	12.5	0%	5.1	25.5	20%
Fairoak Ward	3.0	12.0	25%	0.0	9.5	0%	3.0	21.5	14%
Forest Beck Ward	0.6	7.6	8%	0.0	8.9	0%	0.6	16.5	4%
Whinfell Ward	6.3	11.3	56%	0.0	21.5	0%	6.5	33.0	20%
Marshaw Ward	3.0	10.0	30%	0.0	11.4	0%	3.0	21.4	14%

[3] 'Nursing assistants' include the following staff roles; nursing assistants, health care assistants, support workers, assistant practitioners and other support staff.

Elmridge Ward	1.1	11.0	10%	0.1	17.0	1%	1.2	28.0	4%
Bleasdale Ward	2.3	11.3	20%	0.0	23.0	0%	2.5	34.5	7%
Mallowdale Ward	0.0	5.7	0%	0.7	9.5	7%	0.7	15.1	5%
Dutton Ward	0.4	11.0	4%	1.2	14.0	9%	1.6	25.0	7%
Langden Ward	3.5	11.3	31%	0.0	21.5	0%	3.8	33.0	11%
Fellside East Ward	1.4	10.9	13%	0.8	14.0	6%	2.1	24.9	9%
Fellside West Ward	1.8	9.0	20%	0.0	11.0	0%	1.8	20.0	9%
Hermitage Ward	1.5	8.3	18%	1.0	11.0	9%	2.8	19.5	14%
Health and Justice Mangt	0	0	0%	0	0	0%	0.0	0.0	0%
Forensic Shop Guild Lodge	0	0	0%	0	0	0%	0.8	0.8	100%
Core service total	40.2	168.0	24%	13.7	237.3	6%	67.5	465.8	14%
Trust total	399.1	2330.8	17%	161.0	1381.7	12%	1408.5	6483.8	22%

NB: All figures displayed are whole-time equivalents

Between 1 August 2016 and 31 July 2017, bank staff filled 43% of shifts that needed to be covered for sickness, absence or vacancy for qualified nurses.

Certain teams had shifts filled totalling more than the total available shifts, the data quality of this metric is therefore unreliable.

In the same period, agency staff covered 10% of shifts for qualified nurses. 22% of shifts were unable to be filled by either bank or agency staff.

Ward/Team	Available shifts	Shifts filled by bank staff	Shifts filled by agency staff	Shifts NOT filled by bank or agency staff
Secure Services Management	138	0	0	0
Guild Lodge Cont-Room	21	11	8	50
Fairsnape Ward - Guild Lodge	97	22	22	20
Greenside Ward - Guild Lodge	168	21	16	19
Calder Ward - Guild Lodge	115	54	19	55
Fairoak Ward - Guild Lodge	117	22	10	25
Forest Beck Ward - Guild Lodge	234	152	15	53
Whinfell Ward - Guild Lodge	138	23	18	5

Marshaw Ward - Guild Lodge	173	78	37	83
Elmridge Ward - Guild Lodge	232	28	36	24
Bleasdale Ward - Guild Lodge	153	38	22	22
Mallowdale Ward - Guild Lodge	279	235	11	74
Dutton Ward - Guild Lodge	214	157	24	72
Langden Ward - Guild Lodge	126	63	13	31
Fellside East Ward - Guild Lodge	153	69	26	31
Fellside Ward - Guild Lodge	195	157	6	16
ABI Step Down - Guild Lodge	238	75	7	24
Core service total	2791	1205 (43%)	290 (10%)	604 (22%)
Trust Total	25,229	14,495 (57%)	4,469 (18%)	4,384 (17%)

***Percentage of total shifts

Between 1 August 2016 and 31 July 2017, 40% of shifts were filled by bank staff that needed to be covered for sickness, absence or vacancies.

In the same time period, agency staff covered 4% of shifts. 5% of shifts were unable to be filled by either bank or agency staff.

Ward/Team	Available shifts	Shifts filled by bank staff	Shifts filled by agency staff	Shifts NOT filled by bank or agency staff
Catering - Guild Park	1	0	0	0
Guild Lodge Cont-Room	256	187	0	3
Fairsnape Ward - Guild Lodge	1198	195	9	52
Greenside Ward - Guild Lodge	2010	96	7	11
Calder Ward - Guild Lodge	1567	257	28	47
Fairoak Ward - Guild Lodge	533	37	4	15
Forest Beck Ward - Guild Lodge	417	106	10	29
Whinfell Ward - Guild Lodge	1668	113	21	40
Marshaw Ward - Guild Lodge	1012	441	29	65
Elmridge Ward - Guild Lodge	3377	51	17	20

Bleasdale Ward - Guild Lodge	3381	101	18	50
Mallowdale Ward - Guild Lodge	610	533	16	93
Dutton Ward - Guild Lodge	1061	484	13	33
Langden Ward - Guild Lodge	833	413	14	41
Fellside East Ward - Guild Lodge	1047	274	19	53
Fellside Ward - Guild Lodge	162	136	3	7
ABI Step Down - Guild Lodge	188	84	1	21
Core service total	19321	3508 (18%)	209 (1%)	580 (3%)
Trust Total	75,152	31,495 (42%)	2282 (3%)	3327 (4%)

***** Percentage of total shifts

This core service had 38 (9%) staff leavers between 1 August 2016 to 31 July 2017. Turnover was higher than at the time of the last inspection (7%) (15 July 2016)

Ward/Team	Substantive staff	Substantive staff Leavers 1 August 2017- 31 July 2017	Average % staff leavers
Management Secure Services	16	3	17%
Specialist Services Mangt	4	2	35%
Control Room Guild Lodge	7	0	0%
Reception Guild Lodge	1	0	0%
Secure Services Medics	13	5	35%
Admin Secure Services	26	2	8%
Forensic Out Reach Service	15	3	21%
Fairsnape Ward	22	1	4%
Greenside Ward	23	0	0%
Calder Ward	22	0	0%
Fairoak Ward	20	0	0%
Forest Beck Ward	19	1	5%
Whinfell Ward	27	3	10%
Marshaw Ward	18	1	5%

Elmridge Ward	28	2	7%
Bleasdale Ward	33	5	16%
Mallowdale Ward	15	2	19%
Dutton Ward	24	2	9%
Langden Ward	33	1	4%
Fellside East Ward	25	0	0%
Fellside West Ward	23	2	9%
Hermitage Ward	16	2	10%
Forensic Shop Guild Lodge	0	1	150%
Admin Parkwood	0	0	0%
Tarnbrook Unit - Guild Lodge	0	0	0%
Core service total	420	38	9%
Trust Total	6709	881	13%

The sickness rate for this core service was 8% between 1 August 2016 to 31 July 2017. The most recent month's data 31 July 2017 showed a sickness rate of 8%. This was slightly higher than the sickness rate of 7% reported at the last inspection in 15 July 2016.

Ward/Team	Total % staff sickness (at latest month)	Ave % permanent staff sickness (over the past year)
Management Secure Services	5%	2%
Specialist Services Management	0%	6%
Control Room Guild Lodge	2%	2%
Reception Guild Lodge	6%	3%
Secure Services Medics	12%	3%
Inpatient Psychology	8%	1%
OT	8%	7%
Admin Secure Services	3%	4%
Fairsnape Ward	14%	6%
Greenside Ward	11%	8%
Calder Ward	11%	6%
Fairoak Ward	2%	7%
Forest Beck Ward	19%	16%
Whinfell Ward	7%	7%
Marshaw Ward	13%	9%

Elmridge Ward	1%	7%
Bleasdale Ward	5%	6%
Mallowdale Ward	6%	13%
Dutton Ward	6%	12%
Langden Ward	15%	9%
Fellside East Ward	16%	13%
Fellside West Ward	2%	9%
Hermitage Ward	13%	15%
Catering Guild Park	1%	1%
Domestic Guild Park	10%	7%
Porters Guild Park	0%	11%
Forensic Shop Guild Lodge	0%	0%
351x Tarnbrook Unit - Guild Lodge	0%	0%
Core service total	8%	8%
Trust Total	6%	6%

The below table covers staff fill rates for registered nurses and care staff during August 2017, September 2017 and October 2017.

All wards had fewer registered nurses and higher level of care staff use than planned, in the day and night.

Key:

> 125%	< 90%

	Day		Night		Day		Night		Day		Night	
	Nurses	Care staff	Nurses	Care staff	Nurses	Care staff	Nurses	Care staff	Nurses	Care staff	Nurses	Care staff
	August 17				September 2017				October 2017			
Bleasdale Ward - Guild Lodge CR	50.72%	154.40%	142.45%	351.60%	55.83%	152.64%	118.96%	344.48%	63.83%	127.71%	151.97%	334.30%
Calder Ward - Guild Lodge CR	43.47%	161.67%	141.35%	194.06%	58.60%	129.46%	132.27%	142.76%	55.68%	134.81%	128.35%	144.00%
Dutton Ward - Guild Lodge CR	44.51%	124.12%	128.26%	120.31%	61.86%	126.86%	124.21%	106.05%	59.77%	116.65%	154.66%	131.49%
Elmridge Ward - Guild	49.49%	163.92%	134.22%	291.46%	54.83%	175.64%	143.22%	355.69%	68.74%	182.71%	133.48%	366.59%

Lodge CR												
Fairoak Ward - Guild Lodge CR	39.78%	96.97 %	143.99 %	128.65%	46.17 %	87.50 %	124.64 %	112.40%	55.96 %	75.48 %	140.16%	111.82%
Fairsnape Ward - Guild Lodge CR	47.97%	66.43 %	86.33 %	80.16 %	41.69 %	64.60 %	88.61 %	70.52 %	39.03 %	84.03 %	83.43 %	76.73 %
Fellside Ward - Guild Lodge CR	37.51%	54.95 %	134.61 %	37.50 %	37.96 %	66.10 %	127.71 %	37.45 %	36.92 %	62.10 %	133.25%	38.39 %
Forest Beck Ward - Guild Lodge CR	41.50%	72.91 %	143.99 %	148.74%	63.14 %	80.35 %	144.03 %	213.08%	63.52 %	55.69 %	131.27%	169.39%
Greenside Ward - Guild Lodge CR	51.00%	143.23 %	158.96 %	264.73%	54.40 %	141.35 %	116.68 %	238.39%	56.41 %	128.11%	154.32%	241.30%
Langden Ward - Guild Lodge CR	54.12%	131.79 %	126.10 %	128.08%	64.36 %	102.47 %	138.46 %	120.60%	70.54 %	108.84%	131.17%	113.53%
Fellside East Ward - Guild Lodge CR	38.86%	65.09 %	145.78 %	114.14%	43.15 %	62.35 %	129.14 %	102.56%	41.63 %	66.76 %	150.28%	107.81%
Marshaw Ward - Guild Lodge CR	47.73%	110.11 %	128.35 %	525.35%	59.49 %	127.07 %	130.13 %	633.65%	62.88 %	105.62%	132.88%	540.72%
The Hermitage ABI Step Down - Guild Lodge CR	76.22%	64.35 %	139.59 %	118.04%	73.81 %	51.30 %	139.92 %	90.12 %	77.28 %	45.59 %	133.85%	62.06 %
Whinfell Ward - Guild Lodge CR	48.60%	170.83 %	88.38 %	89.97 %	72.71 %	168.58 %	96.57 %	103.55%	77.14 %	154.80%	100.54%	92.87 %

Staffing levels were assessed using a recognised tool and minimum staffing levels were agreed across the service. There were high vacancy rates for qualified nurses across the hospital, which staff said impacted on the wards with a high use of bank staff to cover vacancies and sickness rates. Staffing was monitored on a daily basis to ensure safe staffing levels on all wards; a daily meeting was held to discuss ward need and identify staff that could move to ensure safe staffing on other wards to ensure patients requiring enhanced support were sufficiently staffed. Daily reports were submitted to senior managers to ensure constant monitoring was undertaken. Recruitment was ongoing. Sickness and turnover rates were slightly higher than the last inspection.

Ward managers told us that they could adjust staffing levels when patients required enhanced support and to cover sickness etc. Regular bank staff was used on every ward area. Agency staff were used only when bank staff could not be sourced. All bank and agency staff received induction to the ward areas. Staff told us that the emergency alarm system ensured prompt support from other ward areas to ensure there were enough staff present to carry out physical interventions safely and in accordance with hospital procedures.

Patients and staff told us that activities were cancelled at times because of lack of staffing although these were always rearranged; some patients told us that staffing levels had impacted on their one to one sessions with staff as staff were regularly moved to other wards. The daily staffing meeting discussed movement of staff between wards to maintain safe staffing levels. Staff were reassigned to wards with higher staff sickness and acuity levels of patients.

Medical staff

Between 1 August 2016 to 31 July 2017, bank staff to cover sickness, absence or vacancy for medical locums filled 0% of shifts.

In the same time period, agency staff covered 100% of shifts that needed to be covered. No shifts were unable to be filled by either bank or agency staff.

Ward/Team	Available shifts	Shifts filled by bank staff	Shifts filled by agency staff	Shifts NOT filled by bank or agency staff
Guild Lodge	220	0	220	0
Core service total	220	0	220	0
Trust Total	6996	1287 (18%)	5618 (80%)	56 (1%)

***** Percentage of total shifts

There was adequate medical cover day and night for all wards across the hospital. Doctors were able to attend the wards quickly in an emergency. Doctors were allocated to each ward and were available on site during the day. The service employed physical health nurses and GPs visited weekly. Out of hours cover was provided by an on-call doctor's rota. In a medical emergency, the emergency services would be called.

Mandatory training

The compliance for mandatory and statutory training courses at 31 July 2017 was 56%. Of the training courses listed 11 failed to achieve the trust target and of those, 11 failed to score above 75%.

The training compliance reported for this core service this financial year (1 April 2017 – 31 July 2017) was lower than the last financial year (91% compliance rate between 1 April 2016 to 31 March 2017).

Key:

Below CQC 75%	Between 75% & trust target	Trust target and above

Training course	This core service %	Trust target %	Trust wide mandatory/ statutory training total %
Safeguarding Children Level 1	0%	85%	45%
Mental Capacity Act Level 1 (Admin)	0%	85%	85%
Resuscitation (Basic Life Support)	17%	85%	27%
Manual Handling Level 2	29%	85%	40%
Immediate Life Support (ILS)	34%	85%	25%
Information Governance	49%	85%	42%
Safeguarding Vulnerable Adults Level 1	55%	85%	83%
Safeguarding Children Level 2	62%	85%	76%
Infection Control (Clinical)	67%	85%	55%
Conflict Resolution	73%	85%	37%
Fire Safety	73%	85%	57%
Manual Handling Level 1	100%	85%	63%
Health & Safety	110%	85%	52%
Equality & Diversity	141%	85%	71%
Mental Capacity Act Level 1 (Clinical)	156%	85%	99%
Core Service Total %	56%	85%	52%

Training levels were low and below the trust targets at July 2017. Training figures at the time of the inspection at February 2018 had improved with an overall 90% compliance rate with staff receiving and being up to date with mandatory training:

- Safeguarding Children Level 1: **94%**
- Mental Capacity Act Level 1 (Admin): **97%**
- Resuscitation (Basic Life Support): **76%**
- Manual Handling Level 2: **75%**
- Immediate Life Support (ILS): **76%**
- Information Governance: **86%**
- Safeguarding Vulnerable Adults Level 1: **93%**
- Safeguarding Children Level 2: **91%**
- Infection Control (Clinical): **92%**
- Conflict Resolution: **90%**
- Fire Safety: **93%**
- Manual Handling Level 1: **96%**
- Health & Safety: **98%**

- Equality & Diversity: **99%**
- Mental Capacity Act Level 1 (Clinical):**92%**

Assessing and managing risk to patients and staff

We examined 74 records. All patients had an up to date, detailed risk assessment and positive behavioural support plans in place. Recognised risk assessment tools were used such as the historical clinical risk management. The historical, clinical, risk management-20 (HCR-20) is an assessment tool that helps mental health professionals estimates a person's probability of violence.

Other risk assessments were undertaken on admission such as choking, falls, moving and handling and the malnutrition universal screening tool.

Positive risk management was evident in the risk management plans and risk management was conducted in collaboration with the patient. Risk management plans were recovery oriented and recognised the positive aspects of the patient's presentation and motivation to change.

The risk assessments supported self-assessment by the patient and incorporated risk evaluation and reduction, the risk management process and communication of these risks. Multidisciplinary reviews were held weekly and risk assessment was discussed and changes made in response to ongoing and emerging risks. Multidisciplinary team meetings were held weekly on most wards where patient risk was reviewed and openly discussed with patients.

There were effective strategies in place to protect patients, including those with more complex needs, to enable them to be involved in the local community safely. There were multi- agency public protection arrangements in place where necessary.

There was a procedure in place to ensure safe observation of patients. Risks associated with the requirement of higher levels of observation would be reviewed regularly to ensure least restrictive practices were in place. There was a procedure for the searching of patients and their bedrooms. The requirement to search a patient was agreed on an individual basis in relation to personal risk and security and in response to relational security issues.

The service was smoke free and all patients were offered smoking cessation by the trust. Patients were required to leave the premises if they wanted to smoke. For those who did not have leave outside the hospital this proved difficult and there were incidents where patients attempted to smoke within the hospital wards. Clear policies and guidance were in place for staff to address this.

Use of restrictive interventions

This core service had 391 incidents of restraint (on 167 different service users) and 264 incidents of seclusion between 1 August 2016 and 31 July 2017. Over the 12 months, there were fluctuations in the incidence of both restraint and seclusion.

The below table focuses on the last 12 months' worth of data: 1 August 2016 and 31 July 2017.

Ward name	Seclusions	Restraints	Patients restrained	Of restraints, incidents of prone restraint	Rapid tranquilisations
Bleasdale	53	76	19	0 (0%)	0 (0%)

Calder	40	28	20	0 (0%)	0 (0%)
Dutton	9	8	3	1 (13%)	1 (13%)
Elmridge	26	122	43	3 (2%)	5 (4%)
Fairoak	2	3	2	0 (0%)	1 (33%)
Fairsnape	24	35	18	0 (0%)	5 (14%)
Fellside East	3	10	4	0 (0%)	0 (0%)
Fellside West	0	1	1	0 (0%)	0 (0%)
Forest Beck	2	3	3	0 (0%)	0 (0%)
Greenside	5	19	14	1 (5%)	2 (11%)
Hermitage	0	0	0	0 (0%)	0 (0%)
Langden	1	3	2	0 (0%)	0 (0%)
Mallowdale	4	0	0	0 (0%)	0 (0%)
Marshaw	16	13	8	0 (0%)	0 (0%)
Whinfell	79	70	30	0 (0%)	1 (1%)
Core service total	264	391	167	5 (1%)	15 (4%)

Over the 12 months, there were peaks in the use of restraint in March 2017, where there were a total of 52 incidents.

There were five incidents of prone restraint which accounted for 1% of the restraint incidents. The trust does not use prone restraint as a recognised physical intervention hold. These instances occurred unintentionally. All restraints which lead to the use of a prone position are under constant review from the violence reduction nurse.

Incidents resulting in rapid tranquilisation fluctuated throughout the past year, with the highest numbers in March 2017 with six incidents. Rapid tranquilisation was rarely used within the service, with instances of physical restraint and seclusion being higher than the use of rapid tranquilisation figures. Rapid tranquilisation was not routinely used as part of a strategy to de-escalate or prevent situations that may lead to violence or aggression.
There have been 18 instances of mechanical restraint over the past year. These were when handcuffs had been used to escort people outside the hospital, for example to court, hospital appointments, or return to prison. These followed the local policy and were risk managed by the patients multidisciplinary team because of the risks posed to the public if the patients absconded.

Over the 12 months, there were 264 instances of the use of seclusion. On Calder ward there were more episodes of seclusion than restraint, this was a high dependency ward which often had a number of challenging and aggressive patients where seclusion was used as a method of managing patient risk. On Mallowdale ward the incidents of seclusion relate to one particular patient who places themselves in seclusion as a method of personal de-escalation. On Winfell ward two patients use seclusion as part of a detailed management plan to prevent assaults on others.

There have been three instances of long term segregation over the 12 month reporting period. At the time of the inspection there were two patients who were subject to long term segregation within the hospital. Both patients had been subject to formal review as detailed in local policy. These formal reviews were undertaken by senior professionals not involved in the patients care and for both these patients an external hospital review had been undertaken. Both patients were segregated in order to reduce a sustained risk of harm to others which had been a constant feature of their presentation. Plans were in place to reduce the need for seclusion and one patient had been referred to high secure services. Treatment plans were in place, which the safeguarding team was aware of, and there was Independent Mental Health Advocacy involvement.

Restrictive interventions are interventions that may infringe a person's human rights and freedom of movement, including observation, seclusion, manual restraint, mechanical restraint and rapid

tranquillisation. There was a policy within the trust with a strategy to reduce restrictive practice within the service detailing approaches to reduce restrictive practice.

Physical intervention was undertaken in the least restrictive way possible, whilst managing risk and ensuring safety. Violence reduction training was undertaken annually with a compliance rate of 64.44% at the time of the inspection.

Patients were encouraged to draw up advance decisions or advance statements about the use of restrictive interventions, and whether a decision-maker has been appointed for them. These statements included the patients understand that during any restrictive intervention their human rights would be respected and the least restrictive intervention would be used to enable them to exercise these rights. Carers were involved whenever possible with the patient's consent, particularly for service users who lacked capacity.

Safeguarding

A safeguarding referral is a request from a member of the public or a professional to the local authority or the police to intervene to support or protect a child or vulnerable adult from abuse. Commonly recognised forms of abuse include: physical, emotional, financial, sexual, neglect and institutional.

Each authority has its own guidelines as to how to investigate and progress a safeguarding referral. Generally, if a concern is raised regarding a child or vulnerable adult, the organisation will work to ensure the safety of the person and an assessment of the concerns will also be conducted to determine whether an external referral to Children's Services, Adult Services or the police should take place.

This core service made 268 safeguarding referrals between 1 August 2016 and 31 July 2017.

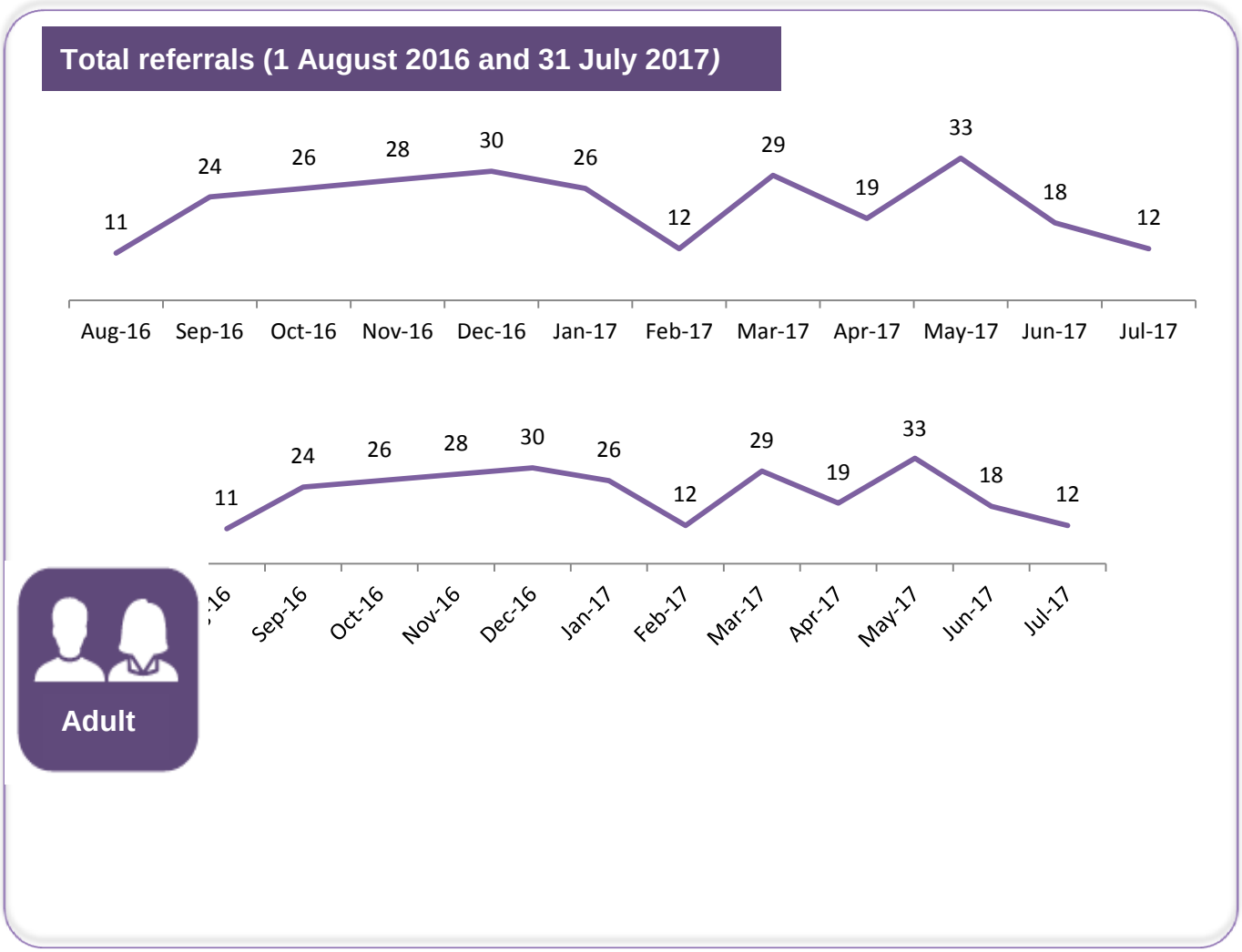
A local safeguarding procedure provided guidance for staff on their responsibilities for the safety and wellbeing patients with particular responsibilities for those patients who are less able to protect themselves from harm, neglect or abuse.

There was a designated safeguarding lead who was able to give advice to staff and ensure all safeguarding issues were raised and resolved in line with local policy. There were systems in place to respond to themes and trends in safeguarding referrals and shared learning.

Systems were in place to ensure that adult and child safeguarding was fully integrated into local systems and practices. A new system of multidisciplinary review involving senior staff at the hospital was in place, where a comprehensive discussion was held relating to new safeguarding alerts.

Staff demonstrated a good understanding of safeguarding procedures and had close links with the local safeguarding service. Staff gave examples of safeguarding incidents at both high and low levels and knew how to report and escalate concerns relating to patient safeguarding. Child visiting arrangements were in place with safeguarding checks in place in relation to child visiting and contact with children for patients whilst on leave.

	Number of referrals	
Adults	Children	Total referrals
268	0	268



Lancashire Care NHS Foundation Trust submitted details of no serious case reviews commenced or published in the last 12 months [1 August 2016 and 31 July 2017] that relate to this core service.

Staff access to essential information

Staff used electronic care records, incident and prescribing systems; some paper records were evident for recording seclusion etc. These were uploaded onto the electronic system to ensure full patient records were accessible to all.

All staff told us that they had good access to the electronic systems in place and there was a procedure in place to enable access to the system.

Information governance procedures guided staff to enable compliance against the law and assess whether information was handled correctly and protected from unauthorised access, loss, damage and destruction.

Medicines management

The local medicines management procedure associated with prescribing, administration, requisitioning and storage of medicinal products supported all staff to manage the roles and risks associated with medicines management. Staff monitored medicines use and potential side effects were also monitored. A procedure was in place for the monitoring of high dose antipsychotic medication monitoring. Physical health was monitored in line with National Institute for Health and Care Excellence guidelines.

There was an electronic prescribing system in place which allowed nurses to check and dispense medication. Nursing and medical staff described the electronic system as a safe method of dispensing and that fewer medication errors had occurred since its introduction. Consent to treatment paperwork was also stored electronically and a pharmacist was available to all staff and could be contacted if there were issues in relation to medication. The pharmacist was also accessible to patients to give advice and support on medications.

Medicines were dispensed from and stored securely in the ward clinic rooms. Stock rotation, transport and storage was in line with procedural guidance. The pharmacy team provided clinical support to all wards including staff and patients, and attended patient meetings on request. The focus was on safe medicines management and medicine optimisation for patients. Alerts and safety information was shared with ward teams and the team were available to offer advice and support to staff and patients.

Track record on safety

An incident reporting procedure and electronic systems were in place to report incidents within the hospital. Staff were aware of how to report incidents on the trust's electronic recording system. Staff we spoke with were confident in how to do this and understood what should be reported. Staff gave examples of incidents that should be recorded and how to escalate issues and raise concerns. Feedback and lessons learnt from investigations following incidents was given to staff via an email bulletin and discussions during staff meetings, staff were able to describe these communications and lessons learnt from incidents. Ward managers explained that a de-brief by staff from the violence reduction team would be completed following serious incidents where it was appropriate. Support was available to staff through peer supervision which included reflective practice and discussion. The psychology team also provide reflective practice sessions for staff working with particularly challenging patients if necessary.

Providers must report all serious incidents to the Strategic Executive Information System (STEIS) within two working days of an incident being identified.

Between 1 August 2016 and 31 July 2017 there were five STEIS incidents reported by this core service. Of the total number of incidents reported, the most common type of incident was unauthorised absence with two.

A 'never event' is classified as a wholly preventable serious incident that should not happen if the available preventative measures are in place. This core service reported no never events during this reporting period.

We asked the trust to provide us with the number of serious incidents from the past 12 months. The number of the most severe incidents recorded by the trust incident reporting system was broadly comparable with STEIS. There was one more incident recorded within the trust's own reporting system.

The number of serious incidents reported during this inspection was lower than the nine reported at the last inspection.

	Number of incidents reported					
Type of incident reported on STEIS	Fairsnape Ward	Calder Ward	Dutton Ward	Elmridge Ward	Marshaw	Total
Unauthorised absence	0	0	1	0	1	2
Disruptive/ aggressive/ violent behaviour	0	1	0	0	0	1
Apparent/actual/suspected self-inflicted harm	0	0	0	1	0	1
Commissioning incident	1	0	0	0	0	1
Total	**1**	**2**	**1**	**1**	**1**	**5**

Reporting incidents and learning from when things go wrong

The Chief Coroner's Office publishes the local coroners Reports to Prevent Future Deaths which all contain a summary of Schedule 5 recommendations, which had been made, by the local coroners with the intention of learning lessons from the cause of death and preventing deaths.

In the last two years, there have been no 'prevention of future death' reports that relate to this core service.

The duty of candour is a legal duty on hospital, community and mental health services to inform and apologise to patients if there have been mistakes made in their care that have led to significant harm. Duty of candour aims to help patients receive accurate, truthful information from health providers.

A duty of candour policy was in place and all staff we spoke with were aware of the policy and were able to describe the steps necessary when something went wrong and when an apology was required. The ward managers informed us that there had not been a reason to initiate this procedure in the previous12 months.

Is the service effective?

Assessment of needs and planning of care

Multidisciplinary assessment of the health and social care needs of patients, as well as the risk of harm posed by them to themselves or others, were assessed and used to inform the treatment and care plan and the enhanced care programme approach. The multi-disciplinary assessment involving the patient was undertaken on admission, orienting the patient to the service and assessing and meeting physical and mental health care needs. There was a process for assessing and managing risk and treatment and care planning.

Pre-admission assessment and ongoing assessment of need was evident within the patient notes. Care planning included clear objectives and outcomes of the inpatient stay and was developed in collaboration with the patient, progress was regularly reviewed.

There was good access to healthcare, with dedicated nurse practitioners in place to coordinate and deliver health based interventions. Health promotion was evident throughout the service, and patients had individual health action plans in place. Patients had access to a GP who visited three times a week, as well as a dietician who worked on a referral basis to support nutritional need.

Care planning was holistic, motivation based and recovery oriented with good patient involvement evident. All patients had positive behavioural support plans, clinical guidelines, care plans and safeguarding care plans in place. Records reviewed showed that the service used the wellness, recovery action planning tool and my shared pathway as patient self-management tools to inform care planning. The Health of the Nation Outcome Scale was also used to assess and record severity and outcomes.

Best practice in treatment and care

This core service participated in 14 clinical audits as part of their clinical audit programme 2016-2017.

Audit name	Audit scope	Audit type	Date completed	Key actions following the audit
Re-Audit Rapid Tranquilisation (Compliance 43%)	Secure Services inpatients	Re-audit	31/03/2017	Ongoing.
Re-Audit Violence and Aggression (Compliance46%)	Secure Services inpatients	Re-audit	31/03/2107	All due by September 2017.
Re-Audit Consent to Treatment (Compliance 94%)	Secure Services inpatients	Re-audit	31/07/2017	The audit confirms that any discussions at Medical Advisory group as a result of clinical audits are shared and disseminated appropriately.
Type 2 Diabetes (57% compliance)	Guild Lodge, Forensic Mental Health Inpatient Wards HMP Liverpool"	Clinical	01/09/2016	Guild Lodge: Barriers to staff undertaking report blood tests to be identified and actions put in place HMP Liverpool: Diabetes to be widely discussed within prisons, informing staff of their responsibilities in these areas. Feasibility of amending Systm One to include reminders for repeat

				blood pressure readings to be investigated.
Consent to Treatment (32% compliance)	Guild Lodge, Forensic Mental Health Inpatient Wards	Clinical	01/08/2016	Report was discussed in detail at Medical Advisory Group to remind doctors of their responsibilities in this area. T2 prescription forms were amended trustwide to include a prompt for doctors to complete the capacity for consent to treatment section of the electronic record. Doctors reviewed their caseload to ensure the correct process had been followed for all service users.
Section 17 (33% compliance)	Guild Lodge, Forensic Mental Health Inpatient Wards	Clinical	01/08/2016	Further discussion at the Mental Health Act Sub-Committee to confirm expectations on recording mental state before and after leave. The findings of this audit were also shared trustwide through this forum.
Length of Stay (67% compliance)	Guild Lodge, Forensic Mental Health Inpatient Wards	Clinical	-	Rapid Improvement event held in conjunction with the Mental Health Network. Discharge pathway including Length of Stay and Obstacles to discharge to be included on the Care Pathway Approach (CPA) agenda and CPA minutes template.
12 week assessment (81% compliance)	Guild Lodge, Forensic Mental Health Inpatient Wards	Clinical	01/12/2016	Decision made to re-design assessment process
Transfer from prison (82% compliance)	Guild Lodge, Forensic Mental Health Inpatient Wards	Clinical	01/12/2016	Admission template to include guidance in relation to seeking the involvement of carers/families in the assessment.
Seclusion (33% compliance)	Guild Lodge, Forensic Mental Health Inpatient Wards	Clinical	01/03/2017	A discussion group will be arranged with staff, of all disciplines, who have recently been involved in seclusion. This will help ascertain staff's values and views around seclusion as well as acting as a forum to discuss any barriers affecting the seclusion process. To fully understand the issues around seclusion and how these can be rectified a quality

				improvement project will be carried out with key members of the network. This will result in a more in depth action plan that will be implemented prior to re-audit.
Re-audit My Shared Pathway (79% compliance)	Guild Lodge, Forensic Mental Health Inpatient Wards	Clinical	01/10/2016	A recommendation has been put forward for a listening event to be arranged to between service users and the senior multidisciplinary team. This will allow the reasons for My Shared Pathway not being fully successful to be defined and a strategy to be put in place to improve this.
Re-audit Risk Assessment (68% compliance)	Guild Lodge, Forensic Mental Health Inpatient Wards	Clinical		As a result of the audit, risk assessment training will be incorporated into the induction process to ensure all staff are aware of their responsibilities. Service users are encouraged to take part in recovery college training around risk assessment which will increase their understanding. The training will be promoted for both staff and service users.
Re-audit High Dose Antipsychotics (79% compliance)	Guild Lodge, Forensic Mental Health Inpatient Wards	Clinical	01/03/2017	Doctors to be reminded of the importance of consulting the patient and patient advocate prior to prescribing of a high dose. Doctors should ensure these conversations are documented.
Re-audit Violence & Aggression (71% compliance)	Guild Lodge, Forensic Mental Health Inpatient Wards	Clinical	01/09/2016	Staff to be reminded to consider completion of an advanced decision/statement for all service users Staff to consider non-instructed advocacy for ABI patients where there is not an advanced statement

We looked at 74 patient care records and 77 prescription records; these demonstrated that the multi-disciplinary teams had taken account of best practice and national guidance. National Institute for Health and Care Excellence guidance was often cited in care planning records taking into account individual need and wishes for treatment options and choice. Prescribing practices took account of national guidance, mental health and physical health conditions.

The service used standardised outcome measures; primarily the health of the nation outcome scales. Outcome measures are used to objectively determine the baseline function of a patient at the beginning of treatment. Once treatment has commenced, the same instrument can be used to determine progress and treatment efficacy.

There was good provision of psychological interventions. Therapies available included group sessions in cognitive behavioural therapy and psycho-educational work. Individual sessions were

available with staff skilled in delivering these therapies. The hospital had developed a gender specific model of care for the women in the service. The women's service psychological interventions were tailored for the women's service pathway focussing on attachment, trauma and abuse. The acquired brain injury pathway, psychological interventions included cognitive rehabilitation re-planning and brain injury awareness. Staff training for staff working in these areas was also tailored to ensure staff had an awareness of the distinct issues pertinent to each pathway.

We found evidence of comprehensive physical healthcare planning in the records. There was a dedicated team of practice nurses who had responsibility to coordinate physical healthcare and wellbeing. GP and dental services were available on an appointment basis. Patients were supported to attend secondary care appointments where necessary.

Health improvement plans were in place and there was good evidence of health promotion throughout the service. A healthy choices group was open to patients through the occupational therapy team, and ward staff supported healthy choices and smoking cessation. There were opportunities to be involved in physical activities and sports and the service had a dedicated sports hall to encourage participation in sports and physical activities.

Staff were involved in local audits such as environment risks, medication audits and care planning audits. The service had an annual audit plan in place. Action planning for audit activity was evident and issues raised from audit activity were reviewed in senior team meetings and discussed with ward teams.

Skilled staff to deliver care

There was a range of staff specialities and the teams consisted of registered mental health nurses and health care support workers, associate practitioners, occupational therapists and technical instructors, ward based occupational therapy assistants, consultant forensic and rehabilitation psychiatrists, trainee psychiatrists, clinical nurse specialists, clinical psychologists, psychological therapists and psychology assistants, social workers, clinical pharmacists, advocacy, primary healthcare services including a general practitioner, practice nurses, dental care, podiatry, dietician and speech and language therapy.

The service also had specialist community based team supporting patients who had left the hospital and provided assertive community follow-up, community support, supervision and crisis response for identified high risk patients.

Staff were skilled and experienced in working with this patient group including patients with learning disabilities and those on the autism spectrum. Staff stated they received regular supervision. A proportion of staff had been trained to deliver a range of interventions such as anger management, sex offender treatment and positive behavioural support.

All staff undertook a period of induction into the service, mandatory training compliance was monitored. We were informed that opportunities to undertake specialist role specific training were available for all nurses to apply.

The trust's target rate for appraisal compliance is 85%. As at 31 March 2017, the overall appraisal rates for non-medical staff within this core service was five per cent.

The rate of appraisal compliance for non-medical staff reported prior to this inspection was lower than the 15% reported at the last inspection (as at 29 June 2016)

Ward name	Total number of permanent non-medical staff requiring an appraisal	Total number of permanent non-medical staff who have had an appraisal	% appraisals
Fairsnape Ward	22	0	0%
Greenside Ward	22	1	5%
Calder Ward	23	1	4%
Fairoak Ward	19	1	5%
Forest Beck Ward	21	1	5%
Whinfell Ward	27	0	0%
Marshaw Ward	18	0	0%
Elmridge Ward	27	4	15%
Bleasdale Ward	30	0	0%
Mallowdale Ward	16	0	0%
Dutton Ward	23	0	0%
Langden Ward	27	0	0%
Fellside East Ward	23	2	9%
Fellside West Ward	19	4	21%
Hermitage Ward	17	3	18%
Core service total	334	17	5%
Trust wide	6007	1996	33%

All staff we spoke with told us that they had an annual appraisal. At inspection the trust indicated staff had begun the new personal development reviews. These had been introduced in April the hospital had achieved 67% of appraisals up to the date of the inspection with plans in place to undertake all remaining staff appraisals within the designated time frame.

The trust's target rate for appraisal compliance is 85%. As at 31 March 2017, the overall appraisal rates for medical staff within this core service was 79%.

Ward name	Total number of permanent medical staff requiring an appraisal	Total number of permanent medical staff who have had an appraisal	% appraisals
Secure Services Medics	14	11	79%
Core service total	14	11	79%
Trust wide	139	109	78%

Between 1 August 2016 and 31 July 2017 the average rate across all nine teams in this core service was 64% against a trust target of 100%.

Ward name	Clinical supervision sessions required	Clinical supervision sessions delivered	Clinical supervision rate (%)
Calder	88	69	78%
Marshaw	73	23	32%
Fairoak	86	37	43%
Dutton	76	48	63%
Mallowdale	60	29	48%
Fellside East	86	35	41%
Fairsnape	99	93	94%
Greenside	82	76	93%
Fellside West	106	96	91%
Elmridge	97	53	55%
Forest Beck	47	30	64%
Bleasdale	78	34	44%
Whinfell	86	38	44%
Langden	79	61	77%
Hermitage	61	49	80%
Core service total	1204	771	64%
Trust Total	17915	12753	71%

At inspection updated figures for clinical supervision rates for January 2018 showed 87% across the whole hospital site, with some wards achieving higher rates than others. Staff we spoke with told us that they received regular supervision and had opportunities to discuss clinical issues on an ad hoc basis with their peers, the governance of supervision particularly the recording of supervision undertaken by staff proved variable. The supervision figures were not reliable as those provided by the trust were inconsistent with ward records.

Multi-disciplinary and interagency team work

The care programme approach was used to assess, plan, review and coordinate patient care, with a formal review of care made at least once a year. A group of professionals met weekly in a multidisciplinary team meeting to discuss recommended treatment options and decisions relating to the care of individual patients. The multidisciplinary meetings were attended by the patient, nurses, consultant psychiatrist and occupational therapist. Other professionals would attend if required and staff described attendance by outside agencies such as community care coordinators.

There was evidence of good communication with local authorities, community mental health teams, social services and links with external agencies were encouraged and supported by the multidisciplinary teams.

Families and carers were involved in the patients care and care planning where appropriate. Advocacy services attended the wards regularly and all patients were aware of how to contact advocacy when they required support and representation at these meetings.

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

Staff we spoke with had a good understanding of the Mental Health Act and associated code of practice. Mental Health Act level 2 training at the time of the inspection had increased to 54% compliance, with training assigned for staff eligible received this training to be completed within the trusts timeframes. There were no figures available for Mental Health Act level1 training compliance.

Mental Health Act Level 1 was not provided by the trust in the routine provider information request from the CQC; however Mental Health Act Level 2 training was included. This is non-mandatory training and had a compliance rate of 7% (Seven out of 99 eligible staff members had completed the training).

The service had a Mental Health Act administrator who had a role in maintaining processes and systems to support compliance with the Mental Health Act and the code of practice. The Mental Health Act administrator led on the day to day administration of the Mental Health Act and ensured that Mental Health Act documents were legally correct and valid. They ensured that mental health section expiry dates were dealt with within statutory timeframes and coordinated hospital manager reviews and mental health tribunals. Patients' rights under the Mental Health Act were communicated to the patient and recorded. Section 17 leave was recorded in the patients' notes which included the conditions of leave and escort requirements, and follow up information as how leave had been experienced by the patient. Patients or staff escorts carried a copy of these leave arrangements whilst on leave. Multidisciplinary assessment of risk was undertaken prior to leave being granted and recorded in the patient notes. Conditions of leave were clearly recorded and leave was reviewed regularly as part of the multidisciplinary review.

Good practice in applying the Mental Capacity Act

The Mental Capacity Act 2005 requires health professionals to assess capacity, and determine best interests for an individual who lacks capacity to make a specific decision. A policy was in place to support staff when making decisions about the capacity of the patients in their care.

Staff received training on the Mental Capacity Act and Deprivation of Liberty safeguards. At the time of the inspection Mental Capacity Act level1 compliance was at 91% and the Mental Capacity Act level 2 training compliance was at 45%.

Staff were able to describe the principles of the Act and describe situations where capacity would be assessed and how they would consider and implement capacity assessment and planning. Staff were aware of where to get advice about the Mental Capacity Act and Deprivation of Liberty. There were arrangements in place to monitor adherence to the Mental Capacity Act.

We observed capacity being discussed in patient review meetings and in patient's records capacity assessments had been completed to a high standard. Capacity assessments were detailed and clearly demonstrated the five statutory principles. Patients' capacity was assessed on admission with ongoing assessment throughout the patients stay. Assessments were decision specific and there was a clear rational regarding why patients lacked capacity.

Patients described their involvement in decision making and care and treatment records also detailed how patients were supported to make their own decisions about their care. Patients were

aware of independent advocacy support they could access to safeguard their interests, and how to contact them.

The trust told inform the CQC that no Deprivation of Liberty Safeguard (DoLS) applications were made to the Local Authority for this core service between 1 August 2016 and 31 July 2017. There were no patients in receipt of DoLS applications at the time of the inspection.

Is the service caring?

Kindness, privacy, dignity, respect, compassion and support

The 2017 PLACE score for privacy, dignity and wellbeing at Guild Park Lodge scored worse than similar organisations.

Site name	Privacy, dignity and wellbeing
GUILD PARK LODGE WHITTINGHAM PRESTON	88.38%
Trust overall	87.58%
England average (mental health and learning disabilities)	90.6%

We spoke with 27 patients and five carers. Most of the patients we spoke with were positive about their experiences during their hospital stay. They told us that staff were kind and caring and always treated them with dignity and respect. They felt that staff had a genuine interest in their wellbeing and were always there to help and support them at difficult times.

We spoke with staff and observed their interactions with patients during the inspection period. We saw that they understood the needs of their patients well. We observed staff treating patients with compassion and respect, providing support, encouragement and reassurance. Staff were aware of individual patient need and worked proactively with patients in developing positive behavioural support and understanding patient wishes; advance statements and decision making were evident in records. Staff were able to respond to patients distress on an induvial basis and demonstrated good de-escalation and least restrictive interventions in line with patients pre-determined plans and wishes.

Observations of staff interactions at all levels were positive and staff were professional in their approach to patients and their families. Patients felt that staff listened and understood their needs and some staff would go out of their way to ensure patients felt supported.

Involvement in care

Involvement of patients

Patients told us they were involved in care planning and understood that care planning and risk assessment process. Patients had opportunities to be involved in events such as understanding risk assessment and management within a secure setting as part of the recovery college events calendar.

There were good examples of patient involvement within the care records and information for patients was shared in an accessible format. Patients told us that they were involved in the decision making process and had information available to them to help them make a decision and choice in the care planning process.

Patients told us that they had access to the multi-disciplinary team and were able to discuss their needs in meetings, therapy sessions and in one to one interactions with staff. Patients felt that staff explained emerging issues and treatment options to them well and were responsive to requests from patients. Carers were encouraged to be involved in the patient's care where appropriate and felt confident in the support given to them. Links to the patients' wider social network were encouraged and supported by staff.
Patients were oriented to the wards prior to admission and there were information leaflets available to patients designed in an accessible way to aid patient understanding of the service.

We noted that communication needs were assessed on an individual basis and staff ensured that patient communication needs were addressed to ensure effective communication. Support was available for patients requiring information in different languages. Each ward had patient noticeboards which contained information on patient rights, how to complain and local services and activities.

Patients were able to raise concerns with staff and felt that the staff listened and acted upon these concerns. Forms were available for patients to address concerns or compliments formally. These were collated and analysed in a thematic way. Patient surveys were in place and with generally positive results. Patients were able to address day to day concerns in community meetings with their peers. Notes from these meetings demonstrated a clear agenda where patients could discuss all issues pertinent to the ward; action planning was evident with clear timelines for completion of the tasks raised. Themes were evident within these notes such as the quality of food in the service, actions raised were to forward patient complaints to the catering service for review, and some improvements had been made in response to these.

A service user champions group where patient representatives have a say in developing service delivery was held monthly. All patients were invited and encouraged to attend and raise issues affecting them. Patients were also involved in the staff recruitment process.

There was an appropriate choice of food available for patients who required special diets for religious and ethnic reasons, although generally patients often complained about the portion size and quality of the food provided.

Chaplaincy and spiritual needs were provided with regular visits by ministers from the Church of England, Catholic Church and the Muslim community. Patients could visit the sanctuary a dedicated space for quiet reflection where religious literature was available for the major faiths.

Involvement of families and carers

The hospital encouraged family and friends to get involved in patients care. Families and carers were routinely invited to care programme approach review meetings and other relevant patient meetings. Communication with carers was encouraged and supported with the option of patients using skype to contact their relatives and friends.

Supportive literature was available to carers within the service from the social work department. Carers were also offered a carers assessment relating to their own needs to ensure they were receiving the appropriate level of support in their caring roles.

There was a family and friends forum meeting held monthly at Guild Lodge to discuss different aspects that affect carers. This was an opportunity for family, friends and carers to learn more about aspects of the care provided at Guild lodge, as well as being supportive forum for those who attend.

The carers we spoke with said that staff communicated all relevant information to them and were involved in their loved ones care as much as possible.

Is the service responsive?

Access and discharge

Bed management

The trust provided information regarding average bed occupancies for all 15 wards between 1 August 2016 and 31 July 2017.

Ward name	Average bed occupancy range (1 August 2016- 31 July 2017)
Calder	82.5%-104.2%
Marshaw	92.3%-100%
Fairoak	89.4%-99.8%
Dutton	87.5%-100.0%
Mallowdale	40.5%-100.0%
Fellside East	83.5%-100.0%
Fairsnape	81.3%-104.6%
Greenside	84.4%-101.9%
Fellside West	84.3%-100.0%
Elmridge	88.9%-100.0%
Forest Beck	82.3%-100.0%
Bleasdale	77.8%-100.0%
Whinfell	73.8%-100.0%
Langden	86.7%-100.0%
Hermitage	93.6%-123.8%

The trust provided information for average length of stay for the period 1 August 2016 and 31 July 2017.

Ward name	Average length of stay range (1 August 2016- 31 July 2017)
Calder	39.0 - 478.3
Marshaw	123.0 - 539.0
Fairoak	14.0 – 1139.0
Dutton	32.0 – 1009.3
Mallowdale	5.0 - 213.9
Fellside East	1.0 - 270.0
Fairsnape	41.0 - 173.0
Greenside	85.0 - 484.8
Fellside West	27.0 – 291.0
Elmridge	54.5 – 1058.7

Forest Beck	30.0 – 1056.0
Bleasdale	1.0 – 867.5
Whinfell	52.0 – 713.0
Langden	147.0 – 1041.0
Hermitage	15.0 – 1543.0

This core service reported no out area placements between 1 August 2016 and 31 July 2017.

This core service reported no patient readmissions within 28 days between 1 August 2016 and 31 July 2017. Between 1 August 2016 and 31 July 2017 there were no discharges within this core service.

Referrals were considered for people who were resident in the catchment area of Lancashire and South Cumbria. The service had a dedicated flow and capacity manager or nominated deputy as a single point of access for all referrals. Referrals were accepted from a person's consultant psychiatrist, or by another practitioner significantly involved in the persons care.

Pre-admission assessments identified the most appropriate placement for each patient who met the criteria for admission to the service. Waiting lists were prioritised according to patient need and bed availability. There was always a bed available for patients on their return from leave. Patients always returned to the same ward and their bedroom was available. There had been no re-admissions in the period reported.

The service comprised of three distinct services; male mental health services, women's secure mental health services and male secure acquired brain injury services. Patients followed a care pathway through the service; a pathway could generally be described as being the movement a patient makes from service to service on their way to eventual maximum mental health and social wellbeing. These pathways are unique and specific to each individual patient. Patients may move up levels of security and down levels of security. There were two patients at the time of the inspection that had been referred to high secure service provision. Plans were in place to improve the women's pathway through the service, recognising the differences in service need for women in line with best practice guidance. .

Patient transfers to other wards within the service were planned in advance and occurred at a time agreed by the clinical team and the patient. Patients would occasionally be transferred to other wards dependent on their needs, such as patient acuity and mix. Potential ward moves were discussed in multidisciplinary meetings and action plans agreed. Records showed that discharge planning was primarily started when patients were ready to move to a lower level of security. Discharge planning was not evident in all patient records; discharge planning was generally evident for those patients ready to move into lower secure provision.

There was a dedicated forensic community team with community psychiatric nurses and social workers who followed up patients after discharge. They offered out of hours support, with staff on call at evenings and weekends. There was effective liaison between services to ensure that discharges were successful. There were no delayed discharges identified for this time period.

Facilities that promote comfort, dignity and privacy

The 2017 Patient-led assessments of the care environment score for ward food at the Guild Park Lodge scored worse than similar trusts.

Site name	Ward food
GUILD PARK LODGE WHITTINGHAM PRESTON	89.04%
Trust overall	90.97%
England average (mental health and learning disabilities)	91.5%

The physical environment of the wards promoted safety, privacy and dignity. All bedrooms were single occupancy with separate washing facilities. There were designated rooms for therapeutic activities and each ward had a separate clinic room for physical examination and care.

All patients had access to a telephone to make personal calls; there were hooded telephones in communal areas and patients could request the use of a cordless phone for use in more private areas. A mobile phone policy gave guidance for patients' personal mobile phone use; patients were assessed on an individual basis and phone use agreed by the multidisciplinary team.

Patients were able to personalise their bedrooms. Secure storage of belongings was available to patients who required this. Every ward had access to outside space attached to each ward. Each ward had areas where patients could make a hot or cold drink throughout the day, snacks were available for all patients.

Visitors to the ward were able to utilise rooms on the wards or quiet areas of the ward. There was a designated child friendly family room where patients could meet their families and other visitors. Safeguarding protocols were in place to ensure the safety of child visitors.

A wide range of activities were available to patients. For patients with limited movement from the wards, occupational support and activities were evident in ward areas. Activities were facilitated by occupational therapists, therapy assistants and nursing staff. For those who had leave from the wards, the Tarnbrook unit provided vocational training for a wide range of therapeutic activity including skills for work, music appreciation, healthy choices group, sports sessions, horticulture, walking groups, gym sessions, yoga, photography, pottery, crafts, woodwork and food preparation. There was also access to a library and sports hall. Many of the courses provided were accredited courses from a local college. Social activities were held at the Gleadale social club with activities such as cinema nights and pool tournaments.

There were opportunities for patients to undertake external activities such as fishing and walking groups. Patients also had access to online courses such as the Open University.

Patients' engagement with the wider community

Patients were encouraged to maintain contact with their social networks and keep in contact with family and friends. Skype facilities were available to patients where contact could be difficult.

Visiting arrangements were in place on site with dedicated visiting areas to facilitate this. Patients were also supported to utilise leave to go out into the wider community and visit relatives. These outings were widely valued by patients to enable them to keep their links with the community.

Patients could access a course to provide them with the opportunity to learn and develop skills required for employment. Guild lodge also worked in partnership with local colleges to provide the delivery of accredited learning opportunities for patients. These opportunities included bespoke learning programmes that supported recovery and promoted emotional health and wellbeing.

Meeting the needs of all people who use the service

All wards except Hermitage ward were on the ground floor level and were accessible for people with mobility issues. Bathrooms on all wards had wide doors and were accessible for people with wheelchairs, although only one bathroom had specific equipment and aids for disabled patients such as grab rails. However, equipment could be accessed if necessary dependent on a patient's requirements, which would be assessed prior to admission to the service.

Information leaflets were available to patients and carers on a range of issues such as how to complain, treatment options and patients' rights. These could be provided in different languages if necessary. All information provided was in an accessible format and support would be given to those patients with literacy and cognitive issues.

Patients and staff had access to interpreters for patients who did not speak English, as well as sign language professionals for those who had hearing difficulties. There were notice boards on all wards with a raft of information pertinent to the patient group.

Patients had access to spiritual support with regular visits from religious leaders onsite. A multi faith room designed to facilitate personal prayer was for all to use. It was equipped with resources such as a bible, rosary, prayer mat and religious reading material. Patients told us that their cultural and religious requirements were supported. Patients had a choice of food to meet their dietary requirements relating to health, religion, culture, and choices such as vegetarian and vegan were also catered for.

Support was available to carers and a patients; a carers group was active in the service. Carers were encouraged to attend these groups with regular invites being offered to all patients' carers and relatives.

Listening to and learning from concerns and complaints

This core service received 246 complaints between 1 August 2016 and 31 July 2017.

Ward/Location	Number of complaints
Treatment Rooms Greater Preston	1
Special Care Dentistry Central	1
Bleasdale	30
Calder	25
Dutton	13
Elmridge	15
Fairoak	12
Fairsnape	7
Fellside East	14
Forest Beck	3
Greenside	11
Hermitage	3
Bleasdale Ward (Secure)	2
Langden	11
Mallowdale	7
Marshaw	28
Whinfell	62
(blank)	1
Total	246

This core service received 30 compliments during the last 12 months from 1 August 2016 and 31 July 2017 which accounted for less than 1% of all compliments received by the trust as a whole.

Patients and carers knew how to raise a concern and complaint with the service. Patients were informed about their rights to complain. Information was available to patients and carers detailing the procedural process including information about the appeal process. Use of advocacy was encouraged; patients were aware of the support offered by advocacy in the complaints process.

Patients we spoke with were aware of the complaints process and felt confident in raising complaints. They were confident that their complaints were taken seriously. Patients told us they received feedback from their complaints both written and verbally. Patients described the response to complaints as being timely, addressing their concerns and demonstrating appropriate actions as a result of these concerns.

Staff were able to describe the complaints process and associated governance structures. Complaints were discussed in team meetings and staff were able to demonstrate learning from complaints. Complaints were seen by staff as an opportunity for patients to provide feedback about their care. Complaints received from patients and carers were continuously reviewed and acted upon to improve quality of care.

Is the service well led?

Leadership

We spoke to fourteen of the fifteen ward managers. The ward managers had managerial and operational responsibility for each ward and all aspects of ward performance. There had been a recent restructure of ward services across the organisation and some ward managers had only been in post for a short period of time. However, they all had the skills, knowledge and experience to perform their role and had a good understanding of the services they managed.

All ward managers informed us that they had effective day-to-day support to support high levels of nursing and patient care. Staff and patients told us that ward and operational managers were approachable and visible in the service to patients' and staff.

All ward managers told us that they had development opportunities available to them and could access good supervision and support for their roles.

There was scope for innovation and an expectation for managers to lead processes to improve the quality and operational management of their wards.

Vision and strategy

Staff described the key values of the trust as teamwork, accountability, respect, integrity, excellence, fairness, compassion, equality, dignity and autonomy. The vision statement outlined three outcomes:

- People who use our services are at the heart of everything we do
- People who deliver and support the delivery of services are motivated, engaged and proud of the service they provide
- A quality focussed culture is embedded across the organisation

Staff knew and understood the vision and values and how they applied to their roles. These values were evident across the service and were included on posters and all communications with staff.

Staff described having good working relationships with ward managers, matrons and senior team leaders. Local leaders were described as visible on the wards although senior managers of the hospital trust and trust board were less visible to staff and patients.

Staff described local consultations on service design and delivery for which they had some input. They were informed of and mindful of the trusts future developments with secure service delivery.

Culture

Between 1 August 2016 and 31 July 2017, there were eight cases where staff had been either suspended, placed under supervision or were moved to a different ward. Four staff had been suspended, two were moved and two were classed as other.

The number of staff placed under supervision, suspended or moved ward during this inspection was higher than those reported at the last inspection (23 between April 2015 and March 2016).

Caveat: Investigations into suspensions may be ongoing, or staff may be suspended, these should be noted.

Staff we spoke with talked positively about their roles and were passionate about the service development. Staff felt able to raise concerns without fear of victimisation and spoke positively about the organisation. Most staff told us that they felt valued, had input into the service, and were consulted and involved in service quality developments.

Staff were aware of the local whistleblowing policy and the role of the local speak up guardian. Staff could describe how they would initiate the whistleblowing process and felt confident their concerns would be acted upon.

Recruitment procedures included identity checks, employment history, professional registration and qualifications, right to work in the UK, health assessment, checks from the disclosure and barring service and reference checks.

Staff described good working relationships within the multi-disciplinary teams. They felt that bringing together different individuals and professional groupings, where all staff input was considered in a respectful and professional manner, lead to constructive decision making.

Equality and diversity was widely promoted within the service with supportive policies in place. Staff undertook training in equality and diversity. Training compliance at the time of the inspection was at 98.67%.

Policies were in place to deal with staff performance and staff sickness and absence was monitored. Action was taken where appropriate to support staff to attend work and flexible working arrangements were in place. There were no bullying and harassment cases on these wards at the time of the inspection.

Staff had access to an occupational team with the aim at keeping staff well at work both physically and mentally. Although sickness levels in the service were high and staff described the working environment as stressful at times, any risks in the workplace that were likely to give rise to work related ill health were recognised and considered for all employees.

Governance

Staff were able to describe the governance arrangements that supported their roles. They were clear about the quality assurance and performance structures in place and how they would input and record data locally and externally. These systems, such as lessons learnt from serious incidents and complaints, were shared and discussed with staff. Action plans were in place to address outcomes and actions from serious incidents.

Staff participated in, and were part of the annual audit programme. Detailed local audits were undertaken in the ward areas. Information from audits was shared with staff and action plans were in place to address issues arising from these.

Staff detailed good working relationships within teams, and good communication and involvement of external agencies relevant to individual patient care.

The trust provided their board assurance framework. None of these relate directly to this core service. The trust has provided a document detailing their highest profile risks. None of these relate directly to this core service.

Management of risk, issues and performance

There was a system in place to identify, monitor and address risks at the service. The service held a risk register which included reference to appropriate issues such as confidentiality and environmental issues. The assessment of risk and the associated risk registers were a component part of the trusts risk management strategy. It is a management tool that enabled the hospital to be aware of its risk profile. As such it was a repository for risk information across all areas of activity.

The risk registers are dynamic living documents which are populated through the trusts risk assessment and evaluation processes. This enables risks to be quantified and ranked.
Local risk registers were in place across the service. Ward managers could access and input into local risk registers.

The trust was required to plan for major incidents and put strategies in place to return to business as normal as soon as possible after an event. The trust had protocols in place for major incidents and business continuity in the event of emergencies. Emergencies could happen at any time, and the trust's patients and staff could be affected by a major flood, fire, failure of utility services or severe weather such as heavy snow, heatwave or a period of very cold weather.

Information management

Staff had easy access to systems that recorded information and submitted data to senior managers and informed the governance framework. The trust had procedures in place to ensure that information was efficiently managed and that the policies, procedures, and management accountability structures provided a governance framework for the monitoring of information management across the service.

Information governance training was mandatory for all staff directly employed by the trust and the compliance rate for this training at the time of the inspection at Guild Lodge was at 82.72%. A dedicated information governance team was responsible for ensuring effective practice in this area. Any breach or suspected breach of confidentiality or information security, including cyber security events, would be reported to a senior manager and recorded on the trust incident electronic recording system.

Ward managers had access to systems to support them in their management role such as mandatory training figures, staff sickness and absence figures. Staff made notifications to external bodies as and when required.

Engagement

The trust held regular engagement events to encourage engagement with staff relating to issues that support shared objectives. Staff received regular bulletins and newsletters and communication from senior member of the trust detailing shared objectives across the trust.

There was a system for staff and patient feedback which was encouraged; this information was collated was acted upon. Patients and carers had opportunities to be involved in local development initiatives, including through local forms. There was a good culture of patient involvement at Guild lodge.

All wards had team information boards, which identified areas for improvement, shared good practice and celebrated team achievements. These were unique to each area and were kept up to date with relevant information.

Learning, continuous improvement and innovation

NHS Trusts are able to participate in a number of accreditation schemes whereby the services they provide are reviewed and a decision is made whether or not to award the service with an accreditation. A service will be accredited if they are able to demonstrate that they meet a certain standard of best practice in the given area. An accreditation usually carries an end date (or review date) whereby the service will need to be re-assessed in order to continue to be accredited.

The table below shows which services within this core service have been awarded an accreditation together with the relevant dates of accreditation.

Accreditation scheme	Service accredited	Comments and date of accreditation / review
Quality Network for Forensic Mental Health Services	Low Secure Unit Medium Secure Unit	February 2017

Innovations were taking place in the service with the development of the recovery college agenda and patient involvement in mentoring/peer support and input into staff training. The women's service had a plan in place to look at the care pathways women take through secure services, with the aim of improving the lives of women who enter secure care.

Staff took part in national audits and research where appropriate. Staff described plans for various quality improvement initiatives and how they were working to improve the experience of the patients who entered the service. All innovative ideas and quality improvement plans were supported and encouraged by senior managers at the hospital.

Child and adolescent mental health wards

Facts and data about this service

Location site name	Ward name	Number of beds	Patient group (male, female, mixed)
The Cove	CAMHS- Tier 4	18	Mixed

Is the service safe?

Safe and clean care environments

Safety of the ward layout

The Cove is an 18 bedded service for males and females aged 13-18 years. There were two separate areas in the building, Pebble and Sand. Pebble had 12 beds and Sand had six beds. Pebble side was intended to be used for assessment and planning. Sand side was to be used for planned intervention. Both Pebble and Sand side were mixed sex accommodation. At the time of the inspection, there were 12 patients at the service and they were all located on Pebble. Prior to Christmas, patients had been split across Pebble and Sand, however, it was agreed to move all patients to one side to enable the service to implement the recovery plan, train staff and make essential repairs to the unit. All bedrooms were ensuite and patients had secure fob access to allow them to enter their rooms.

The bedrooms and rooms used by patients were all across one floor. Patients did not have access to the ground floor which was for staff offices. There were also staff offices on the first floor. Both Pebble and Sand were accessed using fobs.

The building was owned by a separate organisation. This organisation was also responsible for maintenance, housekeeping services and providing meals.

There were broken door panels in the ward. The broken panels were boarded up until they could be replaced. One of the broken panels was on the staff office, meaning staff were not able to see who was behind the door. A staff member commented this did not make them feel safe. The service had identified that certain doors were not fit for purpose. The beading on the glass panels on the doors was not suitable as patients could push the panels out if they used a certain amount of force. An incident had occurred in August 2017 where the investigating officer identified the unsuitable door panels as one of the root causes for one of the elements of the incident.

The service had to arrange the replacement of the doors with the owners of the building which had caused delays. Staff were frustrated with the length of time this had taken to arrange and felt it did not contribute to a safe environment for the patients. Staff had an awareness of the environmental risks and how to manage these risks. The service had arranged a date at the start of February 2018 for the work to be completed. During the well-led inspection in February 2018, the trust provided evidence to confirm that the maintenance company had completed the work.

The service was using portable heaters at the time of the inspection. Two of these were outside patient bedrooms. We were informed that one of the two boilers had broken before Christmas. The owners of the building purchased the heaters to ensure that the ward environment did not get too cold. The boiler was fixed within two weeks. Staff described that the heating of the building was still not adequate and could differ significantly in certain areas. For this reason, the heaters were still in use. The service had not completed a formal risk assessment in respect of the portable heaters. Staff informed us that they completed a dynamic risk assessment when the heaters were purchased but that this had not been formally written down.

A ligature audit had been completed and updated on the 30 November 2017. The audit covered every room on the unit and detailed the ligature risks throughout, using pictures where necessary. Ligature points are places to which patients intent on self-harm might tie something to strangle themselves. The audit also listed climb points in the garden that had been identified as a risk and pictures were included to highlight where these were. There was a repeated error on the ligature audit as the number of bedrooms for Pebble side was listed as 10 instead of 12 throughout the audit. The ligature audit did not identify the risks associated with the portable heaters.

All staff carried personal alarms. An identified healthcare assistant was responsible for handing the alarms out to staff each day. There was a good supply of alarms and these were checked on a daily basis.

There were no mixed sex breaches for this core service

In the data the trust provided prior to the inspection, there has been one ligature risk assessment undertaken at the Cove (from June 2017 onwards). The risk was deemed low due to general ward fixtures and fittings.

Maintenance, cleanliness and infection control

The maintenance and cleaning of the building was provided by the organisation that owned the building. The ward areas were clean and had suitable furnishings. We reviewed the cleaning records that confirmed that the building was cleaned on a regular basis. Where additional cleaning was required, this was documented on an additional log that confirmed if the actions required had been completed or not.

Two patients felt that the ward environment was not very clean. Patients also reported that the showers caused water to run into their bedrooms. Leaders were aware of this issue and explained that this as due to the layout of the bathroom. Leaders were reviewing if they could take any actions to prevent this from happening.

There were broken door panels in the ward areas that had been boarded up with wood after the glass had been kicked out by patients. Staff noted that some of the doors were not fit for purpose and had led to these issues. Management were trying to resolve this issue and a date had been identified for when this work would be completed. Staff felt that this issue had taken too long to resolve and that it did not promote a ward that felt safe for staff and patients. Management were aware of these feelings and described that the process for working with the external organisation took time and was out of their control.

The service was also limited in being able to make changes to the ward environment as quickly as they would like due to the fact that they did not own the building. This resulted in discussions having to be had about what they could or could not do to the ward environment. Any changes to the environment and building took a long time and changes could not happen immediately.

Staff received mandatory training in infection control. This training was at 96% compliance. Infection control information was displayed in the clinic room and throughout other areas of the ward.

Seclusion room

The seclusion room had a two-way communication system. The room had toilet and washing facilities. There was a minimal blind spot at the toilet area. A viewing aid was in place to reduce the risk of this blind spot. The seclusion room was well ventilated and an air conditioning system was in place to manage the temperature of the room. There was a clock inside the room for the patient and a second clock outside the room.

Clinic room and equipment

There were two clinic rooms within the building, one in Pebble and one in Sand. The clinic room in Sand was not in use as all patients were located on Pebble side. Staff accessed the clinic rooms using secure fobs. Both rooms had emergency grab bags inside and defibrillators. Staff had completed checks on the equipment and recorded this information. These were in date. Staff had access to a range of diagnostic equipment. A computer was available in the clinic rooms which could be used for activities such as completing internet searches of medication. Staff checked the medicine fridges regularly and there was a record of the historical checks completed.

Medication was stored appropriately in individual boxes per person. There was an adequate stock of medication and no reported issues with the supply of this. The clinic rooms had good storage areas and enough space for examinations to be completed when required. An examination couch was present in both clinic rooms. There was appropriate storage for sharps and for the disposal of unused medication which pharmacy services removed.

Safe staffing

Nursing staff

In May 2017, Lancashire Care NHS Foundation Trust co-located its two child and adolescent mental health inpatient wards at the Junction and the Platform in one location at The Cove in Heysham. The data we requested from the trust prior to this inspection was from August 2016 to July 2017. This data and figures submitted by the trust did not reflect the current position of the one location, as the time scale of the data request did not reflect the amalgamated two locations.

At the time of the inspection, the establishment levels at the service were for 18 whole time equivalent registered nurses and 28 whole time equivalent healthcare assistants. The trust provided an update on the vacancies at The Cove. As of 20 January 2018, there were four permanent whole time equivalent vacancies for healthcare assistants; 0.72 whole time equivalent vacancy for a permanent band 5 nurse; 3.72 whole time equivalent vacancies for band 6 nurses, one of which was a temporary post. The trust explained that they were actively recruiting to all vacancies.

The service used a three shift system covering days, nights and twilights. The baseline numbers for the day shift was four registered nurses and five healthcare assistants. There were two healthcare assistants on the twilight shift. The night shift consisted of three registered nurses and four healthcare assistants. The service had recently increased the numbers of staff required on shift above the baseline due to the level of observations and the acuity of the ward.

The service was heavily reliant on bank and some agency workers. A number of bank staff used were regular staff from the Cove team, working additional shifts. The service tried to use the same bank staff on a regular basis to maintain stability and familiarity for the patients. This had been difficult in the month prior to the inspection and there had been less consistency in the staff used. In December 2017, bank staff usage was reported to be 30%. Managers stated that all bank staff were required to complete the trust induction as mandatory. A local induction was given to bank and agency staff when attending the ward. Managers stated this should happen for all staff, however, could not guarantee that it happened every time.

Staffing on the ward felt strained. Patients required a high level of observations and staff were spending large periods of their shift on observations. We observed that patients on general observations were entering other patient's bedrooms without staff being aware. Patients reported that this happened regularly and staff did not challenge this behaviour. Patients explained that it could feel that staff did not give much attention to those patients on general observations. Three

patients reported feeling intimidated by other patients and that staff were not available to witness or respond to this. We escalated these concerns with the trust during the inspection.

At the time of the inspection, four registered nurses were on short term sickness leave. One registered nurse had started their phased return to work that week. Two healthcare assistants were on long term sickness leave and one healthcare assistant was on short term sickness leave. The establishment level for the service was 18 whole time equivalent registered nurses and 28 whole time equivalent healthcare assistants. The trust reported that the sickness rate for this service during December 2017 was 17%.

The trust had a process for ensuring that sickness absence was covered. The service would escalate to a central point, a duty matron. This would be the process out of hours, as during the day these issues would be referred to the matron in the unit. The duty matron would allocate and move staff accordingly. The duty matrons would be from adult mental health and the staff sent to The Cove would be from adult mental health. These staff members did not necessarily have a background in or knowledge of child and adolescent mental health. The service was looking at arranging an induction for the duty matrons at The Cove to familiarise themselves with the service and make them aware of the complexities. It was felt that this would ensure the duty matron would send more appropriate staff to provide cover at The Cove. At the time of the inspection, this had not yet happened.

Medical staff

There were two consultant psychiatrists allocated to the ward. The service also had two speciality doctors. One of the consultant psychiatrists had resigned and was leaving their post shortly. An on-call rota was in place for out of hours cover.

Between 1 April 2017 and 31 July 2017, all shifts were filled by bank staff (a medic locum medic) to cover sickness, absence or vacancy for medical locums.

Ward/Team	Available shifts	Shifts filled by bank staff	Shifts filled by agency staff	Shifts NOT filled by bank or agency staff
The Cove	5	5 (100%*)	0	0
Core service total	5	5 (100%*)	0	0
Trust Total	6996	1287 (18.4%)	5618 (80.3%)	56 (0.8%)

***** Percentage of total shifts

Mandatory training

The following table indicates the mandatory training figures that the trust sent as part of the Provider Information Request (for the period: 1 April 2017 to 31 July 2017).

Key:

Below CQC 75%	Between 75% & trust target	Trust target and above

Training course	This core service %	Trust target %	Trustwide mandatory/ statutory training total %
Immediate Life Support (ILS)	25%	85%	25%
Safeguarding Children Level 3	29%	85%	83%
Manual Handling Level 2	33%	85%	40%
Resuscitation (Basic Life Support)	43%	85%	27%
Information Governance	56%	85%	42%
Infection Control (Clinical)	72%	85%	55%
Fire Safety	83%	85%	57%
Health & Safety	83%	85%	52%
Safeguarding Vulnerable Adults Level 1	100%	85%	83%
Mental Capacity Act Level 1 (Clinical)	111%	85%	99%
Equality & Diversity	175%	85%	71%
Core Service Total %	66%	85%	52%

The mandatory training figures provided on the day of the inspection were significantly higher than the figures that the trust had provided in the Provider Information Request which are displayed in the above table. The figures at the time of the inspection were the most up to date and reflected the current status of the mandatory training. Mandatory training was monitored on a spreadsheet that listed each mandatory training course and the staff members who had either completed the training or not. Of the 12 mandatory training courses listed on the spreadsheet, all but one course was above 90%, which was at 88%. All 12 mandatory training courses were above the trust target of 85%.

The core service also had a further six training courses which were considered essential. The courses considered essential included PREVENT – elearning (100%), PREVENT – WRAPS (56%), Mental Capacity Act – Level 2 (64%), Mental Health Act – Level 2 (52%), Violence Reduction Training (61%) and Safeguarding Vulnerable Adults Level 2 (20%).

Assessing and managing risk to patients and staff

Assessment of patient risk

We reviewed five care records and all had a detailed risk assessment. Three of the five risk assessments were up to date. The gatekeeping team completed an initial risk assessment for patients under 16, with the adults team assessing over 16s. The service used a trust-wide tool for risk assessing patients. This tool considered current and historical risks. The risk assessments were updated following incidents. Risks, incidents and observation levels were reviewed during the handover meetings.

Management of patient risk

Levels of observation required were high at the time of the inspection. This resulted in staff being on observations for long periods of time. Between the 5 January 2018 and the 8 January 2018, there were two days where three staff members were on continuous observations for three hours and one day where two staff members were on continuous observations for three hours. The trust had an observation policy that detailed the levels of observation and key information about observations. The policy did not specify the maximum number of hours a staff member could be allocated for observations. Guidance from the National Institute for Health and Care Excellence states that an individual staff member should not undertake a continuous period of observation above the general level for longer than two hours. Patients explained that the levels of observations resulted in staff spending less time speaking to or helping them.

One female patient explained during an interview that they had requested a female member of staff to complete night time observations due to historic abuse. This was also noted in their care plan. We reviewed the allocations of nine nights between 1 January 2018 and 9 January 2018. Six of the nine nights had a female member of staff on observations, whilst three of the nine nights had a male member of staff on observations.

The kitchens remained locked at all times. Staff had identified that the cookers would be a risk to certain patients if they were given unsupervised access. This meant that patients did not have free access to snacks and hot drinks at all times. Patients stated that they had to request snacks and drinks from staff. Patients noted staff would normally do this promptly, however two patients stated that at busy times on the ward this did not happen. A water cooler was available, with cordial, which was accessible to all. The service had not completed individual risk assessments to review if access to the kitchen was appropriate for individual patients.

Access to outside space was limited. The service locked the doors to access the internal courtyard and staff facilitated patients going outside. Staff noted that access to the outdoor space was particularly limited at the time of the inspection due to the high levels of observation that meant access to the courtyard space had to be restricted. This meant that patients did not have access to an outdoor space at all times. The service had not individually assessed this risk for each patient.

Use of restrictive interventions

The two previous locations did not have seclusion rooms and staff had therefore not used seclusion rooms previously. Staff received training in the use of seclusion as part of the violence reduction training, however, this training had not been conducted using the facility at the Cove. At the time of the inspection, both the seclusion room and extra care area were being used. One patient had been transferred to a seclusion room off site due to the seclusion room at The Cove being occupied.

Staff were trained in violence reduction to deescalate situations and ensure they carried out restraint in the correct way. The violence reduction training was an essential training course and had a 61% compliance rate for those staff required to complete it. Patients felt that staff used restraint at appropriate times and as a last resort. One female patient noted that staff tried to make sure that only female members of staff restrained her. One patient felt that the staff used positive de-escalation techniques during restraint and that staff supported the patient after being restrained. One patient stated that support following a restraint was dependent on the staff involved, whilst a further patient stated this did not happen.

Between June 2017 and January 2018 there had been 156 incidents of restraint. These incidents had significantly increased between the period of November 2017 and January 2018, with 114 of the 156 incidents taking place in this period.

This core service had 16 incidents of restraint and four incidents of seclusion between 1 April 2017 and 31 July 2017.
The below table focuses on the last four months' worth of data: 1 April 2017 and 31 July 2017. This data could not be compared to that of the previous inspection due to The Cove ward being a new location.

Ward name	Seclusions	Restraints	Patients restrained	Of restraints, incidents of prone restraint	Rapid tranquilisations
The Cove	4	16	Not provided	0 (0%)	1 (6%)
Core service total	4	16	Not provided	0 (0%)	1 (6%)

There were no incidents of prone restraint and no instances of mechanical restraint over the reporting period.

There were four incidences of seclusion between 1 April 2017 and 31 July 2017.

Long term segregation information could not be provided by the trust.

Safeguarding

Staff completed safeguarding training as part of their mandatory training. Safeguarding children level 3 was at 96% compliance at the time of the inspection. Safeguarding adults level 1 was at 92% at the time of the inspection. Safeguarding vulnerable adults level 2 training was part of the essential training. At the time of the inspection, this was at 20% compliance.

Staff understood how to identify a safeguarding concern and how to report it. A safeguarding duty contact was available to staff when they had questions or needed guidance about safeguarding. The service had safeguarding leads that held a safeguarding supervision session every month that was available to staff as a drop-in session. Staff also had access to a social worker in the service who they would speak to for safeguarding advice. The social worker would liaise with the local authority safeguarding teams in respect of any safeguarding referrals.

Staff discussed any safeguarding issues for each patient as part of the nursing and multidisciplinary team handover meetings. Staff recorded these discussions within the minutes of the handover meetings.

We reviewed an incident report from an incident that had taken place in August 2017. An issue identified in the report was that staff had not completed the safeguarding module on the electronic care record for the patient following the incident.

A safeguarding referral is a request from a member of the public or a professional to the local authority or the police to intervene to support or protect a child or vulnerable adult from abuse. Commonly recognised forms of abuse include: physical, emotional, financial, sexual, neglect and institutional.

Each authority has their own guidelines as to how to investigate and progress a safeguarding referral. Generally, if a concern is raised regarding a child or vulnerable adult, the organisation will work to ensure the safety of the person and an assessment of the concerns will also be conducted to determine whether an external referral to Children's Services, Adult Services or the police should take place.

This core service made seven safeguarding referrals between 1 August 2016 and 31 July 2017, of which one concerned adults and six children.

	Number of referrals		
Ward name	**Adults**	**Children**	**Total referrals**
The Cove	**1**	**6**	**7**

Lancashire Care NHS Foundation Trust confirmed there had been no serious case reviews commenced or published in the last 12 months (1 August 2016 to 30 July 2017) that relate to this core service.

Staff access to essential information

The service used electronic care records and also kept hard copy paper records. Staff did not raise any concerns about being able to access essential information. A paper file containing the notes from the nursing handovers was stored in the staff office.

Medicines management

We reviewed 12 medication charts. Medications were dispensed using an electronic prescription system. The electronic prescription system used meant that there were no errors of signing or dating for medications. We found no issues with the storage, dispensing or ordering of medication.

Track record on safety

At the time of the inspection, two serious incidents had been reported on the DATIX system since The Cove opened. Both of these incidents occurred in August 2017. We saw evidence that managers had investigated and reviewed the incidents, or were in the process of completing these. One of the incidents was still open due to the complexities of the incident. We observed that the service was taking and recording appropriate actions in respect of this incident. Both incidents were recorded on the Strategic Information Executive System (STEIS).

Following the inspection, the trust informed us of a third serious incident that had been initially graded as level 3 in June 2017. This incident was re-graded and reported on STEIS on 20 February 2018.

Providers must report all serious incidents to the Strategic Information Executive System (STEIS) within two working days of an incident being identified.

Between 01 April 2017 and 31 July 2017 there were zero STEIS incidents reported by this core service.

A 'never event' is classified as a wholly preventable serious incident that should not happen if the available preventative measures are in place. This core service reported no never events during this reporting period.

We asked the trust to provide us with the number of serious incidents from the past 12 months. The number of the most severe incidents recorded by the trust incident reporting system was comparable with STEIS.

The number of serious incidents reported during this inspection was lower than the one reported at the last inspection.

Reporting incidents and learning from when things go wrong

Staff recorded incidents using an electronic recording system. The system recorded these incidents clearly and produced a dashboard that enabled managers to analyse the types of incident received.

The number of incidents had increased significantly throughout November, 115 incidents, and December 2017, 159 incidents. This was compared to a low of 40 incidents recorded in September 2017. Of the 159 incidents in December, 105 of these were patient self-harm incidents. There was a backlog of incidents awaiting review and sign off by the ward managers on the electronic recording system. At the time of the inspection, 147 were overdue on the system. We could therefore not be sure that the ward managers had appropriate oversight of these incidents, although staff told us that they had.

Staff reported that debriefs following incidents did not happen regularly and that lessons learnt from incidents were not shared with the team. Leaders reported that they tried to ensure that they completed informal debriefs and welfare checks following incidents to make sure that staff had appropriate support.

One patient reported that staff did not offer support following an incident of restraint. One patient stated that staff did offer support following an incident of restraint and that staff explained why they had used the restraint. Leaders noted that completing formal debriefs with patients following an incident was something that the service needed to improve.

Staff had mixed knowledge of the duty of candour with some staff members being able to describe the principles of the duty of candour. Other staff were either not clear on the principles of duty of candour or did not know what it was. Staff should have an understanding of the principles of the duty of candour and their individual responsibilities in relation to this. When reviewing the serious incidents, we saw that the trust had invoked the duty of candour and that staff had been open and transparent. Within the electronic incident system, the service had saved copies of letters that the trust had sent to family members providing a full explanation of what had happened and where things had gone wrong.

The Chief Coroner's Office publishes the local coroners Reports to Prevent Future Deaths which all contain a summary of Schedule 5 recommendations, which had been made, by the local coroners with the intention of learning lessons from the cause of death and preventing deaths.

In the last two years, there have been no 'prevention of future death' reports sent to Lancashire Care NHS Foundation trust in relation to this core service.

Is the service effective?

Assessment of needs and planning of care

We reviewed five care records during our inspection. All care records had a care plan and risk assessment. Four of the five care records reviewed indicated that staff had examined the patient's physical health on admission and there was evidence that ongoing monitoring was taking place. Staff wrote care plans in the first person but the terminology used throughout had a nursing focus. This indicated it was not the patient's voice. Three of the five records reviewed indicated that the patients had received a copy of their care plan.

Of the six patients interviewed, five reported that they had received a copy of their care plan. Two of the patients stated that the care plans were written by nurses then shown to the patients to sign them.

In the support plan for a patient, it indicated that staff should not give the patient chocolate due to a medical condition. We observed staff offering bourbon biscuits and also overheard a nurse saying she had given the patient three chocolates as they were so upset. We escalated this concern at the time of the inspection with the trust.

The support plan for a patient with a learning disability indicated that staff should use Picture Exchange Communication System cards with this patient. Observations of interactions noted that staff were not using Picture Exchange Communication System cards. A positive behaviour support plan was in place for this patient but staff did not appear to be following it during their interactions with this patient.

Best practice in treatment and care

The service had produced an admission and assessment pathway in December 2017. It was still in draft form at the time of the inspection. This pathway gave clear timescales for each stage of the pathway. The pathway had a focus on psychological formulation alongside incorporating risks and the National Institute for Health and Care Excellence guidance.

Leaders within the service noted that engagement in clinical audits was something to improve on in the future. It was expected that when the service had more permanent staff then this would free up the team leaders time to complete regular audits.

This core service participated in no clinical audits as part of their clinical audit programme 1 April 2017- 31 July 2017.

Skilled staff to deliver care

The team on the ward included staff from a variety of disciplines: doctors, nurses, senior psychologist, consultant psychologist, psychology assistant, social worker, occupational therapist, technical instructor, dietitian, healthcare support workers and administration staff.

The trust policy indicated that clinical supervision should be held a minimum of twelve sessions a year and a minimum of four managerial supervision sessions a year. The service informed us that the figures for managerial supervision were not recorded. For quarter two, the clinical supervision rate was at 54%. Data provided for quarter three indicated that clinical supervision was 35% in October, 25% in November and there were no records for December 2017. Staff reported that

supervision was not regularly taking place. Managers explained that formal supervision sessions had not been taking place due to the pressures on the service. Managers would try to hold informal supervision sessions and welfare checks with staff when they were available.

The appraisal rate at the end of September 2017 was 45%. Managers used an electronic system to record appraisals which gave them oversight. The appraisal rate between October 2017 and December 2017 was 12%.

The trust advised that supervision had not been recorded as per trust policy in all cases and that informal supervision had become common practice at The Cove since opening. It was noted that informal supervision was required due to the high percentage of staff turnover, high acuity levels of the service and a high sickness level. The trust explained that, due to the pressures on the staffing team, the priority was clinical work to ensure the service was delivering safe care, rather than completing formal supervisions and appraisals.

Since The Cove had been open, 31% of qualified nurses and 59% of healthcare assistants were new in post. The service had lost a number of experienced staff due to the move to the new location and staff wanting to find jobs closer to their homes.

Staff were not being given specialist training to meet the needs of the patient group they were responsible for. As the service had more inexperienced staff and was also using staff from an adult mental health background, there was a risk that they may not have the specialist training to provide care and treatment in a child and adolescent mental health environment. Training had not been given to staff in respect of eating disorders, learning disabilities, autism spectrum disorder and mental health awareness. Managers had recognised this as an issue and had a plan to ensure that all staff received the appropriate training and were confident in what they were being asked to do. The plan was in the early stages and they were awaiting approval for this. During the well-led inspection in February 2018, the trust confirmed that they had reduced the bed number to 10 after consultation with the specialist commissioner. This was to implement the recovery plan, train staff and make essential repairs to the unit.

The trust's target rate for appraisal compliance is 85%. As at 15 November 2017, the overall appraisal rates for non-medical staff within this core service was 14%.

The rate of appraisal compliance for non-medical staff reported during this inspection was lower than the 37% reported at the last inspection (as at 29 June 2016).

Ward name	Total number of permanent non-medical staff requiring an appraisal	Total number of permanent non-medical staff who have had an appraisal	% appraisals
The Cove	51	7	14%
Core service total	51	7	14%
Trust wide	**6007**	**1996**	**33%**

In the data the trust provided prior to the inspection, appraisal rates for permanent medical staff for this core service were not provided.
Between 1 April 2017 and 31 July 2017 the average clinical supervision rate across all teams in this core service was 87%.

Caveat: there is no standard measure for clinical supervision and trusts collect the data in different ways, it's important to understand the data they provide.

Ward name	Clinical supervision sessions required	Clinical supervision sessions delivered	Clinical supervision rate (%)
CAMHS Tier 4	200	174	87%
Core service total	200	174	87%
Trust Total	17914.8	12753.1	71%

Multi-disciplinary and interagency team work

Staff held a multidisciplinary handover each morning. All patients were discussed as part of this handover and the meeting would discuss updates for each patient, including any incidents, risks or safeguarding. The notes of these handovers were recorded in a clear and consistent way. Any actions identified from these meetings had an identified person to follow up on them. We observed that these meetings could last for over an hour and a half. The service had plans in place to review how they allocated the time for these handovers to ensure that they were using staff time appropriately.

We observed a multidisciplinary handover meeting. Staff demonstrated knowledge of the patients and their risks and vulnerabilities. The atmosphere of the handover felt open and all staff were able to express opinions.

A nursing handover was held at the start of each shift. This handover provided updates on the last 12 hours for each patient, an update on any risks, safeguarding and the levels of observation. Paper copies of these handover notes were stored in a folder within the nursing office.

Education within the service was provided by a separate organisation. Staff reported positive relationships with the education staff. Leaders were working with the education staff to address issues with low attendance at education and better ways of managing this situation.

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

In the data the trust provided prior to the inspection, Mental Health Act Level 2 training had a compliance rate of 40% (two out of five eligible staff members received this training between 1 April 2017 to 31 July 2017) however this training was non-mandatory. Mental Health Act Level 1 training compliance was not provided.

At the time of the inspection, 52% of staff had had training in the Mental Health Act Level 2 which was an increase in the rate of compliance. Training in the Mental Health Act Level 2 was not mandatory training and only 23 of 50 staff were required to complete the training.

The service received positive support from Mental Health Act administrators who would manage all the original copies of documentation and would notify the service of any errors or issues. The electronic patient records had a Mental Health Act specific section. This would also flag up any gaps or overdue items, such as staff not explaining the patient's rights to the patient on a regular

basis. At the time of the inspection, six patients were detained under the Mental Health Act and six patients were informal. The trust's locked door policy was displayed next to the main entrance. This poster explained the policy and asked that if an informal patient wanted to leave then they should inform a staff member so that the staff member could complete a risk assessment prior to this happening.

Patients had access to an independent mental health advocate. The advocate would attend the service on a regular basis. Staff were pro-active in involving the advocate in new admissions and would ensure patients were aware that advocacy was available to them.

Good practice in applying the Mental Capacity Act

From 1 April 2017 to 31 July 2017, Mental Capacity Act Level 1 (Clinical) training had a compliance rate of 111% (all nine eligible staff had received the training, with one member of staff completing the course twice) and Mental Capacity Act Level 2 training had 0% compliance (none of the 14 eligible staff member had undertaken the training) however this training course was non-mandatory.

At the time of the inspection, 96% of staff had had training in the Mental Capacity Act Level 1. This training was mandatory for all staff to complete. Sixty four percent of staff had had training in the Mental Capacity Act Level 2. Level 2 training was not a mandatory training course.

The service would complete a capacity assessment for each patient on admission. We observed that the capacity of patients had been reviewed and this was documented in the patients' notes. Staff we spoke to had an understanding of the Mental Capacity Act and knew how to access support if they had any questions or needed advice. For young people under sixteen their decision making ability is assessed under Gillick competency, this recognises that some children under sixteen may be capable of making decisions for themselves. The trust policy on consent to examination and treatment provided guidance and information about the concept of Gillick competency, including what is considered good practice.

The trust told us that no Deprivation of Liberty Safeguard (DoLS) applications were made to the Local Authority for this core service between 1 April 2017 and 31 July 2017. Deprivation of liberty safeguards only apply to patients that were over sixteen years of age and would be done via court.

Is the service caring?

Kindness, privacy, dignity, respect, compassion and support

We spoke with six patients who used the service. Patients gave mixed feedback about the service.

All patients reported that they did not feel there was enough staff present on the ward. Patients noted that when staff were on the ward, they were either on observations or in the office, meaning there was little engagement with the patients. Patients explained that it felt that staff often did not have time to talk to them. Patients described that the staff did not know how to control or manage certain patients on the ward and that boundaries were not in place for these patients.

One female patient explained during an interview that they had requested a female member of staff to complete night time observations due to historic abuse. Staff had noted this in the patient's care plan. We reviewed the allocations of nine nights between 1 January 2018 and 9 January 2018. Six of the nine nights had a female member of staff on observations and three of the nine nights a male member of staff was on observations.

Patients felt that the majority of staff were respectful and would knock before entering their bedrooms. Patients felt that their family and loved ones were kept involved by the service. Patients described examples of where staff had treated them with dignity and respect.

We observed mixed interactions between staff and patients.

Whilst being present on the ward, we heard some examples of staff describing patients in a negative manner that were not compassionate or supportive. At times, there was limited engagement by staff with patients, with staff being sat in the office rather than engaging with the patients in activities. During the inspection, we did not observe activities taking place on the ward.

We observed a positive interaction between a staff member and a patient who had injured their hand. The staff member was caring and took the time to explain what actions they would take to care for the injury. The staff member was polite and friendly throughout this interaction.

During the Care Programme Approach meeting that we attended, staff made efforts to ensure that they could facilitate the patient's home leave and to resolve the barriers that could prevent it. There was an issue in respect of transport for the patient and staff put a solution in place to address this. The patient and their family were in attendance and were included in the meeting. We observed that the meeting had a relaxed feel with a clear plan being identified by the end of the meeting.

We observed the multidisciplinary team handover meeting. Staff discussed each patient during the meeting. Staff demonstrated an awareness of the patients as individuals and recognised their needs. Staff considered the safeguarding and vulnerabilities of each patient throughout the meeting.

We undertook a short observational framework for inspection. A short observational framework for inspection is used by CQC inspectors to capture the experiences of people who use services who may not be able to express this for themselves. We observed positive interactions between a staff member and the patient for the first half of the short observational framework for inspection. The staff member engaged with the patient. During the second half of the short observational framework for inspection, with a second staff member present, there were no interactions observed between the staff and the patient. The staff members talked amongst themselves about staffing and other services.

No patient-led assessments of the care environment (PLACE) data was available for this core service. PLACE inspections had not yet taken place as the service was less than a year old.

Involvement in care

Involvement of patients

A fortnightly participation meeting was held by the service. These meetings were independently chaired to enable the patients to speak freely about the service. The minutes of these meetings were recorded and documented the issues highlighted by the patients. The ward managers received a copy of the minutes for them to resolve or address the issues discussed. Patients reported that they did not feel that they always received feedback about the issues discussed at these meetings. The service had recently re-introduced community meetings on the ward to give patients a further opportunity for their voice to be heard.

We observed that the service had produced a draft welcome guide for new admissions to the service. The welcome guide provided detailed information about the service and the treatments on offer. There was also information about key information that the patient would need, such as the Mental Health Act and the complaints procedure. The guide also provided information about the local area and surroundings. Staff had written the guide in a clear format that would be useful for the patients.

Patients had access to an advocacy service. The advocate attended multiple times a week to give the patients time to speak with them. Patients were aware of the advocacy service and knew how to access this. The advocate would assist patients in making complaints and supporting them through this process. Staff supported and encouraged patients to use the advocacy service where appropriate.

Information displayed around the ward environment for patients was limited. Leaders explained that there were limitations about the changes that could be made to the environment as the trust did not own the building. Leaders were assessing what actions could address this situation. Patients reported that they were given information by staff, particularly around their medication.

We reviewed five care plans. All care plans had been written in the first person but the terminology used throughout had a nursing focus. This indicated it was not the patient's voice. Interviews with patients provided mixed feedback as to involvement in care plans. Of the six patients interviewed, five reported that they received a copy of their care plan. One stated they were involved in their care plan and one stated staff helped them to go through it. Two stated they were not involved in their care decisions or plan. Two patients advised that the care plans are written by nurses then shown to the patient for them to sign them.

A positive behavioural support plan was in place for a patient with learning disabilities. The plan stated how best to communicate with and care for the patient, such as using Picture Exchange Communication System cards. We did not observe staff using these when communicating with the patient with a learning disability.

Involvement of families and carers

Carers were kept involved by the service. Staff provided information to families and carers as per the patient's wishes. Families and carers were invited to meetings where appropriate. Family members were in attendance at the care programme approach meeting we observed. Staff offered support to families and carers. We observed that the opinions of families and carers were taken

into consideration by staff and that they were able to have involvement in the care and treatment of their loved ones.

We spoke with one family member during the inspection. The family member felt supported by the staff at The Cove and was happy with the support offered to their loved one. The family member stated that the staff were helpful, caring and would accommodate their needs. The family member noted that staffing levels at the service could be low at times.

Four of the six patients interviewed stated that their families were invited to meetings and could be involved in their care and treatment. Two of the patients did not comment about this. One of the six patients stated that the staff would always accommodate their family and were very welcoming. A further patient noted that they were happy with the way the service treated their family.

Is the service responsive?

Access and discharge

Bed management

The trust provided information regarding average bed occupancies for one ward in this core service between 1 April 2017 and 31 July 2017.

We are unable to compare the average bed occupancy data to the previous inspection due to differences in the way we asked for the data and the time period that was covered.

Ward name	Average bed occupancy range (1 April 2017 - 31 July 2017) (current inspection)
The Cove	78.6%- 94.6%

The trust provided information for average length of stay for the period 1 April 2017 and 31 July 2017.

We are unable to compare the average bed occupancy data to the previous inspection due to differences in the way we asked for the data and the time period that was covered.

Ward name	Average length of stay range (1 April 2017- 31 July 2017) (current inspection)
The Cove	14.7- 67

This core service reported no out area placements between 1 April 2017 and 31 July 2017.

This core service reported no readmissions within 28 days between 1 April 2017 and 31 July 2017.

Discharge and transfers of care

Between 1 April 2017 and 31 July 2017 there were 30 discharges within this core service. This amounts to 1% of the total discharges from the trust overall (3129). Of these discharges none were delayed.

On admission, staff initiated a five day care plan programme approach process with the patient. This process prompted staff to consider discharge planning at the point of admission. At the end of the five days it would be determined if it was appropriate for discharge to take place or not. A draft admission and assessment pathway was created by the service in December 2017. This pathway provided clear stages for admission and discharge that the service would work towards. The pathway was awaiting approval. The social worker within the service supported staff in discharge and identifying any difficulties that may prevent discharge.

The service employed Band 6 nurses as gatekeepers to ensure that appropriate admissions were made to the service during working hours. The trust bed management hub handled admissions outside of working hours. The trust bed management hub was not based at The Cove. Staff at The Cove told us that they had concerns that the trust bed management hub did not take into account the level of acuity of the service or the impact the admission may have when reviewing these admissions. Staff felt that the duty managers within the trust could overrule the decisions made by the gatekeeping nurses when the potential admissions were reviewed again out of hours and the Band 5 nurses within the service felt pressurised to accept these admissions. Staff reported that

they felt these admissions impacted on the quality of care because of the level of acuity and the conflicting demands on staff time. This was contributing to the low morale of the staff team.

The trust were alerted to the concerns in relation to the acuity of the ward and impact on the quality of care. During the well-led inspection in February 2018, the trust confirmed that they had reduced the bed number to 10 following discussions with the specialist commissioner. This was to implement the recovery plan, train staff and make essential repairs to the unit.

Facilities that promote comfort, dignity and privacy

All patients had their own ensuite bedroom that they could access using a secure electronic fob system. Each fob was individual to that room so other patients could not open other bedrooms with their fobs. Patients did not have access to lockable storage in their bedrooms, although the room itself could remain locked at all times. Patients could access their bedrooms during the day unless there was a clinical need for them to have restricted access. This would be documented in the care plans. Staff encouraged patients to bring in items from home and posters to enable them to personalise their bedrooms.

There was a wide range of rooms available on both sides of the unit, including a number of lounges, kitchens and education rooms. The service identified risks with certain rooms and these remained locked. Patients could only access these rooms under staff supervision.

Access to outside space was limited. The Cove had an internal courtyard although the doors remained locked. Staff facilitated patients' access to outdoor spaces. The Cove also had a garden although staff reported this space was not being utilised.

Gym equipment was available for the patients in one of the rooms. Patients could only use the equipment after a risk assessment had been completed. There was a sign on the wall to indicate which patients were able to use the equipment.

Patients were allowed mobile phones on the ward. The service set out ground rules that the patients were expected to follow when using their phones. If used inappropriately, the service would take action & were aware of what potential issues could arise from the use of mobile phones on the ward. Patients were able to access the internet using their mobile phones although the service did not have wi-fi available on site for patients. Patients had access to computers on the ward and these had internet available on them.

Patients and staff told us that the food was of a poor standard. The food was provided by a separate organisation. The criticisms were around the variety on offer, the size of the portions and the overall quality of the meals provided.

Patients reported that they did not have free access to snacks and drinks at all times but could request from staff at any time. Patients noted staff would normally do this promptly, however two patients stated that at busy times on the ward this did not happen. A water cooler was available, with cordial, which was accessible to all.

No patient-led assessments of the care environment (PLACE) data was available for this core service. PLACE inspections had not yet taken place as the service was less than a year old.

Patients' engagement with the wider community

Education was provided on site for this service by a separate organisation. There were three classrooms available on Sand side which were well equipped and spacious. At the time of the

inspection, the education day was split between morning and afternoon. In the morning the children up to Year 11 would be in class. In the afternoon it would be for college age patients.

Staff reported that getting the patients to engage in education was currently difficult. On the first day of inspection we observed two patients accessing education briefly. We were informed that on the second day of inspection only one patient went to education. Staff noted that one potential reason was because of the split between age groups in the morning and afternoon. Leaders reported that they were working with the education provider to promote engagement and analyse the potential of offering an outreach service on the ward for patients who did not want to attend the classrooms.

There were not any work experience opportunities for the patients who were above school age and did not want to attend college. The service recognised that this was an issue.

Due to the location of the service, there were concerns that the patients could be isolated from their families and loved ones. We observed that staff were trying to find solutions to ensure that they could facilitate home leave for one of the patients during their care programme approach meeting.

Meeting the needs of all people who use the service

The service had recently admitted a patient with a hearing impairment. The service did not provide an interpreter for this patient until three and a half weeks post admission and following a tribunal. Staff confirmed that an interpreter had only been put in place as an action following the tribunal.

The service had a hearing loop in the building to assist patients with hearing impairments.

A positive behavioural support plan was in place for a patient with learning disabilities. The plan stated how best to communicate with and care for the patient, such as using Picture Exchange Communication System cards. We did not observe staff using these when communicating with the patient with a learning disability.

Patients reported that the service had met their preferences in respect of their dietary requirements by providing a vegetarian option at mealtimes. Patients and staff reported that the choice of food was limited.

The service had produced a draft welcome pack for patients. The welcome pack contained detailed information about the service itself, treatments on offer, the Mental Health Act, the complaints procedure and information about the local area. It also detailed guidelines for the use of electronic devices and any contraband items.

Listening to and learning from concerns and complaints

Patients reported that they knew how to make a complaint and would be confident to do so. Patients gave mixed feedback about receiving updates on their complaints.

There was limited information about the complaints procedure displayed around the ward. Patients would ask a member of staff for a copy of the complaints form. We observed that the complaints procedure was explained within the draft welcome pack that the service had produced.

Since the opening of The Cove, four level one complaints had been received, one level two complaint and three rapid resolutions. Three of these were still open. Managers were taking

actions in respect of all complaints and were completing investigations. We reviewed these complaints and noted that mangers were responding to them in line with the trust policy. The complaints system contained information about what actions the investigating managers had taken.

The service received 38 compliments between May 2017 and September 2017.

This core service received one complaint between 1 April 2017 and 31 July 2017.

Ward	Type of incident reported	Total
CAMHS – Tier 4	Communications (1)	1
Core service total	Communications (4)	1

Is the service well led?

Leadership

Leaders within this core service displayed an awareness and understanding of the issues that the service currently had. Leaders were open and honest about the challenges. Leaders within this core service had identified key changes that they wanted to implement and displayed a positive attitude in wanting to create a high performing service.

The service manager and lead nurse had only been in post since September 2017 and November 2017 respectively. They had identified that the service was under pressure and required their attention to resolve the issues. Staff recognised that leaders had been more visible in the service since the appointments.

Leaders described that it had been hard to manage the transition and maintain morale within the staffing team. A particular issue that was having an impact was the building and maintenance. The building was owned by a separate organisation that meant changes and improvements to the environment could not happen immediately and required conversations between the two organisations. Repairs and refurbishment were also delayed by this process. Leaders told us that this appeared to staff as if leaders were not taking action on these issues, whereas it was just the length of the process that was causing the delays and leaders were trying to rectify as quickly as possible.

A further difficulty from the transition was uniting the two staff teams from the Junction and the Platform. As these had been two separate services with different purposes, relationships needed to be created as one team rather than two. Leaders noted that the pressures on the service had made this difficult. A team away day took place in September 2017 to address this and find solutions. This had resulted in regular team meetings being booked in from November 2017.

The service had two ward managers that had been in post since August 2017 and September 2017. Leadership training had not been recently completed. Some areas of training and development had been identified which included mentorship by the service manager. Senior leadership training was planned but not completed due to the high patient acuity throughout that time.

Vision and strategy

The trust had a vision and a set of values that had been developed with staff. The trust's vision was to provide 'high quality care, in the right place, at the right time, every time.'

The trust's values were:

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

Staff feedback in relation to the vision and strategy of the trust was mixed.

Staff told us that they felt the transition from the two locations to one had not been managed very well and that the process happened too quickly. Staff noted that a slower transition would have been beneficial to allow the two teams to familiarise themselves with each other and the location. Staff reported it would also have been useful to have had specialist training during this transition, due to the wider range of mental health problems they would be treating at The Cove, as well as now being required to use seclusion facilities, which had not been present at either of the two locations previously.

In the incident report for an incident that occurred in August 2017, the investigation lead had been informed that The Cove had been opened without adequate testing of the security of the building. This had led to issues as some of the doors in the building were not suitable for purpose. This enabled patients to kick out the door panels, increasing the risks within the service. At the well-led inspection in February 2018, the trust provided evidence that replacement doors were now in place.

Staff feedback was positive about local leadership, however, there was a disconnect between the service and the senior management of the organisation. Staff described feeling overruled by senior staff outside of the service in relation to some admissions and that the organisational senior management had not taken much interest in the service since moving to the new location.

CQC attended the trust's quality committee at the start of January 2018. Senior leaders in the organisation displayed an awareness of the issues that this core service was facing and had oversight of this as a leadership team. Senior leaders discussed proposals to reduce pressure on the service and were aware that this core service required support to ensure that high quality care and treatment could be fully embedded. At the well-led inspection in February 2018, the trust confirmed that they had reduced the bed number at The Cove to 10 following consultation with the specialist commissioner. This was to implement the recovery plan, train staff and make essential repairs to the unit.

Culture

Staff and leaders at this service reported that there was a low morale due to the pressures that the service was facing. Staff noted that the local leadership had been supportive, although raised concerns about the timeliness of changes being made to help improve the service. Leaders were aware of these concerns and were attempting to introduce changes to help resolve this.

Leaders were able to give examples where poor performance or issues were addressed and how these had been managed. Leaders understood the process to follow in these situations.

Governance

The trust has provided their board assurance framework, which details any risk scoring nine or higher (those above) and gaps in the risk controls which impact upon strategic ambitions.

The trust has provided a document detailing their 81 highest profile risks. Each of these has a current risk score of three or higher. The following two relate to this core service.

Key:

High (15-20)	Moderate (8-15)	Low 3-6	Very Low (0-2)

Opened	ID	Description	Risk level (initial)	Risk score (current)	Risk level (target)	Link to BAF strategic objective no.	Last review date
10 February 2017	8362	The Cove: Staffing/Vacancies	12	12	6		29 September 2017
19 June 2017	8578	There may be a reduced response following an incident due to The Cove being a stand alone unit.	15	10	5		17 July 2017

The service introduced fortnightly team meetings in November 2017. Staff we spoke to noted that leaders needed to consider when the meetings were booked in and how to ensure more staff could attend. It was felt that the nursing staff had not had the opportunity to attend the team meetings. The next two team meetings were booked for January 2018. We reviewed the minutes of the two meetings that took place in November 2017. The meetings had a clear structure and agenda. The minutes had not been stored in a central place and could not be accessed immediately when requested. It was unclear if all team members could access the minutes in an appropriate manner.

Staff reported that shared learning, lessons learnt and debriefs were not happening within the service. The leaders of the service recognised that this was an area to improve and were looking at actions to resolve this.

The service had systems in place that allowed leaders to monitor and review incidents, training and other key information. Leaders within the service sent updates on the key performance indicators for the service on a quarterly basis with commissioners as part of a quarterly performance report. This was compiled by the modern matron who had oversight of this data.

Management of risk, issues and performance

The service had a number of risks recorded on the risk register that reflected a number of concerns that the service had at the time of the inspection. Each risk had a specific named owner.

The modern matron was able to provide more information about each risk and what actions the service had taken to manage and monitor the risks.

Information management

The service had systems in place to record data on the ward in a clear manner. A quarterly provider report was produced which listed data in relation to the service's key performance indicators. There was a dashboard that recorded incident, complaint and safeguarding information. This dashboard gave leaders an oversight of these areas and could be looked at in more detail.

Systems for recording certain information were not as clear. When requesting to view the team meeting minutes from November 2017, the service could not locate these quickly and did not appear to be stored in a central drive. We could not be sure if all staff had access to these minutes.

Engagement

The service held fortnightly participation meetings. The meetings were independently chaired and gave the patients an opportunity to voice any concerns or issues. These issues were then fed back to leaders in the service for them to resolve. We observed that the minutes of these meetings were recorded. It was not clear how leaders notified the patients of actions taken as a result of these meetings. The service was due to re-introduce regular community meetings for patients to give them a further voice within the service.

Learning, continuous improvement and innovation

NHS trusts are able to participate in a number of accreditation schemes whereby the services they provide are reviewed and a decision is made whether or not to award the service with an accreditation. A service will be accredited if they are able to demonstrate that they meet a certain standard of best practice in the given area. An accreditation usually carries an end date (or review date) whereby the service will need to be re-assessed in order to continue to be accredited.

The table below shows which services within this core service have been awarded an accreditation together with the relevant dates of accreditation.

Accreditation scheme	Service accredited	Comments and date of accreditation / review
Quality Network for Inpatient CAMHS (QNIC)	The Junction The Platform (both now moved to The Cove)	Not provided

The Cove was not accredited by the Quality Network for Inpatient CAMHS (QNIC) at the time of the inspection. The service had recently had a peer review from QNIC that had provided feedback on areas that the service needed to improve to gain accreditation. Leaders would be creating an action plan following this review to meet their target of achieving accreditation. Leaders noted that

they would be including specific targets and goals within the appraisals of staff members to help them meet this target.

Leaders explained that the staff team had been proud of the high quality work produced by this core service when they were based at two locations. It was felt that this quality had been lost since the move to The Cove and that this had a negative impact on staff morale. Leaders expressed a desire to return to those standards and produce a higher quality of care.

Mental health crisis services and health-based places of safety

Facts and data about this service

Location site name	Team name	Description	Patient group (male, female, mixed)
Royal Preston Hospital	Mental Health Decision Unit	N/A	Mixed
Blackpool Victoria Hospital	Mental Health Liaison Team - Blackpool	N/A	Mixed
Daisyfield Mill	Access to Treatment Team (HTT) - Blackburn with Darwen	Appointments are made with Service Users, there are no set clinics for this service	Mixed
Pendle House	Access to Treatment Team (HTT) - Burnley & Pendle	Appointments are made with Service Users, there are no set clinics for this service	Mixed
Royal Blackburn Hospital	Towneley Unit	n/a	Mixed
Royal Blackburn Hospital	Mental Health Liaison Team Blackburn (Adult)	n/a	Mixed
The Mount	Access to Treatment Team (HTT) - Hyndburn Rossendale & Ribble Valley	Appointments are made with Service Users, there are no set clinics for this service	Mixed
The Stadium	Crisis Resolution Home Treatment Team (CRHTT)	Appointments are made with Service Users, there are no set clinics for this service	Mixed
West Strand House	Access to Treatment Team (HTT) - Preston	107	Mixed

The information provided by the trust about the services they provided under this core service was inconsistent. We visited all the section 136 suites so this information is correct. We visited both crisis support units, although the Preston unit was in transition and its name was not clear. We visited a sample of teams that came under the category of crisis and home treatment, but it was not possible to clearly link them with the information provided by the trust. We did not visit any mental health liaison services as part of this inspection.

HBPOS/136 suites

Location site name	Team name	Description	Patient group (male, female, mixed)
Burnley General Hospital	136 Suite	1 suite	Mixed
Ormskirk Hospital	136 Suite	1 suite	Mixed
Royal Blackburn Hospital	136 Suite	1 suite	Mixed
Royal Preston Hospital	The Rigby Suite (136 Suite)	2 suites	Mixed. Under 19s, but also takes 19 years and older.
The Harbour	136 Suite	2 suites	Mixed

The Orchard	136 Suite	1 suite	Mixed

Crisis support/mental health decision units

Royal Preston Hospital	Crisis Support Unit Preston	n/a	Mixed
Royal Blackburn Hospital	Towneley Unit	n/a	Mixed

Mental health liaison teams

	Mental Health Liaison Team (Lancaster)	n/a	Mixed
	Mental Health Liaison Team (Preston)	n/a	Mixed
	Mental Health Liaison Team (Chorley)	n/a	Mixed

Crisis/home treatment teams (from trust information)

	Access to Treatment Team Lancaster & Morecambe	n/a	Mixed
West Strand House	Access to Treatment Team Preston	n/a	Mixed
Daisyfield Mill	Access to Treatment Team Blackburn & Darwen	n/a	Mixed
The Mount	Access to Treatment Team Hyndburn, Rossendale & Ribble Valley	n/a	Mixed
	Access to Treatment Team Fylde & Wyre	n/a	Mixed
	Access to Treatment Team Chorley & South Ribble	n/a	Mixed
	Access to Treatment Team West Lancashire	n/a	Mixed
	Crisis Resolution Home Treatment Team Blackpool	n/a	Mixed
	RITT Blackpool Fylde & Wyre	n/a	Mixed

Crisis/home treatment teams we visited, or were told about onsite

	Blackburn and Darwen specialist triage assessment team (START)	n/a	Mixed
	Blackburn and Darwen home treatment team	n/a	Mixed

	Hyndburn, Ribble Valley and Rossendale specialist triage assessment team (START)	n/a	Mixed
	Burnley and Pendle specialist triage assessment team (START)	n/a	Mixed
	East home treatment team	n/a	Mixed
	Preston specialist triage assessment team (START)	n/a	Mixed
	Preston home treatment team	n/a	Mixed
	Lancaster assessment and treatment team	n/a	Mixed
	Lancaster home treatment team	n/a	Mixed

Is the service safe?

Safe and clean environment

- 136 Suites

The trust had eight 136 suites across six sites, which were all physically different. The suites were generally adequate, but did not meet all the recommendations of the Mental Health Act code of practice. Five of the suites were adjoined to acute mental health wards. The Harbour suites were the only self-contained facility. The suites had access to toilets, sinks and showers, but this was not always within the suite. Patients using the suites in Burnley had access to a shower in the adjoining ward. Patients using the suites at The Harbour had access to a shower in the adjoining seclusion room, but only if the seclusion area was not in use. Patients were able to lie or sit within the suites. There was no clock in two of the suites. Some of the suites did not have a television, but staff told us a radio was available. Some of the suites had blind spots, particularly in the ensuites. The suites in Preston had windows that adjoined staff offices. These had reflective film, which were intended to obscure the patients view into the office, but actually made it difficult for staff to see into the suites because they created a mirror effect. Only The Harbour had access to outdoor space, but this was a very small area with high walls.

- Home treatment teams

The home treatment teams saw some patients onsite, but most patients were visited in their own homes or at other venues such as GP surgeries. The teams were based in office buildings, which were typically shared with other community services. The teams we visited had a main reception and waiting area, and interview and meeting rooms that were shared with other community services. The rooms were clean, tidy and well maintained. Staff had access to an alarm system, and could call for help if required. There were clinic rooms for carrying out physical health assessment of patients. These were usually shared with the other community services. Staff told us that these were not regularly used by the home treatment teams.

- Crisis support units

Both crisis support units appeared clean and maintained. Environmental assessments had been carried out, and there were anti-ligature fittings in bathrooms and toilets. Access to kitchens and laundry rooms was supervised by or restricted to staff. The unit at Preston had private outdoor space. The Towneley unit was above ground floor and had no outdoor area. There were facilities for patients to lock away medication. Restricted items, such as mobile phone leads, were stored by staff.

Safe staffing

The information provided by the trust about the services they provided under this core service was inconsistent. We visited a sample of teams that came under the category of crisis and home treatment, but it was not possible to clearly link them with the information provided by the trust.

The staffing figures below do not include staff in the 136 suites, except the Harbour. The Harbour had a permanent staff team, but the other 136 suites were staffed as required by staff from the acute inpatients wards.

Definition

Substantive – All filled allocated and funded posts.
Establishment – All posts allocated and funded (e.g. substantive + vacancies).

Substantive staff figures			Trust target
Total number of substantive staff	At 31/07/2017	38	N/A
Total number of substantive staff leavers	01/08/2016–31/07/2017	1	N/A
Average WTE* leavers over 12 months (%)	01/08/2016–31/07/2017	2%	10%
Vacancies and sickness			
Total vacancies overall (excluding seconded staff)	At 31/07/2017	17.7	N/A
Total vacancies overall (%)	At 31/07/2017	27%	5%
Total permanent staff sickness overall (%)	At 31/07/2017	7%	4.5%
	01/08/2016–31/07/2017	7%	4.5%
Establishment and vacancy (nurses and care assistants)			
Establishment levels qualified nurses (WTE*)	At 31/07/2017	41.2	N/A
Establishment levels nursing assistants (WTE*)	At 31/07/2017	19.8	N/A
Number of vacancies, qualified nurses (WTE*)	At 31/07/2017	6.3	N/A
Number of vacancies nursing assistants (WTE*)	At 31/07/2017	8.8	N/A
Qualified nurse vacancy rate	At 31/07/2017	15%	5%
Nursing assistant vacancy rate	At 31/07/2017	45%	5%
Bank and agency Use			
Shifts bank staff filled to cover sickness, absence or vacancies (Qualified Nurses)	01/08/2016 - 31/07/2017	1297 (51%)	N/A
Shifts filled by agency staff to cover sickness, absence or vacancies (Qualified Nurses)	01/08/2016 - 31/07/2017	19 (1%)	N/A
Shifts NOT filled by bank or agency staff where there is sickness, absence or vacancies (Qualified Nurses)	01/08/2016 - 31/07/2017	127 (5%)	N/A
Shifts filled by bank staff to cover sickness, absence or vacancies (Nursing Assistants)	01/08/2016 - 31/07/2017	554 (45%)	N/A
Shifts filled by agency staff to cover sickness, absence or vacancies (Nursing Assistants)	01/08/2016 - 31/07/2017	30 (2%)	N/A
Shifts NOT filled by bank or agency staff where there is sickness, absence or vacancies (Nursing Assistants)	01/08/2016 - 31/07/2017	78 (6%)	N/A

*Whole-time Equivalent

This core service reported an overall vacancy rate of 15% for registered nurses at 31 July 2017. Across the 12 months (starting 1 August 2016) the vacancy rate for this core service was generally slightly below the trust wide rate. However, between April and May the rate was higher than the trust wide average at 28-29%.

The vacancy rate for registered nurses was lower than the 64% reported at the last inspection.

This core service reported an overall vacancy rate of 45% for registered nursing assistants. For seven of the 12 months the vacancy rate for nursing assistants in this core service was slightly below the trust average. However, it increased in March 2017 to 16% and remained above the trust wide average for the remainder of the period, peaking at 51% in May 2017.

The vacancy rate for nursing assistants was higher than the 0% reported at the last inspection.

This core service has reported a vacancy rate for all staff of 27% as of 31 July 2017; this cannot be compared to the last inspection. Across the 12 months (starting 1 August 2016) the vacancy rate for this core service steady at slightly below the trust wide rate. However, between April and July the rate was higher than the trust wide average, peaking at 37% in May 2017.

	Registered nurses			Overall staff figures		
Team	Vacancies	Establishment	Vacancy rate (%)	Vacancies	Establishment	Vacancy rate (%)
Towneley Unit CSU (25-65)	0.1	4.8	3%	1.9	9.6	20%
Mental Health Liaison Team (Fylde Coast) (25-65)	0.0	7.5	0%	0.0	7.5	0%
Crisis Resolution Home Team Blackpool (25-65)	0.0	13.7	0%	1.5	21.1	7%
Harbour - 136 Suite (25-65)	1.2	6.2	19%	3.4	12.4	27%
Mental Health Liaison Team (Chorley) (25-65)	0.0	4.0	0%	0.0	4.0	0%
Crisis Resolution Home Team Lancaster	-	0	-	-	0	-
Crisis Support Unit Preston	4.0	4.0	100%	9.8	9.8	100%
Crisis Resolution Home Team Central Mental Health	-	0	-	-	0	-
Crisis Resolution Home Team Burnley & Pendle	-	0	-	-	0	-
Crisis Support Unit Blackpool	-	0	-	-	0	-

Crisis Resolution Home Team West Lancs & Chorley	-	0	-	-	0	-
A&E Liaison - West Lancs	1.0	1.0	100%	1.0	1.0	100%
Crisis Resolution Home Team Blackburn, Hyndburn & RV	-	0	-	-	0	-
Core service total	6.3	41.2	15%	17.7	65.4	27%
Trust total	399.1	2330.8	17%	1408.5	6483.8	22%

NB: All figures displayed are whole-time equivalents

Between 1 August 2016 and 31 July 2017, bank staff filled 51% of shifts to cover sickness, absence or vacancy for qualified nurses.

In the same period, agency staff covered 1% of shifts for qualified nurses. 5% of shifts were unable to be filled by either bank or agency staff

		Shifts filled/unfilled by qualified nurses		
Team	Available shifts	Shifts filled by bank staff	Shifts filled by agency staff	Shifts NOT filled by bank or agency staff
CRHT - Lancaster	286	23	0	2
A&E Liaison - Lancaster	5	4	0	0
ATT - Lancaster & Morecambe - Start Team	24	0	0	0
ATT Lancaster & Morecambe - HTT Team	227	65	0	3
Preston CSU	5	3	0	5
ATT - Preston HTT Team	2	0	0	0
Pr.CRHT - Preston	281	167	0	2
A&E Liaison - Preston	88	85	0	3
TOWNELEY CSU - Blackburn	186	172	0	13
CRHT - Blackburn	178	149	0	1
A&E Liaison - East Lancs	111	23	0	0
East Lancashire ATT - HTTTeam	17	17	0	1

CRHT - Burnley & Pendle	145	141	0	6
A&E Liaison Fylde Coast	257	64	0	0
CRHT - Fylde Coast	274	53	0	4
ATT - Fylde Coast	1	1	0	1
Harbour - Suite 136	189	154	19	79
ATT - HTT Chorley & South Ribble	175	63	0	2
CRHT - Chorley	1	1	0	0
Chorley A&E Liaison	4	2	0	0
ATT - HTT West Lancs	110	110	0	5
Core service total	2566	1297 (51%)	19 (1%)	127 (5%)
Trust Total	25229	14495 (57%)	4469 (18%)	4384 (17%)

***Percentage of total shifts**

Between 1 August 2016 and 31 July 2017, 45% of shifts were filled by bank staff to cover sickness, absence or vacancy for nursing assistants. In the same time period, agency staff covered 2% of shifts. 6% of shifts were unable to be filled by either bank or agency staff.

Shifts filled/unfilled by nursing assistants

Team	Available shifts	Shifts filled by bank staff	Shifts filled by agency staff	Shifts NOT filled by bank or agency staff
CRHT - Lancaster	194	24	0	3
ATT Lancaster & Morecambe - HTT Team	91	14	0	3
Preston CSU	4	1	0	0
Pr.CRHT - Preston	5	3	0	0
TOWNELEY CSU - Blackburn	280	235	9	12
CRHT - Blackburn	4	4	0	0
A&E Liaison - East Lancs	32	30	0	2
A&E Liaison Fylde Coast	1	0	0	0
CRHT - Fylde Coast	164	25	0	2
Harbour - Suite 136	404	185	21	54
ATT - HTT Chorley & South Ribble	28	17	0	1
ATT - HTT West Lancs	16	16	0	1

Core service total	1223	554 (45%)	30 (2%)	78 (6%)
Trust Total	75152	31495 (42%)	2282 (3%)	3327 (4%)

***** Percentage of total shifts

This core service had 1 (2%) staff leaver between 1 August 2016 and 31 July 2017. This is lower than the 12.5% reported at the last inspection (for 6 months up to 30 April 2016).

Team	Substantive staff (across 12 months)	Substantive staff Leavers (across 12 months)	Average % staff leavers
Crisis Resolution Home Team Blackpool (25-65)	25.2	1	4%
Harbour - 136 Suite (25-65)	11.5	0	0%
Crisis Resolution Home Team Lancaster	2	0	0%
Crisis Resolution Home Team Central Mental Health	3.2	0	0%
Crisis Resolution Home Team Burnley & Pendle	1.5	0	0%
Crisis Resolution Home Team West Lancs & Chorley	3	0	0%
Crisis Resolution Home Team Blackburn, Hyndburn & RV	0.5	0	0%
Core service total	46.8	1	2.1%
Trust Total	6744.2	881	13.0%

The sickness rate for this core service was 7% between 1 August 2016 and 31 July 2017. The most recent month's data (July 2017) showed a sickness rate of 7%. This was comparable to the sickness rate of 7% reported at the last inspection in April 2016.

The sickness rate lay between 5% and 9% for this core service across the 12 months. In 10 out the 12 months, the rate was higher than the trust wide average, though never by more than two percentage points.

Team	Total % staff sickness (at latest month)	Ave % permanent staff sickness (over the past year)
Mental Health Liaison Team (Lancaster) (25-65)	0%	0%
ATT Lancaster & Morecambe (25-65)	7%	8%
Crisis Support Unit Preston	7%	7%
ATT Preston (25-65)	5%	6%
Mental Health Liaison Team (Preston) (25-65)	1%	2%
ATT Blackburn & Darwen (25-65)	5%	5%

Towneley Unit CSU (25-65)	8%	13%
AMH. Mental Health Liaison Team (Pennine Lancs) (25-65)	11%	6%
ATT Hyndburn, Ross & Ribble Valley (25-65)	5%	8%
Mental Health Liaison Team (Fylde Coast) (25-65)	0%	2%
Crisis Resolution Home Team Blackpool (25-65)	10%	9%
ATT Fylde & Wyre (25-65)	13%	3%
Harbour - 136 Suite (25-65)	2%	15%
ATT Chorley & South Ribble (25-65)	8%	5%
Mental Health Liaison Team (Chorley) (25-65)	15%	5%
ATT West Lancs (25-65)	12%	15%
Crisis Resolution Home Team Lancaster	-	0%
Crisis Resolution Home Team Central Mental Health	44%	9%
ATT Burnley & Pendle	0%	1%
Crisis Resolution Home Team Burnley & Pendle	-	1%
Crisis Resolution Home Team West Lancs & Chorley	0%	0%
Crisis Resolution Home Team Blackburn, Hyndburn & RV	-	0%
Core service total	7%	7%
Trust Total	6%	6%

The information provided by the trust about the services they provided under this core service was inconsistent. We visited a sample of teams that came under the category of crisis and home treatment, but it was not possible to clearly link them with the information provided by the trust.

- 136 suites

The Harbour had a permanent team of staff who worked in the 136 suite. The other 136 suites were staffed as required by staff from the acute inpatients wards. This was coordinated by the nurse in charge, or the duty senior nurse in the larger units. Patients in the 136 suites always had a member of staff with them, and this was usually a support worker or nurse from a ward. Staff told us that this placed additional pressure on the wards. The arrangements at each site varied, but additional staff were allocated or booked to cover the 136 suites. If additional support was required this depleted staffing levels on the wards. Staffing of the 136 suite was on the risk register for the suite in Ormskirk.

- Home treatment teams

The managers of the teams we spoke with told us they had no or low numbers of vacancies. Each of the home treatment teams had a mix of staff which included mental health practitioners (usually

band six nurses), nurses, social workers, occupational therapists, and support time recovery workers. There was access to psychology, but this was limited within the teams. This was due to posts being shared across more than one team, or long term absence. Staff told us they felt there was pressure on staff, particularly when there was staff sickness or absence.

- Crisis support units

The Towneley Unit was managed by a ward manager of one of the inpatient wards. The service was due to be provided by a third sector organisation in March 2018, which had been delayed from November 2017. This had led to a reduction in the permanent staffing of the unit. However, the staffing level of a band six nurse and a support worker was retained, by using permanent and bank staff. The crisis support unit in Preston was in a transition period from being provided by the trust, to being provided to the trust by a third sector provider. It was staffed by a manager and staff from the third sector provider, with staff from the trust who also covered the 136 suite. After the transition there would be no nursing staff based in either of the units, and access to nursing staff would be through the mental health liaison team.

Medical staff

Between 1 August 2016 and 31 July 2017, 869 shifts (100% of all shifts available) were filled by agency staff to cover sickness, absence or vacancy for medical locums.

- 136 suites

Staff told us they were able to access psychiatrists to carry out assessments in the 136 suites. There was a rota for psychiatrists both during the day, and out of hours.

- Home treatment teams

Patients were allocated a consultant psychiatrists based on the GP surgery they were registered with. This meant that teams had multiple psychiatrists working in their teams. Access to psychiatrists had been a problem in some of the teams we visited. The Lancaster assessment and treatment team had a three week wait for non-urgent appointments, and had placed this on their risk register. Another team had had a short-term backlog of appointments, which it addressed by having appointments on one site so that the psychiatrist could see more patients in one day.

Mandatory training

The compliance for mandatory and statutory training courses for the year which runs from 1 April 2017 to 31 March 2018 was 51% at the time the data was exported. Of the training courses listed, 11 are below the trust target, of those, all are below 75%.

Key:

Below CQC 75%	Between 75% & trust target	**Trust target and above**

Training course	This core service	Trust target %	Trustwide mandatory/ statutory training total %
Safeguarding Children Level 2	200%	85%	76%
Equality & Diversity	125%	85%	71%
Health & Safety	100%	85%	52%
Infection Control (Admin)	100%	85%	71%

Mental Capacity Act Level 1 (Clinical)	86%	85%	99%
Manual Handling Level 1	68%	85%	63%
Fire Safety	62%	85%	57%
Safeguarding Children Level 3	62%	85%	83%
Safeguarding Vulnerable Adults Level 1	57%	85%	83%
Infection Control (Clinical)	56%	85%	55%
Conflict Resolution	53%	85%	37%
Information Governance	44%	85%	42%
Immediate Life Support (ILS)	22%	85%	25%
Resuscitation (Basic Life Support)	20%	85%	27%
Manual Handling Level 3	17%	85%	41%
Manual Handling Level 2	0%	85%	40%
Safeguarding Children Level 1	None Eligible	85%	45%
Mental Capacity Act Level 1 (Admin)	None Eligible	85%	85%

The trust did not provide adequate assurance that staff had received the mandatory training specified by the trust. The information provided by the trust about the services they provided under this core service was inconsistent. We visited a sample of teams that came under the category of crisis and home treatment, but it was not possible to clearly link them with the information provided by the trust.

- 136 suites

The staff working in the 136 suites, except at The Harbour, were from the acute mental health wards, and their training was overseen through the acute wards. The staff we spoke with were unclear about specific training on section 136, but sessions had been provided by the Mental Health Act administrators. All the staff we spoke with were aware of the recent changes to section 136 with regards to the reduction in time patients should spend in the suite.

- Home treatment teams

We looked at training records for the specialist triage assessment team and the home treatment teams in three areas we visited. These showed that most staff were up to date with their mandatory training, which was consistent with feedback from staff and managers. Each of the three teams was over 89% compliant overall.

- Crisis support units

The Towneley Unit staff were managed and their training overseen by the manager of one of the inpatient wards. Staff at the unit in Preston were trust staff from the liaison team, or third sector organisation staff. At the time of our inspection, the service was going through a transition period, so there was no clear training information.

Assessing and managing risk to patients and staff

Assessment of patient risk

- 136 suites

The 136 forms included an initial risk assessment. This was completed by the police, ideally in discussion with staff in the 136 suite. This informed how long the police remained in the suite for, with them staying longer for higher risk or more violent patients. Nursing and medical staff carried out a detailed assessment of patients in the suite, which included risk.

- Home treatment teams

The team that people were referred to varied across the trust. Some areas had specialist triage assessment teams (START) that assessed patients and then referred them to the appropriate service for further support. This may be services provided by the trust, such as home treatment teams and Mind Matters for psychology, or services outside the trust. Other areas of the trust had assessment and treatment teams, which had a similar role but also provided short term interventions for some patients. All patients, whichever team they were referred to, had an initial assessment which included risk, and were triaged and referred on, where necessary, for further support and treatment.

The home treatment teams carried out enhanced risk assessments of patients, which were reviewed and updated regularly. This was clearly documented within the electronic care records. Formulations of patient's needs and plans of care were made in response to this.

- Crisis support units

Patients had a pre-screening assessment completed before they were accepted to the crisis support unit. Staff in both units were clear about the need for robust risk assessments, and their admission thresholds, in order to keep patients, staff and others safe. The purpose of the units was to provide short-term support (up to 23 hours), and not for patients who needed more intensive or longer term care, or who were detained under the Mental Health Act.

Management of patient risk

- 136 suites

Medical and nursing staff carried out a detailed assessment, which included risk, and tailored their care in response. For example, if a patient was considered to present a high risk of harm to themselves or others, additional staff may be provided to stay with the patient in the suite. The Harbour suite had an adjacent seclusion room, and there were occasions where patients in the other suites had been secluded because of their level of risk.

- Home treatment teams

There were no waiting lists for assessment or allocation to the home treatment teams that we visited. Assessments were usually carried out within a maximum of 48 hours, but usually sooner than this. Urgent assessments may be carried out the same day. Care plans were developed in response to the assessments, which included relapse indicators, triggers, and preventative factors. The frequency of visits was tailored to the patient's needs and level of risk. Patients were followed up if they missed an appointment, or could not be contacted.

The teams had lone working policies for staff. If the risks presented by a patient were high or unknown, then staff would visit in pairs, or arrange to meet the patient in a GP surgery or office. There were procedures for checking staff had returned from visits. The home treatment teams provided a 24 hour service. However, visits were usually only carried out during the day. In the evening, support was offered by telephone.

Safeguarding

A safeguarding referral is a request from a member of the public or a professional to the local authority or the police to intervene to support or protect a child or vulnerable adult from abuse. Commonly recognised forms of abuse include: physical, emotional, financial, sexual, neglect and institutional.

Each authority has their own guidelines as to how to investigate and progress a safeguarding referral. Generally, if a concern is raised regarding a child or vulnerable adult, the organisation will work to ensure the safety of the person and an assessment of the concerns will also be conducted to determine whether an external referral to Children's Services, Adult Services or the police should take place.

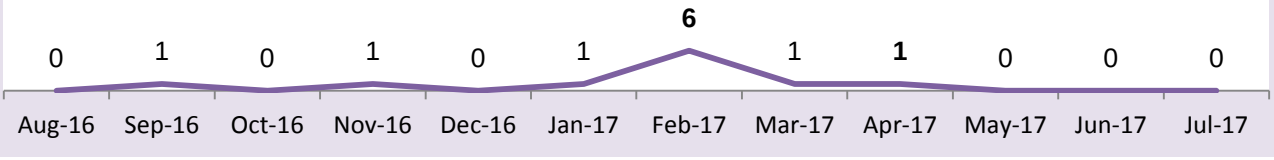
This core service made 11 safeguarding referrals between 1 August 2016 and 31 July 2017, of which six concerned adults and five children.

Referrals		
Adults	Children	Total referrals
6	5	11

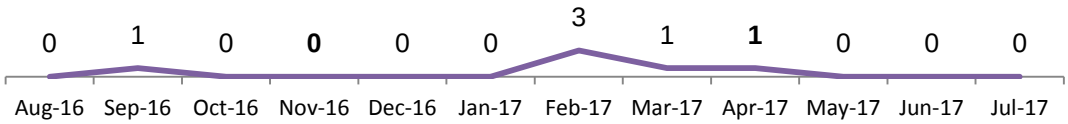
There was one peak identified in both adult and child referrals in February with three adult referrals and three child referrals respectively.

The trust had procedures for raising and acting upon safeguarding concerns. Staff were trained in safeguarding up to level two or level three. The staff we spoke with were knowledgeable about safeguarding issues, and how to respond to them. They provided examples of occasions when they had identified and acted upon potential safeguarding concerns. The trust had safeguarding leads that monitored safeguarding within the trust, and provided advice to staff.

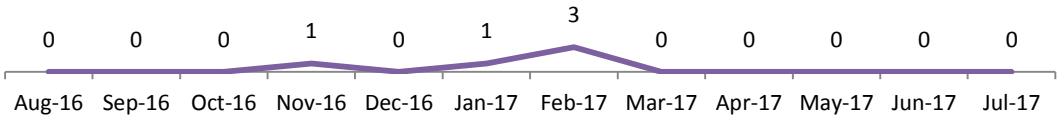
Total referrals (*01/08/2016 to 31/07/2017*)



Adult



Child



Lancashire Care NHS Foundation Trust has submitted details of five serious case reviews commenced or published in the last 12 months that relate to this core service.

The serious case review related to CCT and CRHHT Single Point of Contact. At the time of writing there is not yet a completed action plan for this serious case review.

Staff access to essential information

The trust had an electronic records system which all staff had access to. All staff had access to the trust's policies and procedures on the trust's intranet.

- 136 suites

The police initiated the detention of a person under section 136 of the Mental Health Act. They completed a paper 136 document, which followed the patient throughout their journey. The 136 documentation stayed with the staff who co-ordinated the 136 process (for example the duty nurse). When the patient left the suite (which could be several days after the section 136 had ended) the paperwork went to the Mental Health Act co-ordinator who put the information into the patient's electronic record. Entries were made on the electronic record throughout the patients stay in the 136 suite.

- Home treatment teams

Some staff in the home treatment teams had laptops or tablets that they could use to access patient's records remotely. However, this was sometimes difficult because of poor mobile phone reception in rural parts of Lancashire. Staff took account of this, and ensured they had the necessary information about patients with them.

Medicines management

- 136 suites

The trust had a policy on the administration of medication in the 136 suites. Medication was prescribed and dispensed from an adjoining ward. Information about a patient's medication was assessed when a patient first came into the suite. If the patient was there for some time, a full medication reconciliation was carried out in liaison with the patient's GP. If additional medication was required, for example if a patient was very agitated or aggressive, medication was prescribed and administered in accordance with the trust's policy.

- Home treatment teams

Staff at two of the home treatment teams we visited told us that they did not administer medication, but supported patients to take them. Staff at another home treatment team said they did administer medication. There was no medication stored in the medication cupboard on the day of our inspection. All teams had access to a medication cupboard, and routine checks were carried that ensured medication was stored and disposed of correctly. Staff in the assessment teams were did not manage or handle medication.

Medication was discussed and reviewed as part of the consultant psychiatrist's assessment and medical review of a patient. Psychiatrists prescribed medication when necessary. They prescribed using prescriptions that were administered through community pharmacies. The prescription pads were stored securely, and their use monitored.

- Crisis support unit

Staff did not administer medication to patients. Patients had a locker for storing their medication, which staff held the key to. Patients were expected to approach staff to obtain and take their medication, but would be prompted by staff if necessary. There were occasions when medication was initiated in the crisis support units, and patients were monitored by staff during the day. This was planned and enabled the patient to be monitored, whilst avoiding hospital admission.

Track record on safety

Providers must report all serious incidents to the Strategic Information Executive System (STEIS) within two working days of an incident being identified.

Between 1 August 2016 and 31 July 2017 there were 21 STEIS incidents reported by this core service. Of the total number of incidents reported, the most common type of incident was *Apparent/actual/ suspected self-inflicted harm* with 20.

A 'never event' is classified as a wholly preventable serious incident that should not happen if the available preventative measures are in place. This core service reported no never events during this reporting period.

We asked the trust to provide us with the number of serious incidents from the past 12 months. The number of the most severe incidents recorded by the trust incident reporting system was broadly comparable with STEIS.

The number of serious incidents reported during this inspection was higher than the 12 reported at the last inspection.

The team with the highest number of STEIS incidents was Access to Treatment Team (HTT) - Blackburn with Darwen with seven.

	Number of incidents reported		
Type of incident reported on STEIS	Apparent/actual/ suspected self-inflicted harm	Commissioning incident	Total
Access to Treatment Team (HTT) - Blackburn with Darwen	7		7
Access to Treatment Team (HTT) - Burnley & Pendle	1		1
Access to Treatment Team (HTT) - Hyndburn Rossendale & Ribble Valley	5		5
Access to Treatment Team (HTT) - Preston	3		3
Crisis Resolution Home Treatment Team (CRHTT)	4		4
Towneley Unit		1	1
Total	**20**	**1**	**21**

The information provided by the trust about the services they provided under this core service was inconsistent. We visited a sample of teams that came under the category of crisis and home treatment, but it was not possible to clearly link them with the information provided by the trust.

- Home treatment teams

Staff provided examples of serious incidents that had happened, and the changes that had been made in response to this. This included improvements to the electronic record system, and clarity about role of the mental health practitioner. These had made it clearer who was involved in a patient's care, and what actions needed to be taken, to prevent actions being missed.

Reporting incidents and learning from when things go wrong

The Chief Coroner's Office publishes the local coroners Reports to Prevent Future Deaths which all contain a summary of Schedule 5 recommendations, which had been made, by the local coroners with the intention of learning lessons from the cause of death and preventing deaths.

In the last two years, there have been no 'prevention of future death' reports sent to Lancashire Care NHS Foundation Trust regarding this core service.

The trust had systems for reporting, reviewing and investigating incidents. All incidents were reported and reviewed through the trust's electronic reporting system. Staff knew what needed to be reported and how to do this. Managers reviewed incidents, and information was sent to other managers and teams within the trust. Feedback following incidents was provided individually or through team meetings and trust-wide emails.

- 136 suites

Incidents in the 136 suites were recorded, but it was not easy to interrogate or analyse this information in electronic system, and identify patterns or trends. Any incidents that happened in the suites were logged under the adjoining ward, or the ward that the member of staff recording the incident happened to work on. In the electronic system, "136 suite" could be selected as a subcategory of a ward, but was at the same level as 'kitchen' or 'lounge'.

Is the service effective?

Assessment of needs and planning of care

- 136 suites

We looked at 30 records of patients who were or had been detained under section 136 of the Mental Health Act. They were completed appropriately and included a plan of care. All patients had an assessment of their mental state by a nurse and a doctor. Patients had further assessment for possible detention under the Mental Health Act or informal admission carried out when necessary. Patients who were waiting for a bed had a plan of care in their records, and there was evidence that action was taken to review their needs and request progress on finding a bed for the patient.

- Home treatment teams

We looked at a random sample of 14 patient records across four teams. All patients had a comprehensive health and social care needs assessment carried out. This was detailed and included mental and physical health, risks to self and others, medication, social and cultural issues, and family and carers. A formulation of needs was developed from this, and a plan of care documented. Care plans were sometimes a separate document, or were included in the assessment or daily record. The care plans were personalised and included the patient's views, strengths and goals. The patient was given or offered a copy of the care plan. Patient's physical healthcare needs were not always clearly recorded as part of the assessment. However, we saw that patient's physical healthcare needs were identified and responded to. Staff presumed that a patient had capacity to make decisions, so this was not always referred to in the record. We saw that where there were concerns about a patient's capacity a more detailed assessment was carried out.

There were plans of contact and interventions, with specific dates, which were routinely updated and followed up on. Discharge planning was included as part of the initial assessment, and included and followed up within the record of contacts with the patient.

Best practice in treatment and care

This core service participated in 1 clinical audit as part of their clinical audit programme 1 August 2016 – 31 July 2017.

Audit name	Audit scope	Audit type	Date completed	Key actions following the audit
Re-Audit – Domestic Abuse (Compliance 53%)	Inpatients with Adult Mental Health Service Users within Crisis Teams, A&E Liaison, Single Point of Access	Re-audit	31/01/2017	A steering group was formed to develop a local action plan to address the issues from the findings. A question was included within the enhanced and standard risk assessment to remind staff and capture details around routine enquiry.

The information provided by the trust about the services they provided under this core service was inconsistent. We visited a sample of teams that came under the category of crisis and home treatment, but it was not possible to clearly link them with the information provided by the trust.

- Home treatment teams

Staff told us they followed National Institute for Health and Care Excellence guidance in relation to anxiety and depression, and schizophrenia. Treatment and prescribing practices followed a recovery model, which aimed to support patients outside of hospital.

Patients had a comprehensive assessment carried out when they presented to the service, which included a physical health assessment. Staff monitored patient's physical health observations, such as blood pressure, during visits if this was necessary.

The service used the mental health care clustering tool to monitor patients at entry to and discharge from the service. This can be helpful for monitoring the progress of an individual patient, but is also used to make comparisons about general populations of patients across different services.

Staff told us they did not routinely use rating scales to monitor a patient's progress, but may use them with individual patients.

Skilled staff to deliver care

- Home treatment teams

Each of the home treatment teams had a mix of staff which included mental health practitioners (usually band six nurses), other nursing staff, social workers, occupational therapists, and support time recovery workers. There was access to psychology, but this was limited within the teams. This was due to posts being shared across more than one team, or due to long term absence in some teams. Patients who required psychological input were referred to Mind Matters, part of the government's improving access to psychological therapies programme.

The trust's target rate for appraisal compliance is 85%. As at 31 March 2017, the overall appraisal rates for non-medical staff within this core service was 29%.

All teams except ATT Blackburn & Darwen (25-65) (95%) failed to achieve the trust's appraisal target with rates between 0% and 58% across the other teams.

Team name	Total number of permanent non-medical staff requiring an appraisal	Total number of permanent non-medical staff who have had an appraisal	% appraisals
ATT Blackburn & Darwen (25-65)	21	20	95%
ATT West Lancs (25-65)	14	2	14%
ATT Hyndburn, Ross & Ribble Valley (25-65)	32	4	13%
ATT Chorley & South Ribble (25-65)	19	1	5%
ATT Lancaster & Morecambe (25-65)	16	0	0%
ATT Preston (25-65)	25	0	0%
Crisis Resolution Home Team Blackpool (25-65)	25	0	0%
ATT Fylde & Wyre (25-65)	5	0	0%
Harbour - 136 Suite (25-65)	11	0	0%

Crisis Resolution Home Team Central Mental Health	3	0	0%
Crisis Resolution Home Team West Lancs & Chorley	3	0	0%
Core service total	174	27	16%
Trust wide	6275	2053	33%

The information provided by the trust about the services they provided under this core service was inconsistent. We visited a sample of teams that came under the category of crisis and home treatment, but it was not possible to clearly link them with the information provided by the trust.

- 136 suites

The Harbour had a permanent staff team. The other 136 suites had staff allocated from the inpatient wards.

- Home treatment teams

Managers and staff at the sample of teams we visited told us their appraisals were up to date.

There are no medical staff within this core service.

- 136 suites

The 136 suites did not have dedicated medical staff. There was a rota for psychiatrists to assess patients in the suites.

The trust's measure of clinical supervision data is the number of sessions delivered.

Between 1 August 2016 and 31 July 2017 the rate across the three teams in this core service for which data was provided was 0%.

Caveat: there is no standard measure for clinical supervision and trusts collect the data in different ways, it's important to understand the data they provide.

Team name	Clinical supervision sessions required	Clinical supervision delivered	Clinical supervision rate (%)
Access to Treatment Team (HTT) - Preston	192	0	0%
Crisis Resolution Home Treatment Team (CRHTT)	20	0	0%
Towneley Unit	0	0	0%
Core service total	212	0	0%
Trust Total	17915	12753	71%

The information provided by the trust about the services they provided under this core service was inconsistent. We visited a sample of teams that came under the category of crisis and home treatment, but it was not possible to clearly link them with the information provided by the trust.

- 136 suites

Staff at The Harbour told us they received regular supervision. Staff in the other 136 suites received supervision through their primary role on the inpatient wards.

- Home treatment teams

Staff told us they felt supported by their teams and managers. However, the arrangements for and frequency of supervision varied across the teams. Some staff were very positive about the clinical and managerial supervision they received, but others said they had managerial supervision but no clinical supervision.

Multidisciplinary and interagency team work

- 136 suites

There was an overarching protocol for the use of section 135 and section 136 of the Mental Health Act across Lancashire. This was developed jointly and signed up to by the trust, other NHS hospital trusts, local authorities, ambulance services, and the police. The trust met with the other signatories to the protocol every quarter. The use of section 135 and 136, and any significant or recurring concerns was raised at this meeting.

- Home treatment teams

The multidisciplinary team was an inherent part of the home treatment teams which included nurses, doctors, occupational therapists and social workers. The teams linked with community mental health teams and third sector services. They liaised with the police and local authority safeguarding teams as necessary.

The assessment and treatment team in Lancaster was formed of mental health practitioners. The team had access to a range of occupational therapy and psychological assessments and interventions via the multi-disciplinary team. There were no routine multidisciplinary team, meetings, and this was on the risk register.

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

As of 31 July 2017, 0% of the eligible workforce had received training in the Mental Health Act Level 2. The trust stated that this training is non-mandatory for all core services for inpatient and all community staff and renewed every three years. No data was provided for Mental Health Act Level One training.

The information provided by the trust about the services they provided under this core service was inconsistent. We visited a sample of teams that came under the category of crisis and home treatment, but it was not possible to clearly link them with the information provided by the trust.

- 136 suites

The 136 suites were staffed by nurses and support workers from the acute wards. The exception to this was The Harbour, which had its own permanent group of staff. Staff training records were maintained by the ward managers. It was unclear if there was specific training on section 136 of the Mental Health Act. However, the staff we spoke with were familiar with the recent changes to the Act, and this was evident in the care records we looked at.

The 136 suites were mostly in accordance with the Mental Health Act and its code of practice. There was access to toilet facilities, but the showers were not always within the suites, or immediately accessible. Some of the suites did not have clocks, or entertainment, even though patients could be held in the suite for extended periods. Some patients had been taken out of the

suites into adjoining seclusion rooms. We were told that when this occurred, the seclusion procedures and paperwork were followed.

The Mental Health Act states that once a patient has been brought to a health based place of safety (a 136 suite) they cannot be held under section 136 for more than 24 hours. Information provided by the trust showed that since the 11 December 2017 there had been 11 breaches of the 24 hour limit across five of the sites, with none at Preston. Patients who remained in the suites after this time period, were not detained under the Mental Health Act, and must either agree to be there or are held in their best interests. The shortest breach was by 25 minutes, the next was six hours over the 24 hour limit, and the remainder were above this with the longest being over 181 hours (over 7 days). For patients who had been to an accident and emergency department or a police station before coming to the 136 suite, there were six breaches, ranging from just over three hours to 133 hours (over 5 days). However, this information did not include a breach at Ormskirk that we saw the records for, or for breaches we were made aware of in the suites at the time of our inspection. All patients who were in the 136 suites for over 24 hours were awaiting an inpatient bed. Some patients had agreed to informal admission, and others had two medical recommendations for detention under section 2 or section 3 of the Mental Health Act, and were waiting for a bed to become available before a final assessment by the approved mental health professional. An approved mental health professional cannot complete the application for a patient to be detained under the Mental Health Act until a bed has been identified.

- Home treatment teams

The Mental Health Act was not included as part of mandatory training for crisis or home treatment teams. Social workers or approved mental health professionals had separate training for this role through the local authority.

Staff were aware of the Mental Health Act, and the recent changes to section 136 timescales. There were approved mental health professionals within the teams, who were involved in Mental Health Act assessments for any patient, not just those seen by the home treatment teams. The consultant psychiatrists were section 12 approved (under the Mental Health Act), and were usually the first contact for patients who were out of area, and did not have a consultant within the trust, or a GP within its catchment area. In these situations, the consultant psychiatrist may complete the first medical recommendation for detention under the Act. Staff told us they may be involved in supporting patients subject to a community treatment order under the Mental Health Act; but this was not common as these patients were usually engaged with the community mental health teams. If a patient was in the process of being detained under the Mental Health Act but was waiting for a bed, then the home treatment teams may support them until a bed was found.

Good practice in applying the Mental Capacity Act

As of 31 July 2017, 86% of the eligible workforce had received training in the Mental Capacity Act Level 1 (Clinical). No admin staff were stated to be eligible for Mental Capacity Act training

No staff within this core service were reported as eligible for Mental Capacity Act Level 2.

The trust stated that this training is non-mandatory for all core services for inpatient and community staff and this training is renewed every three years.

- 136 suites

Patients had their capacity assessed, but the documentation of this varied in quality and detail. Some of the records included very brief assessments, with statements that the person either had capacity or didn't with limited detail. However, some assessments were detailed, and clearly showed that the staff member had thoroughly assessed the patient's understanding and capacity to consent, and followed the key principles in order to make a judgement about the patient's capacity. Some of the records included reference to providing care in a patient's "best interest" but the discussion supporting this wasn't always clear. Patients waiting for a bed were held in the section 136 suite after the section 136 had lapsed. Staff were aware that the patient was no longer detained, and had them assessed at the point the 136 lapsed, and again if the patient said they wanted to leave. There were occasions when a patient may wish to leave, for example to go for a cigarette or a walk, but they were persuaded not to.

- Home treatment teams

All patients had their capacity assessed as part of their overall assessment, though no specific tools were used to record this. Staff told us that if there were any particular concerns about a patient's capacity, then they would discuss this with the rest of the team, and particularly the consultant psychiatrist. If a patient did not want to engage with the team, they would assess the risks, and the person's capacity, and withdraw if appropriate. Staff gave some examples where a patient had been assessed as capacitous, even though other people thought they were making poor decisions. Staff told us they were aware of the Mental Capacity Act and best interest, but Deprivation of Liberty Safeguards or formal best interest processes were not usually relevant to the patients they worked with.

Is the service caring?

Kindness, privacy, dignity, respect, compassion and support

We had limited opportunities to speak with patients or observe care during this inspection.

- Crisis support units

Interactions we observed between staff and patient in the crisis support units were positive and respectful.

Involvement in care

- Home treatment teams

Patients were provided with information about the service at their initial assessment. They were sent a letter describing who their team was, and a welcome pack. This included information about the services available, how to access advocacy services and how to make a complaint.

Involvement of patients

Managers told us that patients were not directly involved in the development of the service. This was due to patients tending to be engaged with the service for a short period of time whilst they were in crisis or acutely unwell.

- Home treatment teams

Care plans were holistic and person centred, and took account of their views. Care records showed that patient's views were included in their care plans, and that they were individualised and tailored to the individual, taking account of their needs. Staff told us that although they followed up patients who missed appointments, patients had to want to engage with the service.

Involvement of families and carers

- 136 suites

We looked at 14 feedback forms in two of the 136 suites, and they were generally positive. We asked the trust for friends and family information for the 136 suites. They told us that this was not reported.

- Home treatment teams

The care records showed involvement of families with the permission of the patient, and reflections of their views.

We asked the trust for feedback from friends and family test for the crisis and home treatment teams. We were told that there was no data available for the Blackburn, Hyndburn and Ribble Valley CRHTT or the Burnley, Pendle and Rossendale CRHTT. We received results for four teams. The number of responses ranged from nine to 185. The combined result ranged from 80.88% to 97.78% positive feedback.

Is the service responsive?

Access and waiting times

Data on waiting times was not provided for this core service (in the PIR).

136 suites

The 136 suites did not have waiting lists. They were available 24 hours a day, and their use was co-ordinated by the central bed hub. When the police had detained a patient under section 136, they contacted the bed hub, who identified where the nearest empty suite was.

There were no explicit restrictions on patients who had used drugs or alcohol coming to the suites, provided staff were able to carry out a mental health assessment. If there were concerns about a patient's physical health, the police were expected to take the patient to the accident and emergency department first.

Home treatment teams

There were no waiting lists for the specialist triage assessment teams and home treatment teams we visited. All referrals were reviewed by the specialist triage assessment teams. They assessed the patient and referred or signposted them to appropriate services where necessary, which included the home treatment teams. The specialist triage assessment teams were available during the day. The home treatment teams took over their role in the evening and during the night. Non urgent referrals were triaged and left for the specialist triage assessment teams to follow up the following day.

The home treatment teams provided a 24 hour service. Staff carried out visits during the day, but these stopped in the early evening. During the evening and overnight there was one member of staff available who provided telephone support to patients.

The mental health liaison teams saw people in accident and emergency departments, and on inpatient wards in acute hospitals. If the liaison nurses thought a patient was suitable for the home treatment team they would refer them for assessment. In the services we visited, the home treatment teams did not assess patients on the mental health wards. If a patient could be discharged from a mental health ward with the support of the home treatment team, a referral would be made through the specialist triage assessment teams.

The home treatment teams completed gatekeeping statements. These state why the home treatment team is not suitable for a particular patient at that time, and why they may need admission to hospital. All inpatients should have a gatekeeping statement, to show that alternatives to admission have been considered, unless they have been transferred between wards. Mental health liaison nurses completed gatekeeping assessments for the patients they assessed.

A central bed hub managed the allocation of beds across the trust. The home treatment teams were an alternative to admission, but they were not part of the bed management process. The central bed hub was not involved in allocations to the home treatment teams, and the home treatment teams were not part of the routine phone calls and reviews of the availability of beds. The teams were represented on the calls by the service managers. Staff in the home treatment teams told us that they may support a patient whilst they waited for a hospital bed. The home treatment teams also carried out follow ups of patients 48 hours after discharge, if they did not have a care co-ordinator.

Patients may be seen for up to three months by the home treatment teams and assessment and treatment team. This may be extended if a patient was waiting for allocation to another service.
Care records showed that patients were given flexibility when making appointments. If appointments needed to be cancelled or rescheduled staff carried out a risk assessment, prioritised appointments, and contacted the patient. Staff followed up patients who missed appointments.

Staff at the Lancaster assessment and treatment team told us that there was a gap in provision for 16-17 year olds. In Lancaster, child and adolescent mental health services discharged patients at age 16. These patients can then contact the assessment and treatment team, but they could only offer an assessment and then referral to MindsMatter for psychologically based therapies. However, the local MindsMatter service had a waiting list of 33 weeks. There was no other provision for child and adolescent services within the assessment and treatment service. It was not clear if this was a problem in other areas of the trust.

Crisis support units

Staff told us that access to the units varied. There were no waiting lists, but if they were full then they couldn't accept patients. At the time of our inspection there were places available in both units.

The facilities promote comfort, dignity and privacy

136 suites
The trust had eight 136 suites across six sites, which were all physically different. The suites were generally adequate, but did not meet all the recommendations of the Mental Health Act code of practice. Five of the suites were adjoined to acute mental health wards. The Harbour suites were the only self-contained facility. Some of the suites had televisions and seating areas. The Preston suites had a room for families to sit in. However, this only had beanbags to sit on which may not be comfortable for adults. Some of the suites had limited entertainment or diversional activities for patients. However, we saw that if patients were in the suites for extended periods they had spent time on adjoining wards, or could access the open activity programme. There was access to food and drink for patients in the suites.

Home treatment teams

The home treatment teams saw some patients onsite, but most patients were visited in their own homes or at other venues such as GP surgeries. The teams were based in office buildings, which were typically shared with other community services. The teams we visited had a main reception and waiting area, and interview and meeting rooms that were shared with other community services. The rooms were clean, tidy and well maintained.

Crisis support units

The purpose of the crisis support units was to provider immediate support to patient for a short period of time (up to 23 hours). As such, there were no beds in the crisis support units, as they not expected to stay for an extended period of time. Patients were provided with a reclining chair, in a room with up to five other male and female patients. The chairs were in a lounge area in both units, and faced the television. The chairs were comfortable, and may be adequate for sitting in and watching television or having a short sleep. However, they were not suitable for sleeping in for extended periods. Staff in the Preston unit showed us an alternative room that up to two reclining chairs could be moved into overnight, for example if some patients did not want to sleep in the main lounge with all the other patients.

At the time of our inspection there were two patients in the crisis support unit at Preston who had been there for over five days. Records showed that since the 18 December 2017, 36 patients had been accepted into the unit, and nine of these had been there because they were waiting for a bed. The unit's standard operating procedure allowed for up to three patients to be in the unit because they were waiting for an inpatient bed. Of the nine patients who had been waiting for a bed in Preston, there was no information about duration of stay for one patient, but only one of the remainder had left within the 23 hour timeframe. Of the remainder one patient was there for 39 hours, with the rest between 71 and 114 hours. This meant that patients had been sleeping in reclining chairs for three to five days. At the time of our inspection, there were two patients in the Towneley Unit who had been there over 23 hours. Staff said patients were made aware before they came into the unit that there were reclining chairs, and no beds.

The shower room in the Preston crisis support unit adjoined a former bedroom, now an empty room, with a close circuit television camera from the corner of the room into the shower. Staff told us that they could not see any feed from that camera on, and that they reminded patients to close the door when showering. The grouting around the walk-in shower was cracked and mouldy in places. Toiletries were stored in a set of office drawers in the room. There was a note on the door saying the lock was broken.

There were kitchen facilities in the crisis support units, and a choice of refrigerated ready-made meals that could be heated for patients at any time. Vegetarian meals were available, and staff told us other diets such as halal and kosher could be ordered if required. Bread, milk and other snacks and drinks were available for patients. The kitchens were staff-only, but drinks were placed in the communal areas, and patients could ask staff for food when required. Checks carried out in the kitchen of the fridge and food temperatures, showed that food was stored and reheated safely.

Laundry facilities were available for patients. Patients were allowed their own mobile phones in the unit.

There were no planned activities on the crisis support units. However, staff worked with patients, and there was an open activity programme staff patients could access from the Towneley Unit.

Patients' engagement with the wider community

Not applicable.

Meeting the needs of all people who use the service

The 136 suites were accessible for people in a wheelchair. The offices in which the home treatment teams were based were accessible by people in a wheelchair.

Staff told us that interpreters were available when needed, and that this would usually be face-to-face and not through a telephone interpreting service. Information was available for patients, but this was not always on display. Staff told us that information could be provided in languages other than English if required. The 136 suite and the crisis support units provided food for patients throughout their stay. Meals were available that for people who required special diets, such as vegetarian or halal.

Listening to and learning from concerns and complaints

This core service received 66 complaints between 1 August 2016 and 31 July 2017. The most commonly received complaints across the core service related to:

- Communications (24)
- Access to treatment or drugs (9)
- Clinical Treatment (6)

Ward	Type of incident reported	Total
Access to Treatment Team (HTT) - Preston	Patient Care including Nutrition / Hydration (1)	1
Crisis Resolution Home Treatment Team (CRHTT)	Communications (2) (blank) (1)	3
ATT Blackburn & Darwen (25-65)	Access to treatment or drugs (1) Admissions, discharges and transfers excluding delayed discharge due to absence of care package (1) Clinical Treatment (1) Communications (3) (blank) (1)	7
ATT Hyndburn, Ross & Ribble Valley (25-65)	Waiting Times (1)	1
Harbour - 136 Suite (25-65)	Admissions, discharges and transfers excluding delayed discharge due to absence of care package (1) Appointments including delays and cancellations (1) Commissioning Services (1) Privacy, dignity and wellbeing (2) Waiting Times (1) (blank) (2)	8
ATT Chorley & South Ribble (25-65)	Access to treatment or drugs (1) Communications (1) Other (1)	3
Mental Health Liaison Team Blackburn (Adult)	Clinical Treatment (1)	1
OLD-Crisis Resolution Home Treatment Team (CRHTT)	Access to treatment or drugs (6) Clinical Treatment (3) Commissioning Services (1) Communications (16) Integrated Care including delayed discharge due to absence of care package (1) Other (2) Patient Care including Nutrition / Hydration (1) (blank) (1)	31
Towneley Unit	Access to treatment or drugs (1) Admissions, discharges and transfers excluding delayed discharge due to absence of care package (2) Clinical Treatment (1) Communications (2) Other (1) Privacy, dignity and wellbeing (1) Waiting Times (3)	11

Total	66

The information provided by the trust about the services they provided under this core service was inconsistent. We visited a sample of teams that came under the category of crisis and home treatment, but it was not possible to clearly link them with the information provided by the trust.

This core service received 281 compliments during the last 12 months from 1 August 2016 to 31 July 2017 which accounted for 3% of all compliments received by the trust as a whole.

- 136 suites

Information about how to make a complaint was available for patients. Staff told us there had been complaints about patients waiting for several days for a bed.

- Home treatment teams

Staff were aware of the complaints process. There was information available for patients on how to make a complaint. Staff told us that information about complaints was shared individually or in team meetings. Managers gave examples of complaints, which included patients being unhappy at seeing lots of different staff, or information not being communicated effectively with other organisations.

- Crisis support units

Staff were aware of the complaints process. There was information available for patients about how to make a complaint.

Is the service well led?

Leadership

136 suites
The Harbour had a dedicated staff team which included a manager. There was no dedicated manager of the other 136 suites. Management of the other suites was aligned with the adjoining ward, or rotated amongst inpatient wards.

Home treatment teams
There was clear leadership within the specialised triage and assessment teams, assessment and treatment team, and home treatment teams we visited. A manager oversaw the specialised triage and assessment teams and home treatment teams, who had their own team leaders and deputies. The teams were undergoing a period of restructuring and transition which raised uncertainty for staff.

Managers told us they generally felt supported by the trust. They told us there was support from the human resources department for working through staff related issues such as sickness and disciplinary procedures. The key pressures they identified were staffing levels, access to inpatient beds within the trust (even though they did not work directly with bed management), and local issues such as reconfiguration of the service.

The crisis support units were going through a transition period, which led to uncertainty for staff. The unit at Blackburn was managed by a ward manager of one of the inpatient wards, but this was due to change when it was taken over by a third sector provider. The unit at Preston was managed by a third sector provider, but was in transition and jointly provided by the trust. The units were due to be fully staffed and managed by a third sector provider from April 2018.

Vision and strategy

Staff were aware of the trust's values which were:

- Teamwork - share it
- Compassion - offer it
- Integrity - show it
- Respect - earn it
- Excellence - reach for it
- Accountability - accept it.

Staff told us that the values were on display across the trust, including on the intranet pages. The staff we spoke with believed that their teams reflected the trust's values.

Culture

No staff recorded as suspended or supervised for this core service

- Home treatment teams

Most staff we spoke with were positive about the team they worked with and the service they provided. They generally felt supported by local managers, but found corporate managers less visible. Their main concerns were about the pressure put on them due to the increase in patient

acuity, and a perceived lack of staff to deal with this. Staff generally felt able to speak out and raise their concerns.

- Crisis support units

The crisis support units were due to have been provided by a third sector organisation in November 2017, but this had been delayed to March/April 2018. This had led to uncertainty about the service, and amongst staff during this transitional period.

Governance

The trust was unable to provide a definitive list of teams that fitted within this core service. There was not a clear structure for reporting, which included supervision and incidents in the 136 suites. The information provided did not directly reflect the information that we gathered during our inspection. Other information submitted by the trust, such as training and supervision, was incomplete or was inconsistent as it did not include the same teams.

The availability of inpatient beds impacted on this core service. The bed management process was managed centrally by the bed hub. The crisis support units and home treatment and related teams were identified as alternatives to admission, staff from these services were not directly involved in the daily bed management processes. The breach of the 24 hour deadline for patients in the 136 suites, and patients staying in reclining chairs beyond the 23 hour trust deadline in the clinical support, was attributable to their not being an inpatient bed available for these patients.

There were generally enough staff to provide safe services to patients. Staff on the acute wards provided care in all but one of the 136 suites. Although an additional staff member was resourced for this, additional or short notice staffing depleted the acute wards.

Incidents were reported, investigated and learnt from in the home treatment teams. However, there was no clear way of monitoring and analysing information across the 136 suites.

There were effective arrangements for working with other teams and agencies within and outside the trust.

There were effective systems for cleaning and maintaining the premises in which patient were seen.

Management of risk, issues and performance

The trust has provided documents detailing their highest profile risks. Those with a score of 15 or above are classified as High. The following relates to this core service.

The funding of the three-shift staffing model was identified as a high risk (16), the risk score has been reduced to moderate (12) with a target risk level of 8.

Key:

High (15-20)	Moderate (8-15)	Low 3-6	Very Low (0-2)

Opened	ID	Description	Risk level (initial)	Risk score (current)	Risk level (target)	Link to BAF strategic objective	Last review date

						no.	
07/10/15	6906	The three-shift staffing model at the Harbour has not been funded by commissioners.	16	12	8	-	29/09/17

The information provided by the trust about the services they provided under this core service was inconsistent. We visited a sample of teams that came under the category of crisis and home treatment, but it was not possible to clearly link them with the information provided by the trust.

Managers were able to add items to their local risk register, or were aware of the items on it. For example, the staffing of the 136 suite at Ormskirk was on the local risk register. Another manager identified that although it was not on the risk register, there was a concern about having multiple record systems between the trust, the GP services, and the improving access to psychological therapy systems. Staff in the Lancaster assessment and treatment team told us that there could be waits of up to three weeks to see a psychiatrist, and this had been put on the risk register.

Information management

Staff were able to access care records and information about patients when required. Any paper records were scanned onto the electronic records system. Staff had access to patient's electronic records, so they could access information about previous contact with the trust.

- 136 suites

Section 136 documentation was paper based, and this travelled with the patient. The police completed the initial documentation, and this was then handed over to staff in the 136 suite. Throughout the 136, and afterwards where necessary, the paperwork was held by either the duty nurse or the nurse managing the suite. When the patient left the 136 suite the paper documentation was given to the Mental Health Administrator, who either entered or scanned the information into the electronic care record. Entries were also made into the electronic care record about the patient's care in the suite.

- Home treatment teams

Staff had access to electronic records in the office, and had a tablet or laptop to access records remotely. However, this was sometimes problematic due to poor mobile phone signals in rural areas.

Engagement

Information about the trust was available on the trust's public website, and through information leaflets available across its services. Staff also had access to information about the trust, including its policies and procedures, through the trust's intranet.

Information on the website and around the trust encouraged patients and carers to contact the trust if they had a complaint or a compliment about the service. We asked the trust for feedback from friends and family test or other feedback for the crisis and home treatment teams. We were told that there was no data available for the Blackburn, Hyndburn and Ribble Valley CRHTT or the Burnley, Pendle and Rossendale CRHTT. We received results of the friends and family test for

four teams. The number of responses ranged from nine to 185. The combined result ranged from 80.88% to 97.78% positive feedback.

Learning, continuous improvement and innovation

NHS Trusts are able to participate in a number of accreditation schemes whereby the services they provide are reviewed and a decision is made whether or not to award the service with an accreditation. A service will be accredited if they are able to demonstrate that they meet a certain standard of best practice in the given area. An accreditation usually carries an end date (or review date) whereby the service will need to be re-assessed in order to continue to be accredited.

The crisis services are currently not accredited.

There was no research being carried out in the services we visited.