

Lancashire Care NHS Trust

Evidence appendix

Sceptre Point
Sceptre Way, Walton Summit
Preston
Lancashire
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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 23 locations registered with the CQC (on 28/05/2019).

Registered location	Code	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
Chorley and South Ribble Hospital	RW5DA	Lancashire
Clitheroe Hospital	RW5QM	Lancashire
Darwen Health Centre	RW5RC	Blackburn with Darwen
Dental Care Calderstones Hospital	RW5Y5	Lancashire
Guild Lodge	RW5ED	Lancashire
Longridge Hospital	RW5AQ	Lancashire
Mental Health Decision Unit North, Blackpool Victoria Hospital	RW5X1	Blackpool
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	RW5NE	Lancashire

The trust had 518 inpatient beds across 40 wards, 18 of which were children's mental health beds. The trust also had 695 acute outpatient clinics and 301 community mental health clinics per week.

Total number of inpatient beds	518
Total number of inpatient wards	40
Total number of day case beds	0
Total number of children's beds (MH setting)	12
Total number of children's beds (CHS setting)	0
Total number of acute outpatient clinics per week	695
Total number of community mental health clinics per week	301
Total number of community physical health clinics per week	0

The methodology of CQC provider information requests has changed, so some data from different time periods is not always comparable. We only compare data where information has been recorded consistently.

Is this organisation well-led?

Leadership

The trust's board of directors was made up of six executive directors and six independent non-executive directors in addition to the chief executive and chair. The chief executive was relatively new to the trust having commenced in post on 1st April 2019. Prior to this, the new chief executive had been the chief executive of another NHS trust. The chair had been in post since June 2016.

The executive directors included a director of nursing and quality, an executive director of operations, a director of workforce and organisational development, a chief financial officer, a director of strategic development and a medical director.

There had been a significant number of changes at board level within the trust since the appointment of the new chief executive. There had been an interim director of nursing and quality in post for over a year. This post had recently been appointed to and the new director of nursing and quality was due to commence in post in September 2019. The medical director retired in April 2019 and there had been an interim medical director in post since. The role of chief operating officer had been split into a director of strategic development role and an executive director of operations to strengthen the executive capacity. The director of strategic development officer had recently retired. There was a new acting executive director of operations who had been seconded into post from another NHS trust a month prior to the inspection and the previous director of operations had recently been appointed to the new director of strategic development post. The chief executive told us they had also created a new director for improvement and compliance post and a director for communications post which they were recruiting to over the coming weeks to further strengthen the executive capacity. Of these board members, two were women although this would increase to three with the appointment of the new director of nursing and quality.

The trust had 22 governors made up of elected members of the public, staff and people that had been nominated by partner organisations.

Two of the six non-executive directors had been appointed since our last inspection. 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 equality and diversity lead told us they had engaged in creative recruitment campaigns within local community groups in addition to more traditional routes to improve the diversity within the group and this had led to the recent appointment of a non-executive director member from a black, minority ethnic background. Four of the six members were women. One of the non-executive directors had responsibility for the oversight of the associate hospital managers.

The non-executive directors had diverse backgrounds within the nursing, legal and financial professions in addition to the housing, voluntary and private and public business sectors up to board level.

The trust reviewed the senior leadership capacity and capability on an ongoing basis and when vacancies arose.

The new chief executive was well sighted on the current challenges which the trust faced. They told us they had prioritised the development of a senior leadership team which they were confident had the appropriate range of skills, knowledge and experience to support them in making the improvements and changes needed. To provide assurance that this was the case or to identify any potential gaps, the chief executive had commissioned an external independent well led review which was due to be completed shortly after the CQC inspection. They explained they had commissioned the review to provide a rigorous assessment of the trust board and senior leadership capabilities and capacity in addition to a review of the functionality of the governance structure including the board committee and sub committees which fed into the board.

All the board members we spoke with demonstrated a motivation and commitment to supporting the chief executive within their roles to drive the improvements and changes needed. The trust board and senior leadership team displayed integrity on an ongoing basis. Senior leaders, staff, the non-executive directors and stakeholders we spoke with were unanimous in their views that the changes to the board were necessary and this had resulted in a collective sense of optimism that improvements would be made and embedded.

The board meeting and a quality committee we attended were well planned, attended and chaired.

Members of the board demonstrated collective accountability, transparency and integrity within the meetings. The board members had a comprehensive, consistent understanding of the key priorities and challenges faced by the trust and were able to identify progress made against these and where little or no progress had been made. We observed board members providing respectful, appropriate challenge to other members when clarity or further assurance was sought regarding a particular issue. However; in the board meeting minutes we reviewed and focus groups and interviews we held, there was evidence that some of the non-executive directors had expressed some frustration and concerns in relation to the pace of change and limited/lack of evidence provided in relation to addressing all the actions within the CQC action plan which the trust had developed following our last inspection. This meant the board did not have assurance that existing breaches in regulation following our last inspection had been met and sufficient improvements had been made.

Commissioners told us they felt the board had lacked an understanding of the mental health key issues within the trust and how to resolve them previously. This was evidenced in the quality oversight committee meetings which had been set up following our last inspection which were attended by a range of stakeholders, commissioners and trust leaders. In the meetings, trust leaders were not always able to provide assurance that some key issues had been addressed effectively.

The board had been aware of the significant blockages throughout the entire acute care pathway since our last inspection which meant it was not functioning effectively or meeting the needs of patients.

A risk summit of system leaders and regulators took place in April 2018 and a mental health improvement plan was agreed. Commissioners provided additional resources to support the improvement plan and leaders of the integrated care system agreed to support a review of the urgent care pathway in Lancashire which was led by a neighbouring NHS trust. The review was not completed until April 2019 although the review leader took the step of escalating concerns the visiting clinical team had found to the chief executive of the trust at the beginning of December 2018.

The concerns raised included:

- Patients waiting in 136 suites who have been staying there for more than seven days.
- Delays in accessing beds for patients who have medical recommendations in place for detention under the Mental Health Act.
- Patients potentially being held against their will in the 136 suites without appropriate legal provision under a section of the Mental Health Act.
- Band 5 nurses with less than 2 years' experience being in sole charge of wards.
- Patients not being allocated a trust care co-ordinator when their social worker care co-ordinator transfers back to the local authority over Christmas.

The reviewer lead recommended that the trust investigated these issues and concerns and took appropriate action urgently.

Although we found that sufficient improvements had made within the in-patient child and adolescent mental health ward since our last inspection, we still had significant concerns in relation to:

- The continued breaches in the 136 suites.
- Patients being held without legal authority in the 136 suites.
- Significant delays in accessing an in-patient bed for patients who had medical recommendations in place for detention under the mental health act.
- The functioning and privacy and dignity issues in relation to the mental health decision units.
- Significant lengths of stay patients had in the mental health decision units beyond the 23 hours scope as detailed in the statement of purpose.
- Significant waiting lists within the community mental health teams.
- A number of safety issues within the acute wards for adults of working age and psychiatric intensive care units.

These issues had not been resolved since our last inspection, however; there was evidence the trust had taken action to address some of the issues. The trust had commissioned the provision of 22 additional beds within Preston provided through a contract with a private provider. They had also completed a Hurst staffing review for inpatient services which had resulted in the board agreeing further investment of £3m for 82 extra qualified staff and additional investment for community teams to recruit 21 extra care coordinators. A recruitment drive was underway to fill these additional posts however; at the time of inspection, most of these posts had not been

recruited to. This meant the investment had little impact on these services although staff were optimistic that it would when the posts were filled.

The lack of progress in ensuring the acute care pathway functioned effectively, demonstrated the board and senior leadership team had failed to take effective action to address the issues we identified following our last inspection.

On 01 May 2019, the trust was categorised as being 'offered 'targeted support' by the NHS Improvement Single Oversight Framework. Since our last inspection, a monthly mental health quality oversight committee had been set up with membership from NHSE, NHSI, stakeholders, commissioners and regulators to develop a whole system strategy for mental health across the integrated care system.

Relationships between the trust, GP's, the local authority, police and local acute trusts had become strained since our last inspection largely due to the issues with capacity and flow within the trust which was having a negative impact on these third-party providers. This was acknowledged in the Lancashire urgent mental health pathway review final report, dated May 2019 and a CQC thematic review report which was shared with the trust on 8 May 2019 which reviewed the 136 MHA pathway in Blackpool.

However, since the publication of the reviews, the new chief executive had successfully engaged with all the third sector providers and commissioners identified in the Lancashire urgent mental health pathway review as being instrumental in developing the pathway. This had resulted in all the parties signing up to the plan and agreeing clear actions to meet the recommendations specific to their service which were identified within the report. This included commissioners, police, acute sector, ambulance service, local authority, voluntary, community and the faith sector.

Whilst the review acknowledged that improvements needed to be made by the trust which was their responsibility to achieve, it also identified that actions also needed to be taken by other stakeholders and commissioners to support the whole care pathway redesign across the mental health and learning disability services within the footprint. For example, the report identified that the lack of rehabilitation and learning disability beds and lack of 24/7 crisis response within the trust was having a significant impact on flow and capacity and patients experience.

Commissioners told us they felt the nursing leadership had been strengthened since our last inspection with the appointment of the interim director of nursing, deputy director of nursing and recent appointment of the heads of nursing within the three clinical networks. They said this change had accelerated over the past 8 to 9 weeks and they had noted a significant change in the culture of the organisation with staff reporting they felt more empowered and supported by managers and senior leaders within the trust. Commissioners had recently attended a leadership day with 80 staff who told them there had been a culture of bullying in the past but that this was no longer the case with the recent changes and the appointment of the new chief executive. This reflected the positive change in culture which staff at all levels described to us through interviews and focus groups we held within the core services we inspected and as part of the well led inspection.

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.

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 all the directors in the trust in line with the fit and proper person requirements. We found the trust was mostly meeting these requirements with the exception of evidenced based competency interview documentation not being present in four of the files and an up-dated disclosure and barring check was not in place when an existing director was appointed to a new director role.

There was a programme of board visits to services and staff fed back that leaders were approachable. 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.

Between 12 April 2018 and 6 March 2019, members of the executive team had undertaken 114 visits to clinical areas throughout the trust. 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 told us that senior managers were visible and supportive. In the 2018 staff survey results, 76% of staff stated they knew who the senior managers were which had increased by 2% from 2017. Thirty two percent reported that communication between senior management and staff was effective compared to 30% the previous year.

Leadership development opportunities were available, including opportunities for staff below team manager level. The trust had a leadership and talent management strategy which was incorporated within their three year 'people plan' which was developed in 2016. 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 support the implementation of the strategy. The trust had developed a leadership model in 2018 which described the behaviours that leaders needed to demonstrate to promote staff engagement and well-being. Development opportunities for staff included;

- A co-produced clinical leadership development programme for band 7, 8a and 8bs which had been developed through the people plan. Within the last 12 months, 245 staff had participated in the programme and 244 had participated in the programme in the 12 months prior to this.
- A 'coaching skills' for managers programme which had trained 43 coaches.
- The trust had 167 apprenticeships in place of which, 67 were trainee nurse associate apprentices.
- A number of leadership and management apprenticeships with staff undertaking the ILM Level 5 and the Level 7 Senior Leadership Masters apprentice.
- The Mary Seacole Localised for South Cumbria and Lancashire leadership programme for new and emerging leaders.
- 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, nurse degree apprenticeships

had recently been approved by the board and the first cohort were due to start in September 2019.

In the 2018 staff survey results, 67% of staff stated they had training, learning or development opportunities in the previous 12 months compared to 61% in 2017. Eighty two percent of staff reported they felt the organisation acted fairly for career progression which was slightly higher than the 80% in 2017.

However; the trust did not have a formal talent management process in place. The board did not receive reports of where talent was within the trust therefore they had no oversight of this. The deputy director of organisational development told us that to address this, the trust had co-produced a quality improvement project which was testing a new appraisal conversation which would form the foundation for talent management within the trust moving forward.

Succession planning was in place throughout the trust up to board level. The trust were members of the NHS North West Leadership Academy and had maximised their membership this year, piloting the shadow board programme and using their allocated places on the pushing the boundaries and aspirant director programmes to support succession planning. There was a clear process for the recruitment of non-executive directors that took into account current skill mix, gender, ethnicity and experience.

The trust had refreshed its strategic plan 2017-2022 to ensure it was aligned to the changes within the local health and social care economy and the Lancashire and South Cumbria Integrated Care System. From this, an up-dated operational plan for 2019/2020 was developed which set out the workforce planning for the trust and how leaders would work in collaboration with other stakeholders within the wider Integrated Care System. The human resource directors from all the providers within the Lancashire and South Cumbria Integrated Care System met on a monthly basis to discuss workforce implications across the footprint and explore how they could work together in a collective way.

To support this, the trust hosted the Workforce Repository and Planning Tool Service which was designed to enable organisations to model their workforce at team, department, trust and cross economy levels to help deliver workforce changes.

The trust had an established infrastructure to support international recruitment and the branding of Lancashire and South Cumbria through the establishment of the careers and recruitment hub. The guardian of safe working hours explained to us how doctors had joined the trust because of the international congress which they were pleased about. They also told us out of six consultants at the Harbour, three had been trainees within the trust.

The trust had committed to a number of employment programmes aimed at supporting people within the local community to seek employment within the NHS. These included working closely with other local trusts and statutory organisations to raise awareness in schools of available careers in the NHS. The trust was recognised and accredited as a Disability Confident Employer which ensured that full support would be given to any application received from a disabled applicant and an interview was guaranteed. The trust had also achieved a Silver Employment Recognition award for its dedicated 'Step into Health' programme working with the Armed Forces, supporting service leavers, reservists and veterans to gain employment in the NHS.

In 2018/19 the trust set up a recruitment campaign was for nurse recruitment and through this the trust recruited to over 80 positions alongside substantive adverts. The trust also worked closely with local higher education institutions in providing employment offers for student nurses nearing the end of their courses so that they have employment offers on qualification.

Vision and strategy

The trust's vision and strategy were introduced in 2015 and had remained the same since our last inspection. Local providers and people who use services had been involved in developing the strategy. They had been developed through extensive engagement with key stakeholders and staff. 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 chief executive explained to us that they were reviewing the current strategy and structure within the trust and were aiming to have any changes in place by April 2020. They told us that staff, patients, carers and external partners would have the opportunity to contribute to discussions about the strategy, especially where there were plans to change services.

The trusts' vision and set of values were clear and included quality and sustainability as the top priorities.

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. The trust embedded its vision, values and strategy in corporate information received by staff. These were displayed throughout the trust in clinical areas and on the trust web site. All staff we spoke with knew and understood the trust's vision, values and strategy and how achievement of these applied to the work of their team. However; in the 2018 staff survey results, only 29% of staff said the values of the organisation were discussed as part of the appraisal process which was one percent higher than in 2017.

The trust had a strategy for achieving the trust 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. This included active involvement in sustainability and transformation plans. The trust had planned services to take into account the needs of the local population. 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.

The four largest ethnic minorities within the trust's catchment population are: 'All white' (92.3%), 'Asian/Asian British' (5.7%), 'Mixed/Multiple Ethnic Group' (1.1%) and 'Chinese' (0.4%).

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.

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 had led the trust to work 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 had engaged with stakeholders and the public in discussions involving the Lancashire and South Cumbria sustainability and transformation plan in addition to specific local work streams within the trust.

The trusts' strategy for achieving the priorities and developing good quality, sustainable care was detailed in the trusts' strategic plan which had been reviewed and up-dated in 2017 by the board of directors to ensure it was aligned to the sustainability and transformation plan. The plan had been developed with external stakeholders.

The refreshed 2017-22 strategic plan and operational plan which had been revised in 2019 detailed the trust's commitment to working in a patient focussed way in collaboration with partners to deliver system wide transformation within the geographical footprint.

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.

The trust had four board committees. Each of these had a strategic plan that was aligned to support the implementation of the overarching strategic plan. The trust was delivering year 2 of the strategy which was underpinned by the following key enabler plans:

- Operational plan
- Quality plan
- People plan
- Estates plan
- Health informatics plan
- Network and Support services business plans

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 trusts three-year medicines optimisation strategy [April 2018 to 2021] identified high level priorities for medicines safety aligned to the four domains identified by the World Health Organisation. The progress with the strategy was monitored through the Drug and Therapeutics Committee to the Board. Quarterly review of the 2018-19 Pharmacy and Medicines Management Operational Plan showed good progress against key deliverables. A medicines management workforce strategy was being drafted, aligned to the NHS Long-Term Plan, to support delivery of the trust quality and people plans. The draft plan also considered the future workforce requirements on transfer of services into the trust from Cumbria Partnerships NHS Foundation Trust. The trust was planning to increase the number of non-medical prescribers, as recommended in the Carter Review [Operational productivity: unwarranted variations in mental health services and community health services, May 2018] with a pilot planned for NMP support to early intervention services.

The board assurance framework identified key risks in relation to delivering the trust strategy and actions to mitigate these. The board members were aware of the progress made and areas where further work was required to ensure the strategic priorities were met. However; effective action had not been taken by the board to ensure progress had been made to address key risks in relation to the blockages throughout the acute care pathway and issues we identified within the 136 suites and functioning of the mental health decision units.

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 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.

There was a robust and realistic strategy for achieving the priorities and developing good quality, sustainable care across all sectors. There was evidence to demonstrate that trust leaders considered the cost impact, quality and sustainability when considering expansion opportunities, current contractual agreements and service re-design proposals. The leadership team regularly monitored and reviewed progress on delivering the strategy and local plans.

Since our last inspection, the trust had made the decision not to renew the contract it had with commissioners to provide prison healthcare within HMP Liverpool. The trust ceased to provide this contract from April 2018. An external independent review was commissioned by the trust chair into the governance around the gaining, running of and withdrawal from the contract to provide healthcare services to HMP Liverpool. Whilst the report identifies specific areas for improvement, there were three clear themes within the recommendations. These were:

- Robustness of the due diligence processes

- Quality governance arrangements
- Organisational culture.

The trust board had not been assured through the due diligence process that they could meet the contractible agreement and quality of service provision they aspired to provide based on the revenue attached to the contract. The expenditure for the trust to provide the service in the preceding year had been substantially higher than the revenue received by the trust. The trust board had therefore made the decision to not renew the contract and to re-direct and re-focus the excess expenditure back into its core business.

This is evidenced through the trusts' bid last year for the tender to provide 0-19 community children's health services across the whole of the Lancashire footprint. The local council re-tendered the service provision which had previously been split and provided by the trust and another local NHS trust. The trusts bid was unsuccessful however; it would have been an expansion of the current contract and core service the trust provided and was familiar with.

The trust had agreed to acquire the mental health services currently provided in South Cumbria by another NHS trust which are due to transfer to the trust in October 2019. The due diligence process had been followed. The chief executive and board members told us they were confident that the board and senior leaders had the skills and experience to ensure the acquisition and transfer of services would be smooth for those involved. However; they were mindful and aware of the challenges the transfer posed to the trust. These included ensuring staff felt supported through the transition, practical issues such as the electronic patient record system being a slightly different version to the one the trust had recently implemented and the geography of the services.

Since our last inspection, the trust had re-located the acute in-patient services from Burnley to Chorley which provided a much better environment for patients. Staff told us they had been consulted with and supported by managers with regards to the move. The trust had also opened a new perinatal ward following consultation with people with lived experience and staff involvement.

Extensive consultation had taken place individually and through listening events with staff, service users and carers and stakeholders to inform the Lancashire urgent mental health pathway review.

However; in home treatment teams, there were concerns that staff had not been consulted clearly about a move to full 24 hour working.

Culture

Staff felt respected, supported and valued. Staff in the focus groups we held and in the five core services we visited told us they felt listened to and supported. Morale among staff at the Cove had improved significantly since our last inspection. Staff from across disciplines reported how much the ward environment and culture had improved with the support of senior leaders within the trust and their immediate managers. Staff within the community mental health teams and acute and psychiatric intensive care wards told us they were feeling more positive and prouder about working for the trust and within their teams in recent months despite the staffing challenges they had faced over the previous 12 months. They described how new staff had recently been appointed which had improved the working atmosphere within the teams. Within the dental service, staff reported that managers across the service promoted a positive culture that supported and valued them, creating a sense of common purpose based on shared values. The pharmacy team told us how the whole team met twice a year to celebrate successes and discuss local and national priorities for medicine optimisation. Team priorities were integrated into pharmacist's personal development plans and they felt supported and respected in their work.

The trust's strategy, vision and values underpinned a culture which was patient centred. The trusts' people plan set out the six key aspirational priorities for improving patients and carers experiences and engagement within the trust which were:

- Embed the hearing feedback model
- Introduce and sustain the triangle of care model across all our services
- Create a culture of recovery, resilience and involvement
- Enhance and foster a culture of coproduction
- Sustain the culture of putting patients, their individual needs and those of their families and carers at the heart of everything we do
- Develop our staff at all levels to effectively promote, listen and respond to the experiences of our patients, families and carers.

The trust had recently appointed a new head of patient experience to provide the strategic direction and strengthen the governance arrangements in relation to patients and carers experiences.

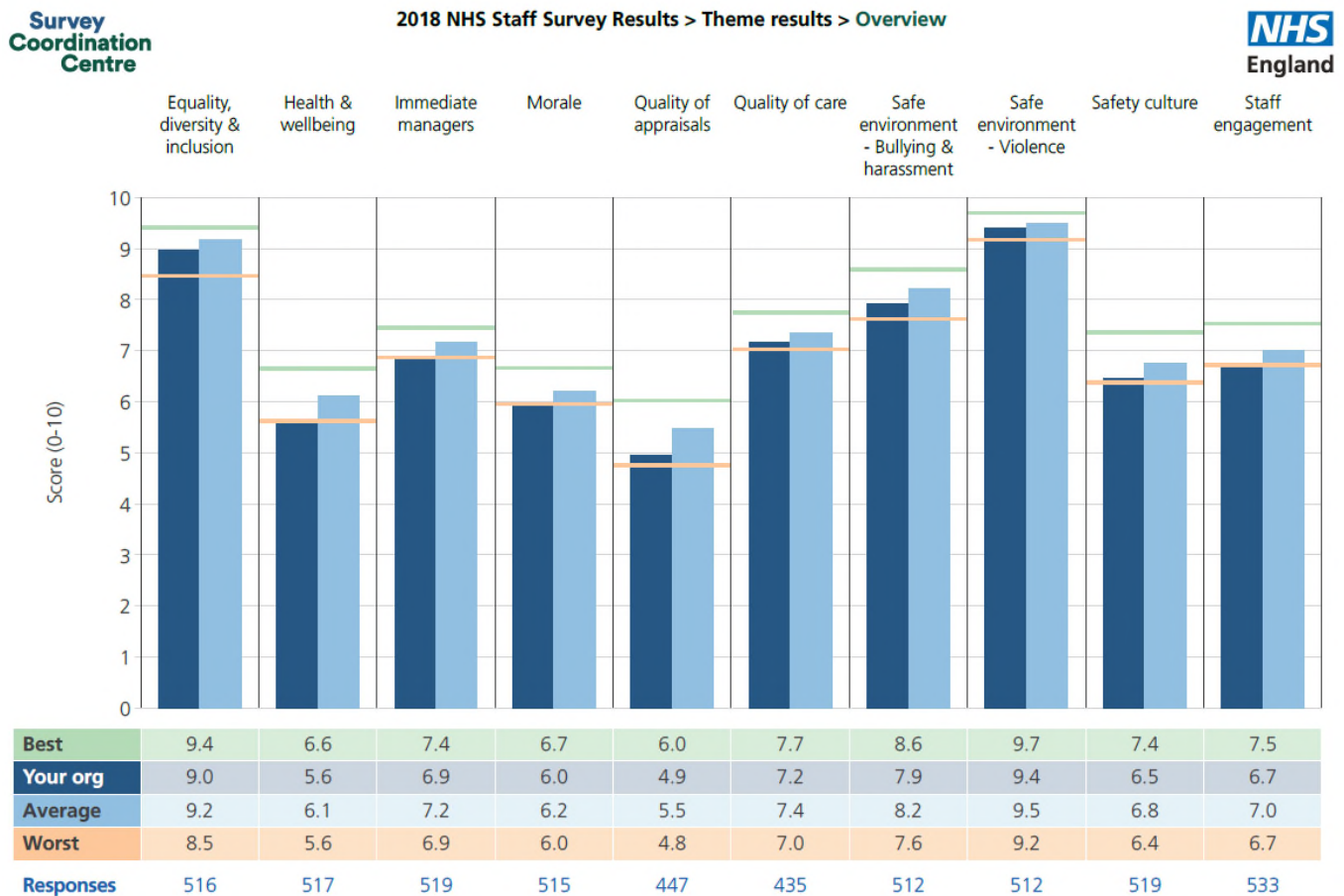
Staff felt positive and proud about working for the trust and their team. Overall, staff we spoke with in the focus groups and within the core services we inspected felt positive and proud about working for the trust and their team. However; although staff in the crisis home treatment teams and mental health decision units felt respected and supported by their immediate managers and their colleagues, some felt their work was not valued within the wider trust and there was little understanding of the function of the services and how other pressures impacted on service delivery. Some staff expressed concern about a constant pattern of short-term changes within the trust, although they did state they felt positive about the changes at board level which had led to a greater focus on providing quality care within the service. This reflected the feedback we received from commissioner who told us they felt the nursing leadership had been strengthened since our last inspection with the appointment of the interim director of nursing, deputy director of nursing and recent appointment of the heads of nursing within the three clinical networks. They said this change had accelerated over the past 8 to 9 weeks and they had noted a significant change in the culture of the organisation with staff reporting they felt more empowered and supported by managers and senior leaders within the trust.

Commissioners had recently attended a leadership day with 80 staff who told them there had been a culture of bullying in the past but that this was no longer the case with the recent changes and the appointment of the new chief executive. In the focus group we held with members of the trade unions, they described how there had been a cultural shift in the trust from a 'blame' culture to a 'just' culture since our last inspection. They were able to provide some good examples of the impact of this in practice. The group told us they felt they had been regarded as the 'enemy' by trust leaders previously and not heard however; this had improved greatly since the appointment of the interim director of nursing who had proactively engaged with them to co-produce work streams to improve staff experiences and the support they received.

In the 2018 staff survey result, 58% of staff were satisfied with the recognition they received for good work which had increased from the 49% in 2017. However; 41% felt satisfied with the extent the trust valued their work which was an increase from the 34% in 2017 but was still much lower than the 74% who felt their immediate managers valued their work, an increase of 3% from the previous year. In Q1 17/18 and Q1 18/19, approximately 50% of staff respondents would

recommend the trust as a place to work and around 70% of staff respondents would recommend the trust as a place to receive care.

The following illustration shows how this provider compares with other similar providers on ten key themes from the 2018 NHS Staff Survey. Possible scores range from zero to ten – a higher score indicates a better result.



The trust's 2018 scores for the following themes were significantly lower (worse) when compared to the 2017 NHS Staff Survey:

- Quality of appraisals
- Safe environment – Bullying & harassment
- Safety culture
- Staff engagement

The trust recognised staff success by staff awards and through feedback. The trust held a staff awards ceremony each year. The trust had received 220 nominations for 2019 and the ceremony was attended by almost 340 staff. Staff and team achievements were reported via the trusts' website in addition to the trusts people at the heart newsletter. Information on how staff could submit news items were detailed in the newsletter.

We held a focus group with the trade unions. 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. During our last inspection, they described how they were 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. They told us this workstream had progressed well with the implementation of a 'just' culture. They explained how suspensions only occurred if all alternatives had been exhausted. These were monitored jointly by human resources and the unions. They described how responses were now fair and proportionate and this reflected the cultural change which was taking place within the trust from a 'blame' culture to a 'just' culture.

They expressed concerns about how newly qualified staff had often been expected to work alone on the wards. They told us they had jointly worked with the director of nursing to develop an induction programme for newly qualified staff which had recently been signed off by the board to address this risk. They also described how all leavers were now provided with an exit questionnaire whereas before, this has been inconsistent.

Managers addressed poor staff performance where needed. The trust had relevant policies and procedures in place in relation to managing poor staff performance. The deputy 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 August 2017, 27 staff had been suspended within the trust and eight had been placed on alternative duties. In the 12 months up to 31 January 2019, 44 staff were subject to disciplinary action. Of these, three had moved wards, 18 had been suspended and 23 were working under supervision on alternative duties.

Staff knew how to use the whistle-blowing process and about the role of the speak up guardian.

The trust had an appointed freedom to speak up guardian shortly after the publication of the Francis report review in February 2015. Staff at all levels of the organisation understood the role of the freedom to speak up guardian. The freedom to speak up guardian was supported in their role by two deputy freedom to speak up guardians, administration support and 20 ambassadors. Bank staff had access to an identified ambassador who could represent them if needed.

The freedom to speak up guardian was part of a regional network of guardians and they attended national meetings and conferences to support them within their role. The freedom to speak up guardian reported directly to the director of nursing and quality who was the executive lead for freedom to speak up. Quarterly reports were submitted to the quality committee in addition to an annual report to the audit committee. All concerns received were reviewed by the director of nursing and quality who determined an appropriate course of action, which ranged from seeking assurance from services to the commissioning of an investigation.

Between the 01 February and 31 January 2019, the trust had received 102 concerns (1 identified as whistleblowing) from staff. Of the staff who had raised a concern in 2018, 71% stated they would feel secure raising concerns about unsafe clinical practice which was slightly higher than the 67% reported in 2017. Staff in the focus groups we held and within the core services we visited to us they felt able to raise concerns without fear of retribution.

However; in the staff survey results for 2018, only 53.7% reported they were confident that the trust would address the concerns and take appropriate action in line with best practice. Staff were not always confident that the trust took appropriate learning as a result of concerns raised.

In response to this, the trust had introduced a new online system in 2019 called speak in confidence. This new system allowed staff to raise a concern totally anonymously, but also allowed the trust to have a two-way dialogue with the member of staff raising the concern. Just over half of the staff raising a concern wished to remain anonymous. Feedback was given to staff raising the concerns and also through the freedom to speak up intranet site. The trust told us this

would replace the 'Dear David' system which enabled staff to raise any concerns directly with the chair.

The trust recorded all raised concerns centrally on a single database. Access to the database system was restricted to the freedom to speak up guardian and their deputy in addition to the director of nursing and quality and the non-executive freedom to speak up lead. This allowed the team to have oversight of all concerns and to triangulate that data with other information they held. A summary of all concerns raised was presented to the board each month in the trust chair's report and a detailed quarterly speak up report was presented to the people and quality committee.

During the last twelve months, the themes identified from concerns raised included; management culture and leadership (including bullying), staff safety including violence, and the challenges and impact of the high demand and pressure in mental health services. These areas correlated to information known within the trust.

The trust had an effective guardian of safe working hours. The guardian of safe working was introduced nationally in 2016 for organisations that employ or host NHS trainee doctors to oversee the process of ensuring safe working hours for junior doctors to protect patients. The guardian was passionate about their role and improving the lives of junior doctors. In the focus group we held with junior doctors, they told us they felt supported by the guardian who they found approachable and genuinely concerned with ensuring their welfare and health was not compromised.

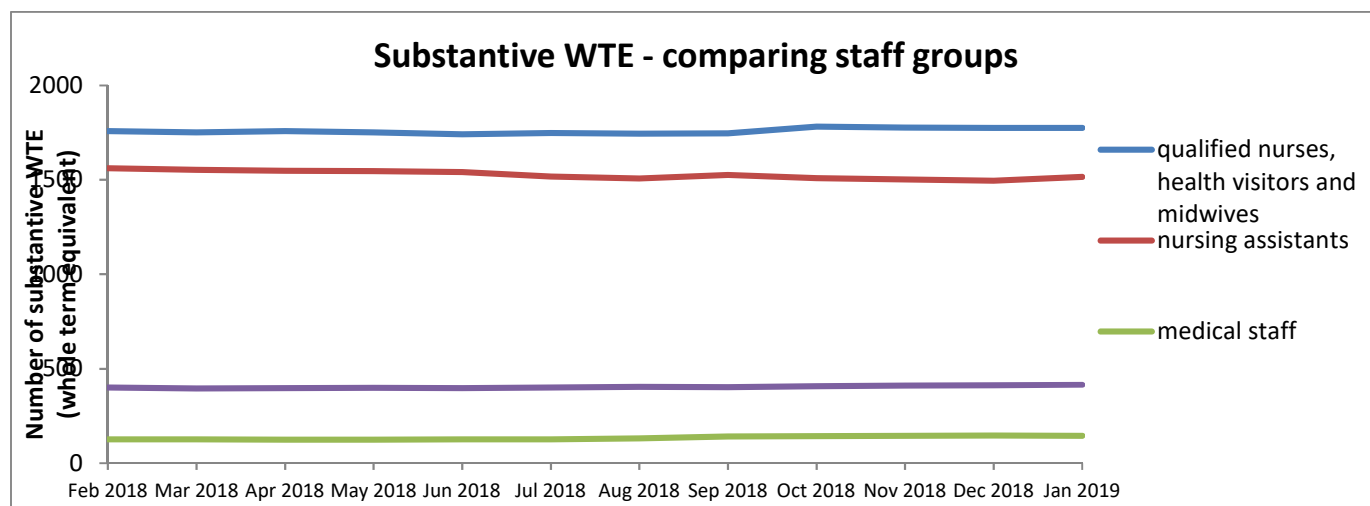
The trust applied duty of candour appropriately. Between March 2018 to February 2019, the trust reported nine duty of candour breaches. The trust applied duty of candour appropriately. The trust's associate director of safety and quality governance was the duty of candour lead for the trust. The trust's '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.

Staff had access to support for their own physical and emotional health needs through occupational health. The trust was a Mindful Employer and had a Health and Wellbeing programme in place which was supported by 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.

However; in the 2018 staff survey results, only 24.5% of staff felt the trust definitely took positive action on health and wellbeing which was slightly higher than the previous year. Forty seven percent reported they had felt unwell due to work related stress which was five percent lower than 2017. Sixty nine percent of staff felt their immediate manager took a positive interest in their health and wellbeing which was one percent lower than the previous year.

Between Sep 2016 and Feb 2017, 72.1% of healthcare workers involved with direct patient care were vaccinated against seasonal influenza, which was better the national average of 62.2%.

The below chart shows the breakdown of staff in post WTE in this core service from 01 February 2018 Year to 31 January 2019.



Annual staffing metrics

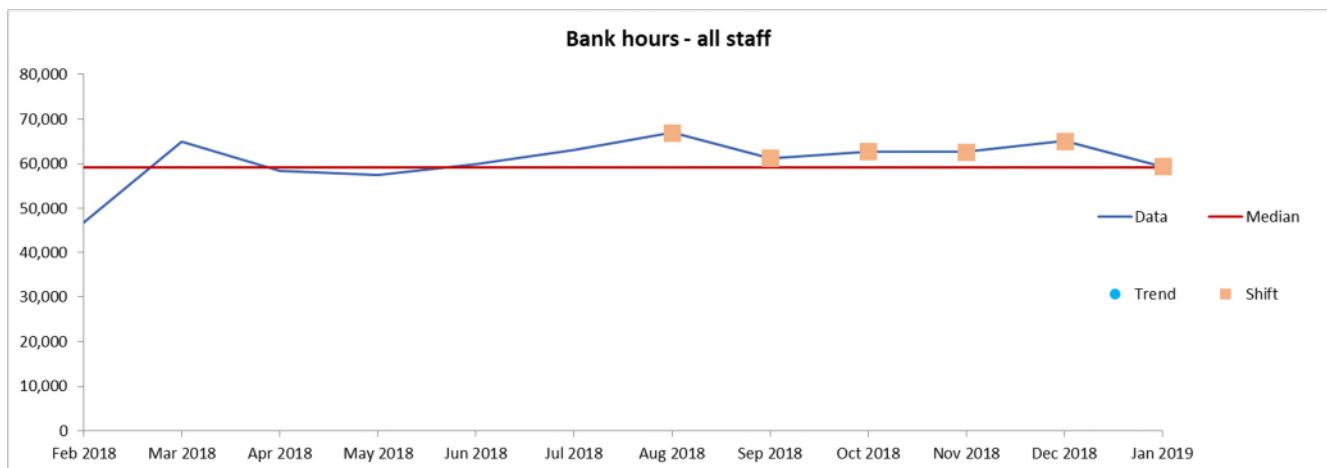
Core service annual staffing metrics							
01 February 2018 – 31 January 2019							
Staff group	Annual average establishment	Annual vacancy rate	Annual turnover rate	Annual sickness rate	Annual bank hours (% of available hours)	Annual agency hours (% of available hours)	Annual “unfilled” hours (% of available hours)
All staff	5,807.5	21%	7%	6.2%			
Qualified nurses	1,983.1	20%	6%	6.5%	151,413 (5%)	14,233 (<1%)	10,642 (<1%)
Nursing assistants	1,634.0	17%	5%	8.4%	577,710 (35%)	34,596 (2%)	26,277 (2%)
Medical staff	243.4	46%	12%	2.7%	33 (<1%)	10,796 (5%)	20,240 (9%)
Allied Health Professionals	449.5	19%	9%	4.3%			

Caveat: The data in the table above is correct in accordance with the PIR data submitted however; the trust stated that the financial establishment figure for medical staff included 65 full time equivalent establishment for rotational trainee medics, who are paid for by the trust but are not a part of the trusts’ core workforce. Taking this into account, this means that the actual overall annual vacancy rate for medical staff is 22.73%.

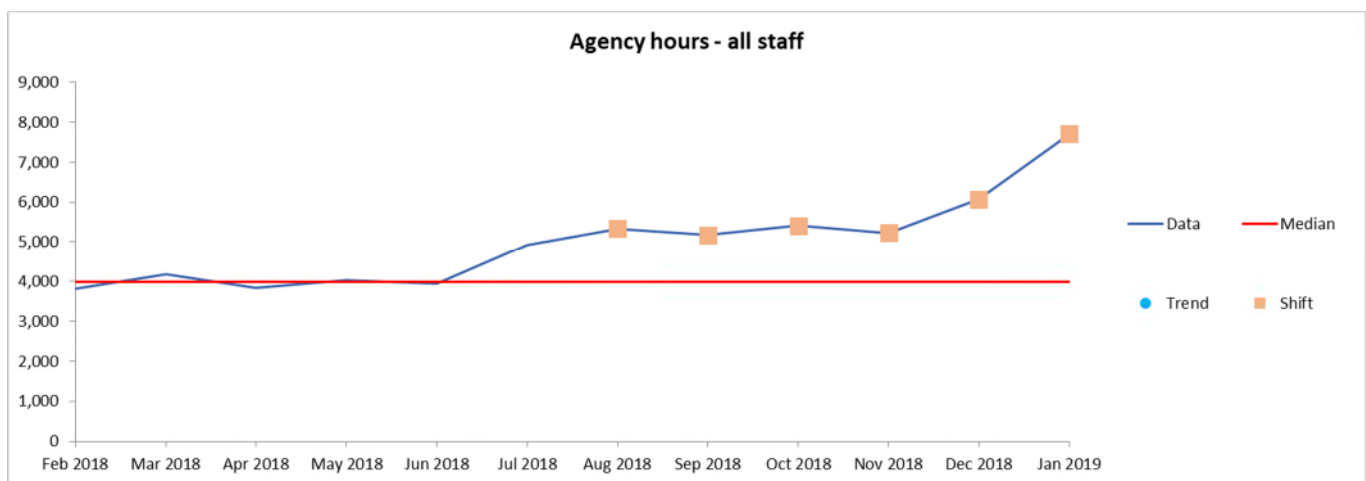
Staffing figures within this core service were compared to other similar services and annual vacancy for all staff, nurses and nursing assistants, sickness rates for all staff, nurses and nursing assistants were found to be in the worst 25% nationally.

Monthly staffing figures for the past 12 months were also analysed, and no indications of improvement, deterioration or change were identified.

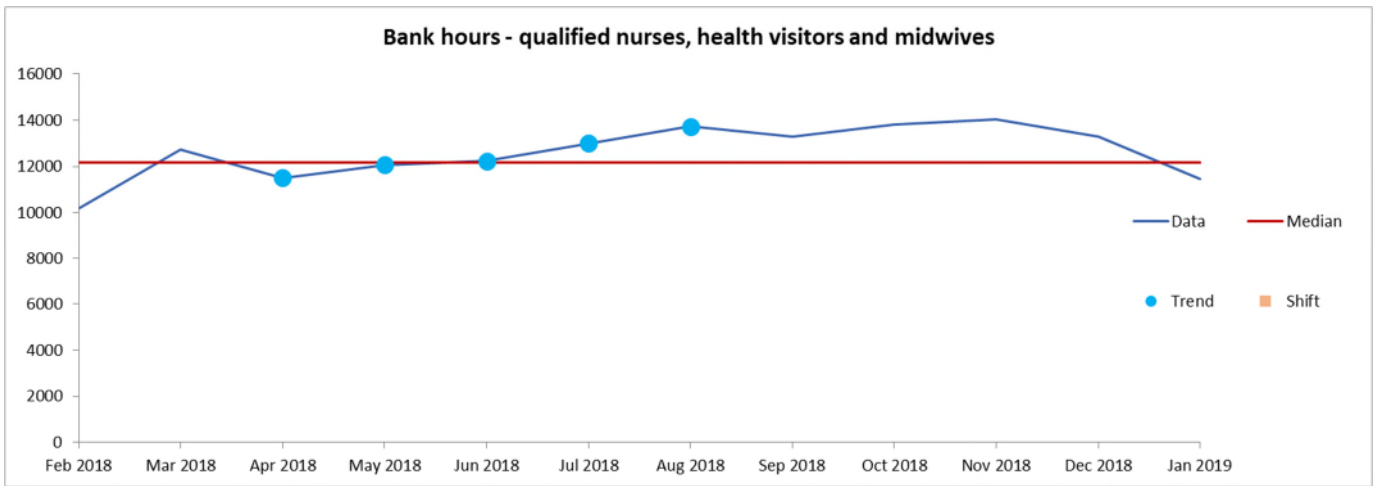
The trust had recently completed a Hurst staffing review for inpatient services which had resulted in the board agreeing further investment of £3m for 82 extra qualified staff and additional investment for community teams to recruit 21 extra care coordinators. A recruitment drive was underway to fill these additional posts however; at the time of inspection, most of these posts had not been recruited to.



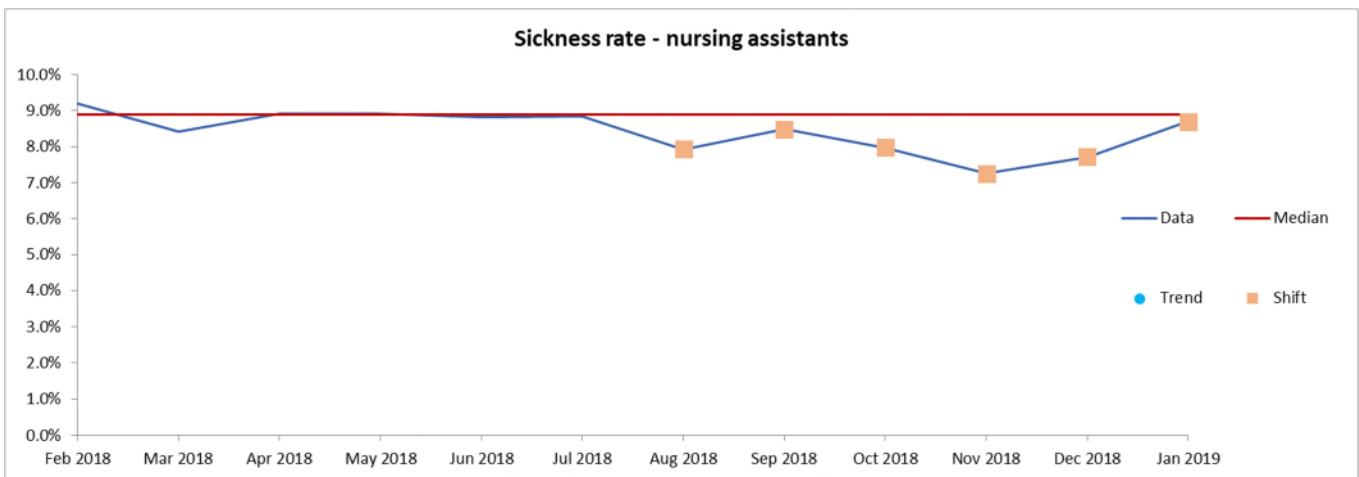
Monthly 'bank hours' over the last 12 months for all staff shows a shift from August 2018 to January 2019.



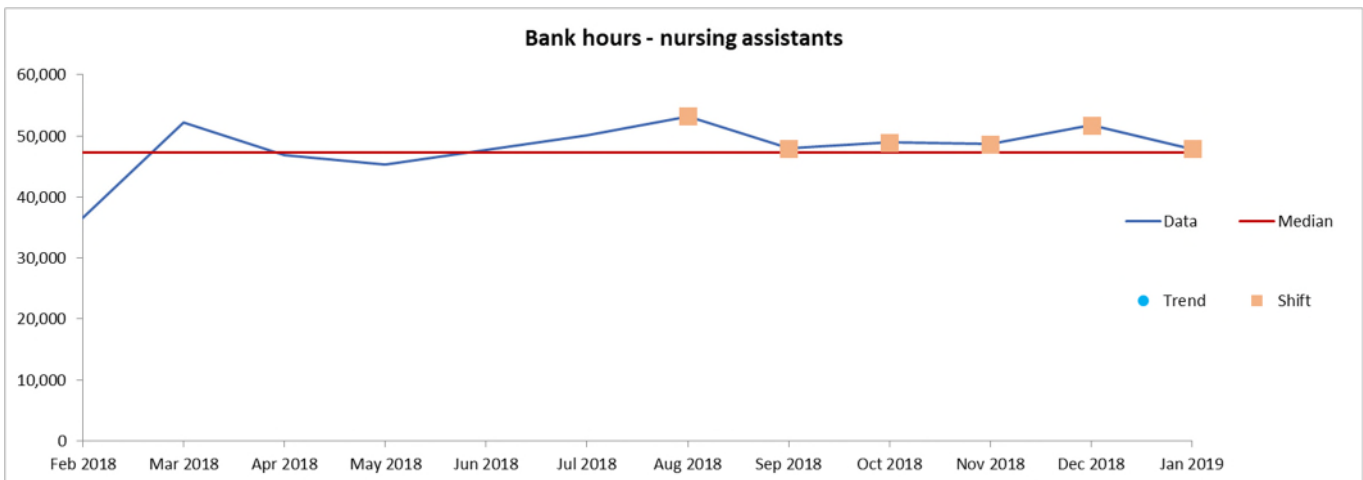
Monthly 'agency hours' over the last 12 months for all staff shows a shift from August 2018 to January 2019.



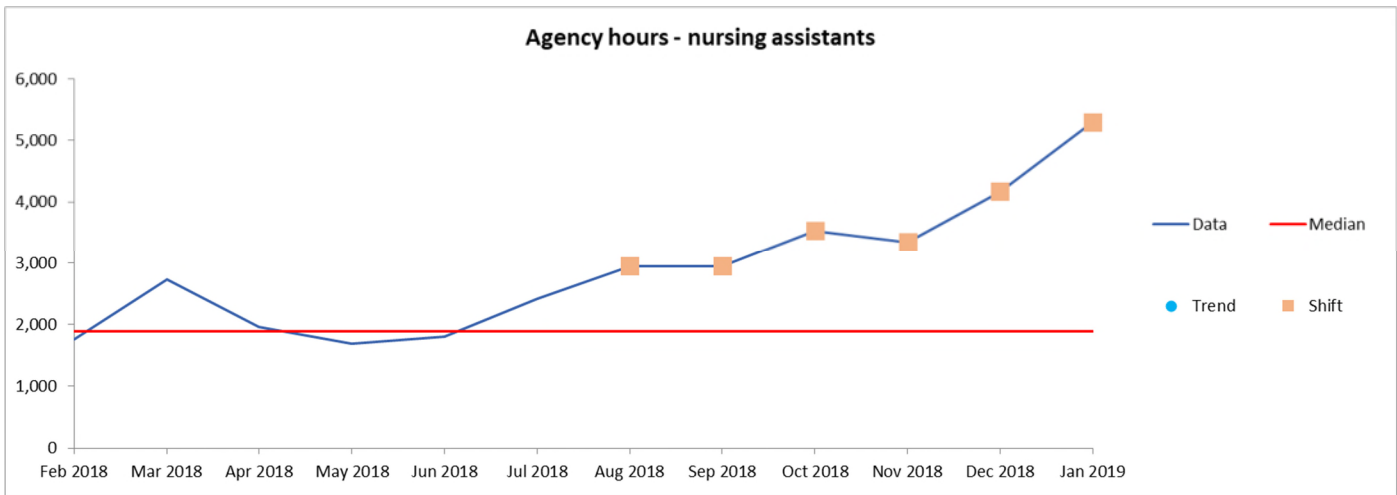
Monthly 'bank hours' over the last 12 months for qualified nurses, health visitors and midwives show an upward trend from April 2018 to August 2018.



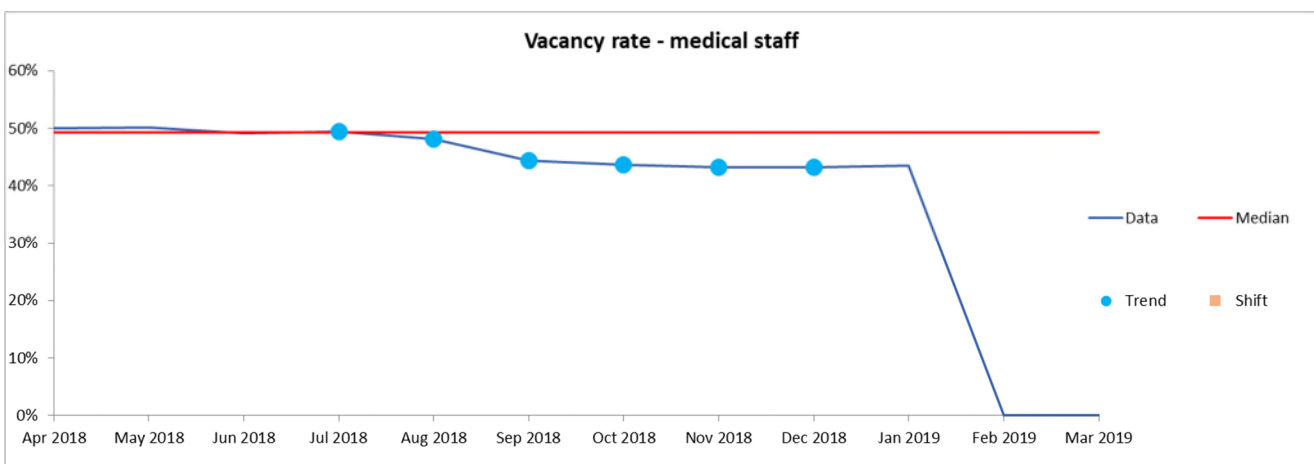
Monthly 'sickness rates' over the last 12 months for nursing assistants shows a shift from August 2018 to January 2019.



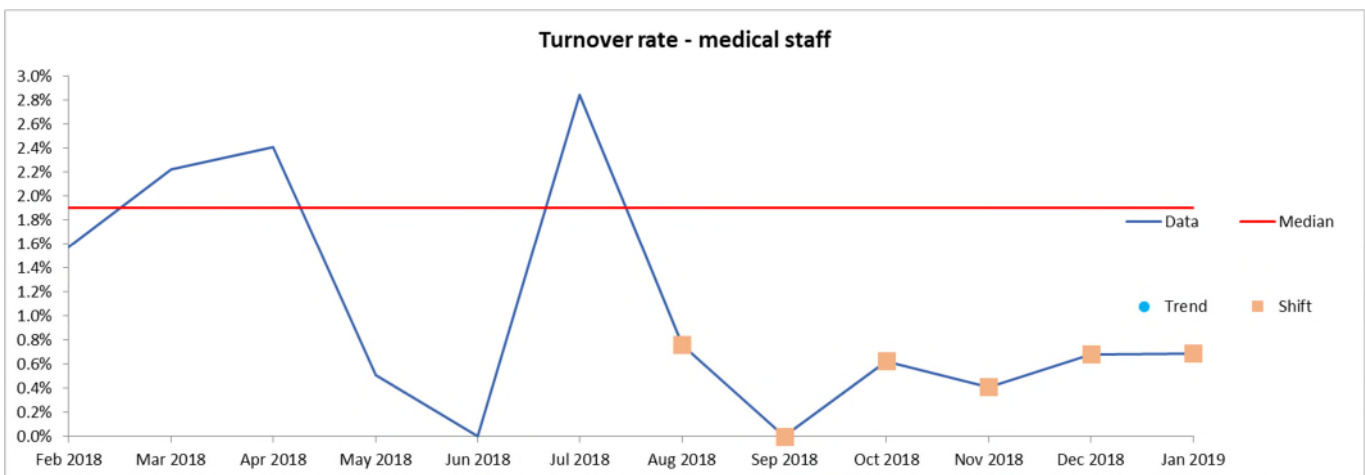
Monthly 'bank hours' over the last 12 months for nursing assistants shows a shift from August 2018 to January 2019.



Monthly 'agency hours' over the last 12 months for nursing assistants shows a shift from August 2018 to January 2019. This correlates with the increase in sickness rate for this staff group over the same period.



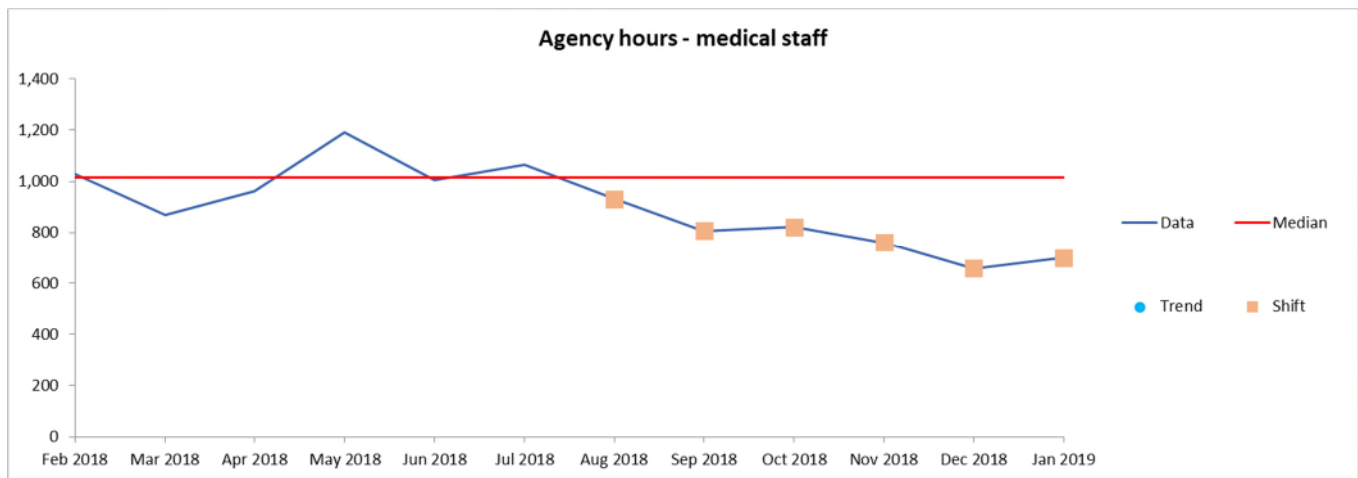
Monthly 'vacancy rates' over the last 12 months for medical staff shows a downward trend from July 2018 to December 2018.



Monthly 'turnover rates' over the last 12 months for medical staff shows a shift from August 2018 to January 2019.

In the consultants focus group, there was an acknowledgment that recruitment and retention of consultants and junior doctors had been challenging over the past 12 months. They attributed this to factors largely outside of the trusts' control such as the high levels of deprivation within the catchment area, a national shortage of doctors, competition from neighbouring and funding issues.

However; they reported that this had enabled the trust to think more creatively in terms of recruitment such as supporting international graduates. They explained how they were leading the way with the mentorship programme which was started December 2017 to support new doctors and how they felt this had been a key factor in improving retention which correlates with the graphs above.



Monthly 'agency hours' over the last 12 months for medical staff shows a shift from August 2018 to January 2019. This could be an indicator of change. This merits investigation to find out the causes and impacts of the possible change, what has worked and how learning was shared more widely.

The compliance for mandatory and statutory training courses at 06 March 2019 was 83%. Of the training courses listed eight failed to achieve the trust target and of those, eight failed to score above 75%.

The trust set a target of 80% for completion of mandatory and statutory training.

The trust compiles these figures at the end of the year.

The training compliance reported for this provider during this inspection was lower than to the 93% reported in the previous year.

Key:

	Met trust target ✓	Not met trust target ✗	Higher ↑	No change →	Lower ↓
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Training Module	Number of eligible staff	Number of staff trained	YTD Compliance (%)	Trust Target Met	Compliance change when compared to previous year
Mental Capacity Act L1	4,246	3,975	94%	✓	↑
Equality & Diversity	5,718	5,305	93%	✓	↓
Safeguarding Children L2	1,357	1,247	92%	✓	↓
Health & Safety	5,718	5,218	91%	✓	↓
Infection Control	4,256	3,813	90%	✓	↓
Fire Safety	5,718	5,065	89%	✓	↓

Training Module	Number of eligible staff	Number of staff trained	YTD Compliance (%)	Trust Target Met	Compliance change when compared to previous year
Safeguarding Children L1	1,466	1,295	88%	✓	↓
Safeguarding Adults L2	4,252	3,727	88%	✓	→
Safeguarding Adults L1	1,466	1,269	87%	✓	↓
Manual Handling L1A	1,462	1,261	86%	✓	↓
Conflict Resolution	3,665	3,109	85%	✓	↓
Manual Handling L2A	1,926	1,610	84%	✓	↓
Manual Handling L1B	1,669	1,383	83%	✓	→
Basic Life Support	3,636	2,708	74%	✗	↓
Immediate Life Support	610	452	74%	✗	↑
WRAP	2,893	2,106	73%	✗	→
Safeguarding Children L3	2,895	2,080	72%	✗	↓
Manual Handling L2B	661	456	69%	✗	↓
Mental Capacity Act L2	4,242	2,918	69%	✗	→
Information Governance	5,718	3,918	69%	✗	↓
Positive & Safe Programme	1,007	644	64%	✗	→
Total	64,581	53,559	83%	✓	↓

However; we found that compliance with basic life support and immediate life support training was as low as 50% within some of the acute and psychiatric intensive care wards. There was not an effective system in place to ensure each shift had staff trained in basic life support and immediate life support on all wards.

All staff had the opportunity to discuss their learning and career development needs at appraisal. This included agency and locum staff and volunteers.

The trust's target rate for appraisal compliance is 80%. At the end of last year (01 April 2017 to 31 March 2018), the overall appraisal rate for non-medical staff was 69%. This year so far, the overall appraisal rate was 86% (as at 06 March 2019). Thirteen out of the 14 core services achieved the trust's appraisal target, this year so far. This is an improvement since the previous year, when five core services achieved the 80% appraisal target. In the latest year, the service with the lowest compliance was 'Acute wards for adults of working age and psychiatric intensive care units' with 75%.

However; only 28% of staff in the survey felt their appraisal helped them to agree clear objectives for their work which was unchanged from 2017.

Here is the data table for non-medical staff 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	% appraisals (as at 06 March 2019)	% appraisals (previous year 01 April 2017 – 31 March 2018)
MH - Community based mental health services for older people	251	236	94%	89%
MH - Child and adolescent mental health wards.	55	51	93%	6%
CHS - Sexual Health	12	11	92%	73%
CHS - Community Dental	113	103	91%	73%
CHS - Community Inpatients	32	29	91%	97%
CHS - Adults Community	1,000	901	90%	87%
CHS - Children, Young People and Families	272	241	89%	84%
MH - Community mental health services for people with a learning disability or autism	130	115	88%	85%
MH - Community based mental health services for adults of working age	435	384	88%	76%
MH - Wards for older people with mental health problems	249	219	88%	31%
MH - Specialist community mental health services for children and young people	102	88	86%	74%
Other	1,469	1259	86%	77%
MH - Eating Disorders	40	34	85%	72%
MH - Secure wards/Forensic inpatient	377	318	84%	39%
MH - Mental health crisis services and health-based places of safety	283	218	77%	65%
MH - Other Specialist Services	108	82	76%	48%
MH - Acute wards for adults of working age and psychiatric intensive care units	602	450	75%	38%
Total	5,530	4,739	86%	69%

The trust's target rate for appraisal compliance is 80%. At the end of last year (01 April 2017 to 31 March 2018), the overall appraisal rate for medical staff was 50%. This year so far, the overall appraisal rate was 100% (as at 06 March 2019).

Core Service	Total number of permanent medical staff requiring an appraisal	Total number of permanent medical staff who have had an appraisal	% appraisals (as at 06 March 2019)	% appraisals (previous year 01 April 2017 – 31 March 2018)
MH - Acute wards for adults of working age and psychiatric intensive care units	46	46	100%	50%
MH - Community mental health services for people with a learning disability or autism	1	1	100%	N/A
MH - Wards for older people with mental health problems	44	44	100%	50%
CHS - Adults Community	1	1	100%	50%
CHS - Community Inpatients	6	6	100%	50%
MH - Specialist community mental health services for children and young people	4	4	100%	50%
MH - Secure wards/Forensic inpatient	16	16	100%	50%
Total	118	118	100%	50%

The trust target of clinical supervision for non-medical staff was 80% of the sessions required. Between 01 April 2018 and 31 March 2019, the average rate across all 17 core services in this service was 31%. This was much lower than the overall rate of 71% at our last inspection. The trust had introduced supervision passports for all staff in 2016. At our last inspection they did not have a standard supervision recording system in place and therefore could not provide consistent or full data in respect of supervision compliance. At this inspection, we found the trust had implemented a standard recording system, but staff told us they were not always recording supervision they had received on the system.

At our last inspection, we found that compliance with supervision was low within the acute and psychiatric wards and the child and adolescent ward which the trust incorporated into a CQC action plan. The updated action plan was presented to the board in April 2019. There was a lack of evidence to demonstrate compliance with the trusts' target of 80% in the teams therefore the board could not be assured that staff were receiving supervision.

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

Core service	Clinical supervision sessions required	Clinical supervision delivered	Clinical supervision rate (%)
Child and adolescent mental health wards	634	334	53%
Specialist community mental health services for children and young people	2,043	978	48%
Other	2,776	1,249	45%
Community mental health services for people with a learning disability or autism	1,316	547	42%
Community-based mental health services for older people	2,504	956	38%
Other specialist services	1,190	449	38%
Community-based mental health services for adults of working age	4,472	1,406	33%
Wards for older people with mental health problems	2,607	728	28%
Secure Wards/Forensic inpatient	4,598	1,054	23%
Acute wards for adults of working age and psychiatric intensive care units	5,948	1,184	20%
Trust Total	31,039	9,569	31%

The Workforce Race Equality Standard became compulsory for all NHS trusts in April 2015. Trusts have to show progress against nine measures of equality in the workforce.

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 percentages of White and BME staff in each of the Agenda for Change (AfC) pay bands 1 to 9, and at Very Senior Manager (VSM) level (including executive board members), compared with the percentage of staff in the overall workforce: In 2018, BME representation at Band 8a-9 has improved overall when compared with last year. However, there is no BME representation at VSM level and only 2.8% of Band 8a-9 are BME with BME staff disproportionately represented in the medical workforce.

The group of Mental Health Act hospital managers was mainly older, middle class, white people. The gender split was 50/50. Efforts were being made to recruit a more diverse group to reflect the demographics of the whole of the county, which varied enormously. This was proving difficult and

the lead Mental Health Act non- executive director acknowledged that the trust needed to consider other avenues to interest the diverse groups in the county, which might include holding hearings at times that were convenient to those willing to participate.

In 2018 within the trust:

- White candidates were 2.63 times more likely than BME candidates to get jobs for which they had been shortlisted. The trust performance against this measure has worsened from 2017.
- BME staff were 1.46 times more likely to be disciplined when compared with White staff.
- White staff were slightly less likely to take part in voluntary training than BME staff.
- The percentage of BME staff on the board was 0% compared with 8.2% BME staff in the overall workforce. The percentage difference between the board voting membership and overall workforce was -8.2%.

In the staff survey results for 2018, 64% of staff felt the trust acted fairly for career progression which was up three percent from 2017. However; the gap between white and BME staff in relation to staff believing there was equal opportunities for career progression and promotion had significantly widened in the 2018 staff survey with 81.5% white staff and 63% BME staff reporting they did.

There was acknowledgment within the Workforce Race Equality Standard report 2018 which was signed off by the board in August 2018, that more needed to be done to improve the opportunities and equality for BME staff. The trust had developed a Workforce Race Equality Standard action plan to improve and monitor compliance against the standards. The plan was RAG rated however; it did not identify timescales, named individuals or progress tracked. The equality and diversity lead told us they were incorporated into the trusts overarching strategy and objectives. This meant it was not possible to track progress against the plan as there was a lack of evidence to demonstrate progress had been made attached to it.

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 a staff network in place which promoted the diversity of staff. The diversity and equality lead told us the trust had initially had different staff networks in place for specific diversity groups but that this had not worked well, and they had therefore decided to have one diversity group which they reported to be more productive due to better attendance. The trust had an established network of equality and diversity champions throughout the trust. They met regularly as a group and had good links with external stakeholders who were invited to attend meetings.

Teams had positive relationships, worked well together and addressed any conflict appropriately. Staff felt equally respected, supported and valued across all sectors. In the core services we inspected and focus groups we held, teams reported they felt supported by their immediate managers, within their teams and they worked well together. This did not reflect the findings of the staff survey 2018 where 54% of staff reported relationships at work were strained. Staff within the community health services were particularly positive about the relationships they had with each other and across disciplines/teams.

Governance

The trusts governance structure had remained the same since our last inspection. The last external independent review of the governance arrangements was completed in July 2016. The

review had provided assurance to the board that there was a clear connectivity at network level up to board level. The recently appointed chief executive had commissioned an external review of the governance structure which was due to be completed shortly after our inspection. They explained they had commissioned the review to provide a rigorous assessment of the trust board and senior leadership capabilities and capacity in addition to a review of the functionality of the governance structure including the board committee and sub committees which fed into the board.

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.

Each of these committees had a strategic plan that was aligned to support the implementation of the overarching strategic plan. The trust was delivering year 2 of the strategy which was underpinned by the following key enabler plans:

- Operational plan
- Quality plan
- People plan
- Estates plan
- Health informatics plan
- Network and Support services business plans.

Non-executive and executive directors were clear about their areas of responsibility despite some being recently appointed into post. However; there was some blurring of boundaries as some of the non-executives had expanded their roles by taking on what should have been within the executive directors' remit. This was largely due to them not having the assurance they required and the slow pace of change which they were frustrated with. They attended committee meetings in line with their responsibilities.

The trust had a council of 22 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 and felt supported by them. They understood their role in terms of holding the non-executive members of the board to account. The non-executive directors were 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 360-degree 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.

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. The trust had completed a review of the governance arrangements for Controlled Drugs in place to minimise the risk of inappropriate opioid prescribing and administration in response to the Gosport Inquiry. Scrutiny of Controlled Drugs handling by the Drugs and Therapeutics Committee had been strengthened.

Medication incidents (including controlled drugs incidents) were monitored quarterly by the Medicines Safety Group and reported to the Drugs and Therapeutics Committee. However, we saw that quoracy was not consistently achieved, reducing decision making capacity. Pharmacists could also raise concerns about individual prescribing practice at the Professional Standards Monitoring Group, to help ensure review of safe prescribing.

The trust had 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, lead nurse, 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. Since our last inspection, the trust had introduced a new clinical cabinet which was supported by a clinical council. The aim of the cabinet was to provide a forum to bring together the clinical professional leaders representing the breadth and depth of the trusts' clinical workforce.

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.

A monthly network report from each of the three networks provided analysis of the quality data and assurance around what actions were in place to support improvements. This was reported to the board through the integrated quality and performance report via the quality and safety sub-committee on a monthly basis.

There were standardised templates for each of the governance meetings within the networks 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.

A clear framework set out the structure of ward/service, division and senior trust meetings however; this was not the case within most of the acute and psychiatric intensive care wards where meeting agendas varied between wards and regular team meetings did not take place. There was a dependence on managers communicating important information to staff via e-mail which staff did not always access in a timely manner therefore they were not always up to date with relevant information and shared learning.

Staff at all levels of the organisation understood their roles and responsibilities and what to escalate to a more senior person.

Governance arrangements were in place in relation to Mental Health Act administration and compliance. However; the governance systems in place for the oversight of the 136 suites was not effective. The trust data was incomplete in relation to patients who remained in the section 136 suites and staff were not consistently reporting all the breaches. Staff within the 136 suites and mental health decision units did not understand their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice. Patients were detained past the expiry of section 136 and subject to restrictive interventions without appropriate legal safeguards in place. We also found that the trust policy for section 136 did not reflect all relevant legislation and the Mental Health Act Code of Practice.

There was a non-executive director with responsibility for oversight of the MHA in the trust who reported to the board. There was a mental health law sub-committee that met each month. The membership of this meeting was operational staff including the mental health law manager, the interim director of nursing and the associate director of effectiveness. Headline issues from this meeting were reported up to the quality committee. There were two full bi-annual reports regarding the MHA presented to the board. The non-executive director acted as a 'bridge' from the board to the associate hospital managers. Each of the non-executive directors sat with the managers on two panels per year as an observer reporting back to the lead non-executive director. Each associate manager attended at least 12 hearings per year as a panel member. The activities of the managers panels were reported to the board in the bi-annual report provided by the mental health law sub-committee.

The MHA manager reported that the workload for the department was enormous. The non-executive director confirmed they were aware of this and the human resources required to safely administer the MHA was being monitored. The non-executive director said there were currently enough staff, but they were working at full capacity. There were seven MHA administrators and nine admin assistants for the trust. There was a MHA manager and a deputy manager. The deputy manager was acting up into the manager's role to cover maternity leave. Each MHA administrator was responsible for 70 patients. The MHA administrator's role was to ensure the scrutiny of detention documents and the lawful administration of the MHA. The MHA assistants took responsibility for arranging the appeals process for patients. There was also a legal advisor employed for two days per week who provided advice and support on mental health law.

The team provided a daily MHA status report to the wards and also a weekly audit of MHA matters. The report included monitoring when section 132 rights were due, consent to treatment, section renewals, mental health tribunals and when clinical reports were required for the hearings.

Detention documents for patients admitted out of hours, were received and checked by the senior nurse on duty, to ensure that they did not contain any fundamental errors that would invalidate the section, and that could not be changed at a later date. A checklist was available to assist nurses performing this function.

There was a North West mental health law group that was open to all MHA administrators in the North west. This group met quarterly and was chaired by a mental health tribunal judge. All the mental health team had access to a national website for mental health law.

Independent mental health advocates were commissioned by the local authorities who monitored the contracts and decided on budgets. The MHA manager met with the individual IMHA services twice each year to report on any concerns about patient access to the IMHA's. This had only recently begun and was not yet fully embedded.

The MHA manager had been invited by NHS England to present on their MHA monitoring systems.

The trust was working with third party providers effectively to promote good patient care. The trust worked in partnership with over 38 different statutory and non-statutory organisations to promote good patient care. This included other NHS trusts, academic bodies, voluntary agencies, local community groups, housing associations and other stakeholders. 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.

There were a number of multi-agency policies and protocols in place which the trust had 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.

The MHA non-executive director told us that efforts were being made by the trust to work with partnership agencies in order to enhance the patient experience, such as the police, ambulance service and social services. A multi-agency operational group had been established across the county which was chaired by Lancashire Constabulary. The trust had set up locality multi-agency groups which they chaired. These fed into the multi-agency operational group. However; attendance at the meetings had been variable and momentum had waned with the multi-agency operational group not having met since November 2018. However; the multi-agency operational group had recently re-formed and the terms of reference for the group had been reviewed and improved on.

Agencies were working together to provide a mental health advice line which was based in a local ambulance control room, staffed by mental health practitioners. The system also included a dedicated police line for them to access advice regarding mentally disordered persons who they encountered.

A partnership arrangement was in place for the provision of psychiatric liaison services with appropriate governance arrangements. However; the trust did not have any service level agreements with acute trusts regarding support for patients detained under the MHA and for those detained by the police under section 136.

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 governance team regularly reviewed the systems. 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. Staff received feedback on incidents they had reported. Risks, incidents and safety priorities were monitored through weekly safety summits which leaders from the clinical networks attended.

The trust also had an established monthly serious incident learning review panel which 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.

The trust had effective systems in place in relation to safeguarding and identifying learning. Staff at all levels understood their responsibilities in relation to safeguarding. Quarterly safeguarding

surveillance reports were monitored and reviewed through the quality safety committee and quality committee. The safeguarding team had a lessons' learnt group which produced bulletins for staff with concise learning points.

The trust has submitted details of 1 serious case review commenced or published in the last 12 months.

Reference Number	Team/Ward/Unit	Recommendations	Actions Taken	Outstanding Actions
Child N	351 L7F9 L3074 CMHT Blackburn (25-65)	15 recommendations were made	Actions were taken in response to all recommendations	Actions Complete

We analysed data about safety incidents from three sources: incidents reported by the trust to the National Reporting and Learning System (NRLS) and to the Strategic Executive Information System (STEIS) and serious incidents reported by staff to the trust's own incident reporting system. These three sources are not directly comparable because they use different definitions of severity and type and not all incidents are reported to all sources. For example, the NRLS does not collect information about staff incidents, health and safety incidents or security incidents.

Between 01 February 2018 and 31 January 2019, the trust reported 112 serious incidents. The most common type of incident was Apparent/actual/suspected self-inflicted harm meeting SI criteria with 51. 17 of these incidents occurred in MH - Community based mental health services for adults of working age. From the trust's serious incident information, there were 28 Pressure Ulcer incidents and these occurred in CHS - Adults Community.

We reviewed the serious incidents reported by the trust to the Strategic Information Executive System (STEIS) over the same reporting period. The number of the most severe incidents recorded by the trust incident reporting system was not comparable with STEIS with 120 reported. Differences were reported in MH - Acute wards for adults of working age and psychiatric intensive care units, MH - Child and adolescent mental health wards, MH - Community based mental health services for adults of working age, MH - Specialist community mental health services for children and young people, Mental health crisis services and health-based places of safety, CHS – Adult Community Services and CHS – Community Dental

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. The trust reported 1 never event during this reporting period.

Type of incident reported	CHS – Adults Community	Community based mental health services for adults of working age	Mental Health Crisis Services & Health Based Places of Safety	Acute wards for adults of working age and psychiatric intensive care units	Community based mental health services for older people	Other Core Services	Total
Apparent/actual/suspected self-inflicted harm meeting SI criteria	0	17	12	4	8	10	51
Pressure ulcer meeting SI criteria	28	0	0	0	0	0	28
Other	1	3	1	3	1	5	14

Type of incident reported	CHS – Adults Community	Community based mental health services for adults of working age	Mental Health Crisis Services & Health Based Places of Safety	Acute wards for adults of working age and psychiatric intensive care units	Community based mental health services for older people	Other Core Services	Total
Disruptive/ aggressive/ violent behaviour meeting SI criteria	0	1	2	3	0	1	7
Confidential information leak/information governance breach meeting SI criteria	1	0	0	0	0	5	6
Slips/trips/falls meeting SI criteria	0	0	0	0	0	0	2
Operation/treatment given without valid consent	0	0	0	0	0	1	1
Apparent/actual/suspected homicide meeting SI criteria	0	0	0	0	1	0	1
Medication incident meeting SI criteria	1	0	0	0	0	0	1
Diagnostic incident including delay meeting SI criteria (including failure to act on test results)	1	0	0	0	0	0	1
Total	32	21	15	10	10	22	112

Between 01 April 2018 and 31 March 2019, the trust notified CQC of the suicide of 0 patients detained under the Mental Health Act.

Providers are encouraged to report patient safety incidents to the National Reporting and Learning System (NRLS) at least once a month. The average time taken for the trust to report incidents to NRLS was 22 days which means that it is considered to be a consistent reporter.

The highest reporting categories of incidents reported to the NRLS for this trust for the period 01 February 2018 to 31 January 2019 were Self-harming behaviour, Infrastructure (including staffing, facilities and environment and Documentation (including electronic & paper records, identification and drug charts. These three categories accounted for 47% of the 13,137 incidents reported. Other accounted for 199 of the 253 deaths reported.

Eighty nine percent of the total incidents reported were classed as no harm (76%) or low harm (13%).

Incident type	No harm	Low harm	Moderate	Severe	Death	Total
Self-harming behaviour	1,751	788	208	26	50	2,823
Infrastructure	1,945	33	54	4	0	2,036
Documentation	1,293	7	5	0	0	1,305
Disruptive, aggressive behaviour	934	163	67	4	0	1,168
Patient Accident	750	265	67	10	3	1,085
Access, admission, transfer, discharge	959	29	31	6	0	1,025
Medication	923	19	29	4	0	975
Implementation of care and ongoing monitoring/review	89	183	317	185	0	774

Incident type	No harm	Low harm	Moderate	Severe	Death	Total
Other	235	159	87	16	199	696
Treatment, procedure	412	20	16	5	1	454
Consent, communication, confidentiality	343	5	4	3	0	355
Clinical assessment	243	3	3	1	0	250
Infection control incident	14	26	31	3	0	74
Patient abuse (by staff/third party)	51	8	2	0	0	61
Medical device/equipment	52	2	2	0	0	56
Total	9,994	1,700	923	267	253	13,137

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 reported fewer incidents from 01 February 2017 to 31 January 2018 compared with the previous 12 months with fewer incidents reported across all categories.

Level of harm	01 February 2017 – 31 January 2018	01 February 2018 – 31 January 2019
No harm	8,342	9,994
Low	1,401	1,700
Moderate	684	923
Severe	176	267
Death	166	253
Total incidents	10,769	13,137

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 three 'prevention of future death' reports sent to Lancashire Care NHS Foundation Trust. Details of which can be found below.

Report to Prevent Future Deaths

Patient A died after voluntarily ingesting a large quantity of morphine at home on 18 April 2017 and was discovered dead by the police on 22 April 2017 after concerns were raised.

The Coroner's concerns were:

- If mental health professionals are expected to provide care to an excessive number of service users – many of whom inevitably pose significant challenges – then there is a genuine risk of future deaths arising as a result of this.

Patient B

The Coroner's Concerns were:

The poor quality of record keeping, including Patient B's use of leave, the lack of a completed risk assessment and no evidence of the Leave Authorisation required to grant leave as required under section 17, prior to Patient B's escorted leave on the 10 September 2017.

Actions taken by the trust include the following:

- Once leave has been agreed by the Multi-Disciplinary Team, the nursing team on each ward will be prompted to fully consider the patients risks and state of mind immediately prior to the patient taking this leave and reminded to document their up to date decision in the clinical record.
- Leave that is given regularly to a patient is already discussed and agreed in the context of the Multi-Disciplinary Team, and should be documented in the clinical record, however some points around how this is care planned are not currently included in our Leave Policy and so the Mental Health Law Manager will consider a minor amendment to the policy by 28 September 2018.
- How leave went for the patient should already be documented and discussed in the wider MDT forum; in addition, a pilot of "leave diaries" is currently taking place in our secure services, if it is found to increase the quality of post leave documentation this will later be rolled out to all wards.
- The Clinical Director will write to consultants and ward managers about these actions by 14 September 2018 and reiterate the importance of documenting the rationale, risks and benefits for each individual accessing leave.
- The impact of the above actions will be included in a clinical audit in January 2019. Matrons and ward managers will then review the findings from these audits and feed the results back during clinical supervision with their teams.

Patient C

Patient C was found dead at his home address on 29 September 2016 having hung himself.

The Coroner's concerns were:

The message explaining his nonattendance and requesting a further appointment was not relayed to the MDT. Had that message been relayed to the MDT, I found that Patient C would have been offered a further appointment and would not have been discharged at that time.

The MDT did not discuss Patient C following his discharge from hospital and nothing was recorded about him. No-one contacted Patient C back to advise him as to whether or not he would have an appointment with the HTT. I heard evidence that the MDT meeting could be disorganised. I am concerned that Patient C was not considered by the team, despite the message being handed over to them. I am also concerned about a lack of record keeping during the MDT. Even where patients are discussed, the notes appear to be very brief.

The trust submitted details of one external review commenced or published in the last 12 months (01 February 2018 – 31 January 2019) related to a complaint following a serious incident investigation. The review was commissioned by the interim director of nursing and quality in response to a complaint about the care and treatment of a patient which the family raised concerns about. The report had not been finalised at the time of this submission.

The trust had an established, investigations and learning team to undertake all serious incident investigations including safeguarding and deaths within the trust. 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. All the team had received human factors training. The team provided post-investigation debriefings for the clinical team and for people who used services, their carers and families.

We reviewed five completed serious incident investigations. The reports followed a set template based on a root cause analysis methodology. The reports were of a high standard and identified any lessons learnt and good practice. The trust had improved lessons learned by introducing a new safety alerts process including a new lessons' learned bulletin and a new incident on a page for every serious incident which were shared with staff. The trust had also appointed a mortality reviewer to strengthen the learning from deaths process since our last inspection. However; some staff on the acute wards told us they did not always receive feedback from incidents therefore learning was not always embedded. This was escalated onto the board assurance framework.

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	99.3%
What is your target for completing a complaint?	25	79.8%
If you have a slightly longer target for complex complaints, please indicate what that is here	N/A	N/A

* 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

The trusts' performance in responding to complaints within three days had improved slightly from 99% at our last inspection to 99.3% and the completion of complaints within 25 days had significantly improved from 58% to 79.8%. In February 2019, this figure had increased to 93.8%. 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. We were satisfied that 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.

	Total	Date range
Number of complaints resolved without formal process*** in the last 12 months	0	01 Feb 2018 – 31 Jan 2019
Number of complaints referred to the ombudsmen (PHSO) in the last 12 months that were upheld	3	1 Feb 2018 – 31 Jan 2019

***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

Between May 2016 and April 2017, there were 36.4 Mental Health Act complaints received by CQC for every 1,000 detentions and community treatment orders.

This trust received 7,291 compliments during the last 12 months from 01 February 2018 to 31 January 2019. This was lower than the 8,792 reported at the last inspection. 'CHS – Community Adults' had the highest number of compliments with 41%, followed by 'and 'Mental Health Crisis/HBPOS' with 17.4% and 'CHS – Community Dental' with 16.5%.

Senior management committees and the board reviewed performance reports. The board performance report was produced monthly and included detailed information against a variety of key performance indicators and targets. Dashboards were provided for each individual team showing a range of quality and safety measures such as incidents, complaints, risks, friends and family data, etc so teams had oversight on their performance. Ward managers on the acute wards told us that imputing the data to generate the governance reports was time consuming for them.

Performance reports presented to the board in April 2019 showed the trust had achieved a performance of 51.9% against a target of 53% across all eight commissioning groups.

However; the trust had consistently and significantly not met the following targets between March 2018 and February 2019:

- Inappropriate out of area placements: target 513 occupied bed days. The lowest figure was 798 in June 2018 and the highest figure was 1723 in January 2019. The target was an average of 15 patients per month however; the number had gradually increase to an average of 60.82 patients in February 2019.
- Average lengths of stay within the acute wards, psychiatric care wards and out of area were also consistently above targets.
- Two weeks wait for treatment for early intervention in psychosis programme against a target of 53%
- Targets for over 19 year olds referred to the eating disorder service were also consistently not been met.
- Number of patients without a care co-ordinator allocated within two weeks: target 0. The figure had fluctuated between 501 to 869 over the period.
- Memory assessment service 6 weeks from referral to diagnosis. Against a target 59%, the lowest compliance was 9.2% in April 2018 and the highest compliance was 32.1% in July 2018.
- The trust had significantly and consistently not met any of the targets set in relation to the mental health liaison teams within any of the localities. For example; in East Lancashire, the percentage of patients seen within the hour in A&E against a target of 95% was between 23.7% to 59.6%. The percentage seen within 4 hours against a 95% target was between 15.0% and 29.3%. The number of 12-hour breaches against a target of 0 was between six and 48 over the time period.
- Against a national target of 0, the number of times the number of section 135/136 exceeded 24 hours was between 23 and 49 times.
- The percentage of patients staying less than 23 hours in the mental health decision units against a local target of 0 was between 23.4% up to 48.8%. The number of breaches ranged from 47 in April 2018 to 111 in November 2018 showing a steady upward trajectory over the period.

This demonstrated that the trust did not effectively use performance reports to manage current and future performance.

Medicines related incidents were in the trust top five incidents (4th – 16.39%). The Medicines Safety Group had completed a 'deep dive' into medicines errors in the East Locality. Actions included:

- Working as part of a Lancashire-wide group to consider medicines incident related to adverse discharges.
- Revision of the incident level descriptions for medication incidents.
- A joint 12-month locality review of medicines errors was presented jointly with the local acute hospital trust to Commissioners.

Additionally, medication error reduction was a safety priority within the trust quality plan 2019-22. Objectives to support mitigation of identified risks regarding pharmacy workforce capacity, and compliance with the Falsified Medicines Directive were included in the Pharmacy & Medicines Management Operational Plan. There were plans for increased pharmacy support to community mental health teams, including a successful bid for specialist pharmacist support to the home treatment team. Following re-audit, the trust found improvement in the monitoring and recording of physical observations following the administration of Rapid Tranquillisation. There were plans to Incorporate Rapid Tranquillisation into the Clinical Assurance Framework Dashboard, so performance was visible at ward level.

The trust participated in POMH-UK (Prescribing Observatory for Mental Health) benchmarking audits of prescribing against national standards and in the NHS pharmacy benchmarking as comparator, to identify good practice and areas for development.

Leaders were satisfied that clinical and internal audits were sufficient to provide assurance. Teams acted on results where needed. There was a robust audit programme in place to monitor compliance against trust policies and best practice guidance which was managed through the trusts audit committee governance structure with oversight from the board. Audits included topics such as restrictive practices, falls, pressure ulcers, podiatry, Mental Health Act, medication and lone working. 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 compliance targets were achieved.

Staff had access to the risk register either at a team or division level and were able to effectively escalate concerns as needed. Staff within clinical areas we visited and within focus groups we held confirmed they could escalate risks onto local risk registers and felt confident doing so. There was a clear process for escalation of risks from networks to the trusts risk register via the committees. Staff concerns matched those on the risk register. 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.

Robust arrangements were in place for identifying and recording risks. Recorded risks were aligned with what staff said were on their 'worry list'.

The trust board had sight of the most significant risks and mitigating actions were clear. All the risks on the board assurance framework were linked to the trusts' strategic priorities. Within the board assurance framework, any risk which scored 15 or higher according to the Risk Rating Matrix was classified as 'significant'. The trust had five overarching risks which were rated as 'significant' and seven rated as 'high'. Of the risks rated as significant, three related to quality, one to workforce (people) and one to finances.

- If we do not meet regulatory standards for quality and safety, we will not be fit for purpose as care provider.
- If we do not provide integrated physical and mental health services, we will lose opportunities to improve patient outcomes.
- If we do not create a culture of learning, then we will be unable to provide high quality care.
- If we do not develop an engaged and motivated workforce and support the health and wellbeing of staff, then the quality of our service may deteriorate.
- If we do not meet financial objectives, we will not be able to provide sustainable services.

Each risk had a rationale for the risk, controls, assurances, evidence of progress, gaps in control, actions, identified lead and date for implementation and which committee was responsible for monitoring the risk. Although we were assured that the trust had good oversight of the risks, sufficient progress had not been made to mitigate and manage all the risks effectively since our last inspection. Many of the key risks we identified during our last inspection were still recorded on the board assurance framework as significant risks for the trust during this inspection.

The trust had a detailed business continuity management plan dated September 2016 and a major incident plan which was issued 31 March 2018. There were associated policies to ensure services could respond effectively in the event of an emergency 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 there were arrangements to consider the impact on patient care. Managers monitored changes for potential impact on quality and sustainability.

Where cost improvements were taking place, they did not compromise patient care. 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. All staff we spoke with 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 and commissioners.

The director of finance had been in post for several years and they had a strong track record in financial management and delivery. The trust has had a stable turnover of over £340m for a number of years. NHS Improvement told us they had clear evidence that financial outcomes in the trust had been consistently strong over several years i.e. cash, capital and revenue plans being delivered in line with plans and national requirements. The trust had consistently managed financial risks and mitigated these effectively. Auditors had not flagged concerns to regulatory bodies. NHS Improvement's single oversight framework currently segmented 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.

In 2018/19 there was a significant increase in demand for the trust's services, generating c£7m of financial pressures. The trust successfully worked with the commissioners to resolve the situation non- recurrently. The trust was planning for a break-even position in 2019/20.

The trust has consistently managed financial risks and mitigated these effectively.

Financial Metrics	Historical data		Projections	
	Previous financial year (2 years ago) (01 April 2016 – 31 March 2017)	Last financial year (01 April 2017 - 31 March 2018)	This financial year (01 April 2018 – 31 March 2019)	Next financial year (01 April 2019 – 31 March 2020)
Actual income	£344,012	£345,998	£350,466	
Actual surplus (deficit)	-£1,018	£3,359	-£1,831	
Actual costs/expenditure - full	£345,030	£342,639	£352,298	
Planned budget or (deficit)	-£1,379	£2,167	-£1,679	£0

Information Management

The board received information on service quality and sustainability which included data on a range of key performance indicators such as staffing, finance, training compliance, incidents reported, safeguarding alerts, appraisal rates and complaints/compliments. Information was in an accessible format and identified areas for improvement. This data fed into a board assurance framework. The reports linked to the trusts' values and strategic objectives and covered operations, quality, workforce and finance. Standard data quality reports were shared with network management teams. Team managers had access to a range of information to support them with their management role. This included information on the performance of the service, staffing and patient care.

The trust had developed internal data kitemarks for their operational performance indicators.

Some teams also used an electronic outcome measures tool which monitored safety, effectiveness, experience and leadership known as a quality 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 trust had a separate senior information risk owner and a Caldicott guardian. In addition, there was a data quality lead in place who was supported by data quality leads within each of the networks.

The trust had assessed policies and procedures against the European Union General Data Protection Regulation which applied from 25 May 2018, when it superseded the UK Data Protection Act 1998 to meet the new regulations.

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 self-assessment for 2017-18 and scored 80% which was 'satisfactory'.

However; the trust recognised there were still areas that they needed to improve on in terms of the accuracy of some of the data the board received. Staff also told us in the focus groups we held and in the clinical areas we visited there were issues with data quality. Several staff told us that they did not always input supervision sessions they had on the system. They told us this was because the staff member and supervisor had to access the system to confirm the meeting had taken place. Other staff kept supervision passports and again, did not always record sessions in their passports onto the system. Managers also told us training figures were not captured in 'real time' and recent training staff had attended were not reflected in the figures.

We also identified issues in relation to the accuracy of data the trust collated in relation to the Mental Health Act and in-patient admissions.

When a patient is detained under the Mental Health Act in hospital, the provider is required to submit a record to the Mental Health Services Data Set each month until the detention ends. Between December 2017 and November 2018, the trust only provided end dates for 23.9% of Mental Health Act episodes for detentions, which had ended. This gives an incomplete picture about the provider's use of the MHA and indicates there may be problems with recording or sharing data externally.

When a patient is admitted to hospital, the provider is required to submit a record to the Mental Health Services Data Set each month until their inpatient admission ends. Between December 2017 and November 2018, the trust only provided end dates for 75.7% of inpatient episodes, which had ended. This gives an incomplete picture about discharges from hospital and patients length of stay and indicates there may be problems with recording or sharing data externally.

Ward managers on the acute and psychiatric intensive care wards said the monthly governance reports they completed were time consuming and not the best use of their time.

Staff within the community mental health teams expressed concerns about not being able to access patient records for patients who had a social worker care co-ordinator in the local authority. This was because the local authority social workers had recently been removed from the teams back to the local authority. Some still care coordinated some service users as there was not enough trust staff to take over their care. These social workers documented all records within the local authority electronic record system which trust staff did not have access to. Social work staff had agreed to make entries into the trust's electronic record system if any significant events occurred however, this meant trust staff were reliant on social work colleagues completing these entries to share information.

The trust had a number of systems and processes in place to monitor and assure data quality. The trust had a Data Quality policy and the data quality lead co-ordinated monitoring and action across the clinical networks in collaboration with network performance leads. The trust had bi-weekly meetings to address inconsistencies in reported data. Issues raised were analysed and actions agreed and monitored until the issue was resolved and signed off. Feedback to the Each of the networks received feedback through the performance management meetings which were attended by network performance leads.

The trust had a quality assurance check and sign off process for all data/information reported outside of the trust, which enabled information to be reviewed, contextualised and triangulated. Random sampling audits, as well as internal audits, were conducted against the standard operating procedures in order to review quality/integrity of data reported in terms of both data input

and handling. Data quality hotspots were reported in the trusts quality performance report which was received by the board each month.

The trust used a bespoke electronic clinical record system which was separate to the patient administration system they used. This posed challenges for the trust in terms of consistent data entry by staff because of user accessibility and the lack of connectivity of the two systems. This had impacted upon the trusts' ability to evidence and improve the effectiveness and efficiency of their operational performance. The chief clinical information officer told us that this would be addressed with the implementation of the new electronic patient record which was currently being rolled out. This was part of a £5m programme of investment the trust had embarked on in new systems to support patient care.

Other information technology initiatives which were included in the programme were;

- The procurement of ward-based automated medicines cabinets at Guild Lodge to help support a reduction in medicine administration errors and provide a full medicines audit trail
- Investment in innovative new systems via the Global Digital Exemplar Programme including Virtual Reality Headsets to support patients with a range of Mental Health conditions
- Further implementation of bedside mobility solutions to support patient physical and mental health observations in near real time
- The introduction of information systems to support clinical and managerial dash boards utilising cloud-based Power BI technology.

The trust had also used Refine and Define databases to enable comparison of prescribing and medicines usage both within the trust and with comparable organisations.

Leaders used meeting agendas to address quality and sustainability sufficiently at all levels across the trust. Staff said they had access to all necessary information and were encouraged to challenge its reliability.

IT systems and telephones were working well and they helped to improve the quality of care.

Staff had access to the IT equipment and systems needed to do their work.

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.

Information governance systems were in place including confidentiality of patient records. Information governance training compliance across the trust was 69%.

The trust had not reported any data security breaches. The trust undertook regular cyber security audits which had not identified any risks.

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 had recently appointed a new head of patient experience to provide the strategic direction and strengthen the governance arrangements in relation to patients and carers experiences. They recognised that this was work in progress and more could be done. However; they were able to provide examples of positive changes which had taken place in relation to staff training, co-production work with carers and patients and responding to feedback/concerns. The head of patient experience reported quarterly to the board through the people and quality sub-committee.

The trust's External Communication and Engagement Plan 2019/20 set out actions the trust was taking to ensure the public, patients, carers and other organisations were involved in improving service delivery.

The objectives of the plan were;

- To share information about the Trust in an open and honest way
- To share good news about the Trust and its successes in order to raise its profile locally and nationally
- To encourage two-way dialogue between the Trust and its stakeholders, building relationships and trust
- To align activity with the internal communication plan using the core values as a theme to give consistent messages inside and outside of the organisation
- To position the Trust in the context of its future strategy and place in the wider health economy.

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.

The trust had a council of 22 governors who provided a link between the communities the trust served and the board of directors. However; there was not an overarching strategy for engaging with communities therefore there was a dependence on governors identifying groups to engage with. The governors were able to give us examples of groups they and the trust engaged with in the community people who struggled to engage through different community groups. These included groups supporting people with sensory impairments and people within the LGBT community for example.

In the governors focus group we held, the governors confirmed they had received an induction and training on appointment. They reported they felt actively involved in the operation of the trust.

Patients, staff and carers were able to meet with members of the trust's leadership team and governors to give feedback. 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 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.

The trust had a Hearing Feedback team that supported all areas of the trust and people using services, to receive and respond to feedback. They could be contacted by a range of means including email, phone, post and in person and each case was managed to ensure a timely response was provided. Specific pieces of work around people in hard to reach groups included an Always Event, My Voice Always Matters for people using secure services at Guild Lodge and the co-design of a leaflet and feedback form for people using learning disability services.

Patients, carers and staff had opportunities to give feedback on the service they received in a manner that reflected their individual needs. The trust had a central database for patient and carer experience focused surveys which included:

- Friends and Family Test (Standard Version, Children & Young People's version, including Rights based Friends and Family Test and Learning Disability version). The trust consistently reported above 90% recommendation rates. The trust had extended the Friends and Family Test surveys for services with additional questions looking at whether patient views were considered, were people treated with dignity and respect, had access to staff and would they be happy to be treated again. Feedback the trust received scored over 95% in these areas.
- Children's Integrated Therapies, including speech and language therapy, occupational therapy and Physiotherapy used local patient surveys to inform service development and achieve improved integrated working. Feedback identified duplication and waits, leading to improvements in shared care planning, generic assessment and shared communication.
- Experience of Seclusion survey which identified patients needed information about the use of seclusion and access to therapy. This feedback was included in the trust's seclusion improvement project.
- Carers survey as part of the Triangle of Care (carers) self-assessment audits across inpatient mental health, secure services and crisis teams. The key themes from those returned were the need for improved carer information, carer inclusion in decision making and access to carer assessments.
- The use of comment boxes within the forensic service in response to patients' feedback.

The trust pharmacy team was engaging with Healthier Lancashire and South Cumbria as part of NHS England's Integrating Pharmacy and Medicines Optimisation pilot. Workstreams included adverse discharges and exploring a single solution for electronic transfer of medicines information to community pharmacy on discharge. The trust has 'signed up' to the Choice and Medication website to for staff and patients to support active discussions about their medicines.

Overall, the teams and divisions had access to feedback from patients, carers and staff and were using this to make improvements.

The trusts' system for collating surveys generated real time reports at organisation, network and clinical team levels which all staff could access directly.

The trust had a structured and systematic approach to staff engagement which was detailed in the trusts' Communication and Engagement Plan 2018/19 which had been developed following the previous staff survey results. Some staff within the core services we visited and within the focus groups we held told us that they felt involved in decision making about changes to the trust services. However; some staff within the crisis teams told us they had not felt involved in discussions to change the service to full 24 hours. Staff survey results for staff feeling involved in decisions were low for the previous two years. Only twenty seven percent of staff felt senior managers tried to involve them in important decisions compared to 24% in 2017, and 27% felt senior managers acted on staff feedback compared to 23% the previous year.

Extensive consultation had taken place however; individually and through listening events with staff, people who used services, carers and stakeholders to inform the Lancashire urgent mental health pathway review. The review had involved listening events which were attended by 100 service users and carers, over 100 staff from across the system, over 50 GP's and individual discussions with commissioners and senior leaders from all providers and the wider health and social care system.

Communication systems such as the intranet and newsletters were in place to ensure staff, patients and carers had access to up to date information about the work of the trust and the services they used. Division leaders/middle managers, on behalf of front-line staff, engaged with external stakeholders such as commissioners and Healthwatch. The trust had 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 had engaged with stakeholders and the public in discussions involving the Lancashire and South Cumbria sustainability and transformation plan in addition to specific local work streams within the trust.

External stakeholders said they received open and transparent feedback on performance from the trust.

Learning, continuous improvement and innovation

The trust had a governance structure in place to support and drive quality improvement within the trust. This was underpinned by the trusts' quality plan 2019/22 which had been co-produced with staff. The plan was aligned to the delivery of the trust's four quality priorities and was monitored through the people and quality committee. The people and quality committee were presented with a people story on a quarterly basis where clinical staff talked about quality improvements that they had implemented at team level.

Each network had a quality improvement plan with clear timescales for completion.

The trust had appointed a new innovation manager in June 2018 to promote and support continuous improvement throughout the trust. The trust used an established 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 67 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 areas 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.

Staff were involved in a number of continuous improvement initiatives which were taking place across the trust. These included projects such as; digital dentistry training technology, a virtual reality avatar-based children's mental health programme, desktop anti-microbial resistance diagnostic tools, virtual violence reduction training and an innovative evidential monitoring tool to assist remote assessment by tissue viability teams. The trust had also piloted the use of pharmacy independent prescriber support to two acute wards which had found improvements in medicines reconciliation and safe prescribing.

The trust was also involved in wider improvement initiatives with partner organisations such as the Change Talks early intervention and prevention service which was a 6-week programme delivered throughout Lancashire schools and colleges, with a key aim to develop more resilient young people through educating positive coping strategies to help with their mental health. The trust had also partnered up with a counselling charity to provide bespoke support to people who are addicted to or harmed by gambling.

Staff were encouraged to make suggestions for improvement and gave examples of ideas which had been implemented. In the 2018 staff survey results, 79% of staff reported they were able to make suggestions to improve the work of their team or department which had increased from 73% in the previous survey. Fifty two percent felt involved in deciding changes that affected their work and increase of four percent and 57% felt they were able to make improvements happen in their area of work an increase of six percent from the previous year. Seventy percent reported team members often met to discuss the team's effectiveness which was a six percent increase.

Staff were aware of their contribution to cost improvement objectives.

Staff in the core services we visited and focus groups we held were able to provide examples of continuous improvement initiatives they had been involved in and how these had led to improvements.

The trust had an effective process in place to identify and learn from unanticipated deaths which was detailed in the trusts' Learning from Deaths Procedure and incident policy. The learning from deaths process was overseen by the safety summit and reported to the quality and safety sub-committee. The trust produced an annual learning from deaths report.

All deaths had a review completed by the relevant manager within three working days of being reported. They were also reviewed daily by a virtual panel led by the safety director. This panel reviewed the incident and determined whether the three day review was sufficient or whether any of the following additional measures should be enacted:

- Additional questions
- Serious incident investigation / other safety investigation
- Structured case judgement review
- External mortality review.

All deaths were further reviewed by a weekly safety summit. This panel was attended by the nursing director, medical director, safety director and all clinical directors who reviewed the decisions made by the virtual panel.

The trust had appointed a mortality review practitioner since our last inspection who coordinated the completion of all structured case judgement reviews.

Learning from reviews was undertaken through direct feedback to teams, cascading through governance meetings and team meetings, learning events, incident on a page summary sheets, safety lessons learned bulletin and through safety alerts. The trust had recently developed a new safety learning library for staff.

The trust commissioned an internal audit to review its process for lessons learned and the rating allocated was substantial assurance. We examined five completed unexpected death reviews. The reviews were comprehensive and identified good practice in addition to recommendations.

External organisations had recognised the trust's improvement work. Individual staff and teams received awards for improvements made and shared learning. These were shared with staff via the trusts' web-site in addition to the trusts people at the heart newsletter

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	Core service	Service accredited	Comments and Date of accreditation / review
ECT Accreditation Scheme (ECTAS)	-	Preston Blackburn	4 December 2018 5 September 2017
Quality Network for Inpatient CAMHS (QNIC)	MH - Child and adolescent mental health wards	The Cove	QNIC peer review in January 2019. Awaiting report. Planning for accreditation in 2020
Accreditation for Psychological Therapies Services (APPTS)	IAPT	Lancashire Women service	January 2019
Quality Network for Forensic Mental Health Services	MH – Forensic Inpatient	Low Secure Unit Medium Secure Unit	Feb 2017
Memory Services National Accreditation Programme (MSNAP)			Registration in progress for Central, East, Fylde, West and Lancaster & Morecambe teams
Baby Friendly Initiative LCFT LCC Child & Family Health Service Health Visitors	CHS - Children, Young People and Families		First accredited in 04/2016. Re accreditation due March 2019 Wellbeing Prevention & Early Health Services Lancashire 09/2016- this is not our service. We supported their accreditation as part of a contract.
Baby Friendly Initiative		LCFT Blackburn with Darwen Child & Family Health Service Health Visitors	Accreditation 2011. Due sustainability re accreditation end of February 2019.
LGBT Quality Mark Award		Pan-Lancashire CaSH HR Services CAMHS Services (Pan-Lancashire)	July 2016 September 2016 August 2018
Quality Network for Community CAMHS: Eating Disorder Services		A self-assessment has been completed A peer review due on 1st May 2019	
Dementia Action Alliance: Dementia Wards		Dementia Wards - only informally	

Accreditation scheme	Core service	Service accredited	Comments and Date of accreditation / review
NHS Library Quality Assurance Framework (LQAF)			Library Services November 2018
Mindful Employer and Disability Confident Employer			2017
Inclusive Employers Top 50			2018

Glossary of data checks to support exception reporting [delete table and heading before publication]

Evidence Appendices report sub heading	RPM Metric/ Indicator	Analytical Checks 1	Non-random or special cause variation detected? (yes/no) ¹	Analytical Checks 2	Non-random or special cause variation detected? (yes/no) ²
safe staffing	Vacancy rates (all staff/qualified nurses/medical staff/nurse assistants/allied health professionals) over the past 12 months- RPIR/ trust data	Interquartile test for national comparison against other similar services	All staff, medical, allied health professionals	run chart to identify non-random variation	
safe staffing	Staff turnover (all staff/ qualified nurses/medical staff/nurse assistants/ allied health professionals) over the past 12 months- RPIR/ trust data	Interquartile test for national comparison against other similar services	all staff, nursing assistants, qualified nurses	run chart to identify non-random variation	
safe staffing	Staff sickness rate (all staff/ qualified nurses/medical staff/nurse assistants/ allied health professionals) over the past 12 months - RPIR/ trust data	Interquartile test for national comparison against other similar services	all staff, nursing assistants, qualified nurses	run chart to identify non-random variation	
safe staffing	Staff sickness rate (all staff/nurses/medical staff/nurse assistants) over the past 12 months - MH Insight (ESR)	Interquartile test for national comparison against other similar services	No		
safe staffing	Proportion of days sick in the last 12 months - nursing and midwifery staff/medical & staff/other clinical staff/ non- clinical staff - MH Insight (ESR)	Z scored for national comparison against similar services	Yes – qualified nurses, clinical staff		
safe staffing	Bank and agency use (qualified nurses/medical staff/nurse assistants) over the past 12 months- RPIR/ trust data	-	-	run chart to identify non-random variation	Yes – nursing assistant bank

¹ Hyperlinks to analysis included

² Hyperlinks to analysis included

Community health services

Community dental services

Facts and data about this service

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

Location / site name	Team/ward/satellite name	Services provided	Address (if applicable)
Bamber Bridge Clinic	Dental Special Care Dentistry Central (C)	Dental Services	Ashton Health Centre, 67-69 Pedders Lane, Ashton, Preston, PR2 1HR
Ringway Dental Centre	Dental PDS Plus Central (C)	Dental Services	Ringway House, Ringway, Preston, PR1 3HQ
Royal Blackburn Hospital	Dental Special Care Dentistry GA (C)	Dental Services	Level 2 (Blue Level), Royal Blackburn Hospital, Haslingdon Road, Blackburn, BB2 3HH
Dental Care Calderstones Hospital	Dental Special Care Dentistry Calderstones (C)	Dental Services	Mitton Road, Whalley, BB7 9PE
Yarnspinner's Primary Health Care Centre	Dental Special Care Dentistry Yarnspinners (C)	Dental Services	Carr Road, Nelson, BB9 7SR
Bacup Primary Health Centre	Dental PDS Bacup (C)	Dental Services	Irwell Mill, Rochdale Road, Bacup, OL13 9NR
Bacup Primary Health Centre	Dental Special Care Dentistry Bacup (C)	Dental Services	Irwell Mill, Rochdale Road, Bacup, OL13 9NR
Barbara Castle Way Health Centre	Dental PDS Barbara Castle Way (C)	Dental Services	Barbara Castle Way Health Centre Simmons Street Blackburn BB2 1AX
Barbara Castle Way Health Centre	Dental Special Care Dentistry Barbara Castle Way (C)	Dental Services	Barbara Castle Way Health Centre Simmons Street Blackburn BB2 1AX
Oak House Dental Centre	Dental PDS Oak House (C)	Dental Services	34 Church Street, Accrington, BB5 2ED
Oak House Dental Centre	Dental Special Care Dentistry Oak House (C)	Dental Services	34 Church Street, Accrington, BB5 2ED
St Peters Primary Healthcare Centre	Dental PDS St Peters (C)	Dental Services	3rd Floor, Church Street, Burnley, BB11 2DL
St Peters Primary Healthcare Centre	Dental Special Care Dentistry St Peters (C)	Dental Services	3rd Floor, Church Street, Burnley, BB11 2DL
Yarnspinner's Primary Health Care Centre	Dental PDS Yarnspinners (C)	Dental Services	Carr Road, Nelson, BB9 7SR
Oak House Dental Centre	Dental Emergency Service East Lancs (C)	Dental Services	34 Church Street, Accrington,
Oak House Dental Centre	Dental Education Centre East Lancs (C)	Dental Services	34 Church Street, Accrington,
Royal Blackburn Hospital	Dental Special Care Dentistry RBH (C)	Dental Services	Level 2 (Blue Level), Royal Blackburn Hospital, Haslingdon Road, Blackburn, BB2 3HH
Darwen Health Centre	Dental Special Care Dentistry Darwen (C)	Dental Services	Darwen Health Centre, James Street West, Darwen, Lancashire, BB3 1PY

Location / site name	Team/ward/satellite name	Services provided	Address (if applicable)
Clitheroe Hospital	Dental PDS Clitheroe (C)	Dental Services	Chatburn Road, Clitheroe,
Clitheroe Hospital	Dental Special Care Dentistry Clitheroe (C)	Specialist community Dental service	Chatburn Road, Clitheroe,
Sceptre Point	Dental Management (C)	Clinical team/service management	N/A

(Source: Universal Routine Provider Information Request (RPIR) – P2 Sites tab)

The Lancashire Care NHS Foundation Trust Dental service offers specialist services, such as children's and special care dentistry and home visits for patients in the local community. They offer treatment under inhalation sedation and general anaesthesia. Patients requiring specialist services are seen on a referral only basis.

They also provide general dental services and emergency dental services. Emergency patients are triaged by an external organisation.

The service also works with the University of Central Lancashire to provide training and support for undergraduate dental students and dental therapists.

Community and primary dental services are available Monday from 8:30am to 5:00pm and Friday from 8:30am to 4:30pm. During the inspection we received feedback from 35 patients and spoke with 22 members of staff.

Our inspection between 28 and 30 May 2019 was announced (staff knew we were coming) to ensure that everyone we needed to talk to was available. During the inspection we visited Oak House Dental Centre, Yarnspinner's Primary Health Care Centre, Ringway Dental Centre, Barbara Castle Way Health Centre and St Peters Primary Healthcare Centre.

Is the service safe?

Mandatory training

The trust set a target of 80% for completion of mandatory training.

A breakdown of compliance for mandatory training courses from 1 April 2018 to 6 March 2019 at core service level for staff in community dental services is shown below:

Training module name	April 2018 to March 2019				
	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Equality & Diversity	108	113	96%	80%	Yes
Mental Capacity Act L1	78	81	96%	80%	Yes
WRAP	73	76	96%	80%	Yes
Infection Control	86	91	95%	80%	Yes
Manual Handling L1A	20	22	91%	80%	Yes
Fire Safety	102	113	90%	80%	Yes
Health & Safety	102	113	90%	80%	Yes
Safeguarding Adults L2	82	91	90%	80%	Yes
Safeguarding Children L2	77	89	87%	80%	Yes
Conflict Resolution	92	112	82%	80%	Yes
Safeguarding Adults L1	18	22	82%	80%	Yes

Safeguarding Children L1	18	22	82%	80%	Yes
Manual Handling L2A	61	75	81%	80%	Yes
Basic Life Support	23	30	77%	80%	Yes
Information Governance	87	113	77%	80%	No
Immediate Life Support	39	51	76%	80%	No
Mental Capacity Act L2	60	81	74%	80%	No
Manual Handling L1B	7	16	44%	80%	No
Safeguarding Children L3	0	2	0%	80%	No
Infection Control (Admin)	0	0	n/a	80%	
Mental Capacity Act L1 (Admin)	0	0	n/a	80%	
Core service total	1133	1313	86%	80%	Yes

(Source: Routine Provider Information Request (RPIR) – Training tab)

The service provided mandatory training in key skills to all staff and made sure everyone completed it.

Staff were required to complete mandatory training relevant to their roles. Mandatory training included fire safety, infection prevention and control, information governance, conflict resolution and equality and diversity. All dentists, and all dental nurses involved in the provision of inhalation sedation and general anaesthesia were required to complete immediate life support training. Staff told us that they had good access to mandatory training. Training was a mixture of hands on and online. In some cases, such as manual handling it was a combination of both. Staff told us that they had protected time to complete mandatory training. Online training was completed through “training tracker”. They aimed to complete life support training as a team. Managers told us that they had a good working relationship with the quality academy team who arranged training courses.

Mandatory training compliance was actively monitored by management. Managers received a training matrix every week which highlighted their compliance with mandatory training requirements and where staff were due to complete it. Staff were sent an e-mail when training needed to be completed again. Staff were also prompted by the dental team co-ordinators to complete mandatory training when it was due for renewal.

Safeguarding

Safeguarding training completion rates. The trust set a target of 80% for completion of safeguarding training.

Core service level

A breakdown of compliance for safeguarding training courses from 1 April 2018 to 6 March 2019 at trust level for staff in community dental services is shown below:

Training module name	1 April 2018 to 6 March 2019				
	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Safeguarding Adults L2	82	91	90%	80%	Yes
Safeguarding Children L2	77	89	87%	80%	Yes
Safeguarding Adults L1	18	22	82%	80%	Yes
Safeguarding Children L1	18	22	82%	80%	Yes
Safeguarding Children L3	0	2	0%	80%	No

(Source: Universal Routine Provider Information Request (RPIR) – Training tab)

Safeguarding referrals

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 have 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.

Community dental services made seven safeguarding referrals between February 2018 and January 2019, of which six concerned adults and one child.

Referrals		
Adults	Children	Total referrals
6	1	7

(Source: Universal Routine Provider Information Request (RPIR) – P11 Safeguarding)

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so.

The trust had a safeguarding policy and a dedicated safeguarding team. The policy was readily available on the trust's intranet page and staff demonstrated how to access it. The dental service had a dedicated safeguarding lead. Staff were familiar with who the safeguarding lead was. There were contact details for the trust's safeguarding team and also the local authorities displayed at each clinic we visited.

We were told that all clinical staff were required to complete level three safeguarding children and level two safeguarding adults training. Administrative staff were required to complete level one

safeguarding children and adults training. In addition, a member of the trusts safeguarding team had given a presentation about safeguarding at a clinical supervision meeting.

Staff had a good awareness of the signs and symptoms of abuse and neglect. Staff told us about safeguarding referrals which had been made. We reviewed the records relating to these and they had been acted on appropriately. All of the safeguarding referrals had been recorded as significant events and where improvements could have been made to the process these had been identified. Any improvements which could be made were discussed at clinic huddle meetings.

There was a system in place for children who were not brought to appointments. If a child who was not on the looked after children register failed to attend their first appointment, then a letter was sent to the parent and also the referring healthcare professional informing them of a missed appointment. If a child was in a course of treatment and had repeated failed appointments, then staff would liaise with the dental safeguarding lead and also trust's safeguarding team to decide whether further action would be required. The service held a list of looked after children. This was regularly updated through information from the local health visitors. The service identified which children on this register were patients at the service and would notify the health visitors if any children had failed appointments.

Cleanliness, infection control and hygiene

The service controlled infection risk well.

The trust had an overarching infection control policy. There was a dedicated dental decontamination policy laying out how they reprocessed used dental instruments.

The service used a system of local decontamination at each clinic for the reprocessing of contaminated dental instruments and equipment. There were dedicated decontamination technicians who carried out the process.

Decontamination and sterilisation were done so in line with guidelines issued by the Department of Health - Health Technical Memorandum 01-05: Decontamination in primary care dental practices. They followed best practice guidance in that there were separate dirty and clean rooms. The decontamination technicians described the end to end process for the reprocessing of used dental instruments. This was in line with best practice guidance laid down in HTM 01-05. The decontamination technicians described the process for carrying out the daily, weekly and quarterly checks on the decontamination and sterilisation equipment. This was in line with guidance laid down in HTM 01-05.

Adequate hand washing facilities were available and we saw that liquid soap, alcohol gel and disposable paper towels was readily available throughout the service. Personal protective equipment such as gloves, masks and visors were available for staff. Plastic bibs and protective eyewear were also available to protect patients' eyes and clothing when having treatment.

Six-monthly decontamination audits were carried out. Where improvements could be made, an action plan was formulated in order to continually improve. In addition, an "essential step" audit was carried out. This covered hand hygiene, personal protective equipment usage, aseptic non-touch technique and the use of sharps. These were carried out at least annually. The most recent audit showed 100% compliance.

There were processes in place to manage the risks associated with Legionella. A risk assessment had been carried out at each location and an external company was responsible for carrying out water temperature checks and running infrequently used outlets. Staff within the service also helped reduce the likelihood of Legionella developing by using reverse osmosis water with a

conditioning agent and flushing the dental unit water lines before a session, in-between patients and after a session.

Environment and equipment

The service had suitable premises and equipment and looked after them well.

Premises and equipment were clean and well maintained. We saw evidence that equipment such as the machines used to provide inhalation sedation and the wheelchair tipper were serviced on a regular basis. Staff told us that there were sufficient amounts of equipment such as dental handpieces to provide care for their patients.

A radiation protection folder was maintained at each location which we visited. The trust had notified the Health and Safety Executive about the use of ionising radiation as required by the Ionising Radiation Regulations 2017. We saw evidence of local rules displayed in the surgeries and also in the radiation protection folder. We saw that the X-ray machines had been serviced and maintained appropriately to ensure compliance with the Ionising Radiation Regulations 2017. A Radiation Protection Advisor and Radiation Protection Supervisor had been appointed.

The service held medical emergency equipment and medicines to assist staff when dealing with a medical emergency. These kits reflected nationally recognised guidance from the Resuscitation Council (UK) and the British National Formulary. Medical emergency medicines were prepared by the trust pharmacy department and kept in a sealed box. Each box had a "use by date" on it when it had to be returned to the pharmacy. Staff carried out checks on the emergency equipment such as the emergency medical oxygen cylinder and defibrillator to ensure it was present and in good working order.

Assessing and responding to patient risk

The service planned for emergencies and staff understood their roles if one should happen.

During the inspection we looked at a selection of dental care records. The clinicians recorded any medical, physical or social conditions which may affect the safety of the patient. For example, a full medical history was recorded and regularly updated. This included any conditions or medication which may affect dental treatment such as blood thinners or medication which affects the healing of bone.

Staff provided patients with appropriate information about treatments. These included pre and post-operative information about extractions, inhalation sedation and general anaesthetic. Patients were given this verbally and also in the form of a leaflet. This helped reduce the risk of intra-operative and post-operative complications such as fainting, bleeding or infection.

There was a process in place for patients who became acutely unwell during treatment. Trained members of staff would provide initial care and monitoring to the patient. There were emergency call bells in surgeries to alert other staff, so they could provide assistance. If the patient did not make a full recovery, then an ambulance would be called. When domiciliary visits were carried out a full medical emergency equipment kit was taken.

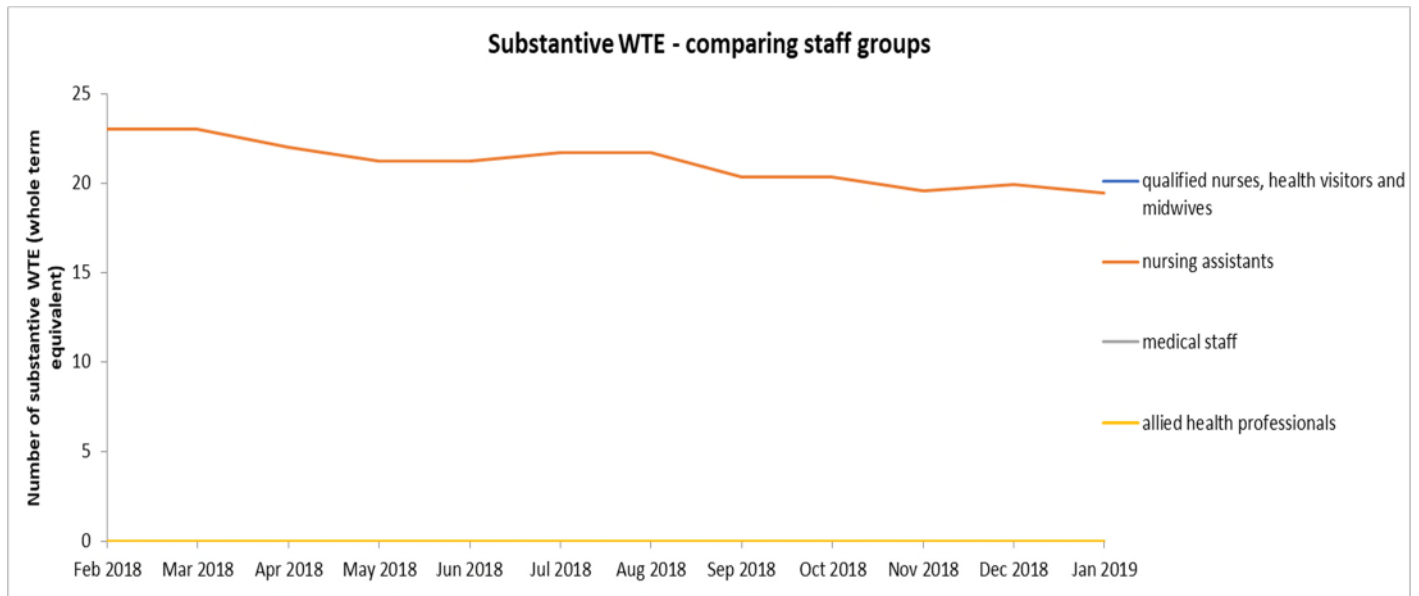
Staff had received training and were familiar with the signs and symptoms of sepsis. We were told that if any patients presented with the signs or symptoms of sepsis then an urgent referral would be made to the hospital, so the patient could receive intravenous antibiotics.

The dentists used rubber dams in line with guidance from the British Endodontic Society when providing root canal treatment.

Mercury and blood spillage kits were readily available at all locations which we visited.

Safe staffing³

The below chart shows the breakdown of staff in post WTE in this core service from 1 February 2018 to 31 January 2019.

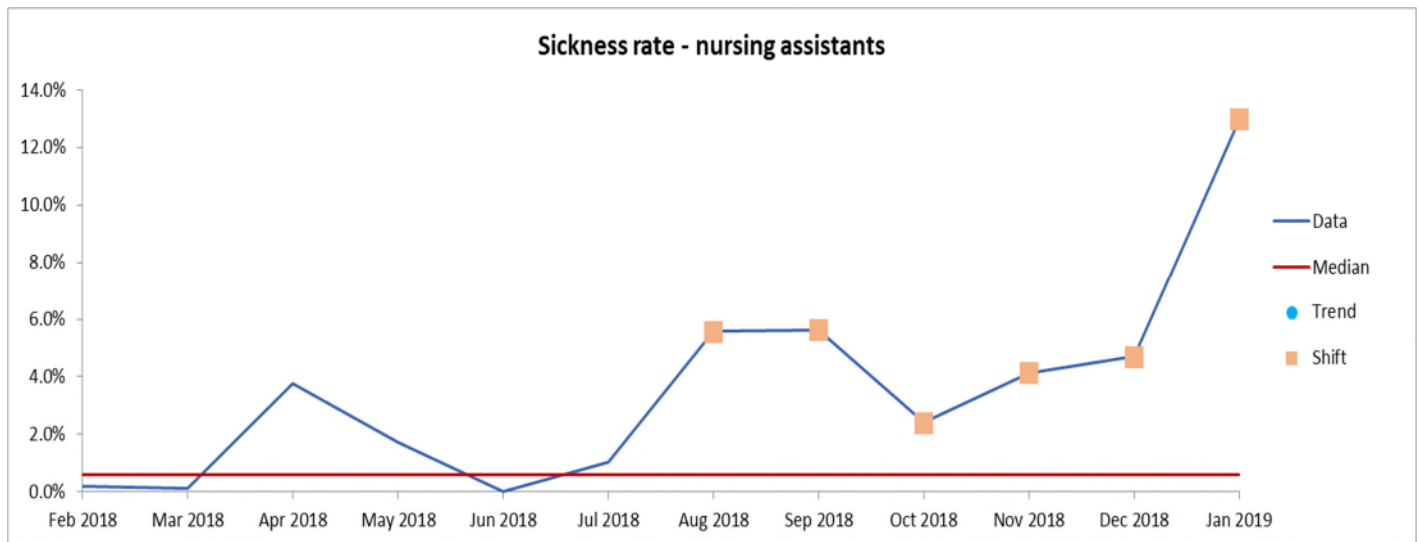


Core service annual staffing metrics 1 February 2018 – 31 January 2019							
Staff group	Annual average establishment	Annual vacancy rate	Annual turnover rate	Annual sickness rate	Annual bank hours (% of available hours)	Annual agency hours (% of available hours)	Annual “unfilled” hours (% of available hours)
All staff	101.3	34%	8%	4.8%			
Nursing assistants	25.0	22%	10%	3.4%			

The following information and charts highlight specific staffing areas where there is noteworthy evidence that may prompt further investigation on site.

The trust set a target of 5% for vacancy rate. From 1 February 2018 to 31 January 2019, the trust reported an overall vacancy rate of 4.8% in community dental services. This met the trust’s target.

³ Cross sector staffing profile



Monthly 'sickness rates' over the last 12 months for nursing assistants shows a shift from August 2018 to January 2019. This could be an indicator of change.

(Source: Universal Routine Provider Information Request (RPIR) Staffing data P16 – P21)

Suspensions and supervisions

During the reporting period from February 2018 to January 2019, community dental services reported that there were no cases where staff have been either suspended or placed under supervision.

(Source: Universal Routine Provider Information Request (RPIR) – P23 Suspensions or Supervised)

The service had enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and abuse and to provide the right care and treatment.

Staffing levels were generally good across the service. At each location we visited there were sufficient numbers of staff to provide safe and effective care to patients. We were told that there were two full time dentists who were cutting down to part-time and two part-time dentists who were leaving. This had impacted on the waiting times somewhat. The service was actively recruiting new dentists.

Staff involved in the provision of inhalation sedation had been appropriately trained. In addition, dental nurses involved in the provision of inhalation sedation and all dentists were required to complete immediate life support training. This ensured they had the correct skills to deal with a medical emergency should one occur.

Quality of records

Staff kept appropriate records of patients' care and treatment.

Dental care records were mainly electronic. The service used a dedicated dental specific software package which was tailored to the need of the service. It enabled the service to input prompt boxes to ensure the clinicians completed certain tasks such as recording a grade and justification for an X-ray.

During the inspection we reviewed a selection of dental care records. We found these to be clear, concise and accurate. We saw evidence that a medical history was checked and updated regularly, an assessment of the patient's oral tissues was carried out, the health of the patients

gums and an assessment of the patient's teeth. We saw that X-rays were justified, graded and reported on to ensure compliance with the Ionising Radiation (Medical Exposure) Regulations.

We asked staff how they managed dental care records when a domiciliary visit was carried out. We were told that any notes were recorded on paper, stored in a secure folder and then transferred to the electronic system when they returned back to the clinic.

Staff told us that record keeping audits were carried out and that any improvements which were identified in the audits were disseminated to the service through the huddle meetings or clinician meetings.

Medicines

Medical gasses used when providing inhalation sedation were stored appropriately. There were systems in place to ensure there was sufficient amounts of gasses available for the proposed treatment. There were also arrangements in place for the scavenging of waste gasses during the inhalation sedation procedure.

The service held a stock of NHS prescription pads. These were stored securely at all times. Staff showed us the logs they kept of the prescriptions. This enabled them to actively monitor the use and security of the prescription pads.

Safety performance

The service managed patient safety incidents well.

In the previous 12 months there had been one never event. This was a wrong site surgery. We discussed the event with the clinical director who had provided input on the investigation of this. A full root cause analysis had been carried out as to why and how this event had occurred. This was detailed and considered all potential factors which could have contributed to the event occurring. There was a chronology of events and statements were taken from the persons involved to help with the investigation. Areas for improvement had been identified and the service worked with the university to help develop a lessons' learned flow chart which disseminated to all staff including those at the university.

Incident reporting, learning and improvement

Never events

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

From February 2018 to January 2019, the trust reported one never event for community dental services. This was under the category of 'Surgical/invasive procedure incident meeting SI criteria' and a description of the incident is shown below:

A dental student extracted upper left 5 tooth instead of the upper left 4 on 26/10/18

(Source: Strategic Executive Information System (STEIS))

Serious Incidents

In accordance with the Serious Incident Framework 2015, the trust reported one serious incident (SIs) in community dental services, which met the reporting criteria set by NHS England from February 2018 to January 2019

A breakdown of the incident types reported is in the table below:

Incident type	Number of incidents	Percentage of total
Surgical/invasive procedure incident meeting SI criteria	1	100%
Total	1	100.0%

(Source: Strategic Executive Information System (STEIS))

Serious Incidents (SIRI) – Trust data

From February 2018 to January 2019, trust staff within community dental services reported one serious incident.

This did not involve the unexpected death of a patient.

The category of this incident was surgical/invasive procedure incident meeting SI criteria.

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
Surgical/invasive procedure incident meeting SI criteria	1
Grand Total	1

(Source: Universal Routine Provider Information Request (RPIR) – P29 Serious Incidents)

Prevention of Future Death Reports

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 two 'prevention of future death' reports sent to Lancashire Care NHS Foundation Trust. None of these related to this service.

(Source: Universal Routine Provider Information Request (RPIR) – P76 Prevention of future death reports)

The service managed patient safety incidents well.

Staff had a good awareness of the importance of reporting and recording significant events and incidents. They talked us through the process of how this was done. Incidents, accidents and near misses would be reported on the trusts electronic reporting system. Staff told us that they had good access to computers in order to report incidents. Incidents were reviewed and investigated by managers. We reviewed a selection of incidents and found that these had been appropriately investigated. Learning from incidents, accidents and near misses were discussed at the team

huddle meetings. In addition, learning from significant events was displayed on notice boards at each clinic which we visited.

Is the service effective?

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence of its effectiveness.

The clinicians had a good awareness of current best practice, nationally recognised guidance. These included guidance from the National Institute for Health and Care Excellence, British Society of Periodontology and the Faculty of General Dental Practice. We reviewed a selection of dental care records and found evidence that confirmed that they followed nationally recognised guidance.

The service offered inhalation sedation for patient who were nervous about treatment. The clinicians followed guidance laid out by the Royal Colleges of Surgeons and the Royal College of Anaesthetists 'Standards for Conscious Sedation in the Provision of Dental Care' 2015. The service had developed a standard operating procedure for the use of sedation. This reflected the relevant guidance. The clinicians we spoke with discussed the process for carrying out inhalation sedation and we saw dental care records which confirmed what they told us. Clinicians monitored the patient throughout the procedure to ensure the level of sedation was safe. This included the patients pulse rate and oxygen saturation.

Clinical holding was used within the service. Staff who carried out clinical holding had received appropriate training to do so. We were told that the dental service had a good relationship with the trusts control and restraint team. The service had developed a standard operating procedure for the use of clinical holding. They had also developed documentation when it was planned to be used. This was a planning document and also a debrief document. We were told that only low-level clinical holding was used, and the patient's family and / or carers would be fully informed of this prior to the procedure and formed part of the treatment plan. Staff told us that patients often felt reassured by the use of clinical holding.

Nutrition and hydration

Patients undergoing general anaesthesia were given appropriate information by staff of the need to fast before undergoing their procedure. The patient, parent or carer were given a pre-operative instruction sheet emphasising the importance of fasting prior to the procedure.

Patients undergoing inhalation sedation were advised to have a light meal prior to their appointment.

Patients were also given advice about the importance of a healthy diet and the links of sugar to dental caries. There were several information leaflets and posters in the waiting areas about healthy diets.

Pain relief

Patients were assessed on their individual needs for the level of anaesthesia required. The clinicians described how they determined what level of anaesthesia a patient required. For example, they took into account the patients age, level of cooperation, anxiety level and complexity of treatment. The service offered treatment under local anaesthetic only, inhalation sedation with local anaesthetic and also general anaesthesia. For very young (pre-co-operative) patients who required multiple extractions then a general anaesthetic would be the preferred

option. For less nervous patients who required smaller amounts of treatment then inhalation sedation with local anaesthesia would be an option.

Local anaesthesia was used for the relief of pain during dental procedures such as fillings or extractions. Staff told us that topical anaesthetic was always used prior to giving injections.

Patient outcomes

Audits

The trust has participated in one clinical audits in relation to this core service as part of their Clinical Audit Programme.

Audit name	Area covered	Key Successes	Key actions
Clinical Aspects of Record Keeping- Dental	CWB	The audit showed that a high number of basic periodontal examinations are being carried out and that there was evidence that appropriate treatment is being carried out following this.	Administrative processes are to be reviewed. Dentists to receive additional training on the clinical aspects of record keeping. Record keeping standard operating procedure to be reviewed.

(Source: Universal Routine Provider Information Request (RPIR) – P35 Audits)

The service monitored the effectiveness of care and treatment and used the findings to improve them.

The service used audit well. This was used to monitor the quality and safety of the service being provided. Audits included record keeping, antimicrobial prescribing, the quality of X-rays, infection prevention and control and the recoding of clinical holding. All audits had detailed action plans and leaning outcomes. Where improvements could be made then these were disseminated and discussed with the relevant persons in order to continually improve the quality and safety of the service. Staff confirmed that audit results were disseminated to them during meetings.

Competent staff

Clinical Supervision

The trust provided the following information about their clinical supervision process:

The Trust has a Supervision Policy that includes clinical supervision, which sets out the requirements for clinical supervision. Clinical supervision is recorded in a bespoke recording system. This enables supervisees to record supervision sessions which are then authorised by supervisors. Identified administrative can also record supervision session on behalf of supervisees and supervisors. This supports efficient recording of supervision particularly when it takes place in groups. The system allows the recording of clinical, managerial, professional and safeguarding supervision for all clinical staff. Individual reports can be seen by staff on their own profile and exported by supervisees for their own monitoring. Line managers can see information for all their direct reports. Compliance reports are available via the Trust reporting portal that enable monitoring and action as required at individual, team, service line, network and Trust-wide level. The Trust Board receive reports on clinical supervision as part of the Quality and Performance Report (QPR) on a monthly basis. This provides a three-monthly rolling average of compliance by

network and an overall Trust compliance percentage. A project lead is in place to support staff and managers improve the recording and quality of clinical supervision.

(Source: CHS Routine Provider Information Request (RPIR) – CHS4 Clin Supervision)

Appraisal rates

From April 2018 to March 2019, 91% of required staff in community dental services received an appraisal compared to the trust target of 80%. In the previous year of 1 April 2017 and 31 March 2018 this core service reported that 73% of staff received an appraisal.

The breakdown by staff group can be seen in the table below:

Community dental services total

Staff group	1 April 2018 to 6 March 2019				
	Staff who received an appraisal	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Support to doctors and nursing staff	22	22	100%	80%	Yes
Support to Scientific, Therapeutic and Technical Staff	8	10	80%	80%	Yes
Public Health and Community Health Services	18	20	90%	80%	Yes
Other Qualified Scientific, Therapeutic, Technician Staff	55	61	90%	80%	Yes
Total	103	113	91%	80%	Yes

(Source: Universal Routine Provider Information Request (RPIR) – P39 Appraisals)

The service made sure staff were competent for their roles.

There was an effective skill mix within the service. The dental nurses had extended duties such as radiograph, sedation, special care dentistry and oral health education. Staff told us that they were able to apply these additional skills within the normal working day.

Staff received regular appraisals. Staff told us that these appraisals were worthwhile, and they were able to request to compete additional qualifications. Staff told us that as a result of the appraisal system this had led to them completing additional qualifications.

Staff received regular supervision. This was either on a one to one basis or as part of group. At supervision meetings they discussed complex cases, safeguarding and any events which learning could have been obtained from.

Staff told us that they felt well supported by the senior clinicians. They told us that they could approach them at any time for advice and support.

Multidisciplinary working and coordinated care pathways

Staff of different kinds worked together as a team to benefit patients.

The service worked well with other healthcare professionals in the best interest of patients. For example, we were told that they would often work with the learning disability nurse in developing a plan which included reasonable adjustments to encourage patients to accept dental treatment. In addition, they would also involve the patient's carers, general practitioner and the anaesthetic team when planning a general anaesthetic. They would liaise with other healthcare professionals

to see if any other treatments were required to be carried out whilst the patient was having a general anaesthetic.

The service used dental hygiene therapists. Dental hygiene therapists are qualified dental professionals who can carry out treatments such as fillings and extraction of deciduous teeth. We spoke with a dental hygiene therapist who told us that they felt fully involved in the dental team and played an important role in patient care.

Healthcare professionals such as dentists, GPs and health visitors could refer in to the service. The service received these electronically. We spoke with the persons involved with dealing with referrals. They had a well organised approach to dealing with these and monitoring the waiting list. Referrals were dealt with centrally to ensure a consistent approach. We were told that staff involved with the incoming referrals had regular meetings with one of the service co-ordinators about the waiting list.

Referrals were also made internally. For example, if a clinician wanted a second opinion about a patient then they could refer to the specialist in special care dentistry for advice. This would be for topics such as a best interest decision meeting.

The service was able to refer out for treatments which they were unable to provide. For example, patients with a suspected malignancy or advice about orthodontics. These referrals were completed electronically and sent securely. There was a log of these referrals.

Health promotion

The clinicians provided oral hygiene advice and treatment in line with the Department of Health's 'Delivering Better Oral Health' toolkit 2017. This is an evidence-based tool kit used for the prevention of the common dental diseases such as dental caries and periodontal disease. Staff told us that they provided oral hygiene advice, toothbrushing instruction, fluoride applications, smoking cessation advice and prescribed high fluoride toothpaste. We saw evidence of this in the dental care records to support this. We saw evidence in the dental care records which we reviewed that this advice and treatment was provided.

The service was taking part in national smile month and currently had displays up in each waiting room highlighting the importance of maintain good oral health. In addition, there were sugar displays in the waiting rooms demonstrating the amount of sugar in different types of drinks.

The service held assessment clinics for new patients. We were told that if staffing allowed then any patients requiring treatment would be seen by a dental nurse to provide oral health education at the same time as the assessment appointment.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Mental Capacity Act and Deprivation of Liberty training completion

The trust set a target of 80% for completion of Mental Capacity Act training.

From 1 April 2018 to 6 March 2019 the trust reported that Mental Capacity Act (MCA) Level 1 training had been completed by 96% of staff within community dental services.

In the previous year (1 April 2017 to 31 March 2018) the completion in this core service was 91%

A breakdown of compliance for MCA/DOLS courses from 1 April 2018 to 6 March 2018 for staff in community dental services is shown below:

Training module name	Number of staff trained (YTD)	Number of eligible staff (YTD)	Completion (%)	Target (%)	Target met (Yes/No)
Mental Capacity Act Level 1	78	81	96%	80%	Yes
Mental Capacity Act Level 2	60	81	74%	80%	No

(Source: Universal Routine Provider Information Request - P38 Training)

Deprivation of Liberty Safeguards

From 1 February 2018 to 31 January 2019 the trust reported that 14 Deprivation of Liberty Safeguard (DoLS) applications were made to the Local Authority. None of these were pertinent to community dental services.

(Source: Universal Routine Provider Information Request (RPIR) – P13 DoLS)

Staff understood their roles and responsibilities under the Mental Capacity Act 2005.

Staff had a good awareness of the need to obtain and record informed consent for dental treatment. Staff talked us through how they obtained informed consent. We were told that different options were discussed, and the risks associated with each treatment option. In addition, where applicable, different types of anaesthesia were also discussed. Patients were provided with an NHS consent form which also highlighted the risks associated with the proposed treatment. We saw evidence of completed NHS consent forms.

Patients who were due to have inhalation sedation provided consent at a pre-assessment appointment, unless in the case of an emergency. The treatment plan was also re-confirmed on the day of treatment. This is in line with guidance set out by the Royal Colleges of Surgeons and the Royal College of Anaesthetists 'Standards for Conscious Sedation in the Provision of Dental Care' 2015.

Staff had a good understanding of the Mental Capacity Act 2005. Staff were required to complete training about the Mental Capacity Act. We were told that best interest decision meetings were held when a patient lacked the ability to consent for themselves. These meetings could involve the patient's carer, family member or an independent mental capacity advocate. Clinicians could refer to the specialist in special care dentistry for help and a second opinion about patients who lacked the ability to consent for themselves.

Staff were aware of the concept of Gillick competence in respect of the care and treatment of children under 16. Gillick competence is used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions.

Is the service caring?

Compassionate care

During the inspection we witnessed positive interactions between staff and patients. Staff were caring, compassionate and caring towards patients. We received feedback from 35 patients during the inspection. They commented that reception staff were friendly and helpful and that the clinical staff were calm, kind and patient. They also said that all staff were professional and courteous and that they felt listened to. There were several comments about how good staff were with children and special care patients.

The service carried out the NHS Friends and Family Test. Patients were encouraged to complete this. Between June 2018 and June 2019, the service received 2379 responses. One location had received 1435 responses in this period. Staff at this location were due to receive a "Shining star" award for the most responses and continually good feedback. Across the whole service 99% of patients would either highly recommend or recommend the service to friends and family.

Staff were aware of the need to protect patient's privacy and maintain confidentiality. During the inspection we did not see any breaches of patient confidentiality. For example, there were no patient identifiable information left unattended or in sight of members of the public, surgery doors were kept shut and computers were locked when staff moved away from their workstations. A private room would be found if a patient requested more privacy.

Emotional support

Staff provided emotional support to patients to minimise their distress.

Staff were aware of the importance of providing emotional support to patients when providing dental treatment. Patients commented that staff made them feel relaxed and at ease especially if they were nervous.

Staff told us that they had sufficient time to provide emotional support to patients and they were under no pressure from management to complete treatments in a certain time frame. We were told that they would carry out an acclimatisation visit for patients due to have inhalation sedation. This would involve allowing the patient to experience the sensation of inhalation sedation prior to having any treatment. Staff told us that this reduced the anxiety at subsequent appointments.

We were provided with a selection of "Patient stories". These were examples of where staff had gone above and beyond for patients. These stories included example of where staff had made reasonable adjustments to enable patients to receive treatment when they were in acute pain or when they were unable to attend the clinic due to emotional reasons. These stories were shared with all staff and also at a divisional level. On occasion, the stories were presented at board level. Each story was linked to the "Trust's Quality Commitments (8C's)". These are care, compassion, courage, commitment, competence, communication, choice and collaboration.

Understanding and involvement of patients and those close to them

Staff involved patients and those close to them in decisions about their care and treatment.

Patient and their families or carers were fully involved in decisions about care treatment. Patients commented that staff explained everything about the different treatment and also throughout the procedure. They also told us that staff explained everything in an understanding way.

Staff described the different methods they used to help them describe treatments to patients. For example, they would use X-rays, models and pictures to help patients better understand different

treatments. They would use age appropriate and non-technical language when speaking to patients to ensure full understanding.

Staff from one of the clinics had developed a "Social story". This was a walk-through of the service and the different areas of the clinic. This story book could be sent to the patient prior to their first appointment to enable them to visualise the clinic prior to their visit.

Is the service responsive?

Planning and delivering services which meet people's needs

The trust planned and provided services in a way that met the needs of local people.

The service was commissioned by NHS England. The services were planned to meet the needs of the local population. The services included community dental services for those who could not be treated in a primary dental setting due to medical, physical, social or emotional reasons, primary dental services and urgent dental services.

Reasonable adjustments had been made to all locations which we visited. All locations were fully accessible for wheelchair users and those with limited mobility. In addition, there were accessible toilet facilities, with hand rails and call bells. The service also had access to wheelchair tippers for patients who could not be transferred out of their wheelchair to receive treatment. These wheelchair tippers could also be used for bariatric patients up to a weight of 32 stone.

The service had access to translation services for patients whose first language was not English. There were posters displayed in the waiting areas informing patients of this service. In Addition, there were hearing loops available.

Meeting the needs of people in vulnerable circumstances

The service took account of patients' individual needs.

The service was designed to meet the needs to vulnerable people. The community dental service was a referral service for patients who could not receive dental care and treatment in a primary dental setting. This was for patients with medical, physical, social or emotional reasons.

The service offered domiciliary visits for patients who could not access a clinic. These were mainly reserved for patients with medical, physical or social issues. The treatments available at domiciliary visits was limited.

Staff told us that they saw homeless patients through their primary dental care service. They took into account these patients' difficult social circumstances when arranging appointments.

The service was contracted to provide in and out of hours urgent dental service. This was for patients who did not have their own dentist or could not access their own dentist in the event of an emergency.

Access to the right care at the right time

Accessibility

The largest ethnic minority group within the trust catchment area is Asian/Asian British with 5.7% of the population.

Ethnic minority group	Percentage of catchment population (if known)
Asian/Asian British	5.7
Mixed/Multiple Ethnic Group	1.1
Chinese	0.4

(Source: Universal Routine Provider Information Request – P48 Accessibility)

Referrals

The trust did not provide any referral to treatment data relating to this core service.

(Source: CHS Routine Provider Information Request – CHS10 Referrals)

Healthcare professionals such as dentists, GPs and health visitors could refer in to the community dental service. The community dental service provides specialised care and treatment for patients who cannot be seen in a primary dental clinic due to medical, physical, social or emotional reasons. Patients were either referred in for a single course of treatment (such as a general anaesthetic) or on-going long-term care. One of the dental co-ordinators was responsible for monitoring the waiting times. We were told that the service aimed to see patients for an assessment and initial treatment (including X-rays) within 18 weeks from the receipt of referral. We were told that the waiting list was starting to increase due to dentists either cutting down their working hours or leaving the organisation. The average referral to assessment time (including commencing any treatment) was 13.1 and 11.5 weeks for paediatrics and special care adults respectively. Within the last six months there had been 11 paediatric and 1 special care adult breach of the 18-week target.

The service also provided emergency dental treatment during normal working hours. Referrals for the emergency service were received from an external organisation and were allocated an appointment time. Staff told us that they had a good working relationship with this external organisation.

Learning from complaints and concerns

Complaints

From 1 February 2018 to 31 January 2019 the trust received 35 complaints about community dental services (3% of total complaints received by the trust). The trust took an average of 19 days to investigate and close complaints, this is in line with their complaints policy, which states complaints should be dealt with within 25 working days.

A breakdown of complaints by subject and site is shown below:

Community dental services Total

Type of complaint	Number of complaints	Percentage of total
Clinical treatment	11	31%
Appointments including delays and cancellations	8	23%
Access to treatment or drugs	5	14%
Other	5	14%
Communication	3	9%
Staff	2	6%
Admissions, discharges and transfers	1	3%
Total		100.0%

(Source: Universal Routine Provider Information Request (RPIR) – P52 Complaints)

Compliments

From 1 February 2018 to 31 January 2019 the trust received 7291 compliments. Of these 1207 related to community dental services, which accounted for 17% of all compliments received by the trust as a whole.

Team	Number of compliments
Management Dental (C)	496
Dental MOS (C)	240
Personal Dental Service Plus Central (C)	234
Personal Dental Service Yarnspinners (C)	55
Personal Dental Service Barbara Castle Way (C)	46
Special Care Dentistry Central (C)	36
Special Care Dentistry Darwen (C)	23
Personal Dental Service Clitheroe (C)	17
Personal Dental Service Oak House (C)	13
Special Care Dentistry Barbara Castle Way (C)	10
Emergency Dental Service East Lancs (C)	10
Special Care Dentistry Oak House (C)	7
Special Care Dentistry RBH (C)	4
Special Care Dentistry Clitheroe (C)	4
Special Care Dentistry Yarnspinners (C)	3
Personal Dental Service St Peters (C)	3
Personal Dental Service Bacup (C)	2
Dental Education Centre East Lancs (C)	2
Special Care Dentistry GA (C)	1
Special Care Dentistry St Peters (C)	1
Total	1207

(Source: Universal Routine Provider Information Request (RPIR) – P53 Compliments)

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, which were shared with all staff.

The trust had a complaints policy which staff were aware of. There were detail about how a patient could raise a complaint about the service displayed in the waiting areas. Staff told us that they aimed to address any verbal complaints raised at a clinic informally initially. If the patient was not satisfied with the response from the clinic then the patient would be provided with the details of the hearing feedback team.

We reviewed the documentation relating to two complaints which had been received. There were comprehensive details of all communication between the service and the patient. We saw that the complaint had been acknowledged within three working days. Complaints were allocated to an individual not associated with the complaint for investigation. A draft letter was created which was sent to the clinical director to be approved and signed off. We saw that the response letters addressed the complainants concerns appropriately.

Is the service well-led?

Leadership

The service had managers at all levels with the right skills and abilities to run a service providing high-quality sustainable care.

Staff told us that leaders were visible and approachable. There were clearly defined roles within the service. There were clear lines of escalation within the management structure and staff were aware of who their direct line manager was.

Clinical leadership was provided by the clinical director who was supported by two clinical directors (one for community dental services and one for primary dental services). They supported the other dentists and provided support when required. There were three service co-ordinators who had oversight for the day to day running of the service. This included managing the waiting lists. There were five dental team co-ordinators who were responsible for certain sites. They were responsible for managing the dental nurses, reception staff and administrative staff. There had recently been a lead dental nurse appointed who was responsible for providing clinical support and mentorship to the dental nurses. There was also a lead professional dental therapist who supported the dental therapists.

There were systems and processes in place to help develop leadership and management. For example, we were told about one member of staff who had started at the service as an oral health promotor and had been mentored and developed in their role and was now working as a dental team co-ordinator.

Vision and strategy

The service had a vision for what it wanted to achieve and workable plans to turn it into action.

The service had a documented "Dental Transformation Project" for 2018/2019. This was to oversee implementation of the new workforce model that will support clinical model, utilisation of clinical roles and drives operational delivery of dental centres, whilst also providing a more sustainable workforce and strong clinical leadership. This document was a live document and there were updates for each of the projects. There were also due dates for when actions had to be delivered. Topics in the project included the implementation of E-Rostering, implementing a 7-day rota for the urgent care service and a new management structure. There was also work going on about implementing a cognitive behavioural therapy workshop. This would help patients who suffer with dental anxiety accept treatment. There was a new vision and strategy for 2019/2020 but this was currently on hold until the upcoming tendering had been completed.

Culture

Managers across the service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.

Staff morale was good within the service. Many staff had worked within the service for many years and had developed within the service. Teamwork was good, and staff were proud to work at the

service. They said that patient care was at the heart of the service and would go above and beyond for their patients.

Staff were aware of their responsibilities to raise concerns about colleagues if the need arose. They told us that they felt able to raise concerns within the service without fear of recrimination and were encouraged to do so. Staff had a good understanding of the need to be open and transparent if things go wrong. During the inspection we were told about an event which required the application of the duty of candour. This had been well documented and there was clear evidence that the service had been open and transparent with the person involved and an apology given.

Governance

The service used a systematic approach to continually improving the quality of its services and safeguarding high standards of care by creating an environment in which excellence in clinical care would flourish.

The trust held its policies on the intranet page. There were many general policies such as consent and equality and diversity. The dental service had also developed dental specific policies and standard operating procedures such as conscious sedation and domiciliary visits. These were reviewed and updated regularly to ensure they reflected current best practice guidance. Staff were familiar with how to locate these policies and procedures.

There was a clear system in place to disseminate information from clinics to senior managers and vice versa. Huddle meetings were held at each clinic either on a weekly or fortnightly basis. These were chaired by the team co-ordinators. Topics included safeguarding, infection control, sharing the learning and radiation protection. The team co-ordinators held monthly meetings which then fed into the monthly performance and governance meetings. Topics such as mandatory training, radiation protection, policy updates and recruitment updates were discussed. These meetings were well attended and there were clear minutes for them. There was an associated action tracker attached to the minutes which had persons identified to each action. Any issues identified at these meetings would be escalated to the core service network meeting.

In addition to these meetings there were also separate quarterly decontamination, therapist, community dental service and primary dental service meetings.

Management of risk, issues and performance

The service had effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected.

The service maintained a risk register which was regularly reviewed and updated. Each risk had an allocated owner who was responsible for putting in actions to help reduce the risk. Each risk had a review date, initial risk rating, current risk rating and target risk rating.

There were quarterly risk review meetings where those responsible for managing the risks discussed any changes to the risk. The current highest risks related to staffing which in turn related to meeting targets. They were actively recruiting for the posts in question as there were two full time dentists who were cutting down to part-time and two part-time dentists who were leaving.

Information management

The service collected, managed and used information well to support all its activities, using secure electronic systems with security safeguards.

Staff could access the information which they required in a timely manner. Dental care records were computerised, and staff could access these remotely at different sites. This meant that if an internal referral was sent to another clinician at a different clinic then all the dental care records were available.

As part of the mandatory training staff were required to complete information governance training. Staff were aware of the importance of protecting patients' personal information.

Computers were password and smart card protected. We were told that all patients records were backed up to secure off site storage. Any paper records relating to patients' dental care records were locked in secure fire proof cabinets. We witnessed staff locking their computers when they moved away from their workstations.

Engagement

The service engaged well with patients, staff and local organisations to plan and manage appropriate services and collaborated with partner organisations effectively.

The clinical director and one of the clinical leads were the founder members of the local managed clinical network for special care and paediatric dentistry. The clinical director was also currently the deputy chair. Managed clinical networks are groups of professionals from primary, secondary and tertiary care who work together to ensure the equitable provision of high-quality effective services. MCNs involve those who are responsible for providing the service, those referring into the service and organisations who commission the service. There were 11 meetings each year and the NHS commissioners were invited to attend some of the meetings. Topics discussed at the managed clinical network meetings included referral management and clinical topics such as caries management. Some of the clinicians also attended the local dental network meetings.

The service produced a monthly dental newsletter which was sent to all staff. This included details of any changes within the service, any new starters, any staff leaving, social and charity events, performance updates and mandatory training updates. Staff confirmed that they received these. The trust also produced a weekly bulletin about what was going on within the trust. Staff found these useful and enabled them to see what other services were doing.

Patients were encouraged to complete the NHS Friends and Family Test. This is a national programme to allow patients to provide feedback on NHS services they have used. Feedback from the NHS Friends and Family Test was positive, and any feedback was discussed at team huddle meetings, so staff were aware of any positive or negative feedback provided about the service.

Learning, continuous improvement and innovation

Accreditations

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.

There are no services within community dental services that have been awarded an accreditation at the present time.

(Source: Universal Routine Provider Information Request (RPIR) – P66 Accreditations)

Learning and continuous professional development was central to the service. Many of the dental nurses had completed additional qualifications such as sedation, radiography and special care dentistry. The dental nurses told us that they had good access to training and were encouraged to complete extended duties to cater for the ever-increasing complexity of the patient base.

The service provided training for undergraduate dental students and dental therapists from the University of Central Lancashire. This was part of an outreach programme where the students were able to obtain the experience of what working within a primary dental facility was like. The students were always supervised by a fully qualified dentist to ensure treatments and care were delivered safely.

The service also provided work experience for school children who wished to pursue a career in dentistry. We were told that there had been several school children who had done this. There were effective systems in place to manage the risks associated with this. This included ensuring patients were fully aware there was a work experience student observing in the surgery, ensuring they were fully aware of the importance of confidentiality and other risks associated with the service such as hazardous substances.

Evidence Appendices report sub heading	RPM Metric/ Indicator	Analytical Checks 2	Non-random or special cause variation detected? (yes/no) ⁴
Staffing	Vacancy rates (all staff/qualified nurses/medical staff/nurse assistants/allied health professionals) over the past 12 months- RPIR/ trust data	run chart to identify non-random variation	No
Staffing	Staff turnover (all staff/ qualified nurses/medical staff/nurse assistants/ allied health professionals) over the past 12 months- RPIR/ trust data	run chart to identify non-random variation	No
Staffing	Staff sickness rate (all staff/ qualified nurses/medical staff/nurse assistants/ allied health professionals) over the past 12 months - RPIR/ trust data	run chart to identify non-random variation	Yes – nursing assistants

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)
Chorley & South Ribble Hospital	PICU Avenham Ward	6	Female
Chorley & South Ribble Hospital	Duxbury Ward	15	Female
Chorley & South Ribble Hospital	Worden Ward	15	Male
Ormskirk Hospital	Scarisbrick Mental Health Inpatients	20	Mixed
Ormskirk Hospital	PICU Lathom Suite Ward	4	Male
Royal Blackburn Hospital	Ribble A Assessment Ward	12	Male
Royal Blackburn Hospital	Hyndburn Ward Mental Health Inpatients	20	Female
Royal Blackburn Hospital	Darwen Ward Mental Health Inpatients	19	Male
Royal Blackburn Hospital	PICU Calder Ward	6	Male
Royal Blackburn Hospital	Edisford Assessment Ward	14	Female
The Harbour	Shakespeare Ward	18	Female
The Harbour	Stevenson Ward	18	Female
The Harbour	Churchill Ward	18	Male
The Harbour	Orwell Ward	18	Male
The Harbour	PICU Byron Ward	8	Female
The Harbour	PICU Keats Ward	8	Male
The Orchard	The Orchard Mental Health Inpatients	18	Mixed

The methodology of CQC provider information requests has changed, so some data from different time periods is not always comparable. We only compare data where information has been recorded consistently.

Is the service safe?

Safe and clean care environments

All wards were safe, clean well equipped, well furnished, well maintained and fit for purpose.

Safety of the ward layout

Staff completed and regularly updated risk assessments of ward areas. We were able to view these on all wards except the Orchard and Darwen wards. Staff on Orchard and Darwen wards told us that the ward manager accessed the risk assessments and the ward manager was not in on that day. This means not all staff would have access to audits of the risk in the environment and how to mitigate the risks.

Ligature risks posed by windows opening into the courtyard at Byron ward were mitigated by staff supervision. Blind spots within the wards were mitigated by mirrors on all wards except Avenham PICU and Darwen ward.

All wards were same sex wards except Scarisbrick ward and the Orchard. These wards met the guidance on eliminating mixed sex accommodation as there was male and female corridors, female only lounges, and all bedrooms were en-suite apart from the dormitory area on Scarisbrick ward. However, patients in the dormitories were able to access bathrooms without having to pass through areas used by the opposite gender.

Over the 12-month period from 1 February 2018 to 31 January 2019 there were no same sex accommodation breaches within this service.

The number of same sex accommodation breaches reported in this inspection was the same as the zero reported at the time of the last inspection.

Staff inductions did not include the ligature audits for the wards. We viewed ligature audits on all wards except the Orchard and Darwen wards. Orchard and Darwen ligature audits were submitted following the inspection. The audits were separated into each room of the ward and examples on Worden ward and Hyndburn ward, included “various ligature points” which did not tell staff what the risk were and how to mitigate these.

There were ligature risks on 17 wards within this service. Prior to the inspection, the trust told us all wards had a ligature risk assessment in the last 12 months.

Ward / unit name	Briefly describe risk - one sentence preferred	High level of risk? Yes/ No	Summary of actions taken
Darwen Ward Mental Health Inpatients	General ward fixtures and fittings	No	
Hyndburn Ward Mental Health Inpatients	General ward fixtures and fittings	No	
Ribble A Assessment Ward	General ward fixtures and fittings	No	Capital Bid to be submitted to replace window and/or fittings
PICU Calder Ward	General ward fixtures and fittings	No	
Scarisbrick Mental Health Inpatients	General ward fixtures and fittings	No	
PICU Lathom Suite Ward	General ward fixtures and fittings	No	
Harbour - PICU Byron Ward	General ward fixtures and fittings	No	
Harbour - Churchill Ward	General ward fixtures and fittings	No	
Harbour - PICU Keats Ward	General ward fixtures and fittings	No	
Harbour - Orwell Ward	General ward fixtures and fittings	No	

Ward / unit name	Briefly describe risk - one sentence preferred	High level of risk? Yes/ No	Summary of actions taken
Harbour - Shakespeare Ward	General ward fixtures and fittings	No	Repair and maintenance of fixtures and fittings
Harbour - Stevenson Ward	General ward fixtures and fittings	No	
The Orchard Mental Health Inpatients	General ward fixtures and fittings	No	
PICU Avenham Ward (Opened November 18)	General ward fixtures and fittings	No	
Duxbury Ward (Opened November 18)	General ward fixtures and fittings	No	
Worden Ward (Opened November 18)	General ward fixtures and fittings	No	
Edisford Ward (female Assessment)	General ward fixtures and fittings	No	Repair and maintenance of fixtures and fittings and install door alarms on bathrooms

Staff had easy access to alarms and the inspection team were provided with these too. However, bedrooms did not have patient call systems. The Department of Health, Health Building note 03-01: Adult acute mental health units states "Service user to staff system call points should be provided in spaces where a service user or attendee may be left alone temporarily, for example within service user bedrooms, en-suite WCs, disabled WCs and therapy or education areas." as patients were mobile and able to ask for assistance. This meant patients could not summon assistance in an emergency. We asked the trust for their risk assessment regarding no nurse call alarms. The trust created and submitted them following inspection. Mitigation included observation of patient and bedroom allocation close to the nurse's office.

Where there were ligature anchor point risks on en-suite bathroom doors, door top alarms had been fitted to alert staff if pressure was put on the top of the door.

Maintenance, cleanliness and infection control

Ward areas were mostly clean, well maintained, well-furnished and fit for purpose. However, there was staining on the ceiling in Calder seclusion room, the window frames were wood and porous and there was a smell of urine in the room. There was staining on the ceiling of Shakespeare ward. One of the bedrooms on Worden ward was soiled and unkempt. Staff told us that the patient had refused for staff to help clear their room. Staff had not completed a capacity assessment regarding the patient's decision making and had not planned how best to address this situation. On Calder ward, the flooring had ripped in parts and had tape covering it. The floor was also uneven and presented a trip hazard.

There was one patient with MRSA who had a specific care plan regarding cleaning regimes, records did not confirm this was being followed.

The PLACE score for condition, appearance, maintenance and cleanliness was the same as similar locations.

PLACE assessments aim to provide a clear message from patients on how the care environment may be improved. They are undertaken by teams of local people alongside healthcare staff and assess privacy and dignity, food, cleanliness, building maintenance and the suitability of the environment for people with disabilities and dementia.

The sites which deliver mental health acute wards for adults of working age within Lancashire Care NHS Foundation Trust were compared to other sites of the same type and the scores they received for 'cleanliness' and 'condition, appearance, and maintenance' were found to be about the same as the England average.

Staff could not locate cleaning records within the wards. They told us an independent cleaning company held the cleaning records. After the inspection we reviewed the cleaning records and found they recorded daily tasks, reasons tasks could not be completed (for example a patient sleeping) and weekly tasks. Cleaning audits took place with areas identified for staff to focus on. Staff signed to say tasks had been completed.

Staff had hand sanitizer attached to their lanyards which we observed staff using.

Seclusion room

There were seven seclusion rooms which allowed clear observation and two-way communication. They had a toilet and a clock. Seclusion rooms in Avenham PICU, Calder PICU and the Harbour did not maintain patients' privacy and dignity. The windows into the viewing area were clear glass, paper had been put on the windows, the second seclusion room at Chorley had clear glass into the viewing area from the corridor, staff passing by could see into the seclusion room and we observed a patient in the seclusion room when walking past, this breached their privacy and dignity. Due to the layout of Calder seclusion room and extra care area, both could not be used at the same time, as you had to use the same entrance. At the Harbour, two seclusion rooms faced each other, at the mental health act reviewer visit on 6 December 2018 to Keats ward, the mental health act reviewer saw that patients could see each other whilst in seclusion through the observation office.

Clinic room and equipment

Clinic rooms were fully equipped, with accessible resuscitation equipment and emergency drugs that staff checked regularly. Hyndburn clinic was well labelled, clean and tidy and items were easy to find. However, on the Orchard, a nurse and junior doctor did not know where the emergency medicines were stored. The emergency medicines were locked in the clinic room and the

emergency grab bag stored in the treatment room. On Edisford ward staff found it difficult to find emergency medicines. On Avenham ward, the grab bag contents did not reflect the laminated contents page. There were gaps in the resuscitation trolley checks for Churchill ward. The trust's procedure for the storage of medicines, March 2017 states 'For clinical emergencies, e.g. cardiac arrest, all sites should have a source of urgent medicinal products held in a container marked "for emergency use". These boxes/grab bags/designated medicines must be tamper-evident and should not be held in a locked cupboard, but at strategic and accessible sites'. The service was not following this policy.

Staff checked temperatures in the clinic rooms weekly, as stated in the trust procedure for the storage of medicines, March 2017. On Hyndburn ward there were two examples of the clinic temperatures being above 25 degrees. Staff told us that they had to review the week's temperatures prior to escalating. This meant medicines may have been compromised without action being taken. There were gaps in the clinic room checks at Churchill ward.

Safe staffing

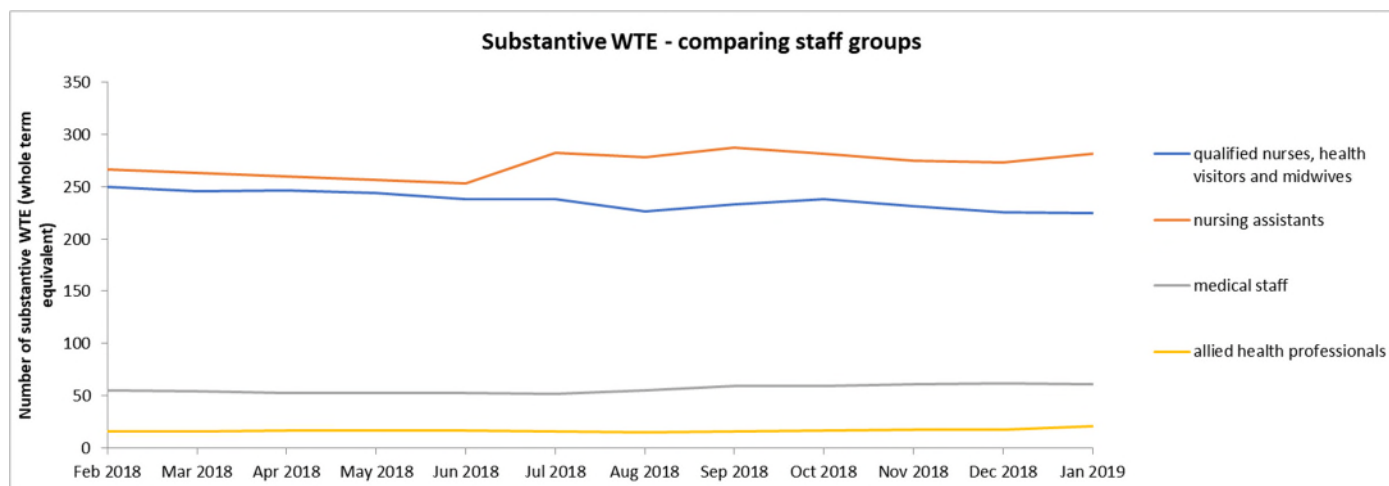
The service did not have enough nursing staff of all grades to keep patients safe. Staffing establishments were at least two qualified nurses on each shift dependent on the ward. In the six months prior to the inspection, there were 428 incidents of one qualified nurse reported by staff via SafeCare (RedFlag) and 1380 incidents of one qualified nurse from data taken from Healthroster." When we inspected the Orchard on Friday 21 June 2019 there was one qualified nurse from 3.30pm until the night shift. The Orchard is a standalone service and there were seven occasions in the last six months when this occurred. This meant that qualified nurses would not be able to leave the building for a break. They might also have a patient in seclusion and another in the 136 suite which would make it difficult to complete the nursing reviews and provide the nursing care required by the ward.

Information submitted by the trust showed 34 incidents of unsafe staffing levels from 1 December 2018 to 31 May 2019. Within the same time period there were 91 incidents of staff not being able to take their breaks. This means that staff were not having time away from the ward to refresh and refocus.

Patients told us, and we observed, on Edisford that there was not a staff member in communal areas at all times. Patients felt vulnerable to being targeted by others. The nurse's office on Edisford did not have sight of the ward. Ribble A had introduced an arrangement where there was always a qualified nurse allocated to the communal area. Positive feedback had been received by staff and patients. When we raised our concerns with managers of Edisford ward, they introduced the same model of allocation as Ribble A ward the following day.

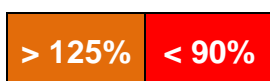
A recent Hurst review had taken place in all wards to review the staffing levels. Staff told us all wards had an increased establishment following this and recruitment was underway for the new posts.

The below chart shows the breakdown of staff in post WTE in this core service from 1 February 2018 to 31 January 2019.



The below table covers staff fill rates for qualified nurses and care staff during December 2018, January 2019 and February 2019.

Key:



	Day		Night		Day		Night		Day		Night	
	Nurses (%)	Care staff (%)	Nurses (%)	Care staff (%)	Nurses (%)	Care staff (%)	Nurses (%)	Care staff (%)	Nurses (%)	Care staff (%)	Nurses (%)	Care staff (%)
	December 2018				January 2019				February 2019			
The Orchard Mental Health Inpatients (25-65)	82%	132%	99%	149%	99%	135%	96%	153%	104%	143%	94%	179%
Ribble A Assessment Ward (25-65)	131%	109%	46%	154%	132%	103%	45%	174%	123%	118%	46%	153%
Worden Ward	85%	194%	88%	181%	96%	181%	94%	174%	74%	188%	100%	158%
Hyndburn Ward Mental Health Inpatients (25-65)	94%	293%	96%	301%	104%	332%	101%	334%	90%	249%	93%	168%
Darwen Ward Mental Health Inpatients (25-65)	75%	173%	98%	135%	75%	162%	94%	127%	63%	180%	89%	111%
PICU Calder Ward (25-65)	74%	294%	78%	305%	69%	306%	76%	329%	78%	286%	83%	301%
PICU Avenham Ward	87%	282%	87%	272%	83%	319%	89%	295%	82%	297%	95%	249%

	Day		Night		Day		Night		Day		Night	
	Nurses (%)	Care staff (%)	Nurses (%)	Care staff (%)	Nurses (%)	Care staff (%)	Nurses (%)	Care staff (%)	Nurses (%)	Care staff (%)	Nurses (%)	Care staff (%)
Edisford Assessment Ward (25-65)	108%	113%	39%	158%	117%	122%	42%	151%	122%	114%	43%	158%
Duxbury Ward	75%	251%	91%	204%	83%	230%	97%	195%	80%	254%	100%	205%
Harbour - Shakespeare Ward (25-65)	60%	136%	76%	130%	57%	167%	82%	137%	56%	198%	84%	186%
Harbour - Stevenson Ward (25-65)	63%	164%	70%	153%	72%	143%	84%	135%	65%	199%	89%	215%
Harbour - Churchill Ward (25-65)	71%	103%	85%	104%	69%	114%	88%	111%	64%	111%	84%	113%
Harbour - Orwell Ward (25-65)	80%	112%	78%	115%	76%	129%	72%	136%	85%	131%	89%	146%
Harbour - PICU Byron Ward (25-65)	61%	205%	83%	222%	65%	203%	93%	198%	62%	193%	89%	195%
Harbour - PICU Keats Ward (25-65)	61%	165%	86%	177%	67%	142%	80%	155%	56%	150%	94%	167%
Scarisbrick Mental Health Inpatients (25-65)	65%	205%	98%	239%	67%	159%	98%	193%	63%	184%	82%	215%
PICU Lathom Suite Ward (25-65)	87%	158%	49%	225%	78%	164%	48%	222%	75%	194%	101%	255%

All wards in this core service had periods with care staff fill rates above 125% and nursing fill rates below 90%. From December 2018 to February 2019, both day and night nursing shifts were consistently below 90% fill and care staff shifts consistently above 125% on PICU Calder Ward, Shakespeare Ward and Stevenson Ward. Ward managers told us where they could not get enough qualified nursing staff they had more health care assistants working as they were skilled and valuable team members and knew the patients well.

Annual staffing metrics

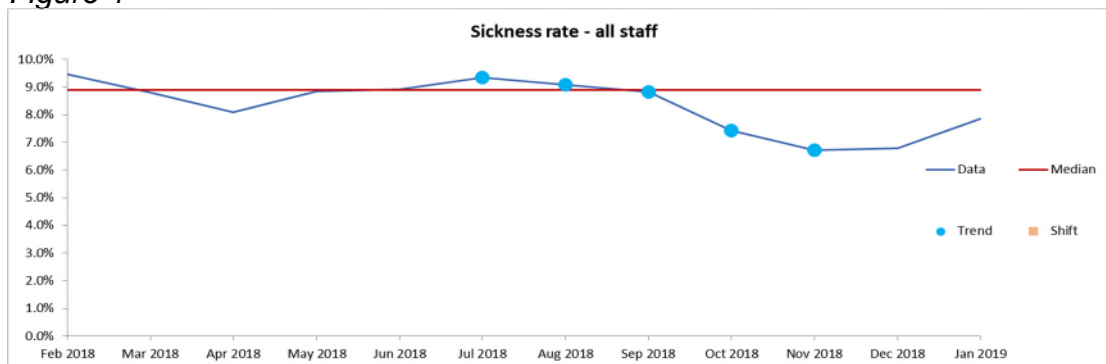
Core service annual staffing metrics (1 February 2018 – 31 January 2019) Vacancy data (1 April 2018 – 31 January 2019)

Staff group	Annual average establishment	Annual vacancy rate	Annual turnover rate	Annual sickness rate	Annual bank hours (% of available hours)	Annual agency hours (% of available hours)	Annual “unfilled” hours (% of available hours)
All staff	791.7	26%	5%	8.3%			
Qualified nurses	311.0	27%	5%	7.4%	38750 (10%)	1644 (<1%)	4401 (1%)
Nursing assistants	311.5	17%	3%	10.1%	273488 (64%)	16596 (4%)	12205 (3%)
Medical staff	106.2	47%	14%	3.6%	20 (<1%)	283 (<1%)	3680 (3%)
Allied Health Professionals	21.9	34%	6%	4.8%			

NOTE: Vacancy data has only been provided for 10 months, from 1 April 2018 to 28 February 2019.

All staff

Figure 1

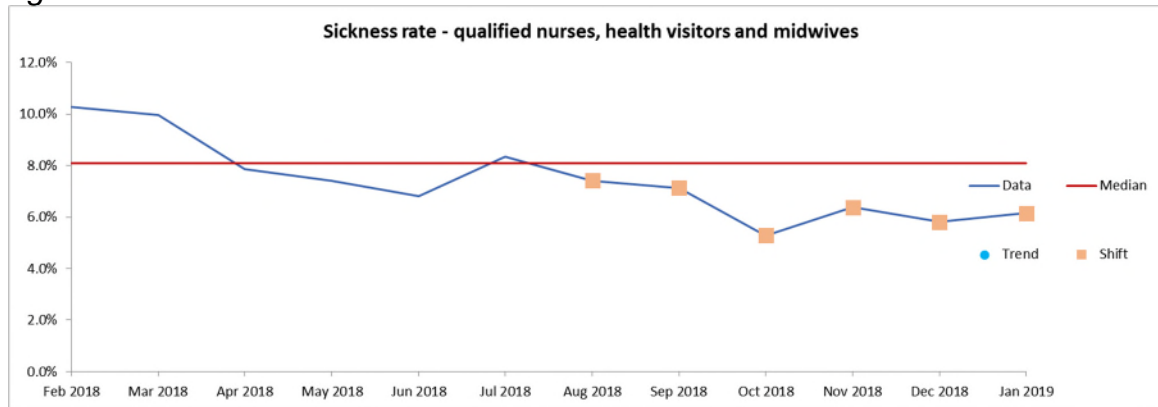


For all staff groups, annual vacancy and sickness rates were both in the highest 25% when compared to other similar core services nationally. However, this does not appear to be due to a high number of staff leavers, as the annual turnover rate was in the lowest 25% when compared to other similar services. While the annual sickness rate is high, monthly 'sickness rates' over the last 12 months for all staff show a downward trend from July 2018 to November 2018. Levels of sickness were reducing.

Managers supported staff who needed time off for ill health and supported a phased return to work.

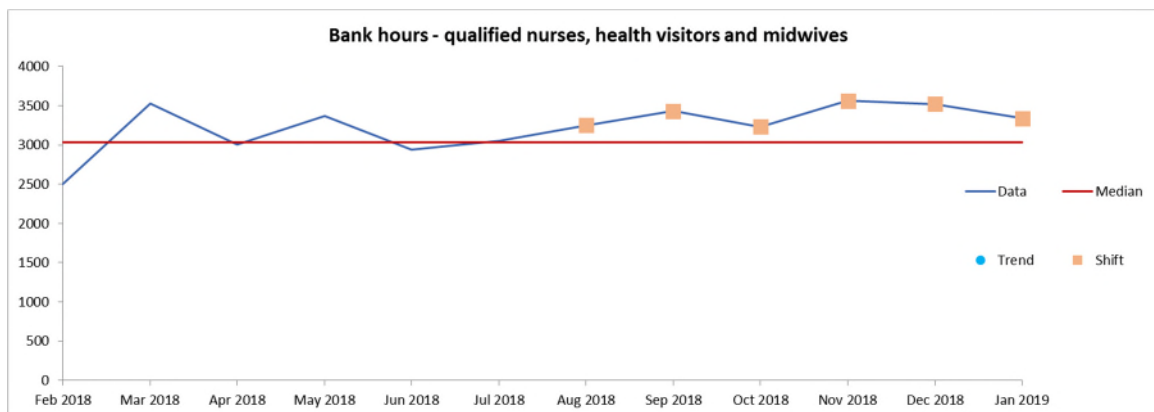
Qualified nurses

Figure 2



The annual turnover rate for qualified nurses was in the lowest 25% when compared to other similar core services nationally. In contrast, the annual sickness rate was in the highest 25% when compared nationally. However, monthly 'sickness rates' over the last 12 months show a shift from August 2018 to January 2019. This could be an indicator of change.

Figure 3

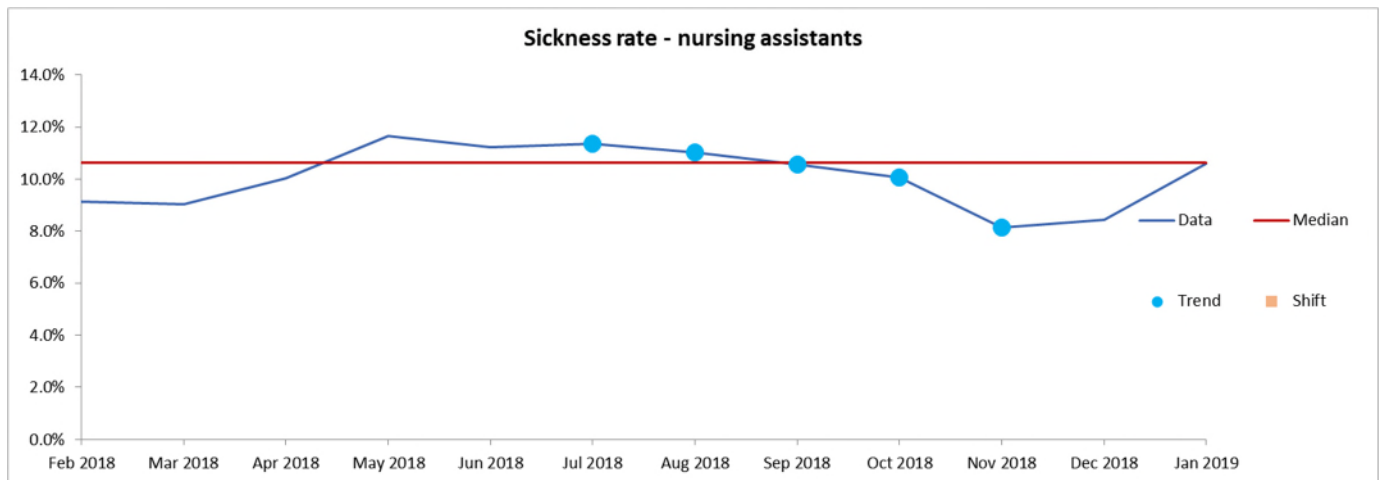


Annually, 10% of available hours were filled with bank nursing staff, with an upward shift between August 2018 and January 2019 (*figure 3*). However, staff fill rate data suggests there is a consistent trend of below 90% fill rates for nurses in both day and night shifts across all wards (except Hyndburn). Fewer than 1% of hours were filled by agency staff. Ward managers told us they used bank staff rather than agency staff as bank staff knew patients better and could provide consistency.

Nursing assistants

Figure 4

The service had reducing rates of bank and agency nursing assistants.



The annual turnover rate for nursing assistants was in the lowest 25% when compared to other similar core services nationally. In contrast, the annual sickness rate was in the highest 25% when compared nationally. However, monthly 'sickness rates' over the last 12 months for nursing assistants shows a downward trend from July 2018 to November 2018. This could be an early indicator of improvement.

Managers limited their use of bank and agency staff and requested staff familiar with the service. Ward managers told us they used bank staff rather than agency staff as bank staff knew patients better and could provide consistency.

Managers made sure all bank and agency staff had an induction and understood the service before starting their shift. We reviewed agency checklists and found these to be partially completed. Ligature audits were not included on the checklist; this meant we were not assured that all staff were aware of the potential risks within the environment and how to mitigate them.

The ward manager could adjust staffing levels according to the needs of the patients.

Patients rarely had their escorted leave or activities cancelled, even when the service was short staffed.

The service had enough staff on each shift to carry out any physical interventions safely.

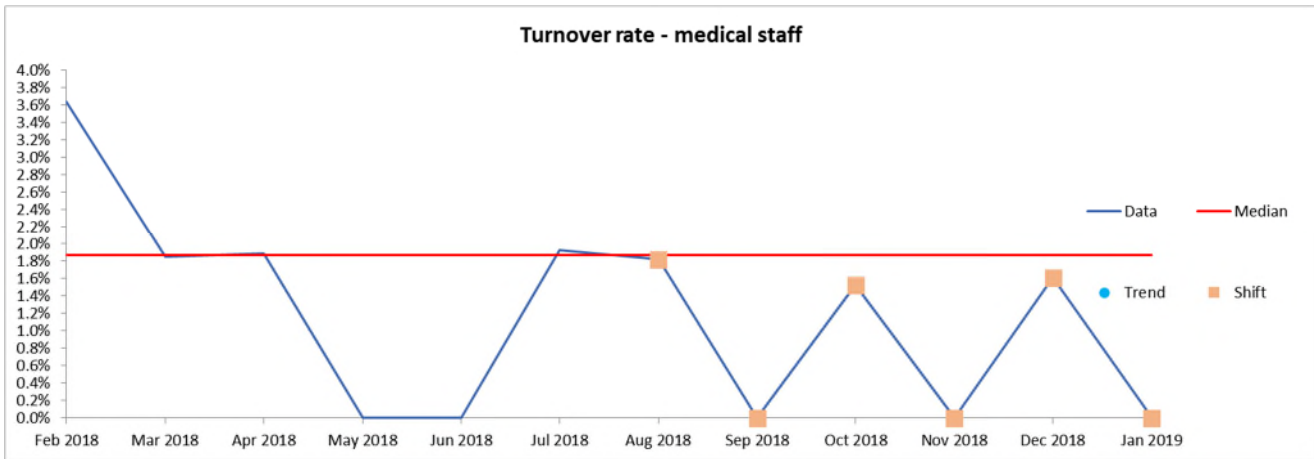
We reviewed the handovers and found they were variable for each ward. Some were paper based and others computerised. They did not all include risk. This meant staff may not have the current information regarding patients and how to keep them safe.

Medical staff

The service had enough daytime and night time medical cover and a doctor available to go to the ward quickly in an emergency. We observed at the Orchard, the consultant was on annual leave and another psychiatrist attended the unit to review patients including in the 136 suite.

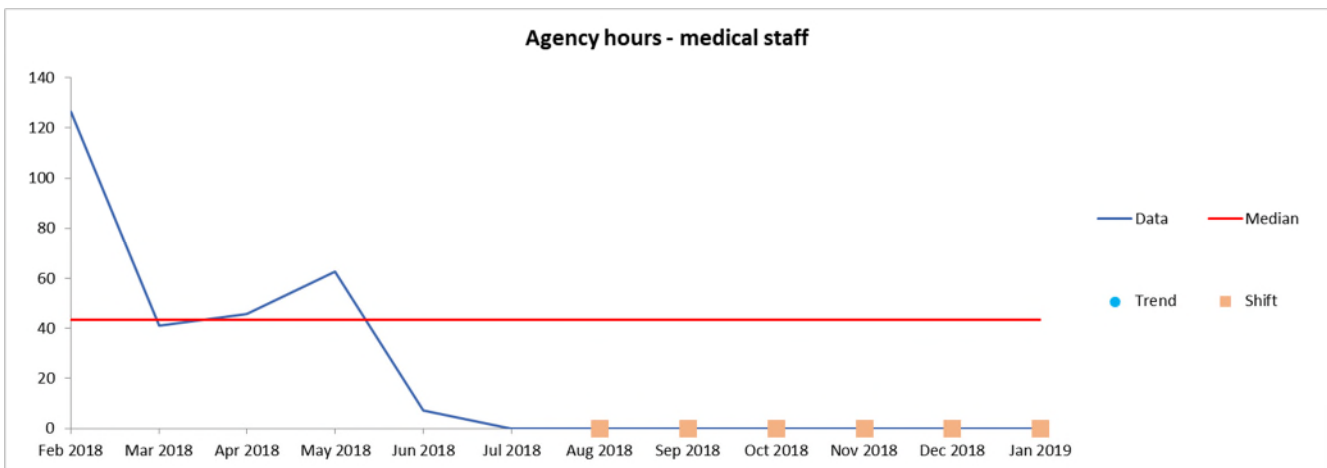
Managers could call locums when they needed additional medical cover.

Figure 5



The average vacancy rate for medical staff was in the highest 25% when compared to other similar core services nationally. Conversely, monthly 'turnover rates' over the last 12 months for medical staff shows a downward shift from August 2018 to January 2019. This could be an indicator of change.

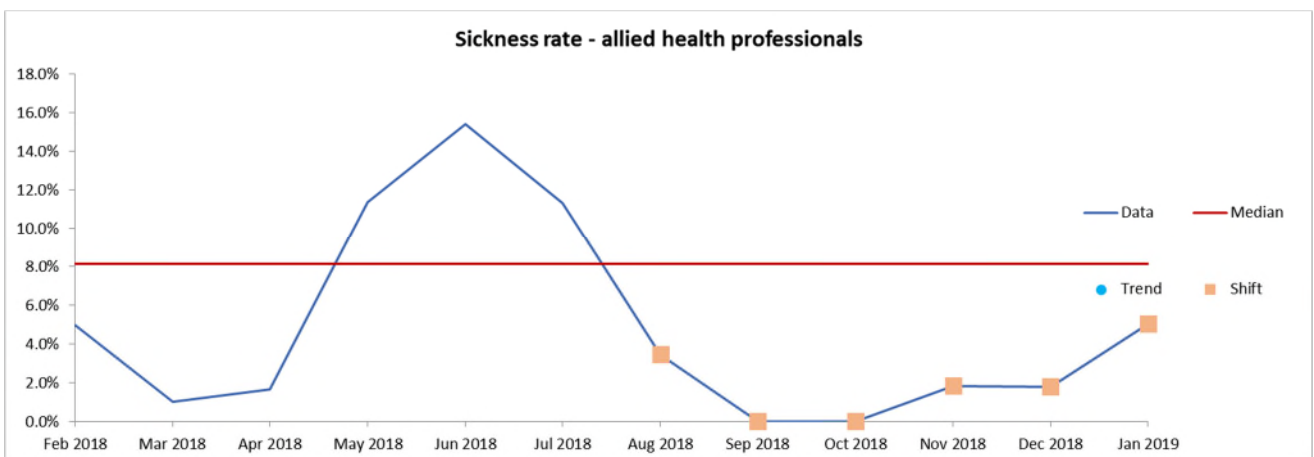
Figure 6



This core service reported 3% of available medical staff hours remaining unfilled. However less than 1% of available hours were filled by bank or agency staff. No agency medical locum staff were used after July 2018.

Allied Health Professionals

Figure 7



The average vacancy rate for Allied Health Professionals was in the highest 25% when compared to other similar core services nationally. Conversely, monthly 'sickness rates' over the last 12 months for allied health professionals shows a shift from August 2018 to January 2019. This could be an indicator of change (figure 7).

Mandatory training

Staff had not completed and kept up to date with their mandatory training.

The compliance for mandatory and statutory training courses at 6 March 2019 was 79%. Of the training courses listed ten failed to achieve the trust target and of those, seven failed to score above 75%.

The trust set a target of 80% for completion of mandatory and statutory training.

Training compliance is reported by the trust on an ongoing monthly basis.

The training compliance reported for this core service during this inspection was lower than the 89% reported in the previous year.

Key:

	Met trust target ✓	Not met trust target ✗	Higher ↑	No change →	Lower ↓
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Training Module	Number of eligible staff	Number of staff trained	YTD Compliance (%)	Trust Target Met	Compliance change when compared to previous year
Safeguarding Children L2	238	225	95%	✓	↑
Equality & Diversity	664	621	94%	✓	↓
Mental Capacity Act L1	603	558	93%	✓	↑
Health & Safety	664	609	92%	✓	↓
Fire Safety	664	593	89%	✓	↓
Infection Control	603	534	89%	✓	↓
Conflict Resolution	168	143	85%	✓	↑
Safeguarding Adults L2	603	512	85%	✓	n/a
Safeguarding Children L1	61	50	82%	✓	↓
Manual Handling L2A	506	411	81%	✓	↓
Manual Handling L1A	61	49	80%	✓	↓
Manual Handling L1B	94	73	78%	✗	n/a
Safeguarding Adults L1	61	46	75%	✗	↓
Safeguarding Children L3	365	275	75%	✗	↓
Immediate Life Support	268	199	74%	✗	↓
Basic Life Support	335	227	68%	✗	↓

Training Module	Number of eligible staff	Number of staff trained	YTD Compliance (%)	Trust Target Met	Compliance change when compared to previous year
Manual Handling L2B	3	2	67%	*	↓
Positive & Safe Programme	444	287	65%	*	n/a
WRAP	345	203	59%	*	n/a
Information Governance	664	388	58%	*	↓
Mental Capacity Act L2	603	321	53%	*	n/a
Total	8017	6326	79%	*	↓

Basic Life Support and Immediate Life Support training levels were low in the information provided by the trust prior to the inspection. We reviewed this information when on inspection and found the training levels were as low as 50% for Basic Life Support and Immediate Life Support. When we asked ward managers how they assured themselves that staff working had current training, they did not have a system in place to assure themselves of this. Staff compliance with training in life support was added to some shift allocation sheets however the sheets were not routinely being completed. National Institute for Health and Care Excellence guidance: Violence and aggression: short-term management in mental health, health and community settings NICE guideline [NG10] Published date: May 2015 states “Staff trained in immediate life support and a doctor trained to use resuscitation equipment should be immediately available to attend an emergency if restrictive interventions might be used.”

Managers received the GAPP (governance and performance portal) report which included their team’s performance in training. Where levels were low, they could arrange for staff to attend courses. Managers told us there had not been any Immediate Life Support training sessions available and now new dates had been arranged but they filled up very quickly, therefore team members had to wait for a date. Attendance at Basic Life Support was difficult for staff who could not drive and needed to attend Preston for training. The Resuscitation Council (UK) Mental health - inpatient care - Quality standards updated 2017 states that staff should attend annual Basic Life support training.

Assessing and managing risk to patients and staff

We reviewed 62 care records.

Assessment of patient risk

Staff completed a risk assessment for each patient when they were admitted and reviewed this regularly, including after any incident. Staff completed the trust enhanced risk assessment documentation which explored risk to self, others and vulnerability. This was formulated using the “five p’s”: presenting, predisposing, precipitating, perpetuating and protecting factors. Risk assessments were mostly detailed and current. We found 11 of the 62 were not detailed and did not include historic risks. We found ten out of 62 were not current, some of which had not been updated following incidents.

Management of patient risk

Staff knew about historic risks to each patient and acted to prevent or reduce risks. Staff had ward summaries which they carried with them, which included the patient's details, which bedroom they were in, levels of observations and any specific risks and vulnerabilities. However, shift handovers did not all include presenting risk of patients from the previous shift. This meant staff, especially bank and agency staff may not have the current information regarding patients and how to keep them safe.

Staff identified and responded to any changes in risks to, or posed by, patients. We observed staff updating each other during the shift with changing needs or presentations of patients. Staff responded to this by offering patients more one to one time.

We reviewed a sample of observation records which were complete.

Staff did not routinely search patients.

There was a no smoking policy in place however this was not being followed on the acute wards. Patients, if they refused to hand them in, had lighters on all wards except the psychiatric intensive care units. Outside spaces of wards had cigarette ends in them. We observed staff escorting patients to the outside space for a cigarette and there was a record of how many times patients had smoked in Darwen ward which was then incident reported. The ward smelt of smoke in Worden and Darwen wards and we observed a patient smoking a pipe in their bedroom on Darwen ward. We observed patients smoking in the ward outside space on Shakespeare, Stevenson, Scarisbrick, Lathom, The Orchard and Duxbury wards. Staff told us they would not remove lighters from patients. Vape vending machines were available in the hospitals and patients could use these in their bedrooms and outside, we observed these to be in use on the psychiatric intensive care units and when patients were authorised leave, they could smoke cigarettes.

Informal patients could leave at will, we observed staff letting patients out of the building. Where there were examples of informal patients wanting to leave and staff assessment concluding the patient was not safe to do so, staff either applied nurses' holding powers or submitted an urgent Deprivation of Liberty Safeguards application on one occasion we reviewed.

Use of restrictive interventions

Levels of restrictive interventions were low on the wards, patients kept their own belongings whilst an inpatient. On the psychiatric intensive care units, patients handed in items that posed a risk or were restricted including razors, glass and tobacco; these were stored in individual lockers. Staff gave these to patients dependent on risk and the level of supervision was assessed accordingly. Carrier bags were a restricted item. Staff were flexible regarding this, for example we observed a patient returning from shopping and they took their items to their room to unpack before handing in their carrier bag. The safety and security procedure for inpatient mental health units (excluding secure services) dated January 2019 states lighters are a prohibited item.

The trust had a reducing restrictive practices policy dated April 2019. This includes the aims of involving patients in their care and decision making.

This service had 2,009 incidences of restraint (709 different service users) and 527 incidences of seclusion between 1 February 2018 and 31 January 2019. Only four of the restraints were prone (chest-down) restraints. Previous inspections showed in the six-month period between 1 December 2015 and 3 June 2016 there had been 957 incidents of restraint on 230 different patients in acute admission and psychiatric intensive care units. In the year between 1 August 2016 and 31 July 2017 there were 2213 incidents of restraint in the acute and psychiatric intensive care units. This shows

a reduction of 204 incidents from 2016-2017 to 2018-2019 (9%). We saw staff deescalating situations by offering one to one time with patients and the opportunity to go out with staff.

The below table focuses on the last 12 months' worth of data: 1 February 2018 and 31 January 2019.

Ward name	Seclusions	Restraints	Patients restrained	Of restraints, incidents of prone restraint	Of restraints, incidents of rapid tranquilisation
Harbour - Stevenson Ward	37	330	53	2 (1%)	124 (38%)
Harbour - Byron Ward	65	224	50	0 (0%)	34 (15%)
Stock Beck Ward PICU	37	177	38	0 (0%)	99 (56%)
Harbour - Shakespeare Ward	21	155	47	0 (0%)	45 (29%)
Harbour - Keats Ward	115	152	45	1 (1%)	39 (26%)
Hyndburn Ward	4	136	45	0 (0%)	44 (32%)
PICU Calder Ward	35	102	35	1 (1%)	40 (39%)
Lathom Suite Ward	40	87	36	0 (0%)	7 (8%)
Dunsop Ward	0	79	35	0 (0%)	26 (33%)
Edisford Assessment Ward	2	73	54	0 (0%)	18 (25%)
Mental Health Inpatients Scarisbrick Unit	21	70	41	0 (0%)	3 (4%)
Darwen Ward	15	68	34	0 (0%)	26 (38%)
Harbour - Orwell Ward	28	68	28	0 (0%)	10 (15%)
Harbour - Churchill Ward	30	62	34	0 (0%)	11 (18%)
Ribble Ward	13	53	46	0 (0%)	33 (62%)
Mental Health Inpatients The Orchard	21	42	27	0 (0%)	7 (17%)
Hodder Ward	9	39	24	0 (0%)	28 (72%)
Avenham Ward PICU	24	39	11	0 (0%)	9 (23%)
Inpatient Management The Orchard North Lancs	8	25	16	0 (0%)	1 (4%)
Duxbury Ward	0	24	7	0 (0%)	15 (63%)
Worden Ward	2	4	3	0 (0%)	4 (100%)
Core service total	527	2009	709	4 (<1%)	623 (31%)

Staff participated in the provider's restrictive interventions reduction programme, which met best practice standards. Feedback from the Quality and Safety Sub-Committee Chair's Reports following the meetings held in July and August 2018 to the Quality committee included key highlights of zonal observations which had seen a reduction in the use of restraint.

Staff made every attempt to avoid using restraint by using de-escalation techniques and restrained patients only when these failed and when necessary to keep the patient or others safe.

There were four incidences of prone restraint, which accounted for less than 1% of the restraint incidents. Over the 12 months, incidences of restraint ranged from 125 to 216. The number of incidences (2,009) had increased from the previous 12-month period (2,034).

There were 623 incidences of rapid tranquilisation over the reporting period. Incidences resulting in rapid tranquilisation for this service ranged from 20 to 79 over (1 February 2018 to 31 January 2019). The number of incidences (623) had decreased from the previous 12-month period (749).

Staff followed NICE guidance when using rapid tranquilisation. At the last inspection, staff were not completing the physical observation of patients following rapid tranquillisation. At this inspection, records reviewed showed staff were completing the reviews post rapid tranquillisation and following the trust's policy in relation to offering oral medicine first and incident reporting occasions where rapid tranquillisation was used. The rapid tranquillisation position paper, April 2019 showed the work of the rapid tranquillisation task and finish group actions included a clear flowchart for staff to follow and prompts in the electronic prescribing system. The trust participated in the POMHUK re-audit of rapid tranquillisation, October 2018 and demonstrated an improvement across the audit standards [15% at baseline to 57%]. However, on Stevenson ward, we found that care plans were not reviewed to acknowledge patient wishes with respect to the management of episodes of disturbed behaviour.

There have been zero instances of mechanical restraint over the reporting period. The number of incidences (zero) was the same as the number of incidences from the previous 12-month period (zero).

The number of restraint incidences reported during this inspection was lower than the 2213 reported at the time of the last inspection.

We reviewed seven seclusion records. At the Orchard, we found doctors and nurses were recording their reviews in the wrong sections, nurses were conducting reviews on their own and the initial nursing review was an hour late. The Mental Health Act Code of Practice 2015 states nursing reviews should be completed by two nurses every two hours throughout seclusion. The service was not following this. The trust's seclusion procedure, reviewed October 2018 states: "Nursing reviews must take place by two nurses at least every two hours throughout seclusion, one of whom is independent and was not involved in the initial decision to seclude". The service was not following this. At Avenham ward, we found doctors were late for their reviews. At Hyndburn ward, there were no 15-minute observation records available for one episode we reviewed and following a further request the trust confirmed they could not be located.

There have been 527 instances of seclusion over the reporting period. Over the 12 months, incidences of seclusion ranged from 24 to 61. The number of incidences (527) had increased from the previous 12-month period (426).

The number of seclusion incidences reported during this inspection was higher than the 399 reported at the time of the last inspection.

There have been zero instances of long-term segregation over the 12-month reporting period. The number of incidences (zero) was the same as the previous 12-month period (zero).

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse, and they knew how to apply it.

Staff received training on how to recognise and report abuse, appropriate for their role. Training compliance levels were 85% for safeguarding adults and 82% for safeguarding children.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them.

Staff followed clear procedures to keep children visiting the ward safe. There were designated rooms used for family visits.

We raised a safeguarding concern during the inspection from one of the patients. The service responded appropriately to this allegation, including completing an incident report, reporting to safeguarding and the police.

Staff knew how to make a safeguarding referral and who to inform if they had concerns.

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 three safeguarding referrals between 1 February 2018 and 31 January 2019 to local authorities, of which all concerned adults. The number of safeguarding referrals reported during this inspection was lower than the 121 reported at the last inspection. Staff told us that they contacted their internal safeguarding team for advice first, before making any referrals to the local authorities. The internal safeguarding team made the decision whether to pass the concern to the local authority.

The trust has submitted details of no serious case reviews commenced or published in the last 12 months (8 February 2018 and 7 February 2019) that relate to this service.

Staff access to essential information

The service used three different electronic records systems: an electronic incident reporting system, an electronic care record and an electronic system for physical health and monitoring purposes. Qualified nurses also used an electronic prescribing system for administering medicines. Paper records were used for admission records and handovers and some seclusion recording.

Access to records was dependant on computer availability, we saw wards had different numbers of computers available to them.

Patient notes were comprehensive. However, doctors did not routinely use the electronic system for health and monitoring purposes. This meant information was not stored in one place.

Although the service used a combination of electronic and paper records, staff made sure they were up to date and complete.

When patients transferred to a new team, there were no delays in staff accessing their records.

Records were stored securely in locked offices.

Medicines management

The service used systems and processes to prescribe, administer, record and store medicines. Staff regularly reviewed the effects of medicines on each patient's mental and physical health.

We reviewed 95 prescription cards. The relevant legal authorities for treatment were generally in place and checked by nurses when administering medicines. However, we found 12 errors in prescribing and consent to treatment.

On Calder ward there was one patient prescribed intramuscular promethazine and it had been administered on 11 June 2019; this was not on their T3. (A T3 is a certificate of second opinion. It is a form completed by a second opinion appointed doctor to record that a patient is not capable of understanding the treatment he or she needs or has not consented to treatment but that the treatment is necessary and can be provided without the patient's consent).

At Darwen Ward there were four errors. One patient was prescribed promethazine orally and it was administered but not on the T3. Another patient was prescribed lorazepam and administered regularly which was not on their section 62(A form completed by a doctor for urgent treatment. Which (not being irreversible or hazardous) is immediately necessary and represents the minimum interference necessary to prevent the patient from behaving violently or being a danger to himself or to others.). Another patient prescribed zopiclone and procyclidine was taking these medicines daily and they were not on the T2. (A T2 is a certificate of consent to treatment. It is a form completed by a doctor to record that a patient understands the treatment being given and has consented to it). Another patient was prescribed lorazepam as and when required. This medicine was administered several times on 4 April 2019, the medicine was not on their section 62. These errors were on four out of eight medicine cards reviewed on this ward. A nurse had picked these up at an audit but not acted on them. We raised these concerns with the staff who ensured the doctor resolved them that day.

On Shakespeare ward, there were two patients where one of their medicines was not recorded on the T3, the inspection team passed this to the pharmacist to address with the doctor.

On Stevenson ward, there was a patient whose T2 did not match their prescription until three days prior to the inspection when the additional medicine of Sertraline was added.

At the Orchard, there were four errors with prescribing of medicines. One patient had a duplicate prescription in place, as they had transferred from the Harbour. The inspection team passed this onto the pharmacist to address and incident report. One patient's medicine was out of stock at the Orchard meaning that the patient had missed five days of medicine. We saw one example where a 'when required' medicine was not included on a patients T2 and a second example where there was no Section 62 for a medicine not included on a T3. We raised this with the ward pharmacist in order that this would be addressed.

This meant there were 12 incidents of patients taking medicines without the appropriate legal safeguards.

Allergies were not noted on 16 of the prescription cards we reviewed. This meant staff would not know if there was a risk of prescribing a specific medicine to a patient.

Staff reviewed patients' medicines regularly at ward rounds and provided specific advice to patients and carers about their medicines. Patients were supported to use formal side-effect rating tools for reporting and monitoring side effects in order that these could be managed effectively. Therapeutic drug monitoring was carried out and recorded when needed.

Staff mostly stored and managed medicines and prescribing documents in line with the provider's policy. On Edisford ward staff found it difficult to find the emergency medicines. At the Orchard a nurse and junior doctor did not know where the emergency medicines were. When located we found the medicines were locked in the clinic room and the emergency grab bag in the treatment room. This meant if there was an emergency staff would not have been able to locate the emergency medicines quickly. On Avenham ward, the grab bag contents did not reflect the laminated contents page, this was passed onto the ward manager to address.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely. This included via the medication safety group and the patient safety team.

Staff reviewed the effects of each patient's medication on their physical health according to National Institute for Health and Care Excellence guidance. We saw that patients were administered their medicines in an ante-room to the clinic, helping to ensure privacy and dignity and to giving patients an opportunity to discuss their medicines with the nurses. The pharmacist also spoke with patients on request and patients and staff had access to information on the Choice and Medication website.

Track record on safety

Between 1 February 2018 and 31 January 2019 there were 10 serious incidents reported by this service. Of the total number of incidents reported, the most common type of incident was 'apparent / actual / suspected self-inflicted harm' with four. There were no unexpected deaths.

We reviewed the serious incidents reported by the trust to the Strategic Executive Information System (STEIS) over the same reporting period. There were 11 incidents STEIS reported, with one being downgraded. Therefore, the number of the most severe incidents recorded by the trust matches with the number of STEIS incidents.

A 'never event' is classified as a wholly preventable serious incident that should not happen if the available preventative measures are in place. This service reported zero never events during this reporting period.

The number of serious incidents reported during this inspection was higher than the seven reported at the last inspection.

Type of incident reported (SIRI)	Number of incidents reported			
	Unauthorised absence meeting SI criteria	Confidential Information	Disruptive/ aggressive/ violent behaviour meeting SI criteria	Total
Edisford Assessment Ward	2	0	0	2
Inpatient Management The Orchard North Lancs	0	0	1	1
Ribble Ward	0	0	1	1
Hodder Ward	0	1	0	1
Hyndburn Ward	0	1	0	1
PICU Calder Ward	0	0	1	1
Harbour - Stevenson Ward	1	0	0	1
Harbour - Churchill Ward	0	1	0	1
Mental Health Inpatients Scarisbrick Unit	1	0	0	1
Total	4	3	3	10

Reporting incidents and learning from when things go wrong

The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

All staff knew what incidents to report and how to report them. They were proficient at navigating the electronic incident reporting system.

Staff reported all incidents that they should report. Managers were able to show us the incident reports for incidents that had been shared with us as examples. Staff reported serious incidents clearly and in line with trust policy.

Staff understood the duty of candour. There were no recent examples of incidents that met the duty of candour threshold for the inspection team to review.

Managers debriefed and supported staff after any serious incident. Records confirmed this took place. Debriefs were also provided to patients and documented on the electronic incident system and in the care record.

Staff received feedback from investigation of incidents, both internal and external to the service. This was via the 'incident on a page' publications and trust newsletter. Safety alerts and lessons learnt were discussed within Darwen team meetings. Staff met to discuss the feedback and look at improvements to patient care. Monthly serious incident learning panels took place where actions

were reviewed including 12-month review of improvements and learning. However, this information was not available at a ward level.

There was evidence that changes had been made as a result of feedback. For example, on Avenham ward, ensuring the locks have been changed to enable staff to have keys to all areas to be able to respond quickly if needed. On Duxbury ward, staff entering a patient's bedroom to ensure they are breathing if that is not evident through the window. On Ribble A ward, piloting body cameras and completing capacity assessments following incidents of violence and aggression to determine if the police will be involved. On Hyndburn ward, including a description of what the patient was wearing to assist with information sharing if a patient goes missing.

The Chief Coroner's Office publishes the local coroners Reports to Prevent Future Deaths which all contain a summary of Schedule 5 recommendations 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 three 'prevention of future death' reports sent to Lancashire Care NHS Foundation Trust. One of these related to this service, details of which can be found below.

Patient A 12 July 2018

A man died after falling from a multi-story car park in Blackpool, having previously absconded from the Harbour Mental Health facility during escorted leave. He had previously been on nine periods of escorted leave without incident and this period of leave was granted provided he was accompanied by a staff member and did not leave the hospital perimeter.

The Coroner's concerns related to:

- Record keeping:
 - While it was felt that the therapeutic team had a good understanding of the extent of the patient's risks, these were not adequately documented in the medical notes.
 - There was little detail in the patient's documentation around the leave, including care planning, rationale, risks etc.
 - There was no documented assessment of the patient's clinical state prior to leave.
 - There was no copy of the Leave Authorisation form.

The following learning / recommendations were given:

No formal recommendations have been given by the coroner, rather they wish to raise the issue of the importance of appropriate record keeping, particularly in the context of patients detained under the Mental Health Act.

Is the service effective?

Assessment of needs and planning of care

Staff assessed the physical and mental health of all patients on admission. They developed individual care plans which were reviewed regularly through multidisciplinary discussion and updated as needed. Care plans reflected patients' assessed needs, and were personalised, holistic and recovery-oriented.

We reviewed 62 care records. Staff completed a comprehensive mental health assessment of each patient either on admission or soon after.

Fifty-four records included a physical health assessment soon after admission and all records included physical health review during their time on the ward. The trust had access to Lancashire Person Record Exchange Service facilitating prompt access to previous blood results, diagnoses and copies of Lancashire discharge letters to support safe prescribing. The trust electronic prescribing and medicines administration (ePMA) alerted prescribers to possible interactions and allergies. 'When required' medicines were flagged for review to ensure they remained appropriate for prescribing.

Staff developed a comprehensive care plan for each patient that met their mental and physical health needs.

Records showed in 59 cases that staff regularly reviewed and updated care plans when patients' needs changed.

In 40 records reviewed, care plans were personalised, holistic and recovery-orientated. Twenty-two records did not include the patient's views. Two records did not include the current detention status of patients.

Best practice in treatment and care

Staff provided a range of treatment and care for patients based on national guidance and best practice. They ensured that patients had good access to physical healthcare and supported them to live healthier lives. Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives.

Staff provided a range of care and treatment suitable for the patients in the service. Patients had access to psychological formulations and psychologically-informed groups including sleep management.

At the Orchard, we found examples of a patient with epilepsy, without an epilepsy care plan. This was not in line with best practice and national guidance. National Institute for Health and Care Excellence Epilepsies: diagnosis and management Clinical guideline [CG137] (2012, updated 2018) states: "All children, young people and adults with epilepsy should have a comprehensive care plan that is agreed between the person, family and/or carers where appropriate, and primary care and secondary care providers. This should include lifestyle issues as well as medical issues."

There was another patient who used a wheelchair to mobilise and they did not have a moving and handling assessment in place. Manual Handling Operations Regulations 1992 Guidance published 2016 states "An individual person assessment should consider the specific moving and handling needs of the person being cared for as part of their care plan. This assessment is likely to change as the condition of the person alters, so carers should be aware of the need to adapt their moving and handling practices."

The service was not following the Accessible Information Standard, which states that services should identify, record, flag, share and meet the communication needs of people including people with a learning disability. At the time of inspection, the service was caring for ten patients with a learning disability. We reviewed one record of a patient with a learning disability; their record was not following the accessible information standard.

At the time of inspection, the service was caring for 30 patients with a personality disorder. Guidance states that patients with a personality disorder should be admitted to hospital for the shortest time possible as that environment is not best suited to their needs. National Institute for Health and Care Excellence guidance Borderline personality disorder: recognition and

management Clinical guideline [CG78] (2009) states: “Before considering admission to an acute psychiatric inpatient unit for a person with borderline personality disorder, first refer them to a crisis resolution and home treatment team or other locally available alternative to admission. Only consider people with borderline personality disorder for admission to an acute psychiatric inpatient unit for: the management of crises involving significant risk to self or others that cannot be managed within other services, or detention under the Mental Health Act (for any reason).” We saw on Duxbury ward, a patient with emotionally unstable personality disorder who had been an inpatient for 659 days. They were struggling to find a community placement for them. The trust did not have a personality disorder strategy or team working proactively with this group of inpatients.

Staff identified patients’ physical health needs and recorded them in their care plans. For one patient who refused to have a physical health assessment, this was recorded in their care record.

Staff made sure patients had access to physical health care, including specialists as required. Records confirmed referrals to other health professionals including dermatology.

Staff met patients’ dietary needs and assessed those needing specialist care for nutrition and hydration. We observed a referral being made to an eating disorder specialist service for one patient.

Staff helped patients live healthier lives by supporting them to take part in programmes or giving advice. Physical health activities took place on wards including yoga. Nicotine replacement therapy was available to patients, including vape vending machines.

Staff used recognised rating scales to assess and record the severity of patients’ conditions and care and treatment outcomes. Occupational therapists used the model of human occupation and psychologists created a formulation including of risk presented.

Staff took part in clinical audits, benchmarking and quality improvement initiatives. These included environmental audits and infection, prevention and control. Management team checklists were completed to review care records, seclusion logs and other tasks including review of the clinic room and activity records.

Managers used results from audits to make improvements. Managers received the governance and performance portal (GAPP) report, which included their team’s performance in training, appraisal and supervision. Managers used this report to focus their time on staff who required training, appraisal or supervision.

This service participated in three clinical audits as part of their clinical audit programme 2018.

Audit name	Audit scope	Core service	Date completed	Key actions following the audit
Prevention of Dehydration	AMH	MH - Acute wards for adults of working age and psychiatric intensive care units	30/09/2018	No actions identified
National Audit of Psychosis	AMH	MH - Acute wards for adults of working	30/09/2018	The results have been shared with all teams who participated in the national audit. LCFT has purchased the access to the Choice & Medication website

Audit name	Audit scope	Core service	Date completed	Key actions following the audit
		age and psychiatric intensive care units		which will support the provision of written information on medication to patients. Work is ongoing relating to the trusts EPR and supporting staff to record patients' physical health.
Risk Assessments	AMH	AMH including inpatients, secure services and community mental health teams	30/09/2018	<p>The Occupational Therapy Professional Lead and Restrictive Practice Reduction Lead will propose at the Secure Services Senior Leadership meeting that training is developed in the completion of the Electronic Risk Assessment Tool. The Occupational Therapy Professional Lead will liaise with the FCMHT manager to understand why care plans are provided to patients instead of risk assessments</p> <p>The question in relation to service user involvement should be reviewed whilst planning the re-audit. The tool should ask for the level of service user involvement. For example: copy of risk assessment given; regular conversations take place; patient declined and this is reflected in care plan. There is currently no risk assessment training programme. Action is required to ensure this is taken forward and a responsible lead identified.</p> <p>Feasibility of developing training package to be investigated and consideration given to face to face training and through training tracker on alternate years. This would include identifying staff groups this training would be appropriate for</p>

Skilled staff to deliver care

The ward teams included or had access to the full range of specialists required to meet the needs of patients on the wards. They supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.

The service had access to a full range of specialists to meet the needs of the patients on the ward. Teams comprised doctors, health care assistants, nurses, occupational therapists and clinical psychologists. Staff referred patients to other disciplines as needed, including speech and language therapy and dieticians. On Keats ward, the responsible clinician was a consultant

psychologist. Staff spoke positively about this addition and the support they offered to the team as well as the patients.

Managers did not ensure staff had the right skills, qualifications and experience to meet the needs of the patients in their care, including bank and agency staff. At the time of the inspection the service were caring for 10 patients with a learning disability and 30 patients with a personality disorder. Staff did not routinely access training for working with people with a learning disability or personality disorder. On Edisford ward, we observed a patient with autism who was visibly distressed. Staff were finding it difficult to support the individual. Following the inspection, the trust told us that they were piloting training in Autism and that the Personality Disorders Managed Clinical network provided training in personality disorder. However, there were no compliance levels for this service. This meant that there was no evidence that staff had the knowledge and skills to support patients with these complex needs.

Managers gave each new member of staff an induction to the service before they started work. However, we reviewed induction checklists and found they did not include everything that would be expected to be discussed with new staff, including the ligature anchor point risks in the ward environment and how to mitigate them. Induction records were not completed in full, with gaps of areas covered. This meant it was not clear if staff had covered that topic in their induction or not.

On most wards, managers supported staff through regular, constructive appraisals of their work. The trust's target rate for appraisal compliance is 80%. At the end of last year (1 April 2017 and 31 March 2018), the overall appraisal rate for non-medical staff within this service was 33%. This year so far, the overall appraisal rates was 76% (as at 6 March 2019). The ward with the lowest appraisal rate at 6 March 2019 was PICU Calder Ward with an appraisal rate of 32%.

The rate of appraisal compliance for non-medical staff reported during this inspection was higher than the 10% reported at the last inspection (at March 2017).

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 (as at 6 March 2019)	% appraisals (previous year 1 April 2017 – 31 March 2018)
Harbour - PICU Keats Ward	21	20	95%	39%
Scarisbrick Mental Health Inpatients	29	27	93%	68%
Harbour - Stevenson Ward	25	23	92%	33%
Edisford Assessment Ward	28	25	89%	7%
Darwen Ward Mental Health Inpatients	24	21	88%	79%
Harbour - PICU Byron Ward	28	24	86%	47%
Worden Ward	26	22	85%	n/a
Hyndburn Ward Mental Health Inpatients	27	22	81%	84%

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 (as at 6 March 2019)	% appraisals (previous year 1 April 2017 – 31 March 2018)
Ribble A Assessment Ward	31	25	81%	7%
PICU Lathom Suite Ward	23	18	78%	64%
Harbour - Orwell Ward	27	20	74%	27%
Harbour - Shakespeare Ward	29	20	69%	67%
Harbour - Churchill Ward	29	20	69%	13%
The Orchard Mental Health Inpatients	37	24	65%	2%
PICU Avenham Ward	19	11	58%	n/a
Duxbury Ward	29	15	52%	n/a
PICU Calder Ward	22	7	32%	30%
Core service total	454	344	76%	33%
Trust wide	5530	4739	86%	69%

The trust's target rate for appraisal compliance is 80%. At the end of last year (1 April 2017 to 31 March 2018), the overall appraisal rate for medical staff within this service was 50%. This year so far, the overall appraisal rate was 100% (as at 6 March 2019).

Ward name	Total number of permanent medical staff requiring an appraisal	Total number of permanent medical staff who have had an appraisal	% appraisals (as at 6 March 2019)	% appraisals (previous year 1 April 2017 – 31 March 2018)
Medics AD MH East	30	30	100%	50%
Medics Step 5 Central	1	1	100%	n/a
Medics North Mid Tier Rota	2	2	100%	50%
Medics ADH North	13	13	100%	50%
Core service total	46	46	100%	50%
Trust wide	118	118	100%	50%

Managers did not support non-medical staff through regular, constructive clinical supervision of their work.

The trust's target of clinical supervision for non-medical staff is 80% of the sessions required. Between 1 April 2018 and 11 March 2019, the average rate across all 17 wards in this service was 18%.

Team name	Clinical supervision sessions required	Clinical supervision delivered	Clinical supervision rate (%)
Darwen Ward Mental Health Inpatients	306	134	44%
Harbour - Orwell Ward	397	128	32%
PICU Avenham Ward	82	23	28%
Hyndburn Ward Mental Health Inpatients	305	83	27%
The Orchard Mental Health Inpatients	496	99	20%
Harbour - PICU Keats Ward	309	59	19%
Edisford Assessment Ward	355	64	18%
Scarisbrick Mental Health Inpatients	359	63	18%
Ribble A Assessment Ward	398	63	16%
Worden Ward	106	16	15%
Harbour - PICU Byron Ward	361	54	15%
PICU Lathom Suite Ward	268	39	15%
Harbour - Shakespeare Ward	373	51	14%
Harbour - Stevenson Ward	388	34	9%
PICU Calder Ward	306	24	8%
Harbour - Churchill Ward	403	31	8%
Duxbury Ward	124	4	3%
Core service total	5,336	969	18%
Trust Total	31,039	9,569	31%

We reviewed the trust's supervision policy dated July 2018, which stated "All staff should have access to line management supervision quarterly." We reviewed 27 supervision files on site and audits and found 14 staff were receiving supervision within three monthly intervals and 13 staff were receiving supervision at less than three monthly intervals or not at all.

The trust has not provided clinical supervision data for medical staff. However, when we spoke to doctors, they told us they received supervision and appraisal and felt supported.

We reviewed the team meeting minutes for the six months prior to the inspection and found Hyndburn, Darwen and the Orchard held regular team meetings of at least monthly intervals. Both Worden and Shakespeare wards had had two team meetings in the last six months. Other wards

were not having regular team meetings. Managers shared minutes and other information with staff via email.

Managers recognised poor performance, could identify the reasons and dealt with these. This included more frequent supervision.

Managers recruited, trained and supported volunteers to work with patients in the service. There were three volunteers at the Orchard providing activities for patients and supporting patients with community participation.

Multi-disciplinary and interagency team work

Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. The ward teams had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.

Staff held regular multidisciplinary meetings to discuss patients and improve their care. Morning business meetings took place, we observed two meetings. These were attended by a variety of disciplines, each patient was discussed, updates provided, and actions allocated.

Staff did not make sure they shared clear information about patients and any changes in their care, including during handover meetings. We reviewed seven handovers and found three included areas of risk, four did not and four were not completed in full.

Ward teams had effective working relationships with other teams in the organisation. We saw care coordinators attending wards to visit their patients and attend ward reviews.

Ward teams had effective working relationships with external teams and organisations. Staff from third sector organisations attended ward reviews for patients. Records confirmed referrals being made to external teams.

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

Staff did not fully understand their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and did not discharge these well in relation to medicines. Managers made sure that staff could explain patients' rights to them.

Staff received and kept up to date with training on the Mental Health Act and the Mental Health Act Code of Practice and could describe the Code of Practice guiding principles. The trust categorised Mental Health Act training as essential, for review every three years.

There were 187 staff eligible to attend the training in this core service and 136 staff had attended the training within three years, equating to 73%.

Staff had access to support and advice on implementing the Mental Health Act and its Code of Practice. Staff knew who their Mental Health Act administrators were and when to ask them for support.

The service had clear, accessible, relevant and up to date policies and procedures that reflected all relevant legislation and the Mental Health Act Code of Practice.

Patients had easy access to information about independent mental health advocacy and patients who lacked capacity were automatically referred to the service. Information was displayed on the wards and leaflets were available for patients. Patients were aware of the advocate and the presence on the ward.

Staff explained to each patient their rights under the Mental Health Act in a way that they could understand, repeated as necessary and recorded it clearly in the patient's notes each time. Records showed examples of individuals who could not understand their rights when staff first attempted to explain them, however staff tried again on a later date when patients could understand and process the information.

Staff made sure patients could take section 17 leave (permission to leave the hospital) when this was agreed with the responsible clinician and/or with the Ministry of Justice. We saw patients leaving the wards, either alone or with an escort, dependent on their leave conditions. Staff followed the processes of recording what patients were wearing prior to going on leave.

Records confirmed staff requested an opinion from a Second Opinion Appointed Doctor (SOAD) when they needed to on Shakespeare ward, Stevenson ward, Byron ward and Calder ward.

Staff stored copies of patients' detention papers and associated records correctly and staff could access them when needed.

Informal patients knew that they could leave the ward freely. We saw patients leaving the wards, both alone and with friends and family.

At the time of inspection there were 121 informal patients and 144 detained under the Mental Health Act.

Managers and staff made sure the service applied the Mental Health Act correctly by completing audits and discussing the findings, we saw discussions taking place in team meetings.

Good practice in applying the Mental Capacity Act

Staff supported patients to make decisions on their care for themselves. They understood the trust policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly for patients who might have impaired mental capacity.

Staff received and kept up to date with training in the Mental Capacity Act and had a good understanding of at least the five principles.

As of 6 March 2019, 93% of the workforce in this service had received training in the Mental Capacity Act Level 1 and 53% had received training in the Mental Capacity Act Level 2. The trust stated that this training is mandatory for all services for inpatient and all community staff and renewed three years.

The trust told us that two Deprivation of Liberty Safeguard (DoLS) applications were made to the Local Authority for this service between 1 February 2018 to 31 January 2019.

The greatest number of DoLS applications were made in August 2018 with two.

CQC received two direct notifications from the trust between 1 February 2018 to 31 January 2019⁵.

The number of DoLS applications made during this inspection was higher than the one reported at the last inspection.

	Number of 'Standard' DoLS applications made by month												Total
	Feb 18	Mar 18	Apr 18	May 18	Jun 18	Jul 18	Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 18	
Standard applications made							1						1

⁵ CRM

	Number of 'Standard' DoLS applications made by month												
	Feb 18	Mar 18	Apr 18	May 18	Jun 18	Jul 18	Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 18	Total
Standard applications approved								1					1

	Number of 'Urgent' DoLS applications made by month												
	Feb 18	Mar 18	Apr 18	May 18	Jun 18	Jul 18	Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 18	Total
Urgent applications made							1						1
Urgent applications approved							1						1

We reviewed the record of a patient at the Orchard where an informal patient was trying to leave on 29 April 2019, the doctor recorded that they were being held under the Mental Capacity Act. We requested the copy of the DoLS application and found that the urgent DoLS application was not completed and submitted until 2 May 2019, this meant that the patient had three days of being detained without the appropriate legal safeguards in place.

There was a policy on Mental Capacity Act and Deprivation of Liberty Safeguards, which staff knew how to access. The Policy for Implementing the Mental Capacity Act and Obtaining Authorisation for Deprivation of Liberty dated June 2017 did not give an accurate definition of capacity, as it said: "Within the Mental Capacity Act (2005) the term capacity relates to the person's ability to consent to or refuse care or treatment." However, the Mental Capacity Act does not just relate to care and treatment it includes all decisions. The policy did include helpful one-page guidance for staff.

Staff knew where to get accurate advice on the Mental Capacity Act and Deprivation of Liberty Safeguards.

Staff gave patients all possible support to make specific decisions for themselves before deciding a patient did not have the capacity to do so.

Staff assessed and recorded capacity to consent when there was reason to doubt a patient's capacity to make an important decision. Records confirmed capacity assessments took place in relation to specific decisions including whether a patient could consent to be an inpatient, managing their finances, physical health needs and accommodation. However, on Scarisbrick unit we found two incomplete capacity assessments.

When staff assessed patients as not having capacity, they made decisions in the best interest of patients and considered the patient's wishes, feelings, culture and history.

Is the service caring?

Kindness, privacy, dignity, respect, compassion and support

Staff treated patients with compassion and kindness. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition. However, they did not always respect patients' privacy and dignity.

We observed staff interaction with patients on all wards. We found staff were discreet and responsive when caring for patients. However, on Edisford ward, we observed, and patients told us, that there was not always a staff member in the communal area and the nurses office did not look out over the ward. Patients told us they felt vulnerable when there was no staff in the communal area for them to approach.

Staff gave patients help, emotional support and advice when they needed it. We observed staff having one to one time with patients who were unsettled or asking questions and requiring reassurance. Staff understood and respected the individual needs of each patient. However, we observed one patient with autism, who was visibly distressed, and staff were finding it difficult to console the individual and know the best way to support them.

Staff supported patients to understand and manage their own care treatment or condition. Positive behaviour support plans were in use for patients who presented with difficulties regarding their behaviour and communicating their feelings and emotions. The positive behaviour support plans we reviewed showed evidence of patients being actively involved in the plan and how staff should respond to them.

Staff directed patients to other services and supported them to access those services if they needed help. This included Chorley Sheds, a local community project providing craft, woodwork and metal work opportunities.

We spoke with 51 patients and observed a patient meeting. Thirty-two patients said all staff treated them well and behaved kindly. Eleven staff said most of the staff were caring and supportive. One patient told us that some agency staff could be disrespectful.

Staff felt that they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients.

Staff followed policy to keep patient information confidential. The information was stored in locked rooms and the summary of the ward had patient initials on for confidentiality.

The sites which deliver mental health acute wards for adults of working age within Lancashire Care NHS Foundation Trust were compared to other sites of the same type and the scores they received for 'privacy, dignity and wellbeing were found to be about the same as the England average.

Involvement in care

Staff involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided. They ensured that patients had easy access to independent advocates.

Involvement of patients

Staff introduced patients to the ward and the services as part of their admission. Patients told us that they received a tour of the ward when they arrived. We saw welcome packs in place at the Chorley wards with mutual expectations, a leaflet on the advocacy service and smoke free. The mental health inpatient stay booklet was out of date and did not include the current wards. This meant patients would not have up to date information about their ward. However, at the assessment wards in Blackburn, there was a recent leaflet explaining to patients what to expect, visiting arrangements, mutual expectations and the roles of the staff they may meet.

Staff involved patients and gave them access to their care planning and risk assessments. Sixteen patients told us they were involved in creating their care plan and 15 patients said they had a copy of their care plan. Twenty-two people knew what their treatment plan was. Patients were involved and consulted for their views and opinions regarding their care and treatment in the care programme approach reviews and ward rounds we observed.

Patients could give feedback on the service and their treatment and staff supported them to do this. We observed this happening at the patient meeting we observed. Patients found ward managers approachable; we observed patients talking with ward managers and giving them feedback about the service. Managers listened and acted upon the feedback or requests of patients.

We saw information regarding the advocacy service on display on the wards, leaflets were available for patients. Patients knew about the advocacy service, how to access it and how it had supported them.

Involvement of families and carers

Staff informed and involved families and carers appropriately.

Staff supported, informed and involved families or carers. We saw family members visiting patients and where leave allowed, going out with patients. There were family rooms and quiet rooms available for patients to have visits with their family and at the Orchard there was the café where patients and their family and friends could meet too. Seventeen of the patients we spoke with told us their family was actively involved in their care and visited regularly.

Staff helped families to give feedback on the service. Friends and family tests were in use and feedback reviewed at Chorley showed two replied for Duxbury ward and five for Worden ward. All responses said they were extremely likely to recommend the service.

Staff gave carers information on how to access a carer's assessment from the local authority. There was a leaflet entitled "information for carers of people admitted to hospital" this included useful information about the hospital, care provided, staff roles and responsibilities and how to access a carer's assessment.

Is the service responsive?

Access and discharge

Bed management

The trust provided information regarding average bed occupancies for 17 wards in this service between 1 February 2018 to 31 January 2019.

All of the wards within this service reported average bed occupancies ranging above the minimum benchmark of 85% over this period.

Ward name	Average bed occupancy range (1 February 2018 - 31 January 2019) (current inspection)
Avenham Ward PICU	97% - 99%
Byron Ward The Harbour	84% - 88%
Calder Pendleview Unit Blackburn	87% - 103%

Ward name	Average bed occupancy range (1 February 2018 - 31 January 2019) (current inspection)
Churchill Ward The Harbour	99% - 103%
Darwen Pendleview Unit Blackburn	98% - 104%
Duxbury Ward	99% - 99%
Female Assessment Ward Burnley General Hospital	89% - 97%
Hyndburn Pendleview Unit Blackburn	99% - 103%
Keats Ward The Harbour	94% - 104%
Latham Suite Scarisbrick Unit Ormskirk General Hospital	98% - 101%
Orwell Ward The Harbour	98% - 114%
Ribble A Blackburn	79% - 112%
Scarisbrick Ward Ormskirk General Hospital	94% - 99%
Shakespeare Ward The Harbour	89% - 101%
Stevenson Ward the Harbour	98% - 102%
The Orchard Lancaster	97% - 104%
Worden Ward	99% - 100%

Managers regularly reviewed length of stay for patients however, barriers to discharge did not seem to be resolved. Facilitating early discharge meetings took place, attended by ward managers, other members or the multidisciplinary team and senior managers. We observed one of these meetings. Staff reviewed each patient and explored barriers to discharge; this included accommodation and waiting for assessments from other professionals. Actions from the meeting included senior managers chasing external assessments with the aim of expediting the process.

The trust provided information for average length of stay for the period 1 February 2018 to 31 January 2019.

Ward name	Average length of stay range (1 February 2018 - 31 January 2019) (current inspection)
Avenham Ward PICU	8 - 49 days
Byron Ward The Harbour	23 - 182 days
Calder Pendleview Unit Blackburn	16 - 89 days

Ward name	Average length of stay range (1 February 2018 - 31 January 2019) (current inspection)
Churchill Ward The Harbour	27 - 78 days
Darwen Pendleview Unit Blackburn	24 - 78 days
Duxbury Ward	8 - 35 days
Female Assessment Ward Burnley General Hospital	7 - 15 days
Hyndburn Pendleview Unit Blackburn	27 - 86 days
Keats Ward The Harbour	13 - 54 days
Latham Suite Scarisbrick Unit Ormskirk General Hospital	8 - 119 days
Orwell Ward The Harbour	15 - 53 days
Ribble A Blackburn	7 - 10 days
Scarisbrick Ward Ormskirk General Hospital	15 - 46 days
Shakespeare Ward The Harbour	32 - 92 days
Stevenson Ward the Harbour	23 - 58 days
The Orchard Lancaster	23 - 92 days
Worden Ward	16 - 30 days

During inspection we found patients with lengthy admissions of 659 days on Duxbury ward, 216 days on Byron ward, 632 days on Scarisbrick unit and 371 days at the Orchard. Awaiting appropriate community placements were the barrier to most of these delays.

This service reported 374 out of area placements between 1 March 2018 to 28 February 2019. As of 6 March 2019, this service had 71 ongoing out of area placements. There were no placements that lasted less than one day, and the placement that lasted the longest amounted to 205 days.

All out of area placements were due to capacity issues within this trust.

The number of out of area placements reported during this inspection was higher than the 158 reported at the time of the last inspection.

There was not always beds available for patients in the catchment area. When we visited wards we saw that patients had been transferred between wards to enable patients to be closer to home. Patients and care coordinators told us that the assessment wards at Blackburn General Hospital were difficult for some families to get to. This meant patients may not have visits from family and loved ones.

Number of out of area placements	Number due to specialist needs	Number due to capacity	Range of lengths (completed placements)	Number of ongoing placements
374	0	374	1 – 205 days	71

This service reported 170 readmissions within 28 days between 1 February 2018 to 31 January 2018. Eighty-three of readmissions (49%) were readmissions to the same ward as discharge. The average number of days between discharge and readmission was 12 days. There were no instances whereby patients were readmitted on the same day as being discharged but there were five where patients were readmitted the day after being discharged.

At the time of the last inspection, for the period 1 August 2016 to 31 July 2017, there were a total of 246 readmissions within 28 days. Of these, 193 were readmissions to the same ward (78%) and the average days between discharge and readmission was 11 days.

Therefore, the number of readmissions within 28 days has decreased between the two periods but the average time between discharge and readmission has increased.

Ward name	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
Female Assessment Ward Burnley General Hospital	81	59	73%	0 - 27	12
Ribble A Blackburn	26	12	46%	2 - 27	13
Scarisbrick Ward Ormskirk General Hospital	15	2	13%	1 - 23	8
The Orchard Lancaster	9	3	33%	1 - 26	15
Churchill Ward The Harbour	8	2	25%	11 - 27	16
Dunsop Ward Burnley General Hospital	6	0	0%	4 - 15	9
Hyndburn Pendleview Unit Blackburn	5	3	60%	6 - 26	16
Darwen Pendleview Unit Blackburn	4	0	0%	3 - 18	9
Orwell Ward The Harbour	4	0	0%	1 - 16	10
Stevenson Ward the Harbour	4	1	25%	5 - 18	10
Hodder Ward Burnley General Hospital	3	0	0%	10 - 22	17
Shakespeare Ward The Harbour	3	0	0%	0 - 9	6
Latham Suite Scarisbrick Unit Ormskirk General Hospital	1	0	0%	6 - 6	6

Patients were moved between wards only when there were clear clinical reasons, or it was in the best interest of the patient, this was usually to be closer to home.

Staff did not move or discharge patients at night or very early in the morning.

The psychiatric intensive care units did not always have a bed available if a patient needed more intensive care. We observed a patient on Worden ward waiting for a bed on a psychiatric intensive care unit, whilst they were still being nursed in an acute ward, they had two to one levels of staff observation.

Discharge and transfers of care

Between 1 February 2018 to 31 January 2018 there were 1,995 discharges within this service. This amounts to 75% of the total discharges from the trust overall (2,653).

Delayed discharges across the 12-month period ranged from one to seven per month.

The proportion of delayed discharges reported during this inspection (2%) was the same as the 2% reported at the time of the last inspection.

A report was created and shared with matrons and ward managers several times a week to show the bed situation. At the time of inspection there were 20 men waiting for an acute bed and eight men waiting for a psychiatric intensive care unit. There were seven women waiting for an acute bed and one woman waiting for a psychiatric intensive care unit. On Ribble A male assessment ward, there were seven patients waiting for a treatment bed and on Edisford ward, female assessment ward there were ten patients waiting for an assessment bed. This meant these wards could not provide the targeted assessment intervention and discharge within three to five days as there were no beds to move patients onto if they required inpatient care.

Patient status was discussed at the daily business morning meetings and tasks were allocated to team members to pursue, to speed up a patient discharge. These included referrals to other organisations and specialists, liaising with care coordinators, meetings with families and support to participate in community activities.

Reasons for delayed discharge from the service were mostly in relation to accommodation options for patients, a number were of no fixed abode or gave up their tenancy during their admission or had split from their partner and could not return to the family home. Support time and recovery workers focused on addressing accommodation needs with patients.

Staff carefully planned patients' discharge and worked with care managers and coordinators to make sure this went well. We observed care coordinators attending the care programme approach reviews and ward reviews.

Staff supported patients when they were referred or transferred between services. This included supporting patients whilst they were patients in acute services, for physical health needs. This ensured patients were supported by staff familiar to them, provided consistency and supported the transition back to the mental health ward.

Facilities that promote comfort, dignity and privacy

Each patient had their own bedroom, which they could personalise except on Scarisbrick unit where there were four two bed dormitories. The trust had developed a proposal to redevelop the four two bed dormitories to single bedroom rooms. This was awaiting approval and funding.

During our tours of Avenham, Duxbury, Worden, Calder, Ribble A, Edisford, Darwen and Hyndburn wards, we found that Vistomatic windows on patient doors were all in open position and patients could not close them from the inside. On one bedroom on Worden ward, there was just plain glass. This meant patients would not have their privacy and dignity protected in their bedroom. At the Scarisbrick unit there were four two-bed dormitories; the bed spaces were separated by a curtain. This meant patients would not have their privacy and dignity respected in their bedroom and may make patients vulnerable. Following the inspection, the trust told us there had been a review of the dormitory accommodation and a proposal to make them single bedrooms. Plans were in place.

We saw windows into the seclusion room and observation area and extra care area from the corridors had paper on the windows in Edisford ward, Worden ward and Calder ward. Avenham ward did not have any paper on the windows and you could see into the seclusion viewing area and the hatch. We observed a distressed patient when we were walking past, this did not protect patient's privacy and dignity when they were most unwell. We reviewed the Post Competition

Issues and Additional Items list for Chorley inpatient services which noted the jobs of Vistomatics required for Chorley and this was due to be completed the week of 8 July 2019.

We saw there were no privacy curtains around the baths in the communal bathrooms on Avenham, Edisford and Worden wards. The bathrooms were off the main corridor. This meant if patients required supervision in the bathroom they would not have their privacy and dignity protected whilst having a bath, if staff needed to enter the room in an emergency, other patients on the ward could see into the bathroom and this would compromise their privacy.

Patients had a secure place to store personal possessions. This was usually a locked space in their bedroom, or their room was locked, or they had lockers.

Staff used a full range of rooms and equipment to support treatment and care. Wards included clinics and treatment rooms, activity rooms and for the wards which were mixed gender there were same sex lounges. Gyms were available in all locations except Chorley and Ormskirk. The wards at Chorley were having a fundraising event to try to raise funds for outdoor gym equipment.

We found at Chorley, that two of the wards were not signposted, it was difficult to locate the wards, Ward managers told us that families had also complained about the lack of signage for the wards.

The service had quiet areas and a room where patients could meet with visitors in private. When children visited there were family visiting rooms off the wards to use.

Patients could make phone calls in private. There were phones available for patient use and most patients had their own mobiles which they could use.

The service had an outside space that patients could access easily for all wards except Ribble A, Hyndburn and Edisford ward. Ribble A and Hyndburn ward patients accessed the outside space by being escorted by staff through Darwen ward. Patients on Edisford ward had to go downstairs with staff escort to access outside space. However, they did not have access to a courtyard.

Patients has access to hot drinks and snacks on all the acute wards except Shakespeare ward, this was following an incident. On the psychiatric intensive care units this was dependent on staff, due to the acuity of the patients and risks presented.

The service offered a variety of good quality food.

The sites which deliver mental health – acute wards for adults of working age within Lancashire Care NHS Foundation Trust were compared to other sites of the same type and the scores they received for ‘ward food’ were found to be about the same as the England average.

Patients’ engagement with the wider community

Staff supported patients with activities outside the service, such as work, education and family relationships.

Staff made sure patients had access to opportunities for community participation and supported patients. This included a shed project and visiting the local community. Activities within the wards included a breakfast group, gardening, baking, ping pong, arts and crafts, pool, yoga and board games.

Staff helped patients to stay in contact with families and carers. We observed families visiting patients and going out with them if their leave allowed.

Staff encouraged patients to develop and maintain relationships both in the service and the wider community. Friends visited patients and they went out into the local community together if their leave allowed.

Meeting the needs of all people who use the service

The service met the needs of all patients – including those with a protected characteristic. Staff helped patients with communication, advocacy and cultural and spiritual support.

The service could support and make adjustments for disabled people and those with communication needs or other specific needs. Wards were accessible for patients with mobility needs. There were accessible bedrooms and bathrooms available. Hospital passports were used for patients with a learning disability. However, easy read information was not displayed on wards.

The sites which deliver mental health acute wards for adults of working age within Lancashire Care NHS Foundation Trust were compared to other sites of the same type and the scores they received for 'disability' and dementia friendliness' were found to be about the same as the England average.

Ward managers told us how they had previously cared for patients transitioning to the opposite gender. They were nursed in the ward that reflected the gender they were living as and used their preferred pronoun.

On Duxbury ward, there was a pregnant patient. Staff told us, and records confirmed that adjustments had been made with the physical intervention team to tailor any physical intervention for her to ensure she and her unborn child were not put at risk.

Staff made sure patients could access information on treatment, local service, their rights and how to complain. Information was on display on the wards and leaflets were available. Current information was available at the assessment wards regarding patients' stay and the mutual expectations. This was being updated for other wards.

Details for the interpreting service for leaflets to be translated into different languages was at the back of leaflets.

Managers had access to interpreters or signers when needed.

The service provided a variety of food to meet the dietary and cultural needs of individual patients. Ward managers told us during Ramadan food was available at a later time for patients that were fasting, and medicines were adjusted accordingly.

Patients had access to spiritual, religious and cultural support. Patients told us of the support available from visiting chaplains.

Listening to and learning from concerns and complaints

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and wider service.

Patients knew how to complain or raise concerns. Complaints forms were available on the wards.

Staff understood the policy on complaints and knew how to handle them. We reviewed two complaints and found staff had investigated them, met with the complainant and reached a resolution.

The service received a low number of complaints reflecting that patients were satisfied with their care.

This service received 182 complaints between 1 February 2018 to 31 January 2019. One complaint was referred to the Ombudsman.

The following table contains only the complaint themes that received more than 10 complaints in the 12-month reporting period.

Ward name	Total Complaints	Communications	Privacy, dignity and wellbeing	Admissions, discharges and transfers excluding delayed discharge due to absence of care package	Clinical Treatment	Staff	Other	Access to treatment or drugs	Theme to be identified on closure
Harbour - Keats Ward	24	7	4	0	0	3	1	2	1
Edisford Assessment Ward	20	4	3	3	6	1	0	1	0
Ribble Ward	16	2	1	0	1	3	3	3	1
Dunsop Ward	15	3	2	1	1	0	1	2	1
Harbour - Stevenson Ward	15	4	2	2	2	0	0	2	2
Darwen Ward	12	2	2	0	2	0	1	2	2
Harbour - Orwell Ward	11	5	1	2	1	2	0	0	0
Mental Health Inpatients Scarisbrick Unit	11	0	2	3	0	1	2	1	0
Hyndburn Ward	10	1	3	1	1	1	1	0	0
Mental Health Inpatients The Orchard	9	3	2	0	0	0	1	0	1
Harbour - The Hub	7	0	0	6	0	0	0	0	0
Harbour - Churchill Ward	6	2	0	0	1	0	2	0	1
Harbour - Shakespeare Ward	5	3	0	0	1	1	0	0	0
Harbour - Byron Ward	5	0	1	1	0	2	0	0	0
Hodder Ward	3	0	0	1	0	0	1	0	0

Ward name	Total Complaints	Communications	Privacy, dignity and wellbeing	Admissions, discharges and transfers excluding delayed discharge due to absence of care package	Clinical Treatment	Staff	Other	Access to treatment or drugs	Theme to be identified on closure
PICU Calder Ward	3	0	1	0	1	0	1	0	0
Medics ADH North	2	1	0	0	0	0	0	0	1
Restart & Recovery The Orchard (25-65)	2	0	0	0	0	0	0	0	2
Inpatient Management The Orchard North Lancs	1	0	0	0	1	0	0	0	0
Stock Beck Ward PICU	1	0	1	0	0	0	0	0	0
Harbour - General	1	0	0	0	0	1	0	0	0
Avenham Ward PICU	1	0	0	0	0	0	0	0	1
Duxbury Ward	1	1	0	0	0	0	0	0	0
Lathom Suite Ward	1	0	0	0	0	1	0	0	0
Total	182	38	25	20	18	16	14	13	13

The service received compliments that reflected patients were satisfied with their care.

This service received 181 compliments during the last 12 months from 1 February 2018 to 31 January 2019 which accounted for 2% of all compliments received by the trust as a whole.

Is the service well led?

Leadership

Leaders did not have the integrity, skills and abilities to run the service. They did not understand the issues, priorities and challenges the service faced and did not manage them. However, they were visible in the service and supported staff to develop their skills and take on more senior roles.

Ward managers and matrons had a background in working within acute mental health services. A number had progressed from being a preceptor to ward manager whilst working in the trust. They had a good understanding of the teams and how they worked. They were also knowledgeable of neighbouring wards and were able to cover for colleagues when needed. We saw this happening during the inspection.

Matrons were visible within the services and staff told us and we observed they were approachable and supportive.

Vision and strategy

Staff understood the trust's vision and values and how they applied to their role. Information regarding the vision and values was on the intranet and the trust's website.

Culture

Staff mostly felt respected, supported and valued. They felt the service promoted equality and diversity and provided opportunities for career development. They could raise concerns without fear.

Staff we spoke with were very passionate about their role. However, staffing challenges were raised as a concern. They told us that there were times when they were short staffed, and staff were moved to other wards. Staff also told us they felt they were spending large amounts of time with patients with personality needs and high levels of self-harm and incidents which required a high level of staff response and staff felt they were not spending enough time with the other patients.

Staff knew how to report concerns and felt their managers were approachable and supportive however some issues raised for improvement included communication regarding new admissions and discharges, staffing levels and safety within the ward. A number of health care assistants had high levels of responsibility, including security nurse, observing patients in seclusion and section 136 suites and at times there were limited qualified nurses available.

Records confirmed managers dealt with poor staff performance when needed.

Teams generally worked well together, there was difficulties within the team dynamics at Hyndburn ward which had been discussed at a team meeting and the clinical psychologist was involved in addressing the situation.

The service's sickness rate was 8.3% which was just below the trust average of 9%.

Staff were being trained to provide trauma support to colleagues, in acknowledgement of the difficult situations they were managing on the wards.

Acknowledgement and recognition were not routinely recognised, except at the Orchard where they completed a star of the week. If staff had 100% compliance with mandatory training, they were entered into a draw for an extra day's annual leave at the Orchard.

Governance

Leaders did not ensure there were structures, processes and systems of accountability for the performance of the service.

The trust had not addressed regulatory breaches from previous inspection in 2018. The no smoking policy was not being followed. Team meetings were not regularly taking place. Staff were not receiving supervision in line with the trust's policy. Staff did not receive training in Learning Disability or Autism.

A further breach of regulation was identified that the trust received a regulatory breach for in the 2016 inspection. Compliance with basic life support and immediate life support training was low and ward managers did not have a system of assurance regarding whether the staff working were trained.

Regular team meetings did not take place on most of the wards. Managers relied on communicating with staff via email, however staff were busy delivering direct care and found it difficult to review their emails. Therefore, staff were not up to date with all information. There was no formal agenda for team meetings, each ward covered different topics, only one ward shared learning from incidents. Staff did not receive supervision in line with the trust's policy.

Ward managers completed monthly governance reports with their ward's performance on safeguarding, medicines, incidents including post incident de-brief, e-rostering, audits, absence and sickness, training, performance and development review, supervision, human resources, finance, team and patient meetings, complaints, duty of candour, good news stories and compliments. Ward managers told us it was time consuming to compile the reports and some of the information could be completed by administration support.

Information about recommendations from learning from deaths or complaints was not available at a ward level.

Inductions did not include the ligature audits for the wards. The audits included "various ligature points" which did not tell staff what the risks were and how to mitigate these.

Although staff took part in clinical audits, it was difficult to see the impact of these audits in a ward environment. Managers received the GAPP (governance and performance portal) report which included their team's performance in training, appraisal and supervision. Managers used this report to focus their time on staff who required training, appraisal or supervision.

Wards were not following the trust's procedure for the storage of medicines, in relation to emergency medicines. There were several examples of medicines being prescribed and administered without the appropriate legal authority. On Darwen ward, although a number of these errors had been identified, staff had not taken any action.

Staff did not ensure patients' privacy and dignity were respected. All wards except the Orchard had the Vistomatics in the open position in patients' bedrooms and patients could not close them. We could see into seclusion room at Chorley and privacy curtains were not in place in communal bathrooms. There continued to be dormitories on Scarisbrick unit.

During the inspection, we were not assured that action had been taken in relation to infection prevention control at Worden ward and Churchill ward. Cleaning records were not available on wards.

Handovers varied across the services and handover and induction checklists were not completed in full, we were not assured of the information shared within teams regarding patients' needs and risks and staff knowledge as part of their induction.

Systems were not in place to ensure the Deprivation of Liberty Safeguards were implemented accurately. A patient on the Orchard had three days of being detained without the appropriate legal safeguards in place.

The service did not have enough nursing staff of all grades to keep patients safe. In the six months prior to the inspection there were 428 incidents of one qualified nurse reported by staff via SafeCare (RedFlag) and 1380 incidents of one qualified nurse from data taken from Healthroster. Information submitted by the trust showed 34 incidents of unsafe staffing levels from 1 December 2018 to 31 May 2019. Within the same time period, there were 91 incidents of staff not being able to take their breaks. This meant that staff were not having time away from the ward to refresh and refocus.

Management of risk, issues and performance

Records showed, and staff told us staffing made them feel unsafe on the wards at times.

The risk register was on the electronic incident reporting system. Ward managers were able to add to this and knew what their risks were.

We reviewed the risk register and found 24 entries related to this service. Fifteen were ligature risk assessments of the ward environments. Two were lack of staffing having an impact on care delivery. Two were not having dedicated staff to support the 136 suites on Scarisbrick unit and the Orchard. Four were a lack of experienced qualified staff and one was in relation to the lack of a dirty utility room on Hyndburn ward. These risks were shared by ward managers, incidents and our observations on the wards.

Information management

The service did not collect reliable information. However, the information systems were integrated and secure.

Ward managers told us the monthly governance reports were time consuming to complete and felt the report could be partly completed by administration support.

The newly introduced performance development review system, where supervisions were recorded were not always an accurate reflection of meetings that had occurred as staff told us the staff member and supervisor had to access the system to confirm the meeting had taken place. They said that if this did not happen, it was not on the system.

Managers told us training took a while to be captured in the training report, as staff had attended recent training, and this was not reflected in the figures.

The GAPP report and bed situation report were sent to ward managers at least weekly and managers felt this was too frequent to be able to make best use of the information.

Staff found it difficult to locate incidents in the electronic incident reporting system unless they had the incident identification. This made it difficult to locate incidents from an event, to reflect, highlight learning or share best practice.

Staff used three different electronic record systems. They were not interconnected. Doctors did not routinely complete the system used for audits and health screening, therefore staff had to search for information via the electronic care record. This meant information was not accessible quickly.

On review of our systems we could see the provider submitted notifications to CQC including death of detained patients, deprivation of liberty authorisations and admitting a child to an adult psychiatric ward.

Engagement

The service engaged well with patients, staff, equality groups, the public and local organisations to plan and manage appropriate services. It collaborated with partner organisations to help improve services for patients.

Staff, patients and carers had up to date information about the trust via the intranet and internet. However, ward orientation booklets were not up to date for each ward.

Patients and carers had the opportunity to feedback about the service via the friends and family tests.

Managers had access to the feedback from patients and carers and used this to make improvements.

Patients were not involved in decision making about changes to the service; regular patient meetings did not take place. However, we observed one patient meeting on Hyndburn ward and patients could give feedback on the service and their treatment and staff supported them to do this.

Meet the matron sessions were in place at Blackburn Hospital for staff however there were no formal opportunities for patients to meet senior staff and give feedback.

Learning, continuous improvement and innovation

All staff were committed to continually improving services.

Wards were implementing elements of 'Safewards' including mutual expectations, reassurance, 'calm down methods', calming boxes and discharge messages which we saw as trees on wards.

Innovations within the service included having a central contact with the police at Ormskirk to assist with monitoring incidents and track outcomes.

Junior medical staff had access to the junior doctor's forum. All medical staff had access to weekly training sessions which included case presentations and consultant led sessions.

At the Orchard, staff of the week was introduced for staff and as an incentive to get their training to 100% staff with 100% compliance were entered into a draw for an extra days annual leave. The violence reduction lead held weekly drop ins for staff to talk through difficult scenarios they had experienced.

Wards were in the process of recruiting practice development nurses to focus on training and quality within the wards.

We did not see any quality improvement methods in place in this core service.

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.

There were no accreditations awarded to this core service.

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 The Cove (MH)	18	Mixed

The methodology of CQC provider information requests has changed, so some data from different time periods is not always comparable. We only compare data where information has been recorded consistently.

Is the service safe?

Safe and clean care environments

Safety of the ward layout

The Cove is an 18 bed service for male and female patients aged 13-18 years. The ward had changed since the last inspection from two distinct wards into one larger ward. At the time of the inspection, the ward had 18 beds, but maximum patients' numbers were capped at 14 patients by agreement with NHS England. At the time of the inspection, there were 12 patients on the ward.

The ward was safe, clean, well equipped, well furnished, well maintained and fit for purpose. The ward environment had improved significantly since our last inspection; space was utilised better and patients had more space across the larger ward.

There were regular safety and security checks to make sure the ward was well maintained and continued to provide a good quality environment.

Staff could observe patients in all parts of the ward. There were good lines of sight through the ward.

The ward provided care for male and female patients. All bedrooms were ensuite. This helped to ensure patients' privacy. Patients' bedrooms were configured together on distinct corridors. There were several lounges available to patients. However, there was no sign to show the ward had a designated female lounge. Following the inspection, managers told us that they had addressed this immediately and made sure a sign was put up and patients informed.

Over the 12-month period from 1 February 2018 to 31 January 2019 there were no same sex accommodation breaches within this service. There were no breaches reported at the last inspection.

Staff completed and regularly updated thorough risk assessments of the ward and removed or reduced any risks they identified. There was significant attention to removing potential ligature anchor points in the service. Staff knew about any potential ligature anchor points and mitigated the risks to keep patients safe. For example, following incidents of patients ligaturing from using the top of the bathroom door in their bedrooms as an anchor, the en-suite bathroom door had been replaced by a privacy shower curtain with a collapsible rail.

There were ligature risks on the only ward (The Cove) within this service. The risk was not deemed high level.

Ward / unit name	Briefly describe risk - one sentence preferred	High level of risk? Yes/ No	Summary of actions taken
The Cove	General ward fixtures and fittings	No	Repair and maintenance of fixtures and fittings

Maintenance, cleanliness and infection control

The maintenance and cleaning of the building was provided by the organisation that owned the building. Managers had improved relations with representatives of the maintenance firm so that repairs occurred more quickly. Managers had ensured that they improved the shortfalls about the maintenance of the ward we found on the last inspection; doors had been repaired and the heating had been had been repaired.

Some patients commented to us that the showers in their en-suite rooms run at a constant temperature which occasionally was slightly hot. We saw that managers had looked into this through testing the showers. This showed that the showers were running at a comfortably hot range most of the time. There were periods of occasional testing where the temperature slightly exceeded the range but they were still safe to use. Managers were working to address patients' concerns with the maintenance firm.

All ward areas were cleaned regularly and cleaning records were up to date. Our observations of the environment and patients we spoke with confirmed that the ward was kept clean.

Patient-Led Assessments of the Care Environment assessments aim to provide a clear message from patients on how the care environment may be improved. They are undertaken by teams of local people alongside healthcare staff and assess privacy and dignity, food, cleanliness, building maintenance and the suitability of the environment for people with disabilities and dementia.

The ward at the Cove was compared to other sites of the same type and the scores they received for 'cleanliness' and 'condition, appearance, and maintenance' were found to be about the same as the England average.

Seclusion room

The Cove had a seclusion suite and de-escalation room. The seclusion room was clean, allowed clear observation and two-way communication. It had a toilet and a clock. It met the requirements of the environmental standards as set out in the Mental Health Act Code of Practice.

Clinic room and equipment

The clinic room was clean, well-stocked, and fully equipped. There some unnecessary clutter in the clinic room such as an excessive number of sharps bins. This was due to the recent change from two wards to one ward and moving to having just one clinic room. Staff were aware and working on this and it did not impact on the proper use of the clinic room due to its size.

Staff completed regular clinic room checks to make sure that good medicine storage and practices were maintained. Pharmacy staff visited weekly to maintain stock and individual medicines so that staff did not run out of medicines. Staff had access to a range of equipment including an electro-cardiogram machine so that they could carry out necessary physical health checks.

Staff checked, maintained, and cleaned equipment including refrigerators to ensure that medicines were stored at the correct temperature and were safe to use. Where appropriate, equipment was calibrated to make sure it was working correctly.

Staff had ready access to resuscitation equipment and emergency drugs in emergency bags. Staff checked these daily to ensure that all equipment was in date and fit for purpose.

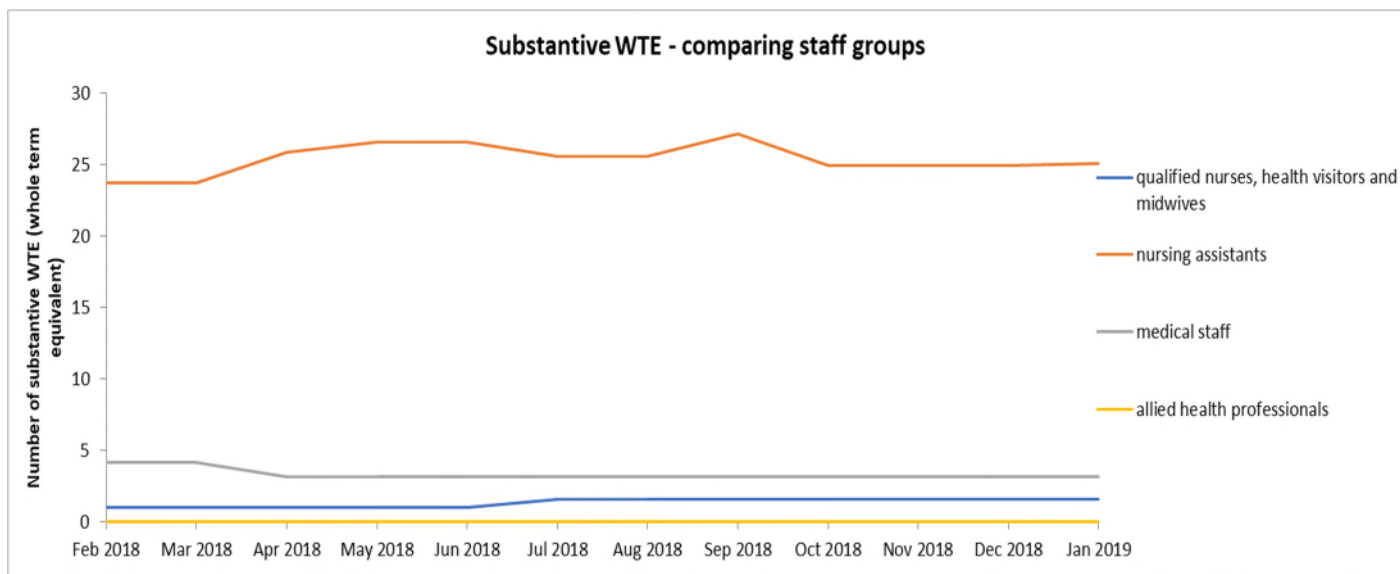
Safe staffing

The service had enough nursing and medical staff, who knew the patients and received basic training to keep patients safe from avoidable harm.

The service had enough daytime and night time medical cover and a doctor available to come to the ward in an emergency. There was one consultant psychiatrist supported by another consultant psychiatrist providing the responsibilities as a responsible clinician on a part time basis. There was also speciality doctor. Out of hours medical cover came from the nearby acute adult mental health ward. Managers confirmed that the out of hours medical cover was responsive and attended without delay where necessary.

Managers could call locums when they needed additional medical cover.

The below chart shows the breakdown of staff in post WTE in this core service from 1 February 2018 to 31 January 2019.



Annual staffing metrics

Core service annual staffing metrics 1 February 2018 – 31 January 2019							
Staff group	Annual average establishment	Annual vacancy rate	Annual turnover rate	Annual sickness rate	Annual bank hours (% of available hours)	Annual agency hours (% of available hours)	Annual “unfilled” hours (% of available hours)
All staff	65.4	22%	8%	6.3%			

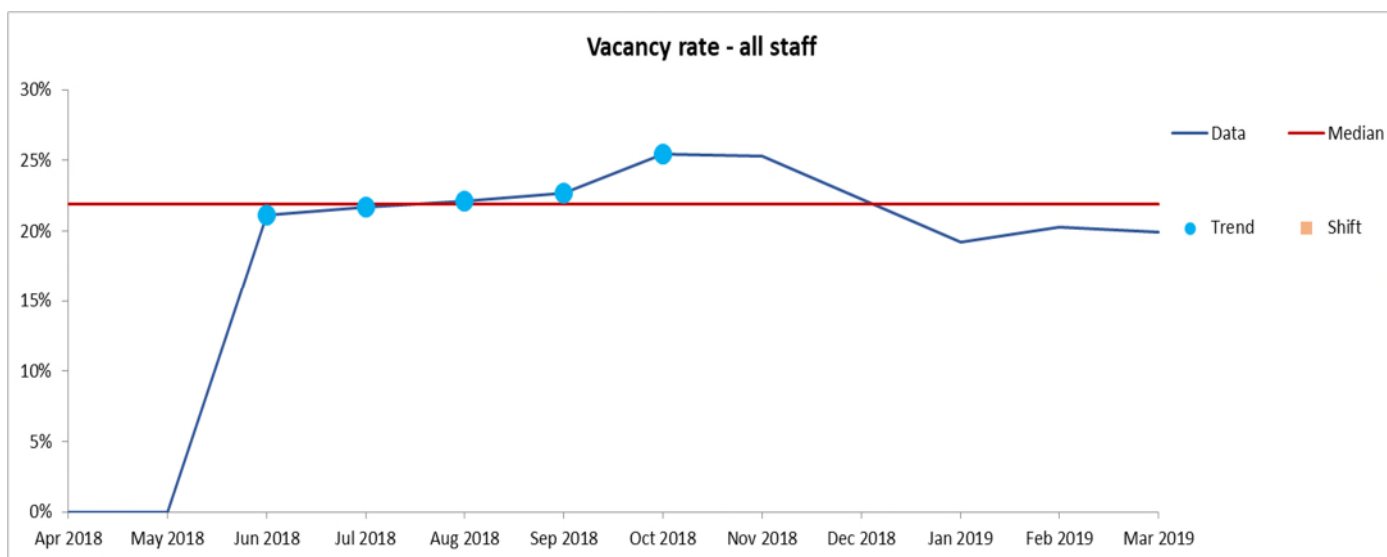
Qualified nurses	25.4	29%	0%	7.0%	1979 (6%)	22 (<1%)	291 (1%)
Nursing assistants	28.1	8%	0%	7.7%	8235 (18%)	128 (<1%)	439 (1%)
Medical staff	4.7	32%	30%	0.2%			
Allied Health Professionals	1.6	14%		0.0%			

The staffing figures detailed above included staff working within the assessment and outreach team attached to The Cove.

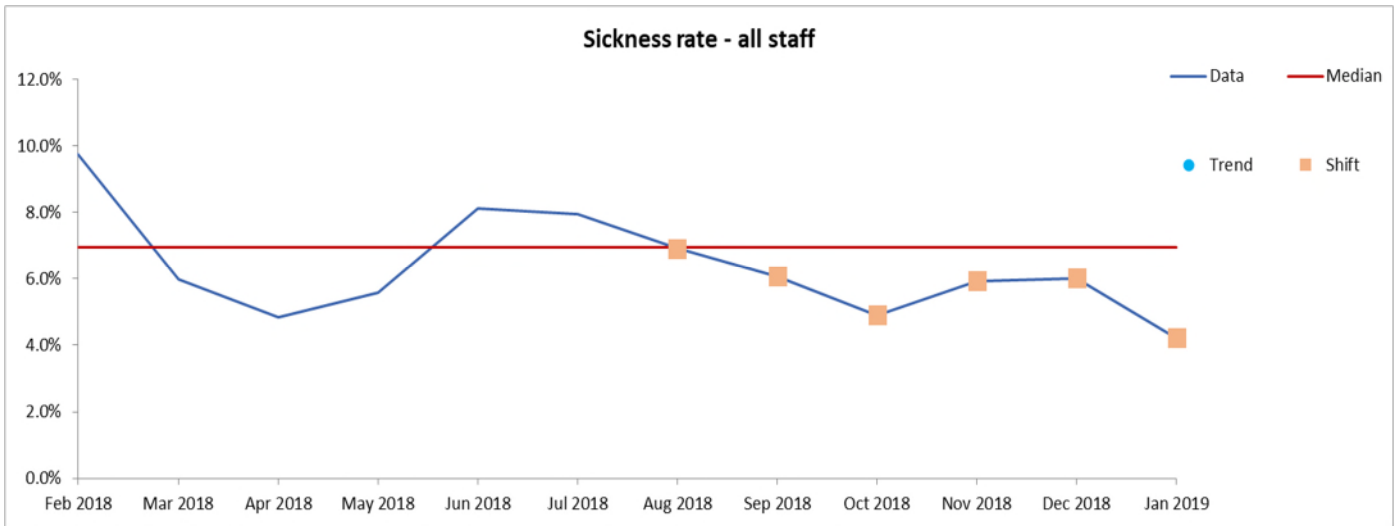
At the time of the inspection, the ward team was fully established apart from two permanent whole-time equivalent vacancies for healthcare assistants and two whole time equivalent vacancies for band 5 nurses. Leaders explained that they were actively recruiting to all vacancies.

The service used a three-shift system covering days, nights and twilights. The baseline numbers for each day and night shift were two registered nurses and four healthcare assistants with additional healthcare assistant support during the twilight shift which straddled the two shifts. The ward was overseen by a ward manager.

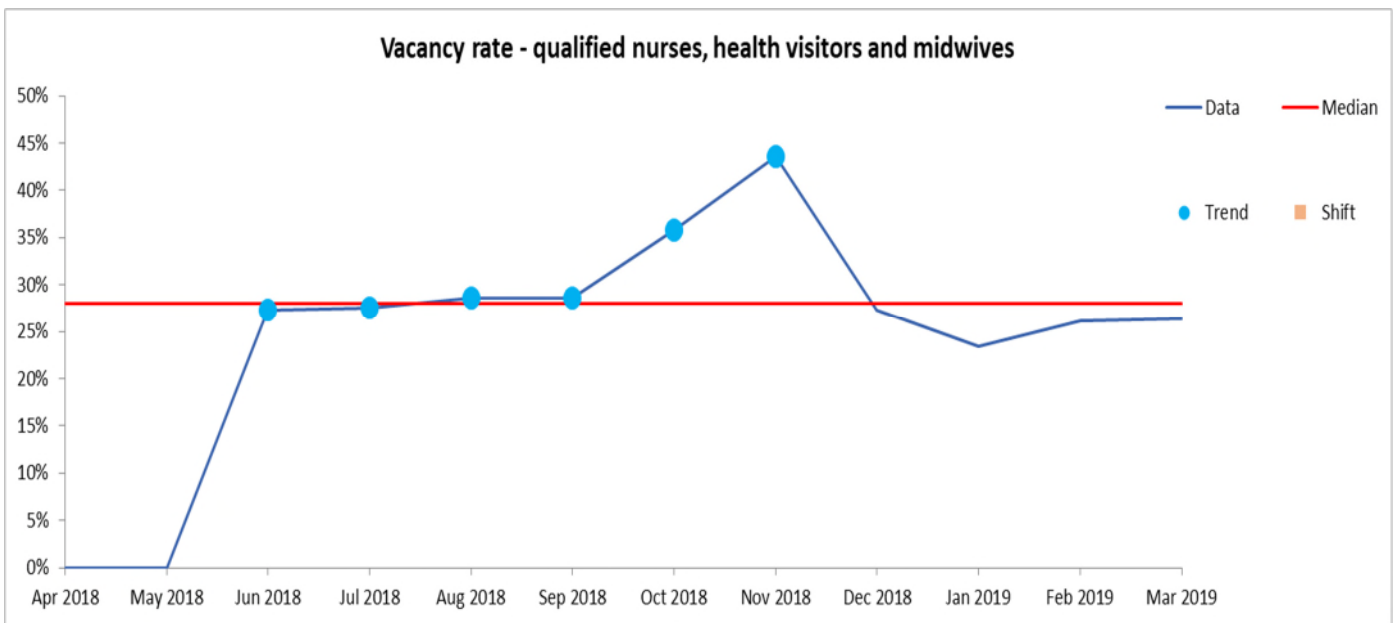
The following information and charts highlight specific staffing areas where there is noteworthy evidence



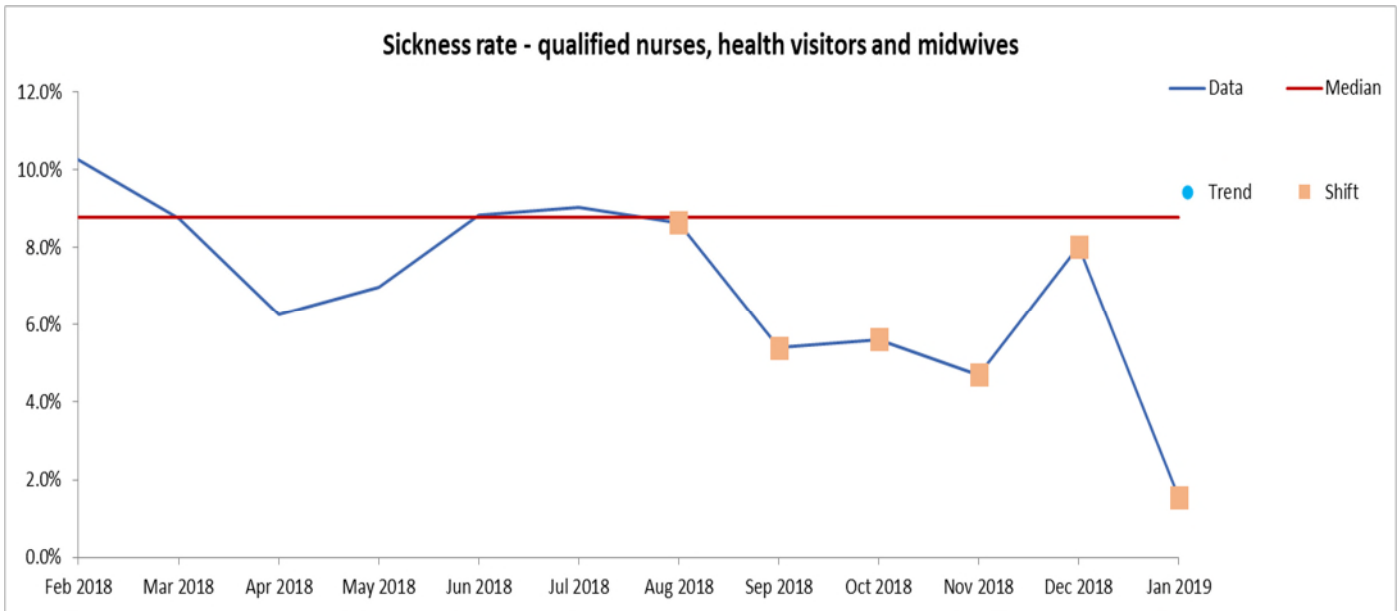
Monthly 'vacancy rates' over the last 12 months for all staff shows an upward trend from June 2018 to October 2018.



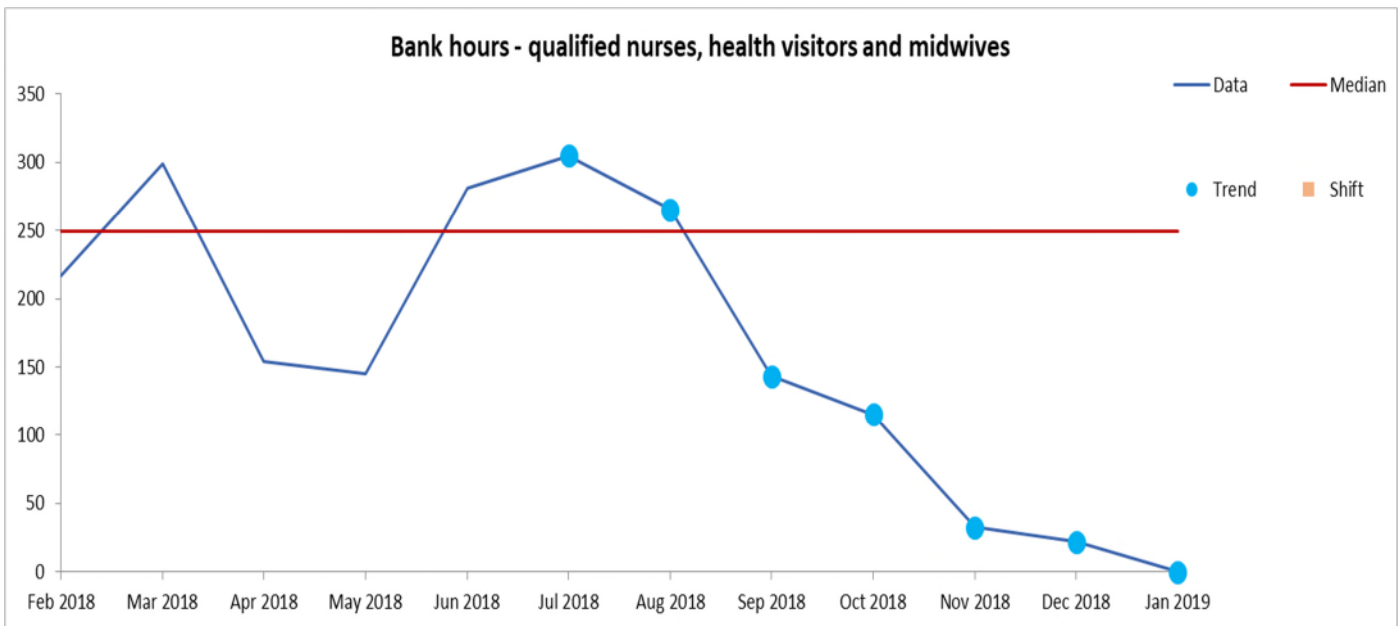
Monthly 'sickness rates' over the last 12 months for all staff shows a shift from August 2018 to January 2019. This shows a trend that all staff sickness rates were reducing.



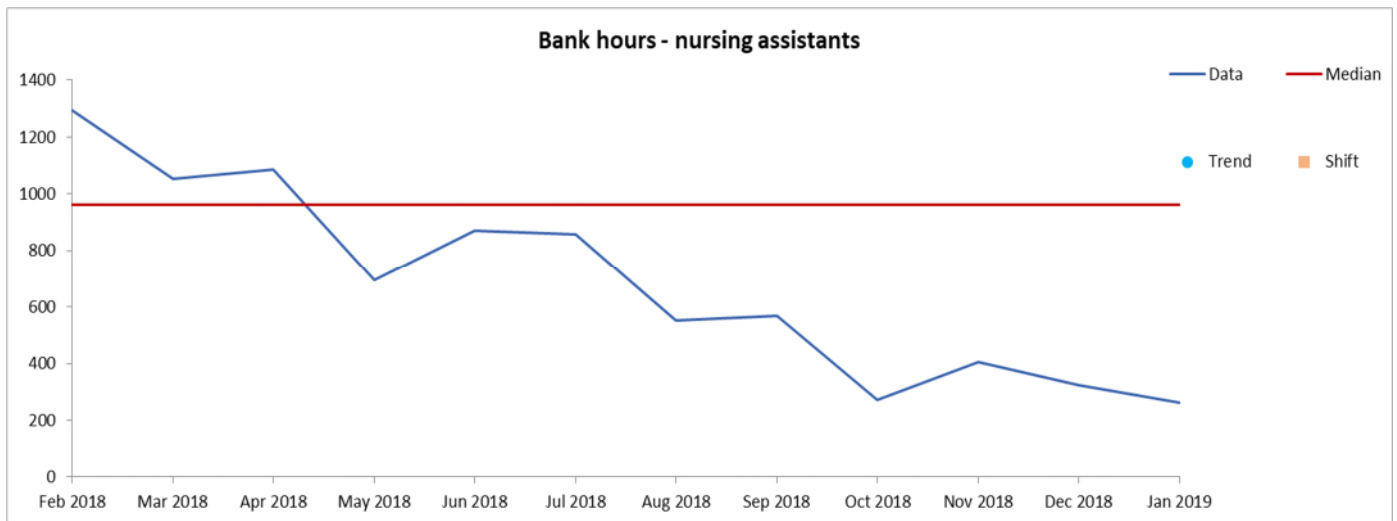
Monthly 'vacancy rates' over the last 12 months for qualified nurses, health visitors and midwives show an upward trend from June 2018 to November 2018.



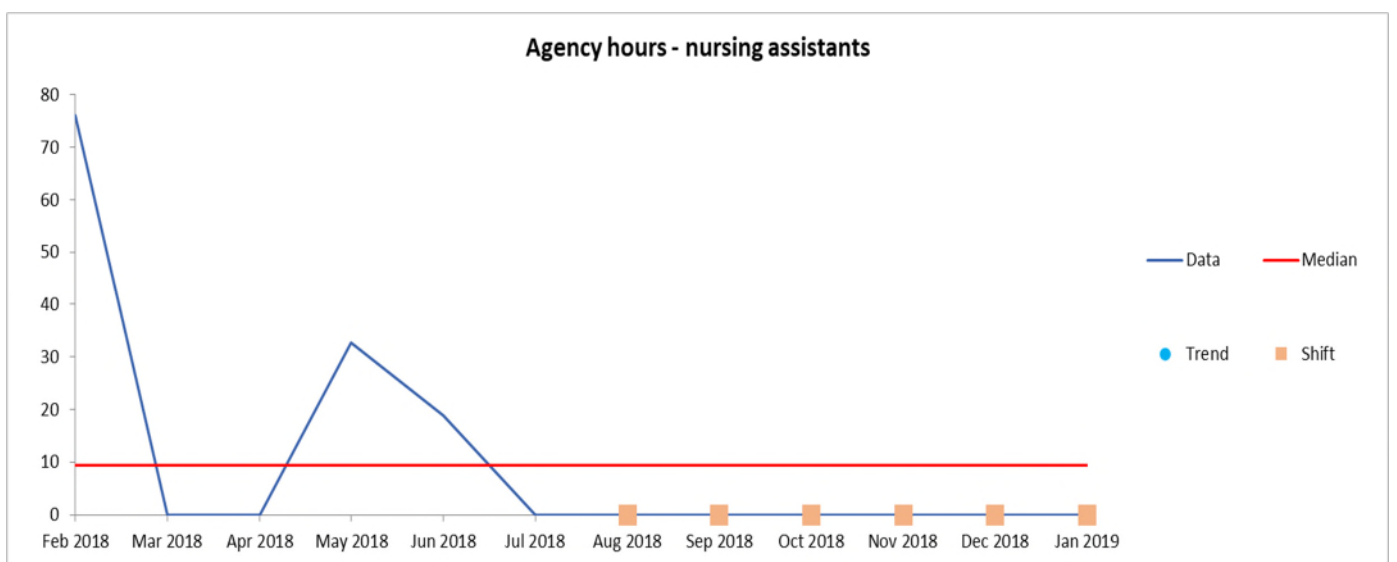
Monthly 'sickness rates' over the last 12 months for qualified nurses, health visitors and midwives show a shift from August 2018 to January 2019. This shows a trend that nursing staff sickness rates was reducing over time.



Monthly 'bank hours' over the last 12 months for qualified nurses, health visitors and midwives show a downward trend from July 2018 to January 2019. This showed leaders were reducing their reliance on bank nursing staff usage.



Monthly 'bank hours' over the last 12 months for nursing assistants are not stable and may be subject to ongoing change.



Monthly 'agency hours' over the last 12 months for nursing assistants shows a shift from August 2018 to January 2019. This could be an indicator of change.

Mandatory training

The compliance for mandatory and statutory training courses at 6 March 2019 was 85%. Of the training courses listed six failed to achieve the trust target and of those, three failed to score above 75%.

The trust set a target of 80% for completion of mandatory and statutory training.

The trust reported that training compliance is monitored on a monthly basis.

The training compliance reported for this core service during this inspection was higher than the 66% reported at the time of the last inspection

Key:

	Met trust target ✓	Not met trust target ✗	Higher ↑	No change →	Lower ↓
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Training Module	Number of eligible staff	Number of staff trained	YTD Compliance (%)	Trust Target Met	Compliance change when compared to previous year
Equality & Diversity	59	56	95%	✓	↓
Safeguarding Children L2	32	30	94%	✓	↓
Health & Safety	59	55	93%	✓	↓
Fire Safety	59	53	90%	✓	↓
Infection Control	59	52	88%	✓	↓
Mental Capacity Act L1	59	52	88%	✓	↓
Immediate Life Support	24	21	88%	✓	↓
Manual Handling L2A	54	47	87%	✓	↓
Wellness Recovery Action Planning	30	26	87%	✓	↓
Safeguarding Adults L2	59	50	85%	✓	↓
Safeguarding Children L3	27	22	81%	✗	↓
Positive & Safe Programme	47	36	77%	✗	↓
Information Governance	59	45	76%	✗	↓
Conflict Resolution	12	9	75%	✗	↓
Basic Life Support	35	26	74%	✗	↓
Mental Capacity Act L2	59	42	71%	✗	↓
Manual Handling L1B	5	3	60%	✗	↓
Total	738	625	85%	✓	↓

We looked specifically in more detail at the adherence to those courses where compliance rates for staff attending these training programmes were below 75%. Through speaking to managers and looking at matron reports, we were assured that the uptake figures had improved for these courses. For example, basic life support training uptake and Mental Capacity Act level 2 training had improved following a push from managers. The manual handling training course showing as 60% was only applicable to administrators and did not relate, or impact on patient care. The matrons received reports on the mandatory training uptake figures in their monthly matron reports so could monitor and encourage improvement in uptake among staff groups.

Assessing and managing risk to patients and staff

Assessment of patient risk

Staff assessed risks to patients and themselves well. Staff completed a detailed risk assessment for each patient when they were admitted and reviewed risks regularly, including after any incident. Risk assessments were reviewed or updated during weekly case meetings or if patients' needs changed.

Staff used a recognised risk assessment tool. Staff assessed and managed risks through identifying risk incidents and their chronology. Staff formulated risk assessments through looking at the presenting, predisposing, precipitating, perpetuating and protective factors for each patient with patients. Staff used the management of self-harm scoring tool to risk assess

patients who self-harmed or were at risk of self-harm. Staff completed this electronically.

Management of patient risk

Staff managed risks to patients and themselves well and followed best practice in anticipating, de-escalating and managing challenging behaviour. Staff identified and responded to any changes in risks to, or posed by, patients. Where risks were identified through risk assessments or incidents, care plans were updated with detailed information to look at how staff could manage these risks.

Due to the improved environment of the ward, risks were much better mitigated. This meant staff spent less time having to observe patients on a one to one basis and did not have to compensate for shortfalls in the ward environment. On the last inspection we found that staff were observing patients for long periods of time without breaks. The trust policy was amended to specify the maximum number of hours a staff member could be allocated for observations. The provider audited observations against the National Institute for Health and Care Excellence observation standards detailed in their guidance on the violence and aggression; short term management in mental health, health and community settings. These standards included:

- all patients being assessed on admission with the required level of observation recorded with a proper rationale when determining observation levels
- observations being reviewed and documented
- staff undertaking observations for no longer than one hour per patient and recorded evidence of engagement with patient during observations and
- staff (registered and unregistered) who carry out supportive observations being assessed as competent.

The most recent audit in May 2019 showed significant improvement and showed that managers had addressed the concerns we raised on the last inspection. For example, overall compliance with these four standards was 89% and that, on most occasions, individual staff member did not undertake a continuous period of observation above the general level for longer than one hour in line with the guidance.

Use of restrictive interventions

The ward staff participated in the provider's restrictive interventions reduction programme. Patients were not subject to unnecessary or blanket restrictions. Patients could access all areas of the ward including external courtyards. Patients could access their own bedrooms without staff assistance through a key fob. Patients could use their mobile phones on the ward. Some individual patients were subject to specific restrictions but there was a corresponding individualised clinical or security reason for those restrictions being in place.

The trust operated a no smoking policy and nicotine replacement therapy was available to patients where necessary.

Where restraint was used, staff completed incident records which gave the full details of restraint including the reasons for restraint, the position of restraint and for how long restraint was used overall.

Managers checked that staff used restraint and seclusion only after attempts at de-escalation had failed. Managers reviewed each incident of restraint to make sure where staff were using restraint it was reasonable and proportionate.

This service had 216 incidences of restraint (31 different service users) and 27 incidences of seclusion between 1 February 2018 and 31 January 2019.

Ward name	Seclusions	Restraints	Patients restrained	Of restraints, incidents of prone restraint	Of restraints, incidences of rapid tranquilisation
CAMHS The Cove (MH)	27	216	31	0	3 (1%)
Core service total	27	216	31	0	3 (1%)

The number of restraint incidences reported during this inspection was higher than the 182 reported in the previous 12-month period. We looked at summarised instances of restraint and saw that a high proportion of restraint were staff guiding patients using minimal interventions and for short periods of time. Managers stated that the slight increase in restraint instances over the last 12 months related to the acuity levels of a small number of patients who presented with disturbed behaviour requiring regular restraint. The restraint records corroborated this showing that the same patient was restrained multiple times while awaiting a more specialised placement.

There were no incidences of prone restraint. The number of incidences was the same as the previous 12-month period. Staff completed 'positive and safe training' which was bespoke for The Cove which looked at how staff respond and restrain patients using age appropriate methods and techniques.

There were three incidences of rapid tranquilisation over the reporting period. The number of incidences (three) had decreased from as the previous 12-month period (15). There had been no recent incidences of rapid tranquilisation at the time of the inspection.

There have been no instances of mechanical restraint over the reporting period. The number of incidences was the same as the number of incidences from the previous 12-month period.

There have been 27 instances of seclusion over the reporting period. The number of incidences (27) had decreased from the previous 12-month period (33).

Staff ensured that they were recording most of the safeguards relating to seclusion, including medical and nursing reviews and observations. The trust audited seclusion against the safeguards prescribed in the Mental Health Act Code of Practice and the most recent audit showed 84% compliance. The audit demonstrated an improvement in staff completing a debrief following an incident of restraint or seclusion. Results also show that in all cases where a post incident debrief was conducted, both a staff member and young person were involved.

We found one example where staff had not recorded that parents or carers were informed of one seclusion episode. Following the inspection, the trust told us that leaders had reminded staff of the importance of informing parents of seclusion episodes and to record their contact in line with the trust's policy.

There have been no instances of long-term segregation over the 12-month reporting period. The number of incidences was the same as the previous 12-month period.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff talked about safeguarding matters appropriately across the meetings we observed. Records showed that staff contributed to discussions and decisions on child protection concerns including informing children's social workers of progress and ongoing concerns informally and formally at case conferences when caring for looked after children and where there were child protection concerns.

Staff had training on how to recognise and report abuse and they knew how to apply it. Ninety-four per cent of staff had completed appropriate training for safeguarding.

The provider had a named nurse and doctor for child safeguarding and the teams had a safeguarding lead. There was also a social worker working at the Cove who took the lead responsibility for liaison with local authority children and families team.

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 nine safeguarding referrals between 1 February 2018 and 31 January 2019, of which one concerned adults and eight children. The number of safeguarding referrals reported during this inspection was higher than the one reported at the last inspection.

Core service	Number of referrals		
	Adults	Children	Total referrals
MH – CAMHS Wards	1	8	9

The trust has submitted details of no serious case reviews commenced or published in the last 12 months (1 February 2018 and 31 January 2019) that relate to this service. There was one serious case review which was still in draft at the time of the inspection.

Staff access to essential information

Staff had easy access to clinical information and it was easy for them to maintain high quality electronic clinical records. Staff recorded care and treatment mostly on electronic records but some information was also stored in paper records. When paper records were used, for example when patients were detained under the Mental Health Act, the paper record was scanned into the system so that it could be seen. The electronic record prominently displayed essential information including alerts on patients' records such as significant risks or allergies.

Clinical records were filed systematically so key documents were in the same place on the electronic system for each patient.

As electronic records were used across the trust, when patients transferred to a new team there were no delays in staff accessing their records. This meant that key information about care, treatment and risks was easy to find or follow, even if patients moved wards.

The electronic patients' system was secure and could only be accessed with a password system. This meant systems were in place to ensure confidential patient records could only be seen by those with privileged access.

Medicines management

The service used systems and processes to safely prescribe, administer, record and store medicines. Staff regularly reviewed the effects of medications on each patient's physical health.

Staff followed national guidance and best practice in all aspects of medicines management. The prescription charts were up-to-date and clearly presented to show the treatment patients had received. Where required, the relevant legal certificates authorising treatment for mental disorder for relevant detained patients were in place and monitored by the ward pharmacist and nurses.

The ward was supported by a clinical pharmacist who completed regular checks of the prescription charts. Staff had access to guidance on prescribing medicines to children and young people.

Medicines including controlled drugs were securely stored and emergency medicines were regularly checked to ensure they were available if needed.

When we checked the clinic room we saw some stock medication exceeding suggested amounts. This was due to the recent change from two wards to one ward and staff were aware and working on this.

Staff reviewed the effects of each patient's medication on their physical health according to the National Institute for Health and Care Excellence guidance. A physical health assessment was completed when patients were admitted.

There are particular rules about consent to treatment for detained patients. In most circumstances, after three months of receiving treatment while detained, the patient needs to consent to the treatment or, if they lack capacity to consent or refuse treatment, ongoing treatment needs to be considered by a second opinion appointed doctor arranged by the Care Quality Commission. The Mental Health Act states that within a month before the end of the three months, the responsible clinician should speak to the patient and assess capacity and consent and either confirm the patient was consenting and had capacity to consent or request a second opinion appointed doctor to authorise treatment beyond three months. Staff routinely checked medication together with the legal authority as part of a regular Mental Health Act audit.

In one case, we identified that the responsible clinician had not considered these matters for one patient and therefore had to authorise the treatment under urgent powers until the patient could be seen by a second opinion appointed doctor. We asked the trust for information about any occurrences where medication had been administered to a detained patient where it was not covered under the appropriate legal authority. They told us that there had been two instances for two separate patients where 'as required' medication had been given which was not covered by the legal authority. This meant that medical and nursing staff were usually following the rules around consent to treatment, but there had been a very small number of isolated instances where medication that patients needed were not fully covered on the correct legal form.

Staff kept records of blood tests, investigations and physical observations in each patient's electronic medical notes. The physical health section of the electronic record had a very clear dashboard which showed clearly and visually physical health checks, concerns, tests and retesting for each patient. The dashboard showed at a glance whether physical health information was in expected or healthy ranges or outside of these with required action. We found physical health monitoring had been completed in accordance with national guidance and the hospital policy.

Track record on safety

The ward had a good track record on safety. The service managed patient safety incidents well.

Between 1 February 2018 and 31 January 2019 there was one serious incident reported by this service. This incident was of the category 'self-harm (suicide)'.

We reviewed the serious incidents reported by the trust to the Strategic Executive Information System (STEIS) over the same reporting period. The number of the most severe incidents recorded by the trust incident reporting system was comparable with STEIS with one reported.

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

The number of serious incidents reported during this inspection was higher than the one reported at the last inspection.

Type of incident reported (SIRI)	Self-harm (suicide)	Total
The Cove	1	1
Total	1	1

Reporting incidents and learning from when things go wrong

Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

Managers debriefed and supported staff after any serious incident. When incidents occurred, there was a debriefing session, which looked at what led up to the incident and helped staff to consider issues that had arisen, how staff reacted and how things could be done differently next time. This was an improvement following the last inspection where it was not clear that debriefing had occurred.

Managers and staff made changes to practice as a result of incidents and feedback. We saw that lessons had been learnt. For example, following an incident where a patient went absent without leave from the outdoor courtyard area by climbing on the outdoor table and then on to the roof, staff had moved the outdoor tables to a more suitable area where they could not be used in this way.

Staff understood duty of candour. They were open, transparent and gave patients a full explanation when things went wrong. There had been one incident that involved moderate or severe harm that met the duty of candour threshold.

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 two 'prevention of future death' reports sent to Lancashire Care NHS Foundation Trust. None of these related to this service.

Is the service effective?

Assessment of needs and planning of care

Staff assessed the physical and mental health of all patients on admission. Staff completed detailed assessments and care plans for each patient with goal based planning and detailed discharge plans. Following the assessment, patients' ongoing needs were discussed at a multi-disciplinary care programme approach meeting within five days of each patient's admission which included families and carers.

Staff developed individual care plans, which they reviewed regularly through multidisciplinary discussion and updated as needed. Care plans followed 'my shared care' pathway and/or a headspace toolkit format and were written using age-appropriate language from a patient's perspective. Written care plans were comprehensive and individualised. Care plans covered a range of needs that included patients' medical needs (physical and mental health needs and medication), developmental progress, consent status, occupational therapy needs and leisure interests, family circumstances, legal status and discharge progress. Care planning was based around a psychological formulation.

Care plans reflected the assessed needs, were personalised and recovery-oriented. Staff completed care plans alongside patients following the 'my shared pathway' format. Care plans were goal-outcome focused and helped patients receive support to address the symptoms of mental disorders and focus on the goals important to them. Care plans recorded the patients' identified aims for their inpatient stay and aims for the mental wellbeing in six months' time.

Best practice in treatment and care

Staff provided a range of care and treatment interventions suitable for the patient group and consistent with national guidance on best practice. Patients had access to treatment for common conditions faced by children and young people. Patients had good access to psychological formulation and interventions available as there were ward-based designated clinical psychologists. Patients had direct access to cognitive, behavioural, trauma based and other psychological approaches whilst being an in-patient on the ward as guided by the National Institute for Health and Care Excellence on best practice treatment for depression, psychosis and self-harm. There was also a designated, trained family therapist. Family members were offered family interventions to support families to work together to help children and young people cope and to reduce stress and improve mental wellbeing.

Staff followed National Institute for Health and Care Excellence in the routine prescribing of medication for children and young people. Clinicians understood the risks of prescribing high dose anti-psychotic medication to patients with psychosis. This is where the dosage exceeded national prescribing guidance in a single or combined dose. At the time of the inspection, no patient was on high dose anti-psychotic medication. Where patients were prescribed Risperidone for their behaviour, they had physical and metabolic checks and patients were monitored for any adverse side effects.

Staff ensured that patients had good access to physical healthcare and supported patients to live healthier lives. Staff completed care plans which covered a range of needs that included patients' physical health needs and medication. Physical health was routinely discussed at ward reviews. Staff made appropriate referrals for further investigations where appropriate.

Staff met patients' dietary needs and assessed those needing specialist care for nutrition and hydration. Staff were aware of national guidance such as 'management of really sick patients with anorexia nervosa' guidelines (commonly known as the marsipan guidelines).

Staff used recognised rating scales to assess and record severity and outcomes. Staff routinely assessed patients using the Health of the Nation Outcome Scales for Children and Adolescents

tool. This was a measure of outcome used by child and adolescent mental health services focusing on general health, social functioning and parents' knowledge of the nature of the young person's difficulties and the services available.

Staff also participated in clinical audit, benchmarking and quality improvement initiatives. Staff completed local audits including looking at staff practice in relation to a number of areas such as care recording, Mental Health Act adherence, medicines management, discharge planning, cleanliness and infection control. There was evidence that there had been improvements because of the audits such as improved observation practice recording benchmarked against national guidance. Modern matrons received a detailed report which benchmarked the ward performance against previous time periods and other services.

This service participated in one clinical audit as part of their clinical audit programme 2018 - 2019

Audit name	Audit scope	Core service	Audit type	Date completed	Key actions following the audit
Risk Assessment	CYP	MH CAMHS Wards	Clinical	19 Feb 2019	Revise standards for reviewing risk assessment in CAMHS and CPS teams. Consider the need to be more specific in standards for time frames in which a risk assessment should be reviewed,

Skilled staff to deliver care

The ward team included or had access to the full range of specialists required to meet the needs of patients on the ward. The staffing included registered nurses, health care assistants, a consultant psychiatrist and another part-time consultant psychiatrist acting as responsible clinician on an interim basis, a speciality doctor an occupational therapist, a technical instructor, a part time dietician, clinical psychologists, a family therapist and a social worker providing regular input to the unit. At the time of the inspection, there were vacancies for a senior occupational therapist and a clinical psychologist but these posts were being advertised for recruitment to fill these vacancies.

Managers made sure they had staff with a range of skills needed to provide high quality care. Staff could show they had expertise to support patients' recovery and address patients' complex and individualised needs including mental health and physical health promotion, the legal frameworks relevant to children and young people, goal-based recovery approaches, emotional and educational development and discharge planning.

Managers supported staff with appraisals, supervision and opportunities to update and further develop their skills. The whole staff team had just undertaken an adapted 'positive and safe' training programme specific to child and adolescent mental health services which looked at improving the therapeutic milieu of the ward underpinned by recovery and trauma informed care principles. The overall aim of the training was to aid staff understanding around the common challenges faced by children and young people with mental disorder, focus on primary prevention and safe and therapeutic secondary and tertiary interventions and to support staff to put things in place to prevent incidents occurring and to minimise the use of restrictive interventions.

Most non-medical staff (including registered nurse and healthcare assistants) had received a recent annual appraisal. The trust's target rate for appraisal compliance is 80%. At the end of last year (1 April 2017 and 31 March 2018), the overall appraisal rate for non-medical staff within this service was 6%. This year so far, the overall appraisal rates was 93% (as at 6 March 2019).

The rate of appraisal compliance for non-medical staff reported during this inspection was higher than the 14% reported at the last inspection.

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 (as at 6 March 2019)	% appraisals (previous year April 2017 to March 2018)
The Cove	55	51	93%	6%
Core service total	55	51	93%	6%
Trust wide	4858	4171	86%	69%

All medical staff had received a recent annual appraisal. The trust's target rate for appraisal compliance is 80%. At the end of last year (April 2017 to March 2018), the overall appraisal rate for medical staff within this service was 50%. This year so far, the overall appraisal rates this was 100% (as at 6 March 2019).

Ward name	Total number of permanent medical staff requiring an appraisal	Total number of permanent medical staff who have had an appraisal	% appraisals (as at 6 March 2019)	% appraisals (previous year April 2017 to March 2018)
The Cove	4	4	100%	50%
Core service total	4	4	100%	50%
Trust wide	156	156	100%	50%

The trust's target of clinical supervision for non-medical staff is 80% of the sessions required. Between 1 April 2018 and 11 March 2019, the average rate across all teams in this service was 53%. On inspection we found that the matrons had made concerted effort to improve supervision uptake rates. Staff had several opportunities in relation to clinical supervision including monthly individual supervision, external supervision bimonthly, regular safeguarding supervision and clinical psychologist-led formulation meetings where each patient was discussed. There were also plans for the family therapist to lead on group clinical supervision. In May 2019, the clinical supervision rate had improved and was 90%.

The rate of clinical supervision reported during this inspection was lower than the 90% reported at the last inspection.

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

Team name	Clinical supervision sessions required	Clinical supervision delivered	Clinical supervision rate (%)
The Cove	634	336	53

Team name	Clinical supervision sessions required	Clinical supervision delivered	Clinical supervision rate (%)
Core service total	634	336	53%
Trust Total	31039	9569	31%

The trust did not provide data for clinical supervision for medical staff.

Managers provided an induction programme for new staff and supported staff with ongoing training. Staff completed 'positive and safe training which was bespoke training for The Cove staff on how to provide care, treatment and interventions in age-appropriate ways to the patients. This helped to ensure effective team consistency in approaches, methods and interventions delivered by staff at the hospital. Staff were also undergoing children and young people's improving access to psychological therapy training which highlighted the principles of participation and evidence-based practice as part of the key national targets known as the commissioning for quality and innovation targets.

Multi-disciplinary and interagency team work

Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. Patients were discussed at regular multi-disciplinary meetings which were well attended. Professionals routinely considered patients' holistic needs. The multidisciplinary meetings we observed followed a structured, clear and comprehensive approach. There was good communication and a respectful attitude between multidisciplinary members. Staff showed a warm and inclusive manner towards the young people in their care.

The ward team had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation. Staff from community child and adolescent mental health teams were regularly invited and attended ward reviews and care programme approach meetings. We saw that where appropriate, staff referred patients to external teams.

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

We carried out a Mental Health Act monitoring visit to The Cove in November 2018. The visit identified that the systems and processes for making sure that the Mental Health Act was followed were largely good. On that visit, we identified a small number of shortfalls including reviewing patients' rights when patients did not understand, discrepancies in relation to the patients' capacity to consent to medication, and shortfalls in recording some of the safeguards when patients were placed in seclusion. The trust sent an action statement addressing the shortfalls we found on the visit. On this inspection, staff had ensured that there had been improvements to shortfalls in the recording of their responsibilities relating to patient rights, competence and capacity and seclusion recording following our Mental Health Act monitoring visit.

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and discharged these well. Staff knew who their Mental Health Act administrators were and when to ask them for support. Staff on the ward told us they received appropriate, timely and professional support on matters relating to the Mental Health Act when required. Staff ensured that copies of patients' detention papers and associated records were stored systematically through scanned copies uploaded on the trust's electronic care notes systems and were readily available for all staff.

There were clear checklists in place for staff to ensure that when patients were detained. All the necessary legal paperwork was provided to ensure that the patient was lawfully detained. While detention papers had been checked by the receiving nurse and scrutinised by an administrator, on three out of four relevant records, we did not find evidence of medical scrutiny to make sure the clinical grounds for detaining patients were made out.

Managers made sure that staff could explain patients' rights to them. Staff explained to each patient their rights under the Mental Health Act in a way that they could understand, repeated this as necessary in accordance with the Mental Health Act Code of Practice and recorded it clearly in the patient's notes each time. Where patients did not understand their rights, staff repeated them and used different ways to try and assist patients to understand their rights.

Staff informed qualifying detained patients of their right to see the independent mental health advocate. Posters were displayed on the ward containing information about the independent mental health advocacy service. The independent mental health advocate attended the ward regularly.

Patients who were informal who were deemed to have competence or capacity that they could leave the ward were aware of their rights to leave the ward. There were signs by the ward entrances to inform informal patients who were deemed to have competence or capacity that they could leave the ward. Records indicated that informal, competent patients had extensive time off the unit.

All relevant staff had received Mental Health Act training according to data provided by the trust. The team included a social worker who was also an approved mental health professional, so staff had access to a person with working and detailed knowledge of the operation of the Mental Health Act.

Good practice in applying the Mental Capacity Act

The Mental Capacity Act applies to people aged 16 years or over. For children under the age of 16 years, the young person's decision-making ability is governed by Gillick competence. The concept of Gillick competence recognises that some children may have sufficient understanding and intelligence to make some decisions for themselves. If patients under 16 years are not competent to make decisions, then care and treatment decisions usually fall within the scope of parental responsibility.

Most staff received training in the Mental Capacity Act and had a good understanding of the five guiding principles. As of 6 March 2019, 88% of the workforce in this service had received training in the Mental Capacity Act (Level One). The trust stated that this training is mandatory for all services for inpatient and all community staff and renewed every three years.

Staff supported patients to make decisions on their care for themselves proportionate to their competence. They understood how the Mental Capacity Act 2005 applied to young people aged 16 and 17 and the principles of Gillick competence as they applied to patients under 16. For example, a decision relating to one patient who had fluctuating capacity was delayed to see if their capacity would improve.

Staff assessed and recorded consent and capacity or competence clearly for patients who might have impaired mental capacity or competence. Where the young person was under 16 and not sufficiently mature to make decisions, records showed that staff sought agreement from the children's parents or legal guardians in line with the scope of parental responsibility. Where patients had sufficient understanding and intelligence to make particular decisions, staff used the

guidelines in the Gillick competence case to determine if patients were competent to make their own decisions independently of their parents or legal guardians. For example, we saw detailed information around capacity and consent in relation to one patient to consider whether they were able to give valid consent to an informal admission.

Where patients over 16 lacked capacity to make specific decisions, staff fully considered patients' best interest prior to making decisions. For example, we saw a detailed best interest consideration for one patient who face restrictions on their food.

The trust told us that one Deprivation of Liberty Safeguard (DoLS) application was made to the Local Authority for this service between 1 February 2018 and 31 January 2019

That one application was made in March 2018.

The ward had only used the Deprivation of Liberty Safeguards for one patient; this was because the main Deprivation of Liberty Safeguards regulations only apply to people over 18. When patients under 18 were subject to a Deprivation of Liberty Safeguards, it was authorised by the Court of Protection rather than the local authority. Staff were using the Mental Health Act when patients were deprived of their liberty as patients were also receiving treatment for a mental disorder.

	Number of 'Standard' DoLS applications made by month												Total
	Feb	March	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	
Standard applications made	0	1	0	0	0	0	0	0	0	0	0	0	1
Standard applications approved	0	1	0	0	0	0	0	0	0	0	0	0	1

Is the service caring?

Kindness, privacy, dignity, respect, compassion and support

Staff treated patients with compassion and kindness. On the last inspection in January 2018, we identified that staff were not always engaging with patients and we observed staff describing patients in a negative manner. On this inspection we saw improvements had been made. We observed positive interactions between staff and patients; staff treated patients with kindness and empathy. Patients were complimentary about staff and told us that staff responded to patients' requests and needs quickly. In our discussions with staff, they spoke about patients in a caring and compassionate manner. Patients confirmed that staff spent time talking with them with time for individual one-to one nursing sessions.

Staff respected patients' privacy and dignity. Patients told us staff treated them with dignity and respect. Carers also told us that staff treated them with the utmost respect. However, we passed over comments from one patient who was not happy about her care and treatment including concerns about her mother's involvement for managers to look into.

Staff understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition. Patients felt they received support to help them with their recovery from mental ill-health. Where medication was prescribed, patients were given information in a way they understood.

In relation to patient-led assessments of the care environment (PLACE) data privacy, dignity and wellbeing, The Cove was compared to other sites of the same type and the scores they received for 'privacy, dignity and wellbeing were found to be about the same as the England average.

Involvement in care

Involvement of patients

Staff involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided. Patients told us they felt involved in the decisions about their care and treatment and received information in a way they could understand. Most records indicated that patients were involved in their own care and treatment from initial assessment through to ongoing treatment underpinned by a focus on working towards discharge. For example, staff recorded in care plans clearly what patients identified as the aims for their inpatient stay and staff worked to deliver these aims. Records showed that patients had been given or offered a copy of their care plan.

Staff and patients had worked together to produce an impressive, large wall display to remind patients of ten of their rights when attending care programme approach meetings. These were displayed in the conference room and were designed to ensure that the care programme approach meetings were as accessible and user-friendly as possible. For example, one of the rights written on the display was that everyone should speak without using jargon. At care programme approach meetings, patients were supported to uphold this right by being given yellow cards which they could hold up if staff used jargon or said anything they did not understand.

Staff ensured that patients had easy access to independent advocates. Advocates supported patients to attend ward review and care programme approach meetings. Staff reported good working relations with the independent mental health advocates and referred patients to receive advocacy support, where appropriate.

Regular patients' meetings were taking place to ensure that patients had the opportunity to raise concerns and have them addressed.

Patients were involved in choosing the colour scheme, décor and furnishings as well as naming the rooms on the unit.

The unit had employed a person with lived experience of using services as a participation consultant. Staff had supported the development of 'The Crew' – a group of ex-patients and family who were looking at aspects of service provision and supporting the unit to improve in these areas. The Crew were involved in interviewing all new staff members and providing training to staff.

Involvement of families and carers

Staff informed and involved families and carers appropriately. Carers told us that staff involved them in meetings and relatives and carers were asked for their views. When important decisions were made carers were included and staff checked out whether they were happy with the plans. Records showed, and our observations of meetings we attended confirmed, that families and carers were involved in patients' care and treatment. Involvement ranged from getting carers' perspectives on the patient's identified needs at initial assessment through to relatives and carers being involved at ongoing weekly reviews and care programme approach meetings.

Is the service responsive?

Access and discharge

Bed management

The Cove was commissioned for patients across Lancashire Care's footprint and patients from South Cumbria. It was also part of the Tier 4 network of hospitals across the north west of England so staff worked with other hospitals region all to co-ordinate admissions, particularly when there were no local beds. At the time of the inspection, there were no patients being treated at The Cove from out of area. The Cove had an access and outreach team which provided the gatekeeping function for the ward and were based within the Cove. They operated seven days a week between the hours of 8am and 10pm. This team assessed new referrals to the service and, following discussion with the multi-disciplinary team, arranged to admit patients who were appropriate for in-patient care. Most referrals were seen within 24 hours.

Most admissions were planned, although some patients were admitted as an emergency via the section 136 suite.

The trust provided information regarding average bed occupancies for one ward in this service between February 2018 and January 2019 based on the cap of 14 beds.

This ward was below the minimum benchmark of 85% in all months over this period

Ward name	Average bed occupancy range (Feb 2018 to Jan 2019) (current inspection)
The Cove	29.2% - 60.1% (average: 49.7%)

The bed occupancy level for The Cove was also below the national average of 84% bed occupancy levels for general admission inpatient child and adolescent mental health wards as detailed in the most recent NHS benchmarking report (2018).

Patients did not have excessive lengths of stay. The trust provided information for average length of stay for the period February 2018 and January 2019.

Ward name	Average length of stay range (date - date) (current inspection) (days)	
The Cove	12 – 87.3	Average: 43.8

Patients were not kept on the ward longer than necessary with average lengths of stay benchmarking lower than the national average. The average length of stay for the ward was well below the national average of 61 days for general inpatient child and adolescent mental health wards as detailed in the most recent NHS benchmarking report (2018).

This service reported no out of area placements between February 2018 to March 2019. As of 6 March 2019 this service had no ongoing out of area placements.

Staff from the access and outreach team led on regularly reviewing cases where patients were placed in more specialised placements such as child and adolescent psychiatric intensive care units.

This service reported no readmissions within 28 days between February 2018 to March 2019.

At the time of the last inspection, for the period 1 April 2017 to 31 July 2017, there were a total of no readmissions within 28 days.

Discharge and transfers of care

Staff planned and managed discharge well. They liaised well with services that would provide aftercare and were assertive in managing the discharge care pathway. As a result, patients' discharge was rarely delayed for other than a clinical reason.

Between 1 February 2018 and 31 January 2019 there were 75 discharges within this service. This amounts to 3% of the total discharges from the trust overall (2653).

There were seven delayed discharges reported over this period.

On admission, the multidisciplinary team routinely discussed the likely discharge date determined through considering the individual patient's presentation. This was then kept under review through discussing the patient's progress to discharge at each weekly case review. Each patient had a discharge care plan which was detailed and kept up to date. This included what measures staff and community services needed to be put in place before patients could be discharged. For example, increased leave, accommodation or short stay respite foster care.

The most common reasons for delayed discharge were, awaiting accommodation, awaiting allocation of a community social worker or more complex cases such as looked after children where care placements needed to be arranged. Where there were delays, this was usually beyond the full control of trust staff.

Staff worked to transition between inpatient or community child and adolescent mental health teams to adult mental health services before they reached the age of 18. At the time of the inspection, one patient was approaching their 18th birthday age and needed a transfer onto an adult ward. Managers worked with staff in other parts of the trust to escalate this individual situation and secured a bed before the patient's 18th birthday.

In exceptional cases, young people may be admitted to other wards but there were good reasons for these. There were three admissions of young people under the age of 18 years to adult mental health wards in the past 12 months up until March 2019. Two were for young people who were within 2 days of their 18th birthday. Staff decided was in their best interests to be admitted to an adult ward rather than requiring transfer. The other young person required a low secure placement and there were no available, appropriate child and adolescent mental health beds.

Although the Cove was equipped with a seclusion room and staff could manage a degree of disturbed behaviour, it did not provide psychiatric intensive care to children and young people. If a patient needed more intensive care, this was provided by two private hospitals nearby, in Greater Manchester. Staff reported that where psychiatric intensive care or low secure care was needed, they could secure a bed quickly.

Facilities that promote comfort, dignity and privacy

The design, layout, and furnishings of the ward supported patients' treatment, privacy and dignity. Each patient had their own bedroom with an en-suite bathroom and could keep their personal belongings safe. There were quiet areas for privacy.

The ward at The Cove was large and spacious and comprised of three separate lounge areas, the den (which contained a pool table, television and computers), a gym, music room, two kitchens, therapy rooms, visit and meeting rooms. Patients had access to a secure garden area. All bedrooms were single occupancy. There was an education suite which provided a meeting room, two classrooms an art room and a therapy room. The patients had been involved in choosing some of the décor, designing murals, choosing the colour scheme and contributed some of the art work on display. Following an appropriate individualised assessment, patients had magnetic key fobs to their bedrooms to open or lock their own bedrooms.

There was Wi-Fi available on the ward so patients could have personal access to the internet.

Staff had produced a welcome pack for patients. The welcome pack contained detailed information about the service itself, treatments on offer, ward routines, the complaints procedure and commonly asked questions.

In relation to patient-led assessments of the care environment (PLACE) assessments, The Cove was compared to other sites of the same type and the scores they received for 'ward food' were found to be about the same as the England average.

The food was of a good quality and patients could make drinks and snacks at any time. Food was cooked fresh on the premises and patients were very complimentary about the improvements to the standard of food available to them.

Patients' engagement with the wider community

There was a full activity, therapy and education programme which patients were encouraged to participate in. Patients had some degree of autonomy and choice over how they spent their day. There were a range of communal and quiet spaces which patients could use without restriction.

Patients were offered eco therapy, which was a joint initiative between the trust and the local wildlife trust involving outdoor work such as bush crafts and mindfulness. The group had redesigned the outdoor area including making furniture from pallets, developing hedges and growing flowers and produce.

There were two kitchens on the unit and patients were supported by staff to use these spaces for organised cookery sessions.

Patients were required to continue their education while they were at The Cove. There was a small education team who were employed by the local authority. The education provision was not registered with the office for standards in education, children's services and skills (Ofsted). At the time of the inspection, some patients were taking their GCSE examinations.

The matrons highlighted that there had been problems with the leadership of the education team but were confident that the issue would be resolved soon following recruitment. The matron told us that the current service had mainly focused on children under the age of 16 and mainstream education provision working up to GCSEs. There were limited education opportunities for post-aged 16 education and vocational training. Due to the limited size of the education team and most patients only staying at The Cove for short periods of time, there was limited input into weekly reviews and care programme approach meetings from education staff. Care plans did not include much detail about patients' education status and needs. In the absence of detail from the education department, managers accepted the need to audit care plans to monitor the quality of care plans relating to educational needs and improve the quality where necessary.

Meeting the needs of all people who use the service

The ward met the needs of all patients who used the service – including those with a protected characteristic. The ward was accessible to patients with physical disabilities, with ramped access into the building and level access throughout the inpatient areas of the building. Parking included designated parking bays directly outside the building so that patients or visitors with limited mobility did not have to walk far to get to the ward.

Staff helped patients with communication, advocacy and cultural and spiritual support. Managers made sure staff and patients could get hold of interpreters or signers when needed. Records we saw showed that an interpreter was arranged for one patient because the patient's family's first language was not English. Interpreters were available to staff when required via a contract the trust had to provide staff trained in interpreting or through a contracted telephone interpreting service, if a patient or carer's first language was not English.

Staff were discussing patients' religious needs with them. However, in one record, these discussions were not fully reflected in the patient's care plans.

The ward was brightly decorated and had safe and comfortable furniture suitable for children and young people.

There was a range of information displayed on the ward, which was arranged to be visually appealing and accessible to young people. This included and a lesbian, gay, bisexual and transgender information board and information on the carers' champion.

In relation to patient-led assessments of the care environment (PLACE) assessments, The Cove was compared to other sites of the same type and the scores they received for 'disability' and dementia friendliness' were found to be about the same as the England average.

Listening to and learning from concerns and complaints

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team.

Patients were given written information about making complaints within the ward booklet when they were admitted. This included details of the trust's patient advice and liaison service who helped patients to raise concerns locally and ensured complaints were resolved. Information on complaints, the patient advice and liaison service and the Care Quality Commission's role in complaints were displayed on the ward. Detained patients qualify for support from an independent mental health advocate. Posters were displayed on the ward containing information about the independent mental health advocacy service.

Following regular complaints about the quality of the food, two chefs had been employed to cook food fresh on the premises.

The service received a low number of complaints reflecting that most patients were satisfied with their care. This service received 14 complaints between 1 February 2018 and 31 January 2019. None of these were referred to the Ombudsman. 80% of complaints were closed within the trust target of 40 days. Records showed that complaints were taken seriously, a full response was produced addressing each aspect of patients' complaints and patients were invited to give feedback if they were unhappy about the way their complaint was handled.

This service received 172 compliments during the last 12 months from 1 February 2018 and 31 January 2019 which accounted for 2% of all compliments received by the trust as a whole (7291).

Is the service well led?

Leadership

Leaders had the skills, knowledge and experience to perform their roles. The ward was managed locally by competent and experienced managers including band 6 nurses, a ward manager and two modern matrons who between them had many years' experience of working in, and managing, inpatient child and adolescent mental health services. Both matrons worked collaboratively to provide leadership across the ward; each matron has distinct responsibilities and priorities for the whole service. One modern matron also took lead responsibility for overseeing the assessment team.

Leaders had a good understanding of the services they managed. Leaders could explain clearly the service offered, what the ward team did well and what they felt needed improving. The modern matron reports received from the trust gave them high quality data on the ward performance.

Leaders were visible in the service and approachable for patients and staff. Staff felt very well supported by the modern matrons, ward manager and their supervisors. Staff felt that the managers had an open-door policy. Staff reported significant improvements in the leadership of the ward since the appointment of the current leaders.

Vision and strategy

Staff knew and understood the provider's vision and values and how they were applied in the work of their team. The ward leadership team had communicated the trust's visions and values to staff. The trust's vision and values were displayed on information boards across the ward.

Culture

Staff felt respected, supported and valued. Morale among the staff team, across all staff grades and across all professional groups positively commented that morale had improved significantly. Staff from across disciplines reported how much the ward environment and culture had improved.

Staff told us that leaders were clear with them about what was expected of them, staff were supportive of each other and staff had worked to improve the culture and resilience of the team. The emphasis placed by leaders on improving the environment of the ward together with investing in staff through supervision uptake and the 'positive and safe' training initiatives were key things that had helped to embed the improvement of morale among the staff group.

Staff knew about the whistleblowing policy and felt confident that they could raise concerns.

Governance

Leaders produced modern matron reports, which provided detailed information to the ward and managers on key indicators for The Cove. Leaders used these reports to access and monitor key performance information regarding their ward. This included restraint episodes, incidents, complaints, staffing levels and sickness, mandatory training, and rates of supervision and appraisals with staff.

Our findings from the other key questions demonstrated that governance processes operated effectively at ward level.

Leaders had ensured that the shortfalls we found on the last inspection had been addressed. On this inspection, we found:

- A much safer environment including significant attention to dealing with repairs and a much more comfortable environment for young patients underpinned by regular environmental audits.
- A significant reduction in the restrictions put on patients, and where restrictions were in place they were based on individual risk assessments.
- Improved staffing levels on shift with staff who were suitably skilled and trained for child and adolescent mental health care.
- Much reduced bank and agency staff usage and local induction.
- Much reduced observation levels and improved allocations of observations.
- Better clinical and management supervision uptake.
- Debriefs held following an incident and lessons learnt from incidents and complaints.
- Improved support plans for individual patients consistently followed by staff.
- Better understanding and action to address patients' individual and specific needs, such as the need for an interpreter.

Management of risk, issues and performance

Performance and risk were managed well. Leaders had good systems and procedures in place to ensure that staff on the ward operated effectively, provided good quality care and met performance targets expected of the team. There were modern matron and band 6 nurse checks in place. There was evidence that there had been improvements because of the audits such as significant improvements in the ward environment.

The service had clear plans for dealing with emergencies and staff understood these. The trust had a suite of emergency plans and business continuity process which included identifying and mitigating the risks in relation to disruption of services including flooding, flu epidemic, extreme weather and other key risks.

Information management

Ward teams had access to the information they needed to provide safe and effective care and used that information to good effect. The monthly modern matron report, which provided detailed information to ward staff and managers on key indicators for The Cove, was compiled using data that staff routinely recorded on an ongoing basis.

Staff had access to equipment and technology that worked well and supported them to do their work. Staff reported that the electronic care recording system worked well for them and they had received training in its use.

Patient records were held mostly electronically with secure password access. Where records were held on paper, they were held in locked cabinets within the nursing offices on the ward. The offices were locked and only accessible to staff.

Engagement

Patients and carers could give feedback about their care and in ways that reflected their individual needs. Managers ensured there were regular community meetings which ensured patients had a voice in not just their own care but how the ward was run.

Leaders listened to, and supported the development of, 'The Crew' – a group of ex-patients and family who looked at aspects of service provision and supported the ward to improve in these areas.

Staff met regularly at staff meetings where they could listen to leaders but also provide a forum for their views on the running of the ward and its progress. Recent staff meeting minutes identified that there were regular and detailed discussions on several matters including incidents, seclusion episodes, restrictive practices and complaints as well as feedback from staff champions such as safeguarding, equality and diversity and carers' champions.

Learning, continuous improvement and innovation

Staff engaged actively in local and national quality improvement activities.

Managers were ensuring that staff were meeting key local targets set by commissioners known as the commissioning for quality and innovation targets. The targets in place at the time of the inspection were expected discharge target, reducing out of area placements and improving ward staff training to meet children and young people's improved access to psychological therapies. As part of the discharge target, the team had established a system for specifying and recording patients' estimated discharge date and created guidance for the management of delayed discharge.

Ward leaders took part in accreditation schemes and learned from this. 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 service have been awarded an accreditation together with the relevant dates of accreditation.

Accreditation scheme	Core service	Service accredited	Comments
Quality Network for Inpatient CAMHS (QNIC)	MH CAMHS Wards	The Cove	The Cove -QNIC peer review in January 2019. Awaiting report. Planning for accreditation in 2020

At the time of inspection, the ward had received their report from the quality network for inpatient child and adolescent mental health service accreditation review. This corroborated the significant improvements made by the ward team. The peer review identified that most of the standards had been met with a few minor shortfalls. Leaders were developing an action plan to address the shortfalls highlighted.

Community-based mental health services for adults of working age

Facts and data about this service

Location site name	Team name	Number of clinics	Patient group (male, female, mixed)
Guild Lodge	Specialist Community Training (S)		
Ormskirk Hospital	CMHT West Lancs	36	mixed
Ormskirk Hospital	ATT - START - West Lancashire	16	mixed
Sceptre Point	Alternative Intervention Programme Ormskirk		
Sceptre Point	AMH Response Service		
Sceptre Point	ATS North		mixed
Sceptre Point	ATT - START - Blackburn with Darwen	No set clinics - daily slots are available for use for urgent reviews.	mixed
Sceptre Point	ATT - START - Burnley & Pendle	No set clinics - daily slots are available for use for urgent reviews.	mixed
Sceptre Point	ATT - START - Chorley and South Ribble	Psychology run clinics for 1 to 1.	mixed
Sceptre Point	ATT - START - Greater Preston	Psychology run clinics for 1 to 1.	mixed
Sceptre Point	ATT - START - Hyndburn, Rossendale & Ribble Valley	No set clinics - daily slots are available for use for urgent reviews.	mixed
Sceptre Point	ATT - START - Lancaster & Morecambe	100 routine clinic apts. 60 urgent clinic apts. This is if all staff are on duty so doesn't account for holidays, training and sickness. Staff also run follow-up clinics offering aprox. 192 apts per month but again this is the max as will be less if leave etc is factored in.	mixed
Sceptre Point	ATT Blackburn & Darwen	Appointments are made with Service Users, there are no set clinics for this service	mixed
Sceptre Point	ATT Fylde & Wyre	No set clinics - daily slots are available for use for urgent reviews.	mixed

Location site name	Team name	Number of clinics	Patient group (male, female, mixed)
Sceptre Point	ATT Lancaster & Morecambe	Appointments are made with Service Users, there are no set clinics for this service	mixed
Sceptre Point	Clinical Treatment Team	Appointments are made with Service Users, there are no set clinics for this service	
Sceptre Point	CMHT Blackburn	16	mixed
Sceptre Point	CMHT Blackpool	no set nurse clinics for this, appointments arranged.	mixed
Sceptre Point	CMHT Burnley	17 outpatient clinics	mixed
Sceptre Point	CMHT Chorley & South Ribble	Skill group, DBT, mood on track. These cover Wyre Fylde and Blackpool	mixed
Sceptre Point	CMHT Darwen	16	mixed
Sceptre Point	CMHT Fylde		
Sceptre Point	CMHT Lancaster	No clinical space at East Barn. 2 consultants have 3 x clinics per week at Cameron House.	mixed
Sceptre Point	CMHT Morecambe	28 Psychiatrist clinics per 4 week month 4 Clozaril / Depot clinics per 4 week month.	Mixed
Sceptre Point	CMHT Pendle	17 outpatient clinics	mixed
Sceptre Point	CMHT Ribble Valley & Hyndburn	16	mixed
Sceptre Point	CMHT Rossendale & Hyndburn	22	mixed
Sceptre Point	CMHT Wyre		
Sceptre Point	Community Living Skills Team		mixed
Sceptre Point	Community Rehab Team East		mixed
Sceptre Point	Community Restart	Do not run clinics	mixed
Sceptre Point	Community Restart Chorley Reform		
Sceptre Point	Community Restart Preston		mixed
Sceptre Point	Community Therapies Chorley Reform		
Sceptre Point	Crisis Cafe		
Sceptre Point	EIS ADHD (MH)		
Sceptre Point	EIS Central & West Lancs (MH)	The service does not have set clinics and individually-arranged appointments take place within the building and in patients' homes	

Location site name	Team name	Number of clinics	Patient group (male, female, mixed)
Sceptre Point	EIS East Lancs (MH)	The service delivers a range of clinics in community locations	
Sceptre Point	EIS Fylde & North Lancs (MH)	The service does not have set clinics and individually-arranged appointments take place within the building and in patients' homes	
Sceptre Point	Fylde and Wyre CMHT	14 days RC clinics for Out patients per 4 week month. 4 Depot clinics per 4 week month Psychology run clinics for 1 to 1. Nursing staff see people daily, no set clinics for this, appointments arranged.	mixed
Sceptre Point	Gloucester Avenue Rehab		
Sceptre Point	Mental Health SRS Heysham Road		male
Sceptre Point	North Lancs Social Inclusion Service Cedar		
Sceptre Point	North Lancs Social Inclusion Service Wyre		
Sceptre Point	OT Basics		
Sceptre Point	PEIS Lancaster & Morecambe (MH)	The service delivers a range of clinics in community locations.	
Sceptre Point	Positive Lifestyle Team	20	mixed
Sceptre Point	Preston CMHT	80- consultant out-patient clinics	mixed
Sceptre Point	Primary Care Integrated Mental Health Team	0	mixed
Sceptre Point	Psychosis Bipolar Network (MH)	The service delivers a range of clinics in community locations	
Sceptre Point	Rehab In-Reach Team SRS North		
Sceptre Point	Restart & Recovery North Lancs		
Sceptre Point	Willow Lane Mental Health Supported Accommodation		mixed
Sceptre Point	Wordsworth Terrace Mental Health Supported Accommodation		mixed

Location site name	Team name	Number of clinics	Patient group (male, female, mixed)
Sceptre Point	CLOSED ATT Chorley & South Ribble		
Sceptre Point	CLOSED ATT Hyndburn, Rossendale & Ribble Valley		
Sceptre Point	CLOSED ATT Preston		
Sceptre Point	CLOSED ATT West Lancs		
Sceptre Point	CLOSED Care Group Management Pennine		
Sceptre Point	CLOSED CMHT Chorley		
Sceptre Point	CLOSED CMHT Preston East		
Sceptre Point	CLOSED CMHT Preston West		
Sceptre Point	CLOSED CMHT South Ribble		
Sceptre Point	CLOSED EIS Reach Project (MH)		
Sceptre Point	CLOSED Harewood Road Mental Health Supported Accommodation		

The methodology of CQC provider information requests has changed, so some data from different time periods is not always comparable. We only compare data where information has been recorded consistently.

Is the service safe?

Safe and clean environment

Staff did regular risk assessments of the care environment. All locations we visited completed monthly environmental audits which identified any actions required. There was evidence of actions being completed.

Interview rooms were fitted with alarms or staff had access to personal alarms and there were staff on site to respond to alarms. The premises in Blackpool had alarms fitted in each interview room. The premises in Preston and Nelson provided staff with personal alarms to use within interview rooms. Staff described immediate responses to alarm calls and appropriate action by staff.

Clinic rooms were well-equipped with the necessary equipment to carry out physical examinations. Service users who were prescribed depot, Clozaril or lithium medication were given regular physical health examinations.

All areas were clean, had good furnishings and were well-maintained.

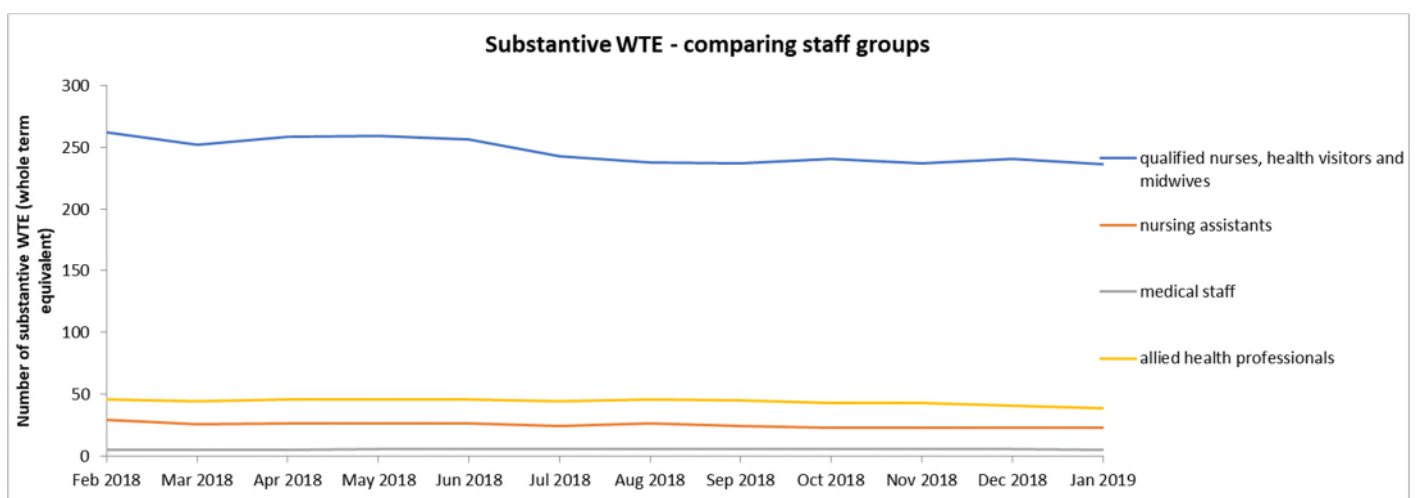
Cleaning records were up to date and demonstrated that the premises were cleaned regularly. We observed all areas to be clean and tidy.

Staff adhered to infection control principles, including handwashing. There was appropriate hand washing facilities where necessary.

Staff maintained equipment well and kept it clean. Any 'clean' stickers were visible and in date.

Safe staffing ⁶

The below chart shows the breakdown of staff in post WTE in this core service from 1 February 2018 to 31 January 2019.



Annual staffing metrics

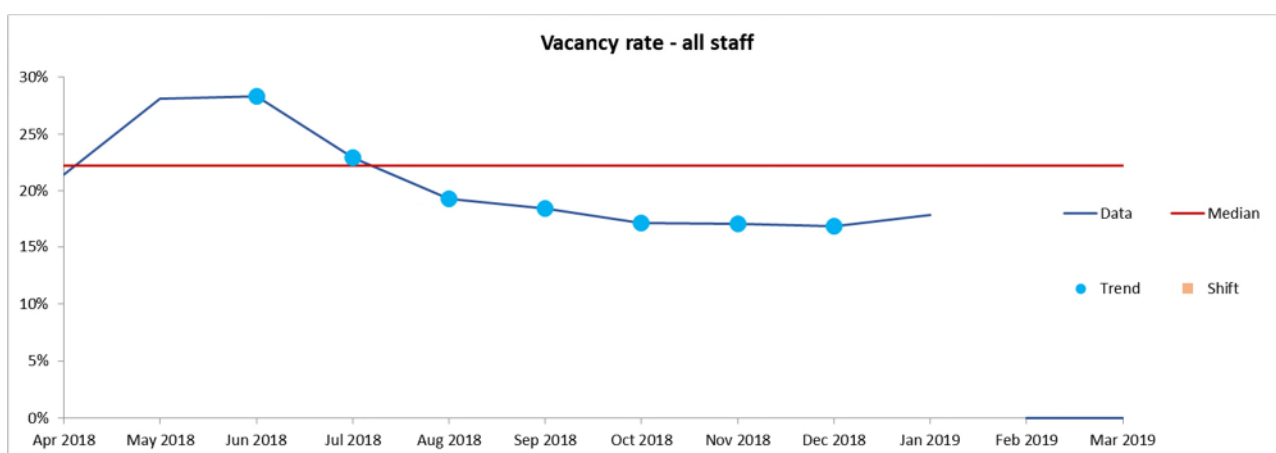
Core service annual staffing metrics (1 February 2018 – 31 January 2019) Vacancy data (1 April 2018 – 31 January 2019)							
Staff group	Annual average establishment	Annual vacancy rate	Annual turnover rate	Annual sickness rate	Annual bank hours (% of available hours)	Annual agency hours (% of available hours)	Annual "unfilled" hours (% of available hours)
All staff	471.9	21%	4%	5.7%			
Qualified nurses	258.0	17%	4%	7.2%	9143 (2%)	1280 (<1%)	527 (<1%)

⁶ Staffing analysis Vacancy benchmark Turnover benchmark Sickness benchmark

Nursing assistants	28.5	34%	2%	5.4%	1845 (1%)	0	17 (<1%)
Medical staff	7.8	26%	0%	1.0%	0	0	0
Allied health professionals	42.0	15%	2%	2.3%			

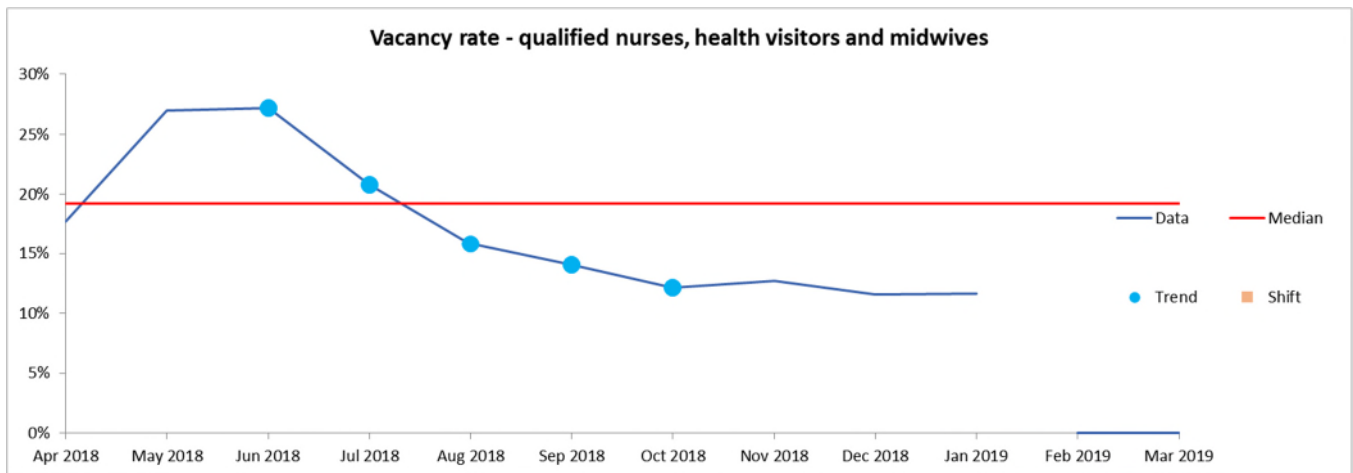
NOTE: Vacancy data has only been provided for 10 months, from 1 April 2018 to 28 February 2019.

All staff



The annual vacancy rates for all staff was in the highest 25% when compared to other similar core services nationally, however, monthly 'vacancy rates' over the last 12 months for all staff shows a downward trend from June 2018 to December 2018. This could be an early indicator of improvement. In contrast, the annual turnover rate for all staff was in the lowest 25% when compared to other similar services.

Qualified nurses

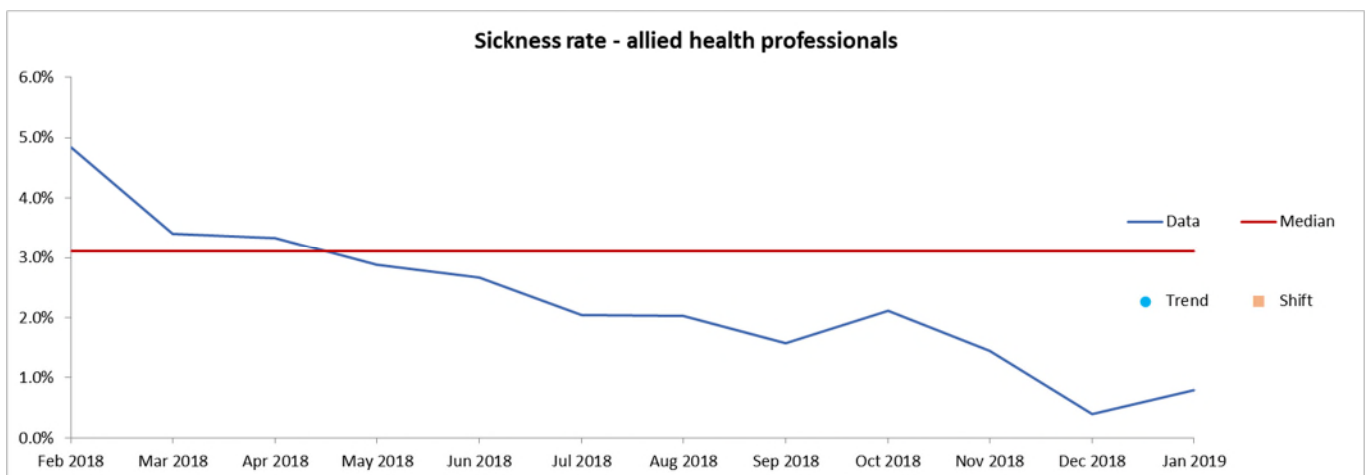


The annual sickness and vacancy rates for qualified nurses were in the highest 25% when compared to other similar core services nationally, however, monthly 'vacancy rates' over the last 12 months for qualified nurses, health visitors and midwives shows a downward trend from June 2018 to October 2018. Conversely, the annual turnover rate for qualified nurses was in the lowest 25% when compared to other similar core services.

Nursing assistants

The annual vacancy rates for nursing assistants was in the highest 25% when compared to other similar core services nationally. In contrast, the annual turnover rate was in the lowest 25% for this staff group. This was a consistent theme across the 12-month reporting period.

Allied Health Professionals



Monthly 'sickness rates' over the last 12 months for allied health professionals are not stable and may be subject to ongoing change.

The provider had not previously determined safe staffing levels by calculating the number and grade of members of the multidisciplinary team required using a systematic approach. A staffing level review had taken place within the last six months. Staffing establishment levels had recently been increased to meet the demands of the service, higher acuity levels and long waiting times to access the service. We reviewed data relating to the number of referrals and the number of

service users discharged from the service. Overall, the service received 6256 referrals over the last 12 months. The service discharged 7178 service users during the same timeframe.

The number, profession and grade of staff in post did not currently match the provider's staffing plan. There was a shortage of nursing staff in each team. All nursing vacancies had been filled except for one post in Blackpool. New staff had been appointed and were due to begin work between June and September 2019. There had been no social workers within the teams since April 2018 due to planned restructuring within the local authority. New social work consultant posts had been created and recruitment was underway.

Managers assessed the size of the caseloads of individual staff regularly and helped staff manage the size of their caseloads. Managers had oversight of staff's caseloads. Each team had an average caseload of approximately 30 service users. Managers were aware of complexities of service users' mental health.

Cover arrangements for sickness, leave, vacant posts and so on did not ensure patient safety. Each team had a high number of service users who had not been allocated to a care coordinator. The use of bank and agency staff was not enough to meet the demand of patient care. Bank and agency staff cover for the four teams we visited was:

- Blackpool – one bank staff nurse working term-time only
- Preston – five agency staff
- Burnley – no bank or agency staff
- Pendle – one bank staff

The service did not always have rapid access to a psychiatrist when required. Service users needing urgent appointments to see a psychiatrist had to wait between seven and eleven working days in Preston. In Blackpool this was five days and in Burnley and Pendle between one and five days. In Blackpool the psychiatrists had four emergency appointments available each week. However, these were filled very quickly, and the wait was often longer.

Service users requiring routine appointments to see a psychiatrist also often had long waits:

- Blackpool – three months
- Preston – four months
- Burnley and Pendle – two weeks

Burnley and Pendle had access to a pharmacist/non-medical prescriber who was available to offer appointments to less complex service users. This allowed the psychiatrist to be available for more complex service users.

Mandatory training

The compliance for mandatory and statutory training courses at 6 March 2019 was 83%. Of the training courses listed five failed to achieve the trust target and of those, all five failed to score above 75%.

The trust set a target of 80% for completion of mandatory and statutory training.

Training compliance is reported by the trust on an ongoing monthly basis.

The training compliance reported for this core service during this inspection was lower than the 94% reported in the previous year.

Key:

	Met trust target ✓	Not met trust target ✗	Higher ↑	No change →	Lower ↓
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Training Module	Number of eligible staff	Number of staff trained	YTD Compliance (%)	Trust Target Met	Compliance change when compared to previous year
Safeguarding Children L2	112	106	95%	✓	↓
Mental Capacity Act L1	428	405	95%	✓	↓
Health & Safety	442	414	94%	✓	↓
Equality & Diversity	442	411	93%	✓	↓
Manual Handling L1A	14	13	93%	✓	↓
Safeguarding Adults L1	14	13	93%	✓	↓
Safeguarding Children L1	14	13	93%	✓	↓
Fire Safety	442	394	89%	✓	↓
Conflict Resolution	430	381	89%	✓	↓
Safeguarding Adults L2	428	376	88%	✓	n/a
Infection Control	428	374	87%	✓	↓
Safeguarding Children L3	316	270	85%	✓	↓
Manual Handling L1B	373	301	81%	✓	n/a
Manual Handling L2A	55	40	73%	✗	↓
Mental Capacity Act L2	428	308	72%	✗	n/a
Basic Life Support	428	298	70%	✗	↓
Information Governance	442	301	68%	✗	↓

Training Module	Number of eligible staff	Number of staff trained	YTD Compliance (%)	Trust Target Met	Compliance change when compared to previous year
WRAP	311	202	65%	✘	n/a
Core service total	5547	4620	83%	✓	↓

During the onsite inspection, all teams visited provided evidence that all training modules were above 75%. Staff explained the information governance module did not always log that it had been completed. Managers were raising this with the appropriate training department staff. Managers were able to demonstrate that staff training was monitored, and staff had booked on to training that was due.

Assessing and managing risk to patients and staff

Assessment of patient risk

Staff did a risk assessment of every patient at initial triage/assessment, however there were gaps in completing regular updates, including after any incident. All teams, (with the exception of Blackpool, had access to specialist triage and assessment response teams who triaged all new referrals. A full risk assessment was completed by the specialist triage, assessment, referral and treatment team if the service user had not been previously known to the mental health team. The service user was added to the waiting list for care coordination if appropriate and signposted to other relevant services. Service users who had previously received care from the mental health team were not assessed by the specialist triage, assessment, referral and treatment team. These service users were referred back to the team and assessed by the duty worker, which included a full updated risk assessment. They were added to the waiting list for care coordination if necessary.

A different system was in place in Blackpool. All referrals were triaged by staff employed by the local acute trust and then discussed within a weekly referral meeting at the community mental health team. Referrals were then assessed face to face within four to six weeks where a full risk assessment was completed.

We examined 23 care records which all contained risk assessments. However; six had not been updated regularly or following significant incidents. For example, one service user's last risk assessment was dated October 2017 and two had not been updated since they had been an inpatient. This meant that vital information such as the need for staff to conduct home visits in pairs had not been included.

Staff did not use a recognised risk assessment tool. The tool had been developed by the trust. All risk assessments contained detailed information such as risk to self, risk to others, vulnerability and risk formulation which were all completed to a good standard. However, information in the risk management plans were below standard.

Risk management plans did not contain detailed information about how to manage each service users risks. Thirteen out of 23 care records had poor risk management plans. Plans were often generic statements that did not correlate to risks identified in the risk assessment or other documents. The records did not provide evidence or assurance that risks were being managed effectively.

When appropriate, staff created and make good use of crisis plans and advance decisions. All service users had crisis plans that contained telephone numbers of who to contact if their mental health deteriorates and other helpline telephone numbers from the voluntary sector. Three crisis plans were personalised and included a list of relapse triggers, indicators and coping strategies to use in a crisis. There was evidence of service users' preferences being considered within one crisis plan relating to avoiding admission and preferring home treatment.

Management of patient risk

It was difficult for staff to respond promptly to sudden deterioration in a patient's health in Blackpool and Preston. There were delays in accessing appropriate psychiatric appointments in urgent situations. Service users in Burnley and Pendle had timely access to urgent psychiatric appointments.

Service users requiring an inpatient admission at all locations experienced delays in accessing the appropriate level of care. Often service users requiring admission remained in the community for more than one week whilst a bed was being sourced. Staff reported joint working with the crisis team during this time. This meant increased home visits and giving priority to service users in crisis. There were seven service users in the Blackpool locality waiting for an inpatient bed on the day of our inspection. Managers confirmed waiting for an inpatient bed was a common theme at all locations. There were daily bed management meetings attended by senior managers to discuss risks and priorities.

Staff monitored patients on waiting lists to detect and respond to increases in level of risk. All service users were sent letters explaining they were on a waiting list and that they could contact the team any time if their needs deteriorate. A number was given for the duty worker. Service users were prioritised dependant on risks. The duty worker in each team made monthly telephone calls to service users on the waiting list. Where necessary service users were offered appointments with the duty worker or psychiatrist if appropriate. Blackpool had access to five staff employed by the third sector who could address any social needs, including substance misuse and domestic violence, with service users on the waiting list.

The service had developed good personal safety protocols, including lone working practices, and there was evidence that staff followed them. Staff had access to a lone worker policy. There was a staff board which showed if staff were out or in the building. Staff noted the time they should be due back and there was a nominated person to contact them if they were late. Staff described how the nominated person telephoned them if they were more than 15 minutes late. None of the locations noted any problems with lone working practices.

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.

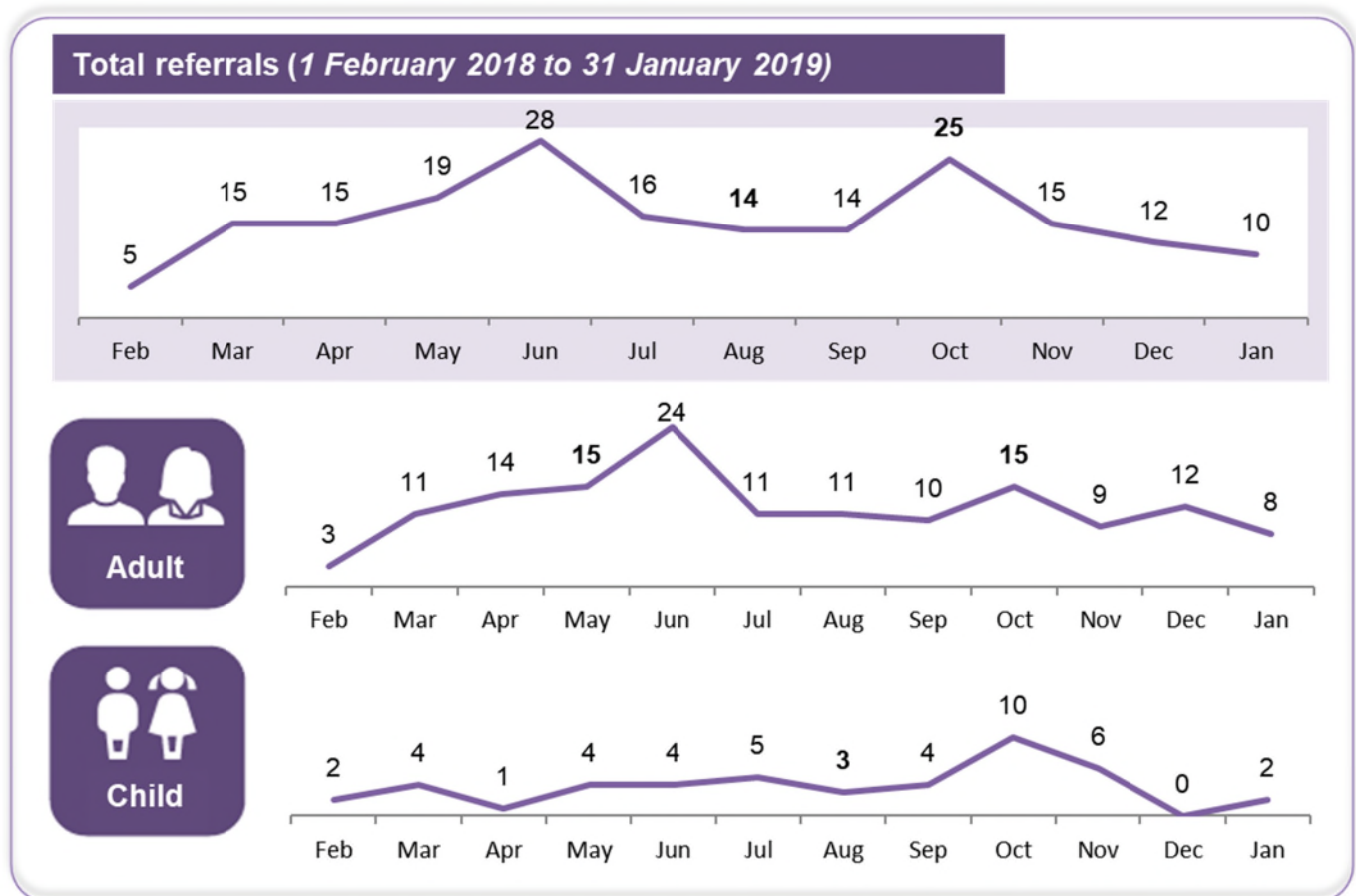
Each authority has their own guidelines as to how to investigate and progress a safeguarding referral. Generally, if a concern is raised regarding a child or vulnerable adult, the organisation will work to ensure the safety of the person and an assessment of the concerns will also be conducted to determine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

This core service made 188 safeguarding referrals between 1 February 2018 and 31 January 2019, of which 143 concerned adults and 45 children.

Core service	Number of referrals		
	Adults	Children	Total referrals
MH - Community based mental health services for adults of working age	143	45	188

The number of adult safeguarding referrals in month ranged from three to 28 (as shown below).

The number of child safeguarding referrals ranged from zero to 10 (as shown below).



Staff were trained in safeguarding, knew how to make a safeguarding alert, and did so when appropriate. Safeguarding adults and safeguarding children training was above the trusts target of 80% for all modules. Staff knew how to identify adults and children at risk of, or suffering, significant harm. Staff could give examples of making frequent safeguarding referrals regarding both adults and children and they described having close working relationships with local authority safeguarding staff. Staff had access to a safeguarding policy. There was a trust helpline for safeguarding advice and staff were familiar with making direct referrals to the local authority.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. Staff received regular equality and diversity training.

The trust has submitted details of three serious case reviews commenced or published in the last 12 months (8 February 2018 and 7 February 2019) that relate to this service.

Reference Number	Team/Ward/Unit	Recommendations	Actions Taken	Outstanding Actions
Adult F	Preston CMHT (also Criminal Justice Liaison – Central and Edisford Assessment Ward)	<p>1. Agencies working in silos with a lack of effective communication, lack of working with a whole family approach and lack of professional curiosity.</p> <p>2. Systems currently ineffective in recognising vulnerable adult status.</p> <p>3. Use of Interpreters and valid consent. When friends/ relatives are used as interpreters, it cannot be assumed that informed and valid consent is given by patients whose first language is not English.</p> <p>When agencies have safeguarding concerns an independent interpreter will always be used, preferably face to face.</p>	<p>1. Learning brief to be drafted and disseminated to agencies highlighting the learning and the importance of information sharing and timely record keeping.</p> <p>2. Audit via Local Authority County AMPH meeting to ensure AMHPs (LCFT and LCC) are confident in the use of LAS.</p> <p>3. All agencies to provide assurance they have policies and procedures in place that their practitioners are aware of and understand and are being used in practice. This action is currently within timescale and needs to be completed by March 2019.</p>	<p>1. Action complete</p> <p>2. Action complete</p> <p>3. One outstanding action but remains in timescale regarding assurance of policies in relation to use of interpreters.</p>
Adult D	CMHT Burnley (Also ATT - HTT - Burnley & Pendle and AMH.Mental Health Liaison Team (Pennine Lancs) (25-65))	The Lancashire Safeguarding Adults Board when considering work with partners to develop training and awareness resources relating to self-neglect (see consideration 2), should consider development of stand-alone best practice guidance for all professionals regarding hoarding, to include identification and assessment of the issue and pathways for action when hoarding is suspected.	LCFT to improve awareness of self-neglect. Awaiting guidance from LSAB. Self neglect is part of the Safeguarding Level 2 within the trust an online elearning package. The Self neglect and Hoarding framework to launch on the 20th March 2019. This information has been disseminated with in the safeguarding champions.	Action complete

Child N	CMHT Blackburn (25-65)	<p>1. LCFT needs to take appropriate measures to address the capacity issues in the service in order to minimise the risk that the care plans for individual service users (including the frequency of visits) are limited by staff pressures, rather than being determined by service user need.</p> <p>2. Actions from the CMHT's Complex Case Consultation Forum (CCCF) need to be configured as SMART goals and reviewed at an appropriate timescale by the relevant line manager via 1:1 supervision with the person responsible.</p> <p>3. Processes for distributing reports from the CCCF process to be reviewed to ensure that CCCF minutes are shared with all relevant parties.</p> <p>4. Consideration needs to be given to how to integrate CPA processes with other review processes for young people.</p>	<p>1. CMHT Managers to implement a recovery plan to address the staffing and capacity issues within the teams, so that staff are able to fulfil their roles efficiently and effectively, in response to service user need. The specific details of the recovery plan should be documented on LCFT's Risk Register. The risk should continue to be managed via LCFT's governance processes for such risks.</p> <p>2. CMHT Team manager to review processes around allocation and monitoring of actions with other CMHT staff responsible for this process, including CCCF chair and Team Leaders who line manage staff in the CMHT.</p> <p>3. CCCF minutes to be distributed to all professionals attending CCCF and the service user's GP as a matter of course.</p> <p>4. Direction to be sent out to CMHT staff to consider how to work to CPA processes in cases where Children's Services are involved, taking account of the need to involve other professionals and potentially utilising other existing meetings to support the CPA process.</p> <p>Same matter to be picked up in Team Business meeting.</p> <p>5.</p>	All actions complete
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Reference Number	Team/Ward/Unit	Recommendations	Actions Taken	Outstanding Actions
		<p>5. CMHT Care Coordinators need to ensure that timely CPA reviews take place, within set timescales, but also in response to changing need, and that these meetings take account of the requirement to support joint working across agencies.</p> <p>6. Processes in CMHT around update of risk assessment documentation to be tightened to ensure risk assessment reflects the current care and circumstances of service users, and to ensure that risk assessments are shared with other professionals involved in a young person's care.</p> <p>7. Improved liaison between Mental Health Services and local Children's Services, particularly on complex and contentious cases.</p>	<p>Direction on coordinating CPA with other review processes to include reminder of Care Coordinator's responsibility to organise reviews in response to changing circumstances, such as discharge from inpatient care.</p> <p>Same matter to be addressed in Team Business meeting.</p> <p>6. Team Manager to direct CMHT staff to update LCFT Risk documentation at 'seven day follow up' i.e. first contact with service user following discharge from inpatient psychiatric care, and to ensure that copies of all risk assessments are shared with other professionals involved in a young person's care.</p> <p>7. CMHT Managers to participate in transitions meeting convened by Children's Services, which will facilitate improved understanding of different professionals' roles and accesses to relevant pathways.</p>	

Staff access to essential information

All service user records were stored electronically and securely.

All information needed to deliver patient care was available to all relevant staff (including agency staff) when they needed it and in an accessible form. That included when service users moved between teams. The electronic record system was easy to navigate, and documents could be located. The system linked to a physical health dashboard that contained physical health information from the acute trust. There was also access to the GP electronic system.

However, the system often froze which caused delays in staff accessing or inputting information. A new electronic records system was due to be introduced imminently. Staff were hoping this would help standardise some documents.

Local authority social workers who had recently been removed from the teams back to the local authority, still care coordinated some service users as there was not enough trust staff to take over their care. This meant that social workers documented all records within the local authority electronic record system and not the trust's system. Social work staff had agreed to make entries into the trust's electronic record system if any significant events occurred. Staff were reliant on social work colleagues completing these entries to share information.

Medicines management

Staff reviewed regularly the effects of medication on service users' physical health for less complex service users. These reviews were in line with guidance from the National Institute for Health and Care Excellence. The clinical treatment team was assigned to checking the physical health and side effects of service users who were prescribed Clozaril, lithium or depot medications. The clinical treatment team held weekly clinics in each location. The team only reviewed service users who were less complex. Higher risk or need service users were prompted to attend GP practices for annual physical health checks. The trust did not collate figures for annual health checks conducted by GP's.

Track record on safety

Between 1 February 2018 and 31 January 2019 there were 21 serious incidents reported by this service. Of the total number of incidents reported, the most common type of incident was 'apparent / actual / suspected self-inflicted harm' with 17. There were no unexpected deaths.

We reviewed the serious incidents reported by the trust to the Strategic Executive Information System (STEIS) over the same reporting period. The number of the most severe incidents recorded by the trust incident reporting system was not comparable with STEIS with 18 reported. The reason given by the trust for the discrepancy was three incidents being added to the STEIS reporting system after the reporting period.

A 'never event' is classified as a wholly preventable serious incident that should not happen if the available preventative measures are in place. This service reported zero never events during this reporting period.

The number of serious incidents reported during this inspection was lower than the 35 reported at the last inspection.

Type of incident reported (SIRI)	Number of incidents reported			
	Apparent / actual / suspected self-inflicted harm	Other	Disruptive / aggressive / violent behaviour	Total
ATT Lancaster & Morecambe	3	0	0	3
ATT Chorley & South Ribble	2	0	1	3
ATT Blackburn & Darwen	2	0	0	2
CMHT Blackpool	2	0	0	2
ATT - START	2	0	0	2
CMHT Lancaster	1	0	0	1
CMHT Morecambe	0	0	1	1
Preston CMHT	1	0	0	1

Type of incident reported (SIRI)	Number of incidents reported			Total
	Apparent / actual / suspected self-inflicted harm	Other	Disruptive / aggressive / violent behaviour	
CMHT Pendle	0	0	1	1
CMHT Hyndburn & Rossendale	0	1	0	1
CMHT Hyndburn & Ribble Valley	1	0	0	1
ATT - START	1	0	0	1
CMHT Chorley & South Ribble	1	0	0	1
CLOSED AAT Preston	1	0	0	1
Total	17	1	3	21

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 three 'prevention of future death' reports sent to Lancashire Care NHS Foundation Trust. None of these related to this service.

All staff knew what incidents to report and how to report them. Staff were familiar with the electronic incident reporting system. Staff could give examples of incidents they had reported.

Staff reported all incidents that should be reported. Staff could give examples of what should be reported and individual examples of incidents they had reported.

Staff understood the duty of candour. They were open and transparent, and provided a full explanation to patients and families if and when something went wrong.

Staff received feedback from investigation of incidents both internal and external to the service. Staff confirmed they received lessons learnt information relating to their team, other trust teams and departments and from outside the organisation. Staff discussed the local authority incident briefing during monthly team meetings.

Staff met to discuss other specific feedback where appropriate. Where serious incidents had occurred, staff were de-briefed by senior staff and support was offered.

There was evidence of changes having been made in response to incidents. Staff gave examples of changes being made as a result of incidents such as the reconfiguration of the reception area in Preston.

Is the service effective?

Assessment of needs and planning of care

Staff completed a comprehensive mental health assessment of each service user. Information in mental health assessments was detailed and personalised.

Staff ensured that any necessary assessment of the service user's physical health had been undertaken and that they were aware of and recorded any physical health problems. There was a clinical treatment team who offered physical health checks to service users who attended for

regular depot medication or Clozaril or lithium monitoring. Staff had direct access to a physical health dashboard that displayed physical health information. There was also access to GP records. There was a plan to offer physical health checks to all secondary care mental health service users. However, this initiative was delayed due to lack of access to phlebotomy training. Most service users were prompted to attend for annual physical health checks provided by their GP practice. However, there was no system in place to check whether service users had attended.

Staff developed care plans that met the needs identified during assessment. Care plans were of a high standard. Care plans were personalised, holistic and recovery-oriented. Information included a range of needs such as social needs, physical health needs and mental health needs. Strengths and goals had been identified for the short and long term.

Staff updated care plans when necessary. Care plans had been updated regularly or when service users' needs change.

Best practice in treatment and care

Staff provided a range of care and treatment interventions suitable for the service user group. The interventions were those recommended by, and were delivered in line with National Institute for Health and Care Excellence guidance. These included medication and psychological therapies. Service users were prescribed mental health medication by their GP as recommended by the consultant psychiatrist. Psychological therapies available included:

- cognitive behavioural therapy
- dialectic behaviour therapy
- eye movement desensitisation and reprocessing therapy
- family therapy

There was group therapy specifically for service users diagnosed with schizophrenia or bipolar disorder. The locations we visited noted an eight to sixteen week wait for psychological therapy.

Care coordinators addressed issues relating to employment and occupation, housing and benefits, and they used interventions that enabled patients to acquire living skills. Each team had an occupational therapist who could assess and support service users with daily living skills, hobbies and employment. Staff were aware of local advocacy services that could support service users with housing and benefit issues. There was a community restart team in Preston that focused on the rehabilitation and social inclusion needs of low risk service users. This service was due to be decommissioned due to restructuring. A new service was being developed by the local authority. In Blackpool the team was complimented by an additional five staff employed by the third sector. These staff provided service users support with substance misuse, domestic abuse and social needs.

Supporting service users to live healthier lives was in its infancy. There were plans to introduce physical health clinics, however delays had occurred due to lack of access to specific training for staff. The plans were for the clinics to offer annual physical health checks, regular physical health observations, smoking cessation and wellbeing advice such as diet and exercise.

Staff did not use a recognised rating scale or other approach to rate severity and to monitor outcomes. Staff described previously using the Health of the Nation Outcome Scale but these had been discontinued.

Staff used technology to support service users effectively. The electronic record system linked to a physical health dashboard that contained physical health information from the acute trust. There

was also access to the GP electronic system. The meant that access to physical health information was easily available to staff.

This service participated in 12 clinical audits as part of their clinical audit programme 2018 - 2019.

Audit name	Audit scope	Audit type	Date completed	Key actions following the audit
Lone Working	AMH	Clinical	30/09/2018	All teams to have a code word and this is included in local induction and written on Team Information Board. A standardised process should be introduced across all community teams that staff should phone into base at an agreed time at lunch time and at the end of the day. Communication to managers requesting all staff receive updated conflict resolution training in line with policy
Non-Medical Prescribing*	TRUSTWIDE	Clinical	30/09/2018	Each network is currently working through an agreed action plan
POMH- Prescribing for bipolar disorder (use of sodium valproate) re-audit	AMH	Clinical	01/06/2018	The actions from the audit were discussed and accepted by the Drugs and Therapies committee. Individual performance has been uploaded to the trusts Consultant Dashboard to allow for individual reflection and discussion in appraisal.
POMH-The use of depot/long acting injectable (LAI) antipsychotic medication for relapse prevention	AMH	Clinical	30/01/2018	A total of three actions were identified following this audit. The EPR clinical forum are considering ways in which RiO may support generation of high quality care plans and identification of the rationale for initiating medication. In addition, there is a trust wide care planning audit due to commence in 2019/20.

Audit name	Audit scope	Audit type	Date completed	Key actions following the audit
Assessing risk to children in AMH	AMH	Clinical	30/04/2018	All service users open to LCFT Mental Health services including those with Minds Matter should have a SGA completed Evidence that the Routine Enquiry around domestic abuse is included in risk assessment (New RIO electronic system to include specific questions around this) Re audit the first part of the audit concerned with Safeguarding Assessment
EIS Use of Extended Assessment	CYP	Network-based, retrospective, baseline clinical audit against LCFT Standard Operating Procedure MR13, EIS Access and Waiting Time Standard – RTT for people experiencing or at risk of FEP.	Mar-19	Actions to focus on the earlier part of the patient pathway and systems for information sharing following decision making.
Emotionally Unstable Personality Disorder	AMH	Clinical	31/03/2018	Crisis care plans should be saved in appropriate section of ECR and should include clear rationale for medication. EUPD protocol to be updated. Audit methodology should be reviewed for re-audit

Audit name	Audit scope	Audit type	Date completed	Key actions following the audit
Risk Assessments	AMH	Clinical	30/09/2018	<p>The Occupational Therapy Professional Lead and Restrictive Practice Reduction Lead will propose at the Secure Services Senior Leadership meeting that training is developed in the completion of the Electronic Risk Assessment Tool. The Occupational Therapy Professional Lead will liaise with the FCMHT manager to understand why care plans are provided to patients instead of risk assessments. The question in relation to service user involvement should be reviewed whilst planning the re-audit. The tool should ask for the level of service user involvement. For example: copy of risk assessment given; regular conversations take place; patient declined and this is reflected in care plan. There is currently no risk assessment training programme. Action is required to ensure this is taken forward and a responsible lead identified.</p> <p>Feasibility of developing training package to be investigated and consideration given to face to face training and through training tracker on alternate years. This would include identifying staff groups this training would be appropriate for</p>
Lone Working	AMH	Clinical	30/09/2018	<p>All teams to have a code word and this is included in local induction and written on Team Information Board. A standardised process should be introduced across all community teams that staff should phone into base at an agreed time at lunch time and at the end of the day. Communication to managers requesting all staff receive updated conflict resolution training in line with policy</p>
Non-Medical Prescribing*	TRUSTWIDE	Clinical	30/09/2018	<p>Each network are currently working through an agreed action plan</p>

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EIS Use of Extended Assessment	CYP	Network-based, retrospective, baseline clinical audit against LCFT Standard Operating Procedure MR13, EIS Access and Waiting Time Standard – RTT for people experiencing or at risk of FEP.	Mar-19	Actions to focus on the earlier part of the patient pathway and systems for information sharing following decision making.

Staff participated in clinical audits such as the clinic room check, clinical records audits and hygiene audits. There was evidence of staff participating in quality improvement initiatives. The introduction of non-medical prescribers was developed following suggestions from staff.

Skilled staff to deliver care

The trust's target rate for appraisal compliance is 80%. At the end of last year (1 April 2017 and 31 March 2018), the overall appraisal rate for non-medical staff within this service was 76%. This year so far, the overall appraisal rates was 88% (as at 6 March 2019). The team with the lowest

appraisal rate at 6 March 2019 was 'PEIS Lancaster and Morecambe' with an appraisal rate of 50%.

The rate of appraisal compliance for non-medical staff reported during this inspection was higher than the 31% reported at the last inspection.

Team members included doctors, nurses, occupational therapists, clinical psychologists, pharmacists and support workers. Social workers were no longer integrated into the teams but could be accessed by informal discussion for advice or referral for direct social work input. There was a non-medical prescriber supporting the role of the doctors within the Burnley and Pendle teams. This model was due to be rolled out throughout the service. There were no assistant practitioners.

Staff were experienced and qualified for their roles. Staff had the right skills and knowledge to meet the needs of the service user group.

Managers provided new staff with an appropriate induction. Staff attended a trust induction and received an induction pack which included relevant policies.

Managers identified the learning needs of staff and provided them with opportunities to develop their skills and knowledge. Managers had identified that solution focussed therapy and further development of cognitive behavioural therapy skills would be useful for the service. Ideas for training and development were discussed during the monthly best practice meeting attended by managers.

Managers ensured that staff received the necessary specialist training for their roles. Three staff within the Burnley and Pendle teams attended specialist training relating to personality disorder. Professionals from other organisations were invited to attend team meetings and deliver training and information sessions. This had included perinatal training, substance misuse and domestic abuse training. As a core service 76 staff had attended formal perinatal training and six staff had attended psychological therapy training.

There were five staff who were subject to disciplinary action within the service. There were no staff who were receiving support for poor staff performance. Managers had access to a human resources department and had policies and procedures to follow regarding disciplinary procedures and performance management.

NOTE: only the teams who did not achieve the trust's target appraisal compliance rate of 80% have been included in the table below.

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 (as at 6 March 2019)	% appraisals (previous year 1 April 2017 – 31 March 2018)
ATT Fylde & Wyre	9	7	78%	0%
ATT - START - Hyndburn, Ross & Ribble Valley	4	3	75%	100%
EIS Central & West Lancs (MH)	16	11	69%	60%
CMHT Blackpool	25	17	68%	86%

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 (as at 6 March 2019)	% appraisals (previous year 1 April 2017 – 31 March 2018)
Primary Care Integrated Mental Health Team	6	4	67%	n/a
CMHT Blackburn	7	4	57%	67%
CMHT Darwen	7	4	57%	42%
ATT - START - Lancaster & Morecambe	7	4	57%	n/a
PEIS Lancaster & Morecambe (MH)	2	1	50%	50%
Core service total	435	384	88%	76%
Trust wide	5,530	4,739	86%	69%

The trust has not provided appraisal data for the medical staff in this core service.

The trust's target of clinical supervision for non-medical staff is 80% of the sessions required. Between 1 April 2018 and 11 March 2019, the average rate across all teams in this service was 33%.

The table below includes all the teams within this core service that are reported to be below the trust target.

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

Team name	Clinical supervision sessions required	Clinical supervision delivered	Clinical supervision rate (%)
CMHT Morecambe	144	108	75%
CMHT Pendle	105	58	55%
Community Living Skills Team	89	46	52%
Community Rehab Team Central	89	46	52%
CMHT Burnley	156	76	49%
Mental Health SRS Heysham Road	109	52	48%
Preston CMHT	147	70	48%
Fylde and Wyre CMHT	117	49	42%
Community Restart Preston	282	116	41%

Team name	Clinical supervision sessions required	Clinical supervision delivered	Clinical supervision rate (%)
Restart & Recovery The Orchard	150	60	40%
Willow Lane Mental Health Supported Accommodation	134	53	40%
CMHT Lancaster	117	45	38%
ATT - START - Greater Preston	74	28	38%
ATT - START - Chorley and South Ribble	64	22	34%
Wordsworth Terrace Mental Health Supported Accommodation	106	36	34%
CMHT Chorley & South Ribble	163	52	32%
CMHT Blackpool	300	92	31%
ATT Blackburn & Darwen	230	66	29%
Community Restart	323	88	27%
CMHT West Lancs	147	39	27%
RITT Blackpool Fylde & Wyre	327	86	26%
ATT - START - Hyndburn, Ross & Ribble Valley	46	12	26%
North Lancs Social Inclusion Service Wyre	12	3	25%
ATT - START - Burnley & Pendle	49	12	24%
Primary Care Integrated Mental Health Team	67	16	24%
CMHT Rossendale & Hyndburn	120	28	23%
North Lancs Social Inclusion Service Cedar	48	9	19%
CMHT Ribble Valley & Hyndburn	138	24	17%
ATT - START - Lancaster & Morecambe	35	6	17%
Community Rehab Team East	188	32	17%
Positive Lifestyle Team	62	10	16%
CMHT Darwen	135	21	16%
ATT Fylde & Wyre	89	12	13%
CMHT Blackburn	110	13	12%
Core service total	4,472	1,486	33%
Trust Total	31,039	9,569	31%

The trust has not provided clinical supervision data for medical staff.

Managers did not provide all staff with supervision of their work performance on a regular basis as the table above demonstrates. Supervision was delivered in sessions every four to six weeks that combined aspects of both managerial and clinical supervision. The percentage of staff that received regular supervision was 33% during the last 12 months. During the on-site inspection three out of four teams we visited were able to demonstrate that their supervision rates had improved and were above the trust target. However, in Blackpool supervision compliance remained low at 46%. This was partly attributed to staff sickness and absence. Other supervision was available that included weekly clinical discussion meetings, monthly group supervision and informal peer and manager supervision. The percentage of staff that had had an appraisal in the last 12 months was 88% as the table above demonstrates.

Multi-disciplinary and interagency team work

Staff held regular and effective multidisciplinary team meetings. Managers ensured that staff had access to regular team meetings. There were monthly team meetings in each location. Issues addressed were relevant and informative to the needs of staff. Information was shared relating to risk, performance and quality of the service.

Staff shared information about service users during supervision sessions with managers. There were weekly huddle meetings to discuss service users on the waiting lists and any changes to presentation and risk.

The community mental health teams had improving working relationships with other teams within the organisation. Staff worked jointly with members of the crisis team. Daily home visits were conducted by staff from the community mental health team and weekend or evening visits were conducted by the crisis team. Information relating to service users care was stored and shared on the electronic records system. Staff also gave verbal handovers. Managers attended inpatient meetings where information was shared relating to patients due to be discharged, out of area patients and barriers to discharge. This information was shared with relevant staff within the community teams. Staff were invited to attend ward meetings.

The community teams had links with primary care, social services, and other teams external to the organisation. Staff had access to GP records via the electronic record system. This supported information sharing relating to physical health. Relationships with GP's had been reported to be strained but improving. GP's had been frustrated regarding service users being discharged back to their care with no clear plan. This had been improved. Relationships with adult social care staff were good. Staff liaised with social workers and sought advice where necessary.

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

The trust's target for Mental Health Act training was all eligible staff to complete it once every three years. Over the last three years 78% of staff had received training in the Mental Health Act. This included training relating to Community Treatment Orders. Staff had a good understanding of the Mental health Act and requirements of Community Treatment Orders.

Staff had access to administrative support and legal advice on the implementation of the Mental Health Act and its Code of Practice. There was a Mental Health Act administrator available. Staff knew who their Mental Health Act administrators were.

The provider had relevant policies and procedures that reflected the most recent guidance. Staff had easy access to Mental Health Act policies and procedures and to the Code of Practice.

The Mental Health Act and Code of Practice was not always complied with. The Mental Health Act requires that a legal form is completed to show decisions regarding capacity and consent are recorded and kept with the medicine chart. This was to ensure that staff and service users knew that the medication was legally authorised when the medication was given. We found that this information was not stored with the medicine charts in Blackpool or Preston. We were not able to check the clinic room in the Burnley/Pendle location as it was in use during our onsite visit. However, this information was available within the electronic records system.

Staff explained to patients their rights under the Mental Health Act in a way that they could understand. However, rights were not always repeated as required. We examined seven care records of service users who were subject to Community Treatment Orders. Five records were completed well. However, staff had not re-attempted to explain Community Treatment Order rights to two service user who had declined their rights. There was evidence of service users being offered independent mental health advocates.

There was confusion regarding the frequency of when Community Treatment Order rights should be offered and explained to service users. The electronic recording system highlighted that Community Treatment Orders rights were due to be repeated on a monthly basis. This is not in line with the Mental Health Act Code of Practice. There was another monitoring system in place that was more effective. The Mental Health Act administrator conducted monthly audits to check on the status of Mental Health Act paperwork. The audit highlighted when rights were due, and this information was shared with managers and staff. There was a policy relating to Community Treatment Orders. The policy stated patients should have their rights explained to them on a six monthly basis.

Care plans referred to identified section 117 aftercare services to be provided for those who had been subject to section 3 or equivalent Part 3 powers authorising admission to hospital for treatment.

Good practice in applying the Mental Capacity Act

As of 6 March 2019, 95% of the workforce in this service had received training in the Mental Capacity Act Level 1 and 72% had received training in the Mental Capacity Act Level 2. The trust stated that this training was mandatory for all services for inpatient and all community staff and renewed three years.

Staff were trained in and had a good understanding of the Mental Capacity Act 2005, particularly the five statutory principles. Staff were able to identify the principles and give examples of when the Mental Capacity Act had been used.

The provider had a policy on the Mental Capacity Act. Staff were aware of the policy and had access to it. The policy was available to all staff on the trust intranet.

Staff knew where to get advice from within the trust regarding the Mental Capacity Act. Staff could get advice regarding the Mental Capacity Act from the Mental Health Act administrator. Staff also sought informal support from other clinicians such as psychiatrists and social workers.

Staff took all practical steps to enable service users to make their own decisions. We saw evidence of staff supporting service users to make informed decisions such as giving information in other formats.

Staff assessed and recorded capacity to consent appropriately. They did this on a decision-specific basis with regard to significant decisions. Staff described specific situations such as refusing medical treatment and how this was assessed and documented on each occasion.

When service users lacked capacity, staff made decisions in their best interests, recognising the importance of the person's wishes, feelings, culture and history. Staff had access to a capacity assessment template within the electronic recording system for guidance.

Is the service caring?

Kindness, privacy, dignity, respect, compassion and support

During this inspection we spoke to nine service users and five carers. We observed staff and service user interactions during home visits, psychiatry appointments and clinic sessions.

Staff attitudes and behaviours when interacting with service users showed that they were discreet, respectful and responsive, providing service users with help, emotional support and advice at the time they needed it.

Staff supported service users to understand and manage their care, treatment or condition. We observed staff discussing mental health symptoms and ways to manage these.

Staff directed service users to other services when appropriate and, if required, supported them to access those services. Staff were aware of third sector organisations that were appropriate for service users. Staff shared this information with service users and encouraged and supported their attendance if needed.

Service users said staff treated them well and behaved appropriately towards them. Service users spoke highly of staff that were supporting them. Service users described staff as helpful and respectful.

Staff understood the individual needs of service users, including their personal, cultural, social and religious needs. Staff were aware of the complex demographics of the local area and understood how to meet the specific needs of service users within their catchment area.

Staff said they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards service users without fear of the consequences. Staff said they were confident to speak to their manager in the first instance.

Staff maintained the confidentiality of information about service users. Staff were discrete when discussing service users or when speaking to service users in the community. Staff ensured all documentation was stored safely.

Involvement in care

Involvement of patients

Staff involved service users in the care planning and risk assessment process. Records demonstrated service user participation. Service users were offered a copy of their care plan and this was recorded. Care plans were written in the first person. Staff ensured service users agreed that care plans contained their perspective and that all other parties were included where necessary.

Staff communicated with service users so that they understood their care and treatment, including finding effective ways to communicate with service users with communication difficulties. Staff frequently used interpreters for service users whose first language was not English. Care plans were written in plain language. Care plans and other documents could be translated into other languages.

Staff involved service users when appropriate in decisions about the service. The Preston team had identified that care plans needed to be improved. Events were held to gain service user input relating to care plan improvements. These changes had been implemented.

Staff enabled service users, carers and families to give feedback on the service they received. Service users and families and carers had access to feedback via:

- friends and family test questionnaires
- feedback forms
- informal feedback to staff

The most recent friends and family test questionnaire gave positive results overall with 94% saying they were likely or extremely likely to recommend the service. The only team to score below 80% was Preston West which scored 72%. Issues raised in Preston West included lack of staff, waiting times, psychiatry provision and contact and communication problems.

Information was collated and fed into team meetings and senior manager meetings. Where necessary, changes were made and information was shared via a poster displayed in waiting areas.

Staff ensured that service users could access advocacy. Staff were aware of local advocacy services and referred service users when appropriate.

Involvement of families and carers

Staff informed and involved families and carers appropriately and provided them with support when needed. Information relating to families and carers was included in the care plan where necessary. Staff supported families and carers in their role and shared information where consent had been given by the service user.

The service had access to a carers organisation that they could be referred to. The carers organisation offered counselling, care plans and carers assessments. Staff regularly referred carers to this organisation.

Is the service responsive?

Access and waiting times

The trust has identified the below services in the table as measured on 'referral to initial assessment' and 'referral to treatment'. Referral to assessment and treatment targets were not available prior to the onsite inspection.

Name of hospital site or location	Name of Team	Days from referral to initial assessment		Days from referral to treatment	
		Target	Actual (median)	Target	Actual (median)
Lancaster & Morecambe	ATT - START - Lancaster & Morecambe	14 days	40	28 days	72
Blackburn with Darwen	CMHT Blackburn	14 days	30	28 days	55
Blackburn with Darwen	ATT - START - Blackburn with Darwen	14 days	19	28 days	44
East Lancs	CMHT Burnley	14 days	34	28 days	50

Name of hospital site or location	Name of Team	Days from referral to initial assessment		Days from referral to treatment	
		Target	Actual (median)	Target	Actual (median)
East Lancs	CMHT Rossendale & Hyndburn	14 days	0	28 days	-
Blackburn with Darwen	CMHT Ribble Valley & Hyndburn	14 days	27	28 days	110
East Lancs	ATT - START - Hyndburn, Ross & Ribble Valley	14 days	42	28 days	94
Fylde & Wyre	CMHT Fylde	14 days	31	28 days	57
Fylde & Wyre	CMHT Wyre	14 days	20	28 days	45
Fylde & Wyre	CMHT Blackpool	14 days	28	28 days	49
West Lancs	CMHT West Lancs	14 days	24	28 days	51
Central Lancs	EIS Central & West Lancs	14 days	27	28 days	34
Lancaster & Morecambe	EIS Fylde & North Lancs (MH)	14 days	24	28 days	31
East Lancs	EIS East Lancs	14 days	22	28 days	33
Lancaster	CMHT Lancaster	14 days	37	28 days	51
Morecambe	CMHT Morecambe	14 days	25	28 days	37
Burnley & Pendle	ATT START Burnley & Pendle	14 days	55	28 days	88
Not Known	EIS The Hub	14 days	12	28 days	17
Blackburn with Darwen	Darwen Community Restart Team	14 days	10	28 days	19
Central Lancs	Ribble Complex Care & Treatment Team	14 days	26	28 days	42
East Lancs	very Team	14 days	34	28 days	58
Central Lancs	Care & Treatment Team	14 days	32	28 days	51

The service had clear criteria for which service users would be offered a service. The criteria were included within the standard operating procedure document. The criteria did not exclude service users who needed treatment and would benefit from it, such as service users with dual diagnosis. The service had a waiting list and managers had a structured approach to prioritising risk and reviewing the waiting list. Service users given priority were:

- perinatal service users
- inpatients
- high risk service users
- veterans

Each service user was risk assessed and priority was classified as high, medium or low risk. Each service user received a letter that included the contact details of the duty worker. Service users were contacted monthly by telephone by the duty worker for an update on their presentation. If risks had increased service users were offered appointments with the duty worker and consideration given to offering a medication review if needed.

There were targets for time from referral to triage/assessment and from assessment to treatment. Assessments should be completed within two weeks and service users should be allocated to a care coordinator within four weeks. Each team (with the exception of Blackpool) had a dedicated

specialist triage, assessment, referral and treatment team who completed assessments of service users who had not been previously known to the service. Service users already known to the community mental health team did not need another assessment by the specialist triage, assessment, referral and treatment team and could be referred directly back to the community mental health team. We reviewed the waiting times for service users waiting for treatment in Preston which were:

- service users with high risks – two to three weeks
- service users with medium risk – four to six months
- service users with low risk – over six months

Other teams had variable waiting time figures. For example, in Burnley and Pendle teams the waiting times for a care coordinator were:

- service users with high risks – within five days
- service users with medium risk – two to seven weeks
- service users with low risk – two to three months

As a core service, the average days from referral to initial assessment varied from between 0 to 55 days. The average days from referral to treatment varied between 17-110 days overall.

Teams were not able to see urgent referrals within an acceptable timeframe. Urgent referrals were not assessed quickly and the wait for treatment was also long. The wait for treatment exceeded six months in some teams.

There were also lengthy waits to access psychiatrist appointments in some teams. The times service users were likely to wait for a routine medication review were as follows:

- Preston; four months
- Blackpool; three months
- Burnley and Pendle; two weeks

Service users requiring urgent psychiatrist appointments had the following waiting times:

- Preston; seven to 11 days
- Blackpool; seven days
- Burnley and Pendle; one to five days.

The Burnley and Pendle teams had a non-medical prescriber supporting the psychiatrists. The non-medical prescriber was able to offer appointments to service users with less complex needs.

Not all teams were able to respond promptly when service users telephoned the service. Team managers described poor administration support, telephone calls not being answered and messages from service users not reaching staff. A review of the administration provision and telephone system was underway.

The teams engaged with service users who found it difficult to or were reluctant to engage with mental health services. We observed staff using an assertive engagement approach with service users. Staff were able to offer intensive support to service users who required a high level of input.

The teams tried to make follow-up contact with service users who did not attend appointments. There was a protocol in place for staff to liaise with referrers if they did not attend for assessment

appointments. Staff responded to service users who did not attend dependant on the level of risk. Staff liaised with managers regarding decisions around service users who did not engage.

Where possible, staff offered service users flexibility in the times of appointments. Staff understood service users' needs and offered appointments at convenient times. We observed staff altering appointment times and dates to fit in with service users' prior engagements. Core working hours for the community mental health teams was nine to five, Monday to Friday. Staff working in early intervention in psychosis teams were available seven days a week from 8am to 8pm. Staff told us there was a flexible working hours scheme due to be piloted. It was hoped this would increase the community mental health teams' availability of staff during weekdays and Saturdays.

Staff cancelled appointments only when necessary and when they did, they explained why and helped service users to access treatment as soon as possible. Appointments were cancelled due to staff sickness and unplanned absence. Service users with high needs or risks received support from other members of the team or the duty worker. Other service users with low needs or risks did not receive ongoing support but were informed about the duty worker system should they require support. Appointments usually ran on time and service users were kept informed when they did not. Service users stated that staff were usually prompt and that they were informed of any significant delay.

The service had access to technology that was used to access physical health results. The electronic record system had a physical health dashboard that displayed physical health results such as blood tests results. The system also linked with the GP electronic records system. This meant that staff could quickly access up to date physical health information. However, the technology was not used to check whether service users had attended for an annual physical health checks.

Staff supported service users whilst they were also under the care of other services or departments. Staff remained closely involved whilst service users were receiving care from the crisis team or inpatient services. Staff increased visits to service users whilst the crisis team were involved. Staff attended inpatient meetings on a regular basis.

The service complied with transfer of care standards. Young people transferring from child and adolescent mental health services received input from both child and adolescent mental health service staff and community mental health team staff.

The facilities promote comfort, dignity and privacy

The service had a range of rooms and equipment to support treatment. There were sufficient clinic rooms to examine service users, therapy rooms and enough chairs in the waiting area. There was the appropriate equipment available to conduct physical health examinations. Interview rooms had adequate soundproofing.

Patients' engagement with the wider community

Staff ensured that service users had access to education and work opportunities. Staff were aware of options for service users to engage with activities relating to education, training and employment. Staff referred service users to these services where appropriate. There were other specific initiatives in place in some locations. In Blackpool, service users had access to staff who were employed by the third sector to deliver social support directly to service users. In Preston there was a community restart team dedicated to promoting social inclusion that included employment, education and training. This team had won awards from organisations such as the

Health and Social Care Advisory Service and The Nursing Times. However, this team was due to be decommissioned and replaced by a local authority service.

Staff supported service users to maintain contact with their families and carers. Staff were aware of the importance of developing and maintaining healthy relationships as part of the recovery model. Family and carer information was included within care plans where appropriate. Service users had access to family therapy sessions to support positive family dynamics.

Service users were encouraged to develop and maintain relationships with people that mattered to them, both within the services and the wider community. Positive relationships were promoted as part of the recovery pathway. Service users were introduced to appropriate support groups and organisations.

Meeting the needs of all people who use the service

The service made adjustments for disabled service users. Access to the premises had been designed or adapted to meet the needs of wheelchair users.

Staff ensured that service users could obtain information on treatments, local services and patients' rights. This was available in leaflet and poster format within reception areas. Staff also highlighted these services to service users when needed. Managers in the Burnley and Pendle teams were planning to collate a selection of information leaflets to give to service users during the assessment process.

The information provided was written in plain English. Easy read versions were available on request for service users with a learning disability.

Staff made information leaflets available in languages spoken by service users. There was a language translation service available so that leaflets and letters could be understood by service users.

Managers ensured that staff and service users had easy access to interpreters and signers. There was a translation service that staff and service users could access. Staff described using this frequently and that there were no delays accessing the service.

Complaints

NOTE: the following table lists only the teams and complaint themes which received more than 10 complaints during the 12-month reporting period.

Team name	Total Complaints	Communications	Access to treatment or drugs	Appointments including delays and cancellations	Admissions, discharges and transfers excluding delayed discharge due to absence of care package	Clinical Treatment	Other	Staff	Patient Care including Nutrition / Hydration
L1076 Preston CMHT	38	3	10	4	4	3	1	2	6
L7075 CMHT West Lancs	27	3	5	3	10	1	1	3	0
L5073 CMHT Blackpool	22	8	1	2	1	4	1	0	0
L3074 CMHT Blackburn	19	7	2	2	1	1	1	3	1
L4072 CMHT Burnley	18	7	0	0	1	3	2	2	1
L4076 CMHT Hyndburn & Ribble Valley	17	4	0	0	1	3	2	4	1
L3073 ATT Blackburn & Darwen	14	5	3	2	0	1	1	0	0
L9534 EIS ADHD (MH)	14	0	2	7	1	1	0	0	0
L4073 CMHT Pendle	11	3	0	2	2	0	2	1	0
L6073 ATT Chorley & South Ribble	10	1	0	2	4	0	1	0	0
L1087 Att - Start - Gp	10	1	3	2	2	0	1	0	1
Core service total	276	58	40	36	33	23	21	21	10

This service received 276 complaints between 1 February 2018 to 31 January 2019. No complaints were referred to the Ombudsman. Themes from complaints relate to problems arising from breakdown in communications, access to treatment or drugs and issues relating to

appointments being delayed or cancelled. Managers confirmed that these themes had been prevalent throughout the service. A letter explaining that treatment was being delayed was now sent to service users on the waiting list as a result of complaints. The letter included an explanation of the duty worker system and relevant telephone numbers. Managers were able to give examples of individual complaints and demonstrated that they had been resolved fairly. There was a complaints policy for staff to follow.

This service received 297 compliments during the last 12 months from 1 February 2018 to 31 January 2019, which accounted for 4% of all compliments received by the trust as a whole.

Is the service well led?

Leadership

Team managers were beginning to work effectively to improve the quality of the service. Service improvements were in their infancy and had not yet taken effect. Managers were aware of the failings within the service.

Leaders were visible in the service and approachable for patients and staff. All staff described team managers as very approachable and supportive in each team we visited.

Leadership development opportunities were available for managers. This included management development, appreciative leadership, sickness and supervision management, handling complaints and serious untoward incidents and performance management training.

Vision and strategy

Staff knew and understood the provider's vision and values and how they were applied in the work of their team. Staff described the appraisal process as making the trusts vision and values relevant to their work.

The provider's senior leadership team had successfully communicated the provider's vision and values to the frontline staff in this service. Visions and values were displayed on the team noticeboard and incorporated within staff appraisal documents. Individual and team-based values were due to be developed based on the trusts vision and values. These were to be developed with staff input.

Staff had the opportunity to contribute to discussions about the strategy for their service, especially where the service was changing. The service had recently received a review of the mental health care pathway. The review was conducted by another trust who was independent of the service. Staff views and opinions were sought throughout this process. The trust had acknowledged the outcome of the review and was in the process of implementing changes based on the results of the review.

Staff could explain how they were working to deliver good quality care within the budgets available. Staff described being aware of budget constraints, reductions in funding and restructuring within other services. Staff identified how this had affected their service. This included the removal of social workers from the team.

Culture

Staff felt respected, supported and valued. Morale had been improving throughout the service since staffing levels were being addressed. Staff described now feeling fulfilled within their roles. Staff survey results were not available separately for this core service.

Staff were feeling more positive and prouder about working for the provider and their team in recent months. Staff described experiencing difficult circumstances over the last 12 months that included, staff shortages caused by sickness, vacancy rates and the removal of social workers from the teams. However, new staff had been appointed and this had improved the working atmosphere.

Staff felt able to raise concerns without fear of retribution. Staff and managers said they could openly discuss concerns in a supportive environment. This included during supervision and team meetings. Staff felt they would be supported regarding any concerns they raised. Staff knew how to use the whistle-blowing process and about the role of the Speak Up Guardian.

Managers dealt with poor staff performance when needed. There had been no instance of poor staff performance over the last 12 months. Staff had policies and procedures to follow if required. There was a human resources department available to support the process.

Teams worked well together and where there were difficulties managers dealt with them appropriately. There were opportunities for team managers to meet and address any issues regarding pathway interactions and look for resolutions locally.

Staff appraisals included conversations about career development and how it could be supported. There was a focus on increasing staff skills within the appraisal process. Staff were encouraged to consider career development. Managers informed staff about options for further training opportunities.

Staff reported that the provider promoted equality and diversity in its day-to-day work and in providing opportunities for career progression. Staff received equality and diversity training as part of a mandatory training programme. There were equality and diversity policies and procedures to support equality.

The service's staff sickness and absence rates had been higher than the provider target. Managers had been addressing sickness and absence issues by considering staff wellbeing. Managers were aware of work-related stress that had been affecting sickness and staff turnover rates. Managers had shared wellbeing initiatives within management meetings. Wellbeing initiatives were being introduced throughout the service.

Staff had access to support for their own physical and emotional health needs through an occupational health service. Staff could be referred to an occupational health service if appropriate. Emotional health needs were being informally addressed by internal wellbeing initiatives.

The provider recognised staff success within the service. There was a staff awards scheme. A manager and care coordinator from the Burnley and Pendle teams had been nominated for awards in leadership and good practice. The Blackpool team had been nominated for the best frontline team award.

Governance

There was a failure to recognise and respond to failings within the service. Senior managers had not promptly addressed shortfalls regarding:

- poor staff supervision rates
- missing information within risk management plans
- low staffing levels

- lack of planning for the loss of social workers from the teams
- long waiting lists for access to assessments, care coordinators and psychiatrists
- compliance with the Mental Health Act for service users on Community Treatment Orders

The service had started to address some of these issues as a result of an independent review of the mental health care pathway.

There was a framework of what must be discussed at a ward, team or directorate level in team meetings to ensure that essential information, such as learning from incidents and complaints, was shared and discussed. This information fed into senior management team meetings. Senior management team meetings did not have a shared template. However, information regarding quality, performance and risk was included. Information relating to learning from incidents and complaints was also included.

Recommendations from reviews of deaths, incidents, complaints and safeguarding alerts had been implemented. Managers and staff described changes made as a result of lessons learnt. Information was shared during team meeting and senior management meetings.

Staff undertook or participated in clinical audits. The audits were sufficient to provide assurance and staff acted on the results when needed.

Staff understood arrangements for working with other teams, both within the provider and external, to meet the needs of the service users. Staff liaised and referred service users to other internal and external resources as required.

Management of risk, issues and performance

Staff maintained and had access to the risk register either at a team or directorate level and could escalate concerns when required from a team level. Teams had added the number of service users on the waiting list for a care coordinator to the risk register. Staff concerns matched those on the risk register.

The service had plans for emergencies. Teams had contingency plans for unexpected events. The Preston team had used their contingency plan recently due to a flood. The plan had worked well and some staff were temporarily relocated until repair work had taken place.

There was a focus on improving service user care. An independent review had recently identified areas of weakness in the service. The service had an emphasis on developing and implementing improvement plans. Service user care was taking priority over budget constraints.

Information management

The service used systems to collect data that was not over-burdensome for frontline staff. The service collated data relating to performance, quality and risk. This information was shared within the governance structure.

Staff had access to the equipment and information technology needed to do their work. The information technology infrastructure was sufficient to meet the needs of staff and service users. There were links to physical health records. However, the telephone system did not always meet service user's needs. Some teams had problems with telephone calls going unanswered and messages for staff not being responded to. A new message template had been introduced. A staffing review of the administrative department was underway.

Information governance systems included confidentiality of service users records. There was an electronic records system that ensured confidentiality of service user records.

Engagement

Service users and carers had opportunities to give feedback on the service they received in a manner that reflected their individual needs. Friends and family questionnaires had been conducted that gave positive overall feedback.

Recent staff meetings demonstrated that feedback from complaints, surveys, incidents, safeguarding and lessons learnt were shared with staff. Changes had been made as a result of this 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.

No accreditations have been awarded to this core service.

There was evidence of some improvements being made to the service. This was mainly in response to findings from a recent review of the mental health care pathway. Improvements included:

- extra nursing posts created to meet the demands of the service
- substance misuse link workers introduced in Blackpool to support joint working with the substance misuse provider
- wellbeing initiatives being rolled out to all teams to address low morale and improve staff sickness and turnover rates
- planning for physical health clinics to improve physical health and offer wellbeing services, dietary advice and smoking cessation
- non-medical prescriber clinics introduced in the Burnley and Pendle teams to allow psychiatrists to focus on more complex care.

Mental health crisis services and health-based places of safety

Facts and data about this service

Location site name	Team name	Number of clinics	Patient group (male, female, mixed)
Royal Preston Hospital	Mental Health Decisions Unit	N/A	Mixed
Royal Preston Hospital	ATT - HTT - Greater Preston	N/A	mixed
Sceptre Point	ATT - HTT - Chorley & South Ribble	N/A	mixed
Sceptre Point	Mental Health Access Line	N/A	Mixed
Chorley & South Ribble Hospital	Chorley- 136 Suite	0	Mixed
Ormskirk Hospital	Scarisbrick - 136 Suite	N/A	Mixed
Ormskirk Hospital	ATT - HTT - West Lancashire	N/A	mixed
Sceptre Point	Crisis Resolution Home Treatment Team Blackpool	N/A	mixed
Mental Health Decision Unit North, Blackpool Victoria Hospital	Mental Health Decision Unit	N/A	Mixed
The Harbour	Helpline	N/A	N/A
The Harbour	Harbour - 136 Suite	N/A	Mixed
Sceptre Point	ATT - HTT - Lancaster & Morecambe	N/A	mixed
Sceptre Point	ATT - HTT - Blackburn & Darwen	N/A	mixed
Sceptre Point	ATT - HTT - Burnley & Pendle	N/A	mixed
Sceptre Point	ATT - HTT - Hyndburn, Rossendale & RV	0	mixed
Royal Blackburn Hospital	Blackburn - 136 Suite	N/A	Mixed
Royal Blackburn Hospital	Towneley Unit CSU	N/A	mixed
Royal Preston Hospital (The Orchard from January 2019 to March 2019)	Preston Rigby 136 Suite	0	N/A
The Orchard	Orchard 136 Suite	0	N/A

The methodology of CQC provider information requests has changed, so some data from different time periods is not always comparable. We only compare data where information has been recorded consistently.

Is the service safe?

Safe and clean environment

Health based place of safety/Section 136 suites

The trust had eight suites across six sites and we visited them all. The physical environment of the health-based places of safety largely met the requirements of the Mental Health Act Code of Practice. However, the suite at Preston had a shower room that had evidence of mould growing and cracked tiles. This had not been addressed by the trust, since we had identified this at the last inspection. The ventilation for the room was poor, but if the door was left ajar, the area would be visible to a surveillance camera that pointed directly at the door. At the Harbour, the only shower room available was within the adjoining seclusion room, so if the seclusion room was in use patients in the 136 suite could not have a shower. In Chorley, a purpose built suite had a toilet and sink, but no shower facility, meaning patients had to walk to one of the inpatient wards if they required a shower. The nearest ward was an all female ward which presented difficulties if the patient in the 136 suite was male. The nearest male ward was a significant distance away.

In the Ormskirk 136 suite, the bedroom window had been fully frosted, so staff were unable to check the patient without opening the door. In practice, the bedroom door was left ajar at night so that staff could observe. In the suite in Blackburn, there was no separate lounge area or office, meaning staff were in the room when patients were trying to sleep.

Ligature risk assessments were completed annually. A ligature risk assessment identifies places to which patient's intent on self-harm might tie something to strangle themselves. Risks had been identified at Blackburn, Preston and The Harbour in 2018 and placed on the trust risk register. The issues at The Harbour had been addressed. Actions at Preston were on hold pending the outcome of an external review.

Staff regularly audited the suites to ensure they were safe.

Staff had the necessary equipment for patients to have physical observations.

Staff made sure cleaning was completed and the premises were clean.

Staff followed infection control guidelines, including handwashing. Personal protective equipment in the form of gloves and aprons was available for staff.

Staff made sure equipment was well maintained, clean and in working order.

All suites had CCTV installed. This was not used for observation or monitoring but could be accessed as part of the review process following incidents or for safeguarding purposes.

Home treatment teams

We visited five home treatment teams. Premises were generally safe, clean, well equipped, well furnished, well maintained and fit for purpose. However, in Ormskirk, there was a hole in the ceiling in the waiting area. The reception office floor was cracked. Ventilation in reception and in the interview rooms was poor. The trust had installed fans, but staff reported these were noisy and merely moved warm air around the rooms. Staff noted issues with soundproofing in three of the

available rooms, meaning that private conversations between staff and patients could be overheard.

All interview rooms used by the teams had alarms and staff available to respond.

Mental Health Decision Units

The trust had three decision units and we visited them all. These units were designed as short-term services where patients would be able to access support in a crisis. The trust's statement of purpose gives a maximum length of stay of 23 hours or less. However, we saw that routinely patients were staying overnight and often for periods of several days in these units.

The units had no bedrooms. Each has one or two lounges with recliner chairs. At night, patients slept in these chairs and were provided with blankets.

The decision units at Blackburn and Blackpool had recently been designated as single sex units, with the decision unit in Preston remaining a mixed sex environment. This is in breach of same sex accommodation guidance where service users in mixed sex accommodation are expected to have individual bedrooms or bed areas which are solely for one gender. Whilst there was a separate lounge for women and separate toilets, there was only one shower room. At the time of this inspection, the shower room was not clean, there was no toilet paper holder, there were used tissues on the toilet and the floor was wet.

Other than the lounges, decision units contained bathrooms, staff offices and an interview room. There was limited space for patients and staff.

Patients told us the chairs were uncomfortable and the units were noisy at times. They also referred to the fridges within the lounge areas as being noisy.

At the last inspection, a requirement notice was issued specifying that the trust must ensure that patients in the mental health decision units were comfortable, and have their privacy and dignity maintained. The only change at this inspection is that two of the units were now single sex, however patients were still sleeping in chairs in a confined shared living space for prolonged periods.

All three decision units had alarm systems, which staff used. At Blackpool, there were issues with the signals used by alarms and poor transmission within the hospital. Managers were exploring alternative options for these.

Ligature risk assessments were completed annually. All three decision units were listed as risks on the trust risk register with the Blackburn unit having been placed on the register in 2016, Blackpool in 2017 and Preston in 2018. Although the rating at Preston had reduced to the target, both Blackburn and Blackpool were still shown as requiring action to reduce risks.

Staff had the necessary equipment for patients to have physical observations.

Staff followed infection control guidelines, including handwashing. Personal protective equipment in the form of gloves and aprons was available for staff.

Staff made sure equipment was well maintained, clean and in working order.

Safe staffing

There were issues relating to staffing across this core service.

Nursing staff

136 suites

At the last inspection, the Harbour was the only unit with a dedicated staff team. We raised concerns that the staffing in 136 suites was usually staff taken from neighbouring wards, with an effect on the staffing levels of wards. The trust had taken action to create dedicated staff teams for most 136 suites and recruitment was ongoing across the trust to achieve this.

At this inspection, the 136 suite at Chorley was being staffed mainly by staff directly recruited for this, and with cover, particularly qualified nurse cover, provided at times from the adjacent ward. The 136 suites in Ormskirk and Lancaster were being staffed by staff from the adjacent wards, but managers told us they had been able to increase their staffing establishment to include this. In Preston and Blackburn, there had been recruitment to establish a staff team responsible for both the 136 suites and mental health decision unit. Staffing models had been derived from the model in use at the Harbour of experienced qualified nurses and support workers. However, at the Harbour, we found only one substantive qualified nurse in post from an establishment of six, with plans in progress to downgrade the qualified nurse posts. Most qualified nurse cover for the Harbour was being provided by bank nurses or from the adjacent wards.

All units were using regular bank and additional staffing to cover for vacancies. Managers told us they would try to use consistent staff.

Home Treatment Teams

Across the teams we visited, turnover rates were low. There was regular bank staffing required at all teams and there appeared to be several reasons for this.

Some bank usage was to cover vacancies, sickness and absence. In some teams, managers felt their establishment level had been set too low, so they were continually using additional staff to ensure the team could operate effectively. We also saw that several teams were continuing to see patients long after they were ready for discharge, most often due to long waiting lists for community mental health team transfer.

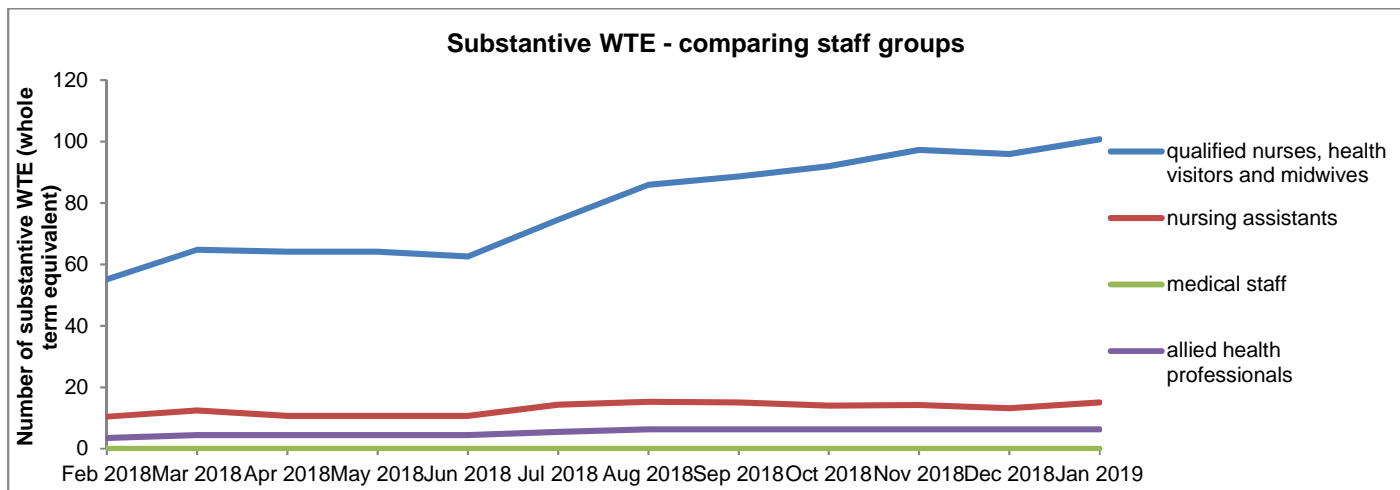
Mental Health Decision Units

The decision units in Blackburn and Preston were staffed by a team who also provided staff cover to the 136 suite. At times there were not enough staff on duty to provide this cover safely and staff used incident reports to highlight this.

In Blackpool, the decision unit was wholly staffed by staff from a partner organisation and was comprised of recovery workers and managers. Nurses from the liaison team would attend if a nurse was needed.

Nursing staff

The below chart shows the breakdown of staff in post WTE in this core service from 1 February 2018 to 31 January 2019.



Annual staffing metrics

Core service annual staffing metrics 1 February 2018 – 31 January 2019							
Staff group	Annual average establishment	Annual vacancy rate	Annual turnover rate	Annual sickness rate	Annual bank hours (% of available hours)	Annual agency hours (% of available hours)	Annual “unfilled” hours (% of available hours)
All staff	122	23%	3%	7%			
Qualified nurses	85.5	17%	3%	6.6%	23969 (14%)	99 (<1%)	817 (<1%)
Nursing assistants	14.9	34%	8%	15.3%	21433(59%)	204 (1%)	646 (2%)
Allied Health Professionals	7.5	25%	0%	1.3%			

The service had high rates of bank nurses.

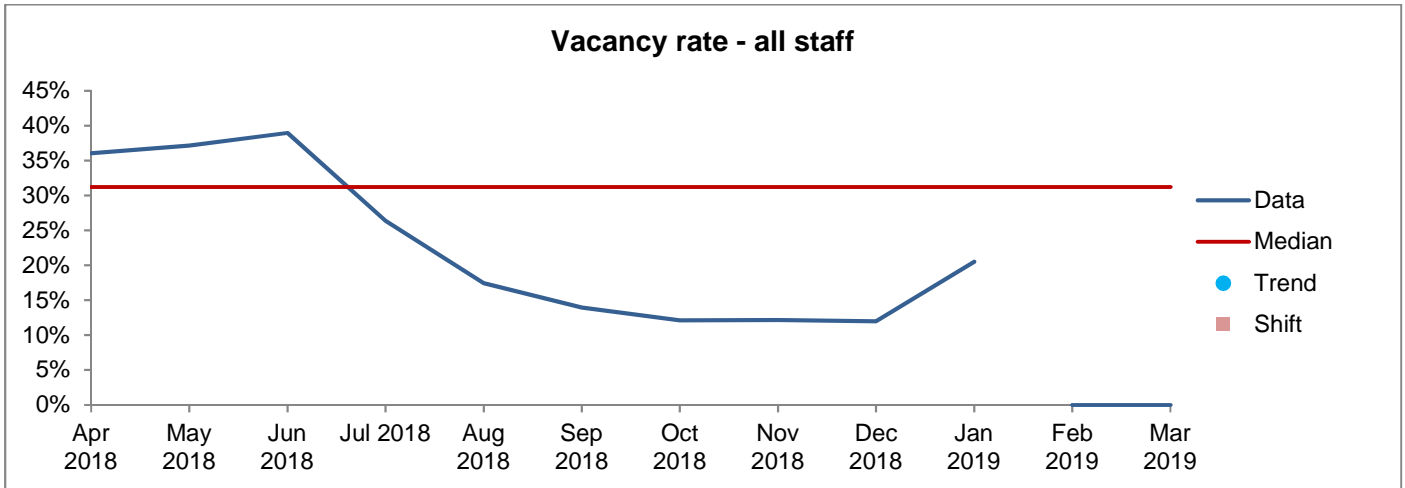
The service had high vacancy rates, although these were falling and staff were being recruited to cover the 136 suites and to increase staffing in home treatment teams. This is shown in the substantive staffing chart above.

Vacancy rates for all staff (23%) and nurses assistants (34%) were both in the upper quartile when compared to similar services within trusts between 1 February 2018 and 31 January 2019

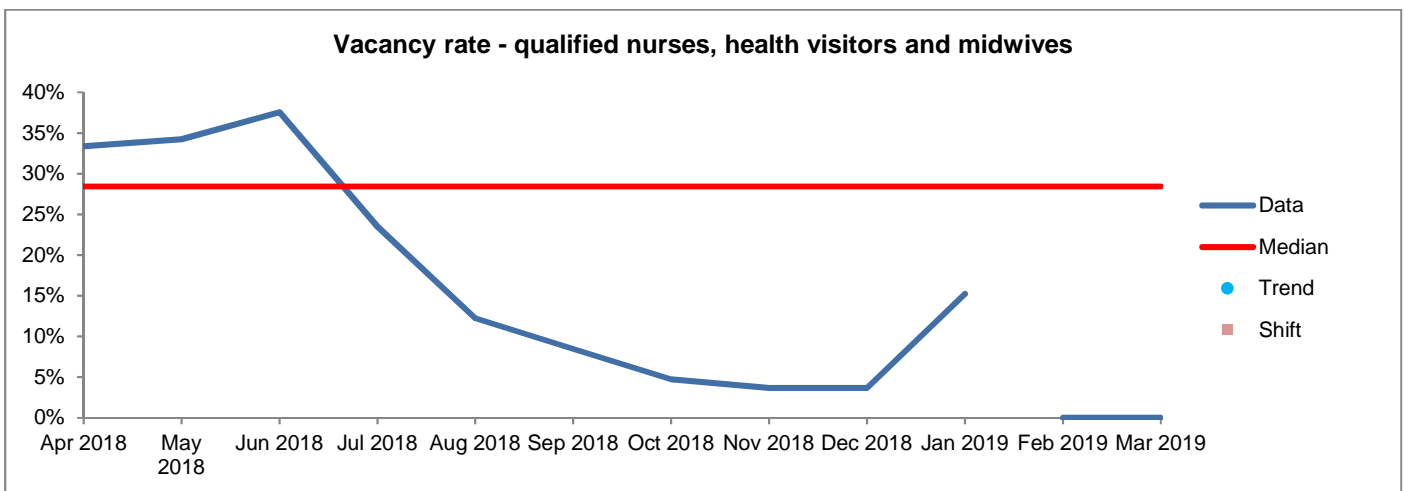
The service had low turnover rates.

Turnover rates were low over the same period were in the lower quartile for all staff (2%) and nurses (0%).

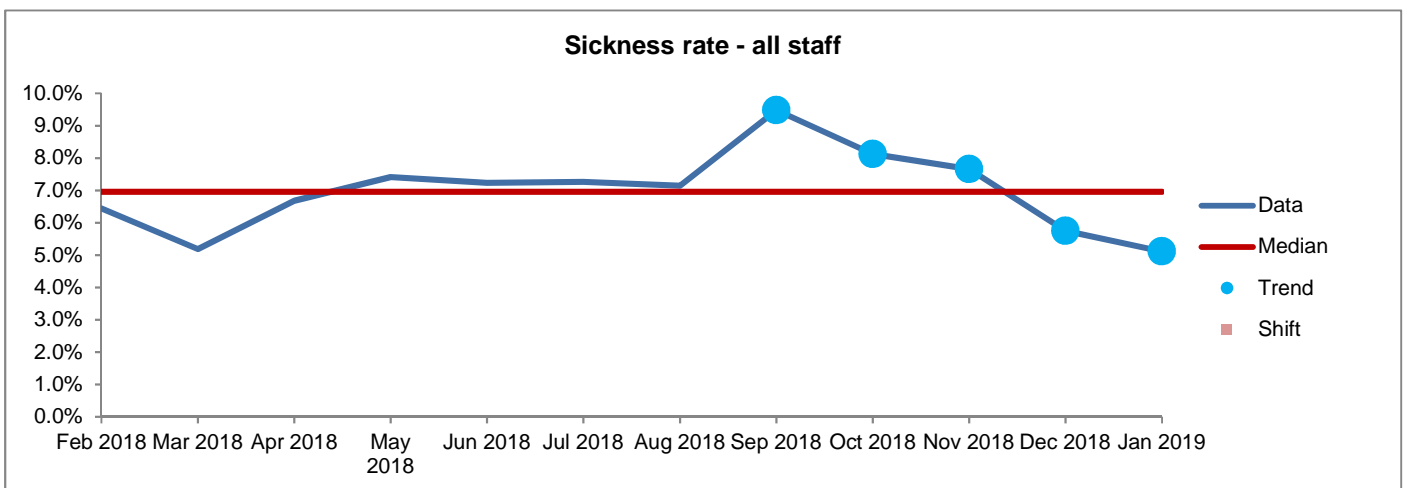
Sickness rates were in the upper quartile for nurses (6.6%) and nurses assistants (15.3%) when compared to similar trusts services nationally.



Monthly 'vacancy rates' over the last 12 months for all staff are not stable and may be subject to ongoing change.



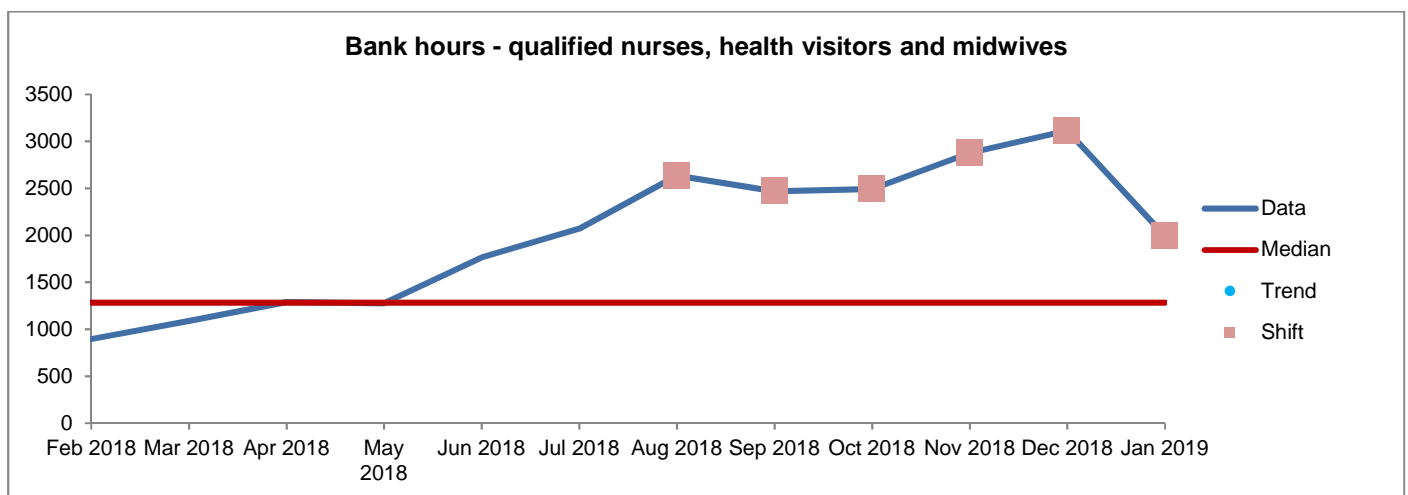
Monthly 'vacancy rates' over the last 12 months for qualified nurses, health visitors and midwives are not stable and may be subject to ongoing change.



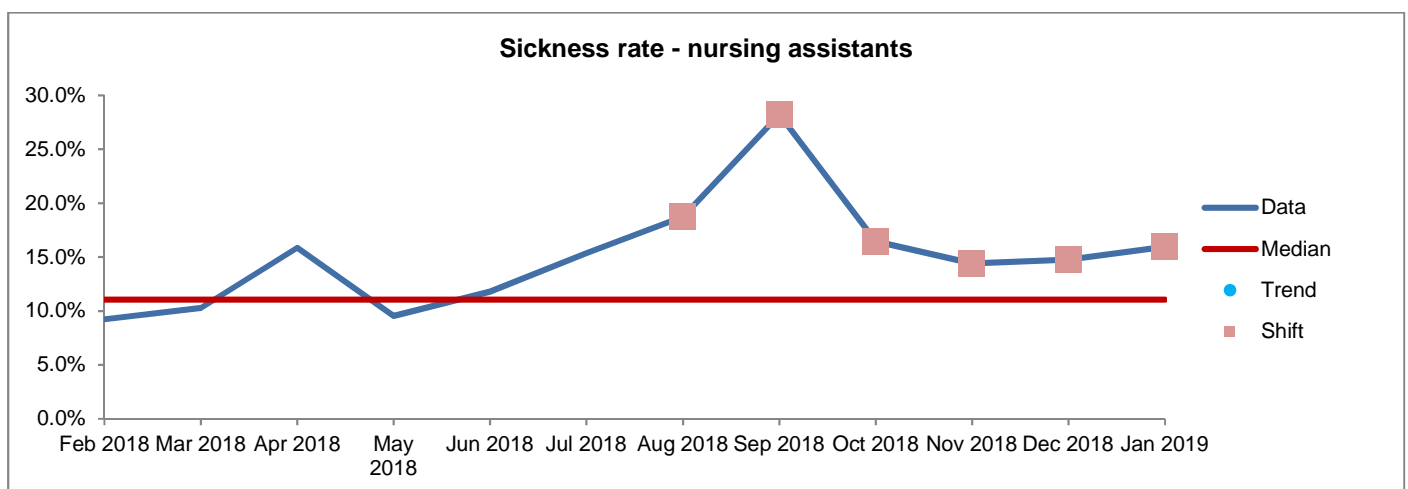
Monthly 'sickness rates' over the last 12 months for all staff shows a downward trend from September 2018 to January 2019. This could be an early indicator of improvement.

Managers supported staff that needed time off for ill health. We spoke to staff who felt highly supported by managers. Managers also used flexible arrangements well.

Sickness rates were reducing.



Monthly 'bank hours' over the last 12 months for qualified nurses, health visitors and midwives are not stable and may be subject to ongoing change.



Monthly 'sickness rates' over the last 12 months for nursing assistants shows a shift from August 2018 to January 2019. This could be an indicator of change.

Managers arranged to cover staff sickness and absence when possible.

Managers made sure all bank and agency staff had a full induction and understood the service before starting their shift.

Medical staff

The service had enough medical staff.

136 suites

Staff told us that medical staff were responsive to requests for assessments and that doctors were available in each location on a rota basis outside office hours.

Home Treatment Teams

The Blackburn team had medical staff available in the team 9-5 through the week. In Ormskirk the team share a doctor with another community team, they had two medical appointments available per day. In the Leyland team, there were two doctors, who worked flexibly Monday to Friday. In Preston, there were two doctors but at the time of inspection, one was off sick. The impact of this was that patients were not being seen within 5 days, this had been escalated to the trust. In Blackpool there were two doctors working in the team. At weekends all teams would contact the consultant on call.

Mental Health Decision Units

Staff in decision units had arrangements with other teams to access medical cover on a daily basis. The unit in Blackpool had two sessions a week consultant cover and additional cover from a staff grade doctor each day. The Blackburn unit had a doctor visit each day from a medical rota. The unit in Preston had a consultant psychiatrist who also worked with the liaison team.

There could sometimes be delays in arranging medical reviews for patients in decision units. On reviewing the incident data for decision units for the month of May 2019, sixteen patients at the Preston unit were delayed beyond the 23 hour timescale for discharge with 'delayed awaiting psychiatric assessment' given as the reason.

Mandatory training

The compliance for mandatory and statutory training courses at 6 March 2019 was 78%. Of the training courses listed seven failed to achieve the trust target and all of these also failed to score above 75%. The trust set a target of 80% for completion of mandatory and statutory training.

The trust reported that training compliance is monitored on a monthly basis.

The training compliance reported for this core service during this inspection was higher than the 89% reported for the previous year.

Key:

	Met trust target ✓	Not met trust target ✗	Higher ↑	No change →	Lower ↓
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Training Module	Number of eligible staff	Number of staff trained	YTD Compliance (%)	Trust Target Met	Compliance change when compared to previous year
Manual Handling L1A	4	4	100%	✓	↑
Safeguarding Adults L1	4	4	100%	✓	↑
Safeguarding Children L1	4	4	100%	✓	→
Immediate Life Support	1	1	100%	✓	↑
Safeguarding Children L2	35	33	94%	✓	↑
Equality & Diversity	165	154	93%	✓	↓
Fire Safety	165	152	92%	✓	→
Health & Safety	165	152	92%	✓	↓
Infection Control	161	144	89%	✓	↑
Mental Capacity Act L1	161	141	88%	✓	↑
Conflict Resolution	160	137	86%	✓	↓
Safeguarding Children L3	126	102	81%	✓	↓
Safeguarding Adults L2	161	128	80%	✓	↑
Manual Handling L1B	124	85	69%	✗	↑
Manual Handling L2A	37	25	68%	✗	↓
Basic Life Support	160	100	63%	✗	↓
WRAP	126	68	54%	✗	↑
Information Governance	165	89	54%	✗	↓
Mental Capacity Act L2	161	84	52%	✗	↓
Positive & Safe Programme	1	0	0%	✗	→
Total	2086	1607	77%	✗	↓

The mandatory training programme included conflict resolution training for staff working in the decision units and 136 suite. However there had been regular instances where staff had used restraint and staff had been reliant on a response team from adjoining wards to attend and assist.

Figures provided by the trust above indicate that only one nurse had required and received immediate life support training. There have been instances of restrictive interventions, particularly the use of restraint, in 136 suites and decision units and guidance indicates qualified nurses should be trained to immediate life support level if restrictive interventions are used. This was further compounded by figures showing just under two thirds of staff across this core service have completed basic life support training.

Managers monitored mandatory training and alerted staff when they needed to update their training.

Assessing and managing risk to patients and staff

Assessment of patient risk

136 suites / Home Treatment Team / Mental Health Decision Units

We reviewed 44 care and treatment records. Of these, 20 records were reviewed in the home treatment teams, 11 records were reviewed in mental health decision units and 13 records were reviewed in 136 suites.

Across all teams, staff completed a risk assessment for each patient when they were admitted and reviewed this regularly, including after any incidents. Most patients had in-depth and detailed formulations completed.

Staff used a trust developed risk assessment tool.

Staff could recognise when to develop and use crisis plans and advanced decisions according to patient need.

Management of patient risk

136 suites / Home Treatment Team / Mental Health Decision Units

Staff responded promptly to any sudden deterioration in a patient's health. We saw examples where staff had sought advice or treatment appropriately across all services.

Home Treatment Teams

Staff continually monitored patients on waiting lists for changes in their level of risk.

Home treatment teams were not providing effective gatekeeping. Home treatment teams accepted assessments completed by others for an admission bed to be sought. Patients awaiting beds in the community were on home treatment team caseloads and assessed on a daily basis. However this appeared to be generally a phone call with no reassessment of the need for an admission or whether more assertive home treatment was appropriate. Best practice guidance emphasises these daily reviews should be face to face, and these patients were likely to be at high risk of harm if needing inpatient admission.

Staff followed clear personal safety protocols, including for lone working, within all the teams we visited.

Safeguarding

Staff received training on how to recognise and report abuse, appropriate for their role.

Staff kept up to date with their safeguarding training.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them.

Staff knew how to make a safeguarding referral and who to inform if they had concerns.

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 one adult and no child safeguarding referrals between 1 February 2018 and 31 January 2019. The number of safeguarding referrals reported during this inspection was lower than the 11 reported at the last inspection for this core service.

Core service	Number of referrals		
	Adults	Children	Total referrals
MH - Mental health crisis services and health-based places of safety	1	0	1

During this inspection, we checked this figure and saw records where staff had raised safeguarding alerts, liaised with local authority safeguarding teams and assisted with safeguarding investigations.

The electronic records system has a specific section for safeguarding and staff used this.

The figure in the table above seems to have been derived from the trust's incident reporting system rather than the electronic patient records. The trust policy only indicates an incident report be completed if staff have directly witnessed a safeguarding incident.

The trust has submitted details of four serious case reviews commenced or published in the last 12 months (8 February 2018 and 7 February 2019) that relate to this service.

Managers took part in serious case reviews and made changes based on the outcomes.

Reference Number	Team/Ward/Unit	Recommendations	Actions Taken	Outstanding Actions
Adults MS	Crisis Resolution Home Treatment Team Blackpool (25-65)	1. Learning from the incident is shared with the Care Coordinator in relation to onward referrals, indepth questioning in relation to risk.	1. Supervision held with Care corodinator and learning shared across CMHT teams.	Action complete
Adults MS	Crisis Resolution Home Treatment Team Blackpool (25-65)	2. Medical staff to review the LCFT PIR for learning around CTO's.	2. Reflection on this review and share the learning.	Action complete
Adults MS	Crisis Resolution Home Treatment Team Blackpool (25-65)	3. A guidance checklist for staff should be created that will support the accepting community team to all risks, concerns, relevant history and 117 status.	3. LCFT Service Manager has communicated with the Blackpool Council Service manager and there is agreement that the Care Act assessment and CPA process addresses action 3 and that there is no longer a need to complete a transfer check list as this would be unnecessary duplication. However the AMH Network have devised a referral form that includes information about S117.	Action complete

Reference Number	Team/Ward/Unit	Recommendations	Actions Taken	Outstanding Actions
Adults MS	Crisis Resolution Home Treatment Team Blackpool (25-65)	4. That staff are encouraged to have a conversation with their local safeguarding team if a service user is expressing delusional beliefs about another person – particularly when there is a previous forensic history and there could be a risk of harm to that person.	4. Service Manager to inform Operational services when this has been completed, via email to all mental health teams highlighting the importance of having a conversation with the safeguarding team when supporting people who present in this way. Learning Brief highlighting and reiterating the learning completed and disseminated across network.	Action complete

Staff access to essential information

Staff working for the mental health crisis teams kept detailed records of patients' care and treatment. Records were clear, up-to-date and easily available to all staff providing care.

Patient notes were comprehensive and all staff could access them easily. The trust used an electronic records system. Where paper records were used, for example, section 136 paperwork, these were uploaded into the system promptly.

When patients transferred to a new team, there were no delays in staff accessing their records.

Records were stored securely.

Medicines management

136 suites

All 136 suites had stock medicines available. Staff generally followed systems and processes when safely prescribing, administering, recording and storing medicines. In the medicine cabinet at The Harbour 136 suite, we found out of date diazepam rectal tubes and a number of strips of tablets with no boxes or labelling. This included strips of metformin, diazepam and paracetamol. These were not being currently prescribed for the patients in the suite. When we highlighted this to staff, the tablets were immediately removed by the hospital pharmacist.

Decision making processes were in place to ensure people's behaviour was not controlled by excessive and inappropriate use of medicines. There had been no use of rapid tranquillisation in 136 suites.

Home Treatment Team

Staff generally followed systems and processes when safely prescribing, administering, recording and storing medicines.

Medical and nursing staff reviewed patient's medicines regularly and provided specific advice to patients and carers about their medicines.

Staff stored and managed all medicines and prescribing documents in line with the provider's policy. In home treatment teams, doctors prescribed medicines using standard prescriptions, which the patient took to their local pharmacy. In all teams, there was appropriate storage for medicines, but these were rarely used.

Decision making processes were in place to ensure people's behaviour was not controlled by excessive and inappropriate use of medicines.

Mental Health Decision Units

The standard operating procedure for these units was for patients to be able to self-medicate and be supported with this. Patients had a locker to store medicines in which staff kept keys for.

In certain circumstances, medication could be administered by qualified nurses. Staff at Blackburn and Preston highlighted that there were difficulties at times if patients needed medicines prescribing or dispensing. They explained that as the service was viewed as a community placement, there had been issues accessing the electronic prescribing system, which was for inpatients. It could also be difficult to undertake effective medicines reconciliation out of office hours.

There had been two controlled drugs errors in the last month, where patients' controlled drugs had been stored on adjacent wards and were then found to have been moved.

In Blackpool, there were no nurses working in the team so if patients were not able to self-medicate or needed medicines administering they would not be admitted.

Track record on safety

Between 1 February 2018 and 31 January 2019 there was eight serious incidents reported by this service. Of these, seven were 'Apparent/actual/suspected self-inflicted harm meeting SI criteria' and one was 'Disruptive/ aggressive/ violent behaviour meeting SI criteria'.

We reviewed the serious incidents reported by the trust to the Strategic Executive Information System (STEIS) over the same reporting period. The number of the most severe incidents recorded by the trust incident reporting system was comparable with STEIS with one reported.

A 'never event' is classified as a wholly preventable serious incident that should not happen if the available preventative measures are in place. This service reported zero never events during this reporting period.

The number of serious incidents reported during this inspection was lower than the 21 reported at the last inspection.

Type of incident reported (SIRI)	Apparent/actual/suspected self-inflicted harm meeting SI criteria	Disruptive/ aggressive/ violent behaviour meeting SI criteria	Total
ATT - HTT - Greater Preston	1		1
ATT - HTT - Burnley & Pendle	2		2
ATT - HTT Hyndburn, Rossendale & Ribble Valley	2		2
Crisis Resolution Home Team Blackpool (25-65)	1	1	2
ATT - HTT	1		1
Total	7	1	8

Reporting incidents and learning from when things go wrong

Staff did not recognise all incidents and report them appropriately. We reviewed incident data for May 2019 for all 136 suites. Staff should complete an incident report whenever a patient remains in the 136 suite past the detention expiry (i.e. after 24 hours). Incident reports were not completed for all patients who had remained in the suites. The Harbour had not reported all incidents on checking against the register completed on site. At Lancaster, an incident form was not completed when a patient had remained in the suite for five days.

Within the incidents of detention expiry, staff had used three different codes to record these under (136 breach, 136 used as a ward, lack of bed availability) and incidents were recorded against the hospital name or ward name.

Similarly, the standard operating procedure for decision units guides staff to complete an incident form if a patient remains in the unit longer than 23 hours. These were being completed by staff at the Preston decision unit, but not at the Blackburn or Blackpool sites. At Blackpool, the register on site contained details of eighteen patients who had been resident on the unit over 23 hours during the month of May 2019, but there were no corresponding incident reports.

Managers investigated incidents that were reported and shared lessons learned with the whole team and the wider service. Managers debriefed and supported staff after any serious incident and staff and managers were able to give examples of incidents and debriefs. Managers also gave examples of changes that had been made as a result of incidents and investigations.

Staff received feedback from investigation of incidents, both internal and external to the service.

Staff understood the duty of candour. They were open and transparent, and gave patients and families a full explanation if and when things went wrong.

The Chief Coroner's Office publishes the local coroners Reports to Prevent Future Deaths which all contain a summary of Schedule 5 recommendations 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 two 'prevention of future death' reports sent to Lancashire Care NHS Foundation Trust. One relates to the core service. A patient sadly died from morphine toxicity. The coroner did not find that the care of the patient contributed to her death but had concerns about the workload of crisis and home treatment team staff. The coroner stated that this raised the risk of future deaths. Lancashire Care NHS Foundation Trust was asked to respond by 24 June 2019, which was after the date of our inspection.

Is the service effective?

Assessment of needs and planning of care

We reviewed 44 care and treatment records. Of these, 20 records were reviewed in the home treatment teams, 11 records were reviewed in mental health decision units and 13 records were reviewed in 136 suites.

Staff completed a comprehensive mental health assessment of each patient within section 136 suites, home treatment teams and mental health decision units.

Staff made sure that patients had a full physical health assessment and knew about any physical health problems. Some staff working in 136 suites and decision units had completed training in venepuncture and undertaking electrocardiograms. Physical health assessments were completed when patients were initially assessed. In home treatment teams, it was expected that patients'

physical health needs were met primarily by the GP, but there was good evidence of liaison by medical and nursing staff in records. Some staff had training in venepuncture but this was rarely undertaken.

Staff developed a care plan for each patient that met their mental and physical health needs. There was some variation between home treatment teams, with some care plans basic and not personalised, and some patient centred, personalised, holistic and recovery orientated.

Staff regularly reviewed and updated care plans when patients' needs changed.

Best practice in treatment and care

136 suites

In 136 suites, patients were cared for by mental health staff. Staff used recognised outcome measures and scales when necessary, for example, alcohol and opiate withdrawal scales.

Home Treatment Teams

In the home treatment teams that we visited, staff provided a range of care and treatment suitable for the patients in the service. This included psychological interventions and practical support. The service did not use formal outcome measures although clustering tools were often used to determine treatment pathways. Some clinical scales for anxiety or depression were used by individual practitioners.

Doctors followed National Institute for Health and Care Excellence guidance in relation to medication choice, treatment and monitoring.

Home treatment teams were fulfilling some aspects of the CORE Fidelity model, for example all teams responded quickly to referrals and had set timescales for referrals. The home treatment team's role in terms of gatekeeping beds on acute mental health wards was unclear and ineffectual. Gatekeeping assessments were mostly made by telephone from other agencies and relied on checklists and leading questions, which generally led to admission as the only choice. The role of home treatment teams in admission prevention and facilitating early discharge were not happening, although the team in Blackpool had ambitious plans for the future and were functioning much more clearly as a home treatment team.

Home treatment teams were described as a 24 hours service. However standard hours for all teams were 9am – 9pm, with phone support available overnight from practitioners based in hubs. Several teams completed their last home visits by 7.30pm. In practice, if a patient wished to see a practitioner face to face in the evening or overnight, they would have to present in the emergency department.

Mental Health Decision Units

Mental health decision units were originally envisaged as placements that would provide short term crisis support. This has changed over time. The most recent operating procedure outlined ten separate pathways into the decision units including patients undertaking community clozapine initiation and support when having electro convulsive therapy treatment. Units could also be used as an alternative health-based place of safety for patients detained by the police under section 136 of the Mental Health Act and for patients with Mental Health Act recommendations in place waiting for a bed. Patients could be admitted as part of crisis plans developed by the community mental health teams. There was also a pathway as a step down from inpatient wards.

The decision unit at Blackpool was being run by a different organisation. Recovery workers had developed links with third sector organisations, housing representatives and local substance misuse services to offer practical support. Staff were also trained in delivering brief interventions, for example, anxiety management. There was one pathway for this unit via the mental health liaison team and it was able to more closely keep to a crisis model. However over 50% of admissions in May 2019 had been for patients awaiting inpatient beds.

Staff cited guidance from the National Institute of Health and Care Excellent (NICE) regarding the use of decision units as an alternative to admission for patients with personality disorder. However, at inspection we reviewed records showing patients re-attending the decision units frequently with little perceived clinical benefit and a number of patients in decision units and 136 suites with a primary diagnosis of personality disorder awaiting an inpatient admission.

The trust had developed a community based programme, the acute therapy service, which was a week long programme for people to attend who were at risk of admission, with sessions on emotional regulation, mindfulness, mentalising, occupational balance, problem solving and more. Patients were referred to the course and were automatically also assigned to the home treatment teams. There was positive feedback for this although patients in some parts of the trust struggled to access this due to transport and cost.

Because decision units were designated as community placements, staff described difficulties at all three units when patients' physical health deteriorated or when there was a medical emergency. Because all three units were based on hospital sites, local urgent and emergency care departments viewed them as wards. This meant that patients had had difficulties seeking treatment in the emergency department or urgent care and would be redirected back on occasion to mental health doctors.

This core service participated in no clinical audits in their clinical audit programme 2018 – 2019.

Skilled staff to deliver care

136 suites

Staff were being recruited into teams to work within the 136 suites. Newly employed staff that we spoke with described having received standard trust induction and then a service specific induction and experiential learning once they started work. The trust had told CQC as part of an in-depth 136 review in Blackpool that a specific 136 training day was held each month, but we did not meet any staff who spoke of attending this.

Newly recruited staff told us they felt well supported.

Home Treatment Teams

Home treatment teams that we visited had a range of professionals to meet patients' needs, including occupational therapists, social workers, clinical psychologists, registered nurses and support time recovery workers.

Managers made sure staff had the right skills, qualifications and experience to meet the needs of the patients in their care, including bank and agency staff. Staff in home treatment teams had been able to undertake additional training to improve their skills. Support time recovery workers had been supported to attend personality disorder skills training and spoke positively of the course. Some staff had undertaken additional training in domestic violence awareness and working with armed forces veterans.

Managers gave each new member of staff a full induction to the service before they started work.

Mental Health Decision Units

Mental health decision units were staffed by registered nurses and support workers in Blackburn and Preston. In Blackpool, staff were employed by a third sector employer. Staff within the decision units had access to additional training, including psychosocial interventions training.

A clinical psychologist visited the Preston decision unit for one day per week, with a focus on working with frequent attenders.

Managers gave each new member of staff a full induction to the service before they started work.

The trust's target rate for appraisal compliance is 80%. At the end of last year (1 April 2017 and 31 March 2018), the overall appraisal rate for non-medical staff within this service was 60%. This year so far, the overall appraisal rates was 76% (as at 6 March 2019).

The rate of appraisal compliance for non-medical staff reported during this inspection was higher than the 16% reported at the last inspection.

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 (as at 6 March 2019)	% appraisals (previous year April 2017 to March 2018)
351 L7F9 L6025 Chorley- 136 Suite	1	1	100%	n/a
351 L7F9 L3298 Towneley Unit CSU	2	2	100%	0%
351 L7F9 L5036 Crisis Resolution Home Treatment Team Blackpool	27	26	96%	81%
351 L7F9 L1089 ATT - HTT - Greater Preston	18	17	94%	76%
351 L7F9 L4082 ATT - HTT - Hyndburn, Rossendale & RV	18	16	89%	82%
351 L7F9 L7080 ATT - HTT - West Lancashire	7	6	86%	n/a
351 L7F9 L5090 Harbour - 136 Suite	7	6	86%	0%
351 L7F9 L6078 ATT - HTT - Chorley & South Ribble	17	13	76%	56%
351 L7F9 L4081 ATT - HTT - Burnley & Pendle	20	15	75%	100%
351 L7F9 L0379 ATT - HTT - Lancaster & Morecambe	14	8	57%	0%
351 L7F9 L1005 Mental Health Decisions Unit	21	12	57%	22%
351 L7F9 L7830 Mental Health Access Line	9	4	44%	60%
351 L7F9 L5050 Helpline	4	0	0%	50%
Core service total	165	126	76%	60%
Trust wide	5530	4739	86%	69%

The trust's target of clinical supervision for non-medical staff is 80% of the sessions required. Between 1 April 2018 and 11 March 2019 the average rate across all teams in this service was 13%.

The rate of clinical supervision reported during this inspection was higher than the 0% reported at the last inspection.

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

Team name	Clinical supervision sessions required	Clinical supervision delivered	Clinical supervision rate (%)
Towneley Unit CSU	27	5	19%
Harbour - 136 Suite	112	18	16%
Crisis Resolution Home Treatment Team Blackpool	290	40	14%
Crisis Support Unit Preston	119	14	12%
Mental Health Decisions Unit	119	14	12%
Mental Health Access Line	78	2	3%
Core service total	715	93	13%
Trust Total	31039	9569	31%

Overall levels of supervision within this core service were low. However, staff told us they approached managers and colleagues regularly for peer supervision or particular issues. In home treatment teams, daily meetings were used to discuss clinical cases and formulations.

Managers also told us of difficulties with the electronic supervision system. One manager outlined their team member's details having been lost to the system recently and these having to be added back on one by one.

Team meetings also varied in how often these were held, with some teams managing to co-ordinate these monthly. The format of these was around sharing of information, and in some teams guest speakers were booked to talk from external agencies. In home treatment teams, staff told us that team related information was also often shared within the daily meetings.

Staff told us that managers supported their training needs and gave them the time and opportunity to develop their skills and knowledge.

Managers' recognised poor performance could identify the reasons and dealt with these.

Multi-disciplinary and interagency team work

136 suites

Staff working in 136 suites described good working relationships within the organisation, including responses and reviews arranged with medical staff. Staff also felt working relationships with external teams and organisations were generally good. Relationships with the police were generally felt to be positive and trust staff understood their responsibilities in terms of the section 136 policy. Staff described effective working with approved mental health professionals and local authority duty teams.

Home Treatment Teams

Staff held regular multidisciplinary meetings to discuss patients and improve their care. All home treatment teams met on a daily basis to review referrals and discuss patients. Some teams held a longer once weekly meeting where medical staff attended. At the home treatment team in Blackpool there were two multidisciplinary meetings each day and medical staff attended these.

Staff made sure they shared clear information about patients and any changes in their care, including during transfer of care. Staff in several teams used at a glance boards where information about number of visits, planned reviews, risk rating and other necessary information was kept and updated regularly. The home treatment team in Leyland captured this information in a spreadsheet accessible to the whole team.

Staff had effective working relationships with other teams in the organisation. All teams we visited were based with other community teams. Staff told us this improved communication with other teams, including the START teams and community mental health teams. There was good practice evident in the Blackpool team, where staff from the mental health liaison team and the home treatment team were swapping teams as part of a planned programme to increase awareness of how other teams worked. Staff in the Leyland team had recently been involved in joint working with the learning disability team to ensure that admission and placement breakdown was avoided. Whilst there was evidence of good working relationships between teams, there were issues with the responsiveness of other teams when patients were ready to move on from home treatment, and in some teams, patients were waiting assessment and or allocation from other teams for long periods.

In some teams, staff described effective working relationships with external teams and organisations, including neighbouring trusts and local authority services. However staff in some teams noted poor working relationships with other organisations, citing time factors and other pressures as a barrier to effective working.

Mental Health Decision Units

Staff did not feel they had effective working relationships with external teams and organisations. Staff described feeling that other organisations did not understand the remit or function of the units and that pressures in other parts of the system, particularly in relation to inpatient beds, impacted on them. Additionally, staff described a lack of effective working with acute hospital trusts, where they were often viewed as an inpatient ward, as opposed to a community setting. This had resulted in them struggling to access treatment for physical health problems, as they would be told to access the psychiatric medical staff rather than attend urgent care services.

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

There were concerns at this inspection with the trust management of patients detained under section 136 of the Mental Health Act. The trust policy for section 136 did not reflect all relevant legislation and the Mental Health Act Code of Practice.

Section 136 is a police power under the Mental Health Act to detain and convey patients to a place of safety for a mental health assessment. Detention under the section is for 24 hours, which can be extended to 36 hours, to allow an assessment to take place. If further detention is needed under the Act following assessment, this should be put in place and the patient admitted to a suitable ward.

Whilst patients were assessed within the 24 hour period, when patients required admission to a psychiatric ward, this frequently could not be arranged within the timescale. Patients would remain in 136 suites or be transferred to mental health decision units whilst awaiting a bed.

Whilst on inspection, we reviewed the registers within 136 suites to understand how often patients “breached” the 24 hour timescale. We also asked for data following inspection from the trust about breaches reported through the incident reporting system and bed management records.

From registers, during May 2019, over half the patients admitted to the Harbour 136 suites remained there past the end of the detention periods (11 out of 21 patients). In Chorley, the figure was 75% of patients (9 out of 12).

Trust data derived from incident reporting shows 25 patients across the trust in May 2019 remained in 136 suites beyond the legal timescale. The data appears incomplete, as only five incidents of 136 breaches were reported in Chorley, against nine reviewed in the register for the same time period.

In four cases, data explicitly shows patients were agreeable to informal admission and waiting within the 136 suite. In at least four cases, patients had been assessed as requiring treatment under the Mental Health Act with medical recommendations completed for detention.

The trust had issued guidance to staff detailing actions to take when a patient remained past the section expiry. Staff told us they had been advised to complete a capacity assessment. If the person lacked capacity, a decision would be made under best interests and documented in the patient records.

The trust had devised leaflets for patients with the headings of “Your rights following the end of the section 136”. These were similar in format and size to the Mental Health Act rights leaflets provided to patients when formally detained. There was a version for formal admission and informal admission. The formal admission leaflet advised patients that either their care team have made a decision that they are to remain in hospital, because they lack capacity to agree to stay in the 136 suite or they have capacity and are not consenting to remain. The leaflet further advises there is no way to appeal this, noting, “Even if you do not agree ... you cannot appeal against the decision to keep you here. Due to the lack of a legal framework Lancashire Care NHS Foundation Trust recognise the need to provide you with the opportunity to seek your own legal counsel and have provided a list of mental health approved solicitors”.

Several staff told us they were uneasy with this approach and were not sure of the legality of detention continuing beyond the legal timescale, particularly for patients who did not want to stay.

At one 136 suite, we reviewed the records of a patient who had continued to stay in the 136 suite, despite wishing to leave. We were told by staff that the patient was “subject to section 2 recommendations”. Whilst this meant that two doctors had assessed the patient and completed forms for section 2, an approved mental health professional had not been able to complete the application, as there was no hospital or ward identified for detention. We were concerned that staff used this phrase as if there was some legal standing to it. The patient had requested to see a solicitor when we visited, when we checked with the trust following inspection whether this had happened we were told the patient had changed their mind. The patient eventually waited over a week for an inpatient bed to become available and an application made for detention under section 2 of the Mental Health Act was completed.

At Ormskirk and Lancaster, there had been occasions where the patient in the 136 suite, having been assessed as needing further detention under the Mental Health Act, had been admitted to the adjacent ward with the 136 suite used as a temporary bedroom. This practice, whilst not ideal in terms of using the place of safety as a bedroom, does ensure that the patient has rights to appeal and is lawfully detained.

On reviewing trust incident data for May 2019, it appears that there were five episodes of seclusion linked to 136 suites and seven episodes of restraint. Only one incident of seclusion appears to be whilst the patient was detained under section 136, the other episodes appear to be once formal detention had ended and in the context of waiting for an inpatient bed.

Mental health decision units were also used regularly for patients awaiting admission to hospital. We noted in the incident data that one patient at the end of May 2019 had been waiting for a bed whilst in the decision unit at Preston, with medical recommendations for section 2 completed. Another patient had had recommendations completed for section 2 whilst in the decision unit at Blackburn. When we asked staff how they would manage patients wanting to leave who were assessed as at increased risk in terms of suicide or violence they told us they would not prevent the patient from leaving but would ring 999 and explain the risk and whether the police could detain under section 136.

The trust provided Mental Health Act training data, which suggested that for this core service, 13% of eligible staff had attended the training this year reduced from last year when 21% of eligible staff had attended the training.

Staff had access to support and advice on implementing the Mental Health Act and its Code of Practice. The trust employed Mental Health Act administrators. Staff knew who their Mental Health Act administrators were and when to ask them for support.

Good practice in applying the Mental Capacity Act

As of 6 March 2019, 88% of the workforce in this service had received training in the Mental Capacity Act (Level One). The trust stated that this training is mandatory for all services for inpatient and all community staff and renewed every three years.

In this core service, we were concerned that the Mental Capacity Act was being relied upon to detain people under best interests, when appropriate assessment under the Mental Health Act had already taken place. Whilst in exceptional circumstances this may be warranted, this was happening routinely in this core service due to a lack of inpatient beds, to the extent that rights leaflets purporting to explain this had been developed and were being given to patients.

Capacity assessments in relation to continuing detention within section 136 suites and mental health decision units were being routinely documented. These were often completed by medical and nursing staff. We saw no records where advocates or solicitors had been involved, although there were some records evidencing discussions with family members.

We saw examples of confusing descriptions, for example, "Agreeable to remain on best interest and assessed as having capacity to do so" and a patient described as lacking capacity to make decisions about staying in hospital but agreeable to staying overnight.

There was a clear policy on the Mental Capacity Act, which staff could describe and knew how to access. This was available to staff on the trust intranet.

Staff knew where to get accurate advice on Mental Capacity Act. Staff contacted the MHA administrators for advice if needed.

Is the service caring?

Kindness, privacy, dignity, respect, compassion and support

During this inspection, we observed staff interactions within 136 suites, mental health decision units and home treatment teams. Staff were discreet, respectful, and responsive when caring for patients.

We spoke to patients during and after inspection. We spoke to eight patients about their experiences of home treatment teams, two carers of patients in home treatment teams and four patients in mental health decision units. We also spoke to two patients in 136 suites and offered to

speak to all patients we visited in 136 suites, but some declined. We also attended three home treatment team patient reviews (all three at different teams).

136 suites

Both patients that we spoke to were awaiting in-patient admission and had been in the suite past the expiry of the section 136 holding power. Patients told us they felt safe. They felt staff were helpful and supportive. They had been able to have family visit whilst they were in the suite.

Home treatment teams

Patients gave positive feedback for home treatment teams, particularly staff being helpful, respectful and caring. Patients said they could access medical support and had been able to arrange prompt prescribing reviews and medication advice. Some patients fed back positively about psychology support they had received. Two patients noted there were sometimes issues relating to consistency of staff and seeing different members of the team, although most patients felt they were seen by the same staff regularly. There was also some negative feedback from one patient who felt they were being moved from one service to another without receiving consistent support.

Staff gave patients help, emotional support and advice when they needed it. Patients spoke of being able to contact staff when they needed to and they felt involved and listened to.

Staff supported patients to understand and manage their own care treatment or condition. Patients told us they were given choices about medicines and treatments. They were involved in planning treatment that met their needs. Patients gave examples of information that they had been given and team bases contained resources and leaflets for patients about treatments and conditions.

Staff directed patients to other services and supported them to access those services if they needed help. Support time recovery workers were based in teams to support patients in accessing community services. Patients gave examples of information that they had been given and team bases contained resources and leaflets for patients about other services available locally.

Patients said staff treated them well and behaved kindly. Patients told us staff kept to appointment times.

Staff understood and respected the individual needs of each patient. Patients gave examples of when staff had respected their preferences and needs, setting individual recovery goals and targets.

Staff felt that they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients and staff.

Staff followed policy to keep patient information confidential. Some patients told us about information sharing arrangements they had in place regarding information given to carers or family members and this was respected.

Mental Health Decision units

All patients that we spoke to were waiting for an in-patient admission (three had been in the unit for several nights). Of these, two felt their care had been inconsistent and that plans kept changing, they were not clear what their current plan was. Two patients described brief medical reviews where they felt decisions had already been made about them. One patient fed back that they were unaware of any specific assessments taking place despite being told they had been admitted for further assessment.

Patients were dissatisfied with sleeping in chairs, difficulties obtaining bedding and nightwear and a lack of privacy (one patient described getting changed in the bathroom). Three patients commented negatively on food, including choice, availability and no snacks or food available away from mealtimes. Patients also commented about the noise, including from fridges and freezers located in the lounge where patients slept.

Staff were generally described as discreet, respectful, and responsive when caring for patients.

Staff directed patients to other services and supported them to access those services if they needed help. The staff at Blackpool had organised housing support for one patient. At Blackburn, one patient was receiving support from staff whilst awaiting a detoxification placement.

Involvement in care

Involvement of patients

136 suites

Patients told us they received information about their rights whilst in the suite.

In some suites, staff sought feedback. In the 136 suite at Chorley, there had been seven feedback forms collected, which included positive feedback on staff attitudes and consistency and being treated well.

Home treatment teams

In home treatment teams, staff involved patients and gave them access to their care plans.

Staff made sure patients understood their care and treatment (and found ways to communicate with patients who had communication difficulties). This included several cases we reviewed where interpreter services had been sought. We attended three patient reviews within home treatment teams. Patients and carers were actively involved in these and their views and wishes actively sought. Reviews were holistic and person centred. At one review in Leyland, staff were using pre-review forms to ensure that patients had the opportunity to record their feelings and wishes before the meeting. This was then used as the format of the meeting to ensure that all areas were covered. There was good evidence of multidisciplinary working at all three reviews. Crisis planning and risk management were also clearly discussed and recorded with patients.

Patients could give some feedback on the service and their treatment and staff supported them to do this. This was limited, and patients were given copies of the friends and family test when they were first seen, but completion of these across teams was felt to be poor.

Staff supported patients to make advanced decisions on their care. We saw that this was sometimes recorded in care plans and crisis plans.

Mental Health Decision units

Some patients described feeling unsure of their plan of care and not involved.

Where patients were admitted for crisis intervention, there were clear plans for their care and evidence of patient involvement in records we reviewed. However, due to bed pressures, decision units were often being used as a service where patients waited for a bed to become available on an inpatient unit.

At the decision unit in Blackpool, a feedback book was available, although it was not clear when feedback had been left as there were no dates. There were eight completed pieces of feedback in

the book, all of them positive, although one patient mentioned needing a bed to sleep on rather than a chair.

Staff did not make sure patients could access advocacy services. Patients told us they were not aware of advocacy services they could access.

Involvement of families and carers

Staff supported, informed and involved families or carers. This was evident in feedback from carers in home treatment teams and 136 suites. We did not see evidence of carer involvement in mental health decision units.

Opportunities for families to give feedback on the service were limited. There were no carers surveys in use.

Staff gave carers information on how to access a carer's assessment from the local authority. We saw evidence of this in home treatment teams from talking to carers and reviewing records. At Leyland, there had been work to improve carer engagement as part of the triangle of care scheme, and information to carers and carer involvement had improved when audited following this.

Is the service responsive?

Access and waiting times

The trust did not provide any data for referral to assessment and referral to treatment times for this core service.

136 suites

The service had clear criteria to describe how persons detained under s136 should be cared for. However as noted previously, patients were frequently remaining in 136 suites after their formal detention had ended. We reviewed figures in services and noted prolonged stays in all of the suites we visited. The longest stays waiting for a bed on an inpatient ward during May 2019 were at the Harbour, where one patient waited 12 days to transfer to a ward. Four patients had waited four days for a bed to be found in an inpatient service including one patient who required a psychiatric intensive care bed. In Chorley, one patient in May 2019 had waited four days, and three patients had waited for three days for a bed to be found.

This meant that all 136 suites across the trust were often occupied. When police detained a person using section 136 powers, they would contact the bed management hub to find where the nearest vacant suite was located. This could be many miles away from the patient's home area. Additionally, if there was no suite available, the police may end up using the local emergency department as a place of safety.

We also noted instances where patients were moved from a 136 suite to a mental health decision unit to await an informal bed. Whilst this freed up limited capacity in terms of 136 accommodation, patients may then face a wait of further days in a unit where they would be sleeping on a chair in a lounge.

Mental Health decision units

The service had clear criteria to describe which patients they would offer services to. A standard operating procedure had been approved for decision units in May 2019. As noted previously, this included up to ten different pathways for patients entering decision units.

Across all three units, we found at least 50% of patients awaiting admission to inpatient wards. Patients were waiting for prolonged periods of time in units that were not designed for this. The operating procedure described a recommended maximum stay of 23 hours within these units. We reviewed incident data and admission records for all three decision units.

In May 2019, there were 50 incidents reported, of which 29 related to delays. The procedure advises that staff complete an incident form for patients who remain on the decision unit after 23 hours. There were 26 incidents related to stays longer than 23 hours at the Preston unit, with only one stay over 23 hours recorded at Blackburn and none at Blackpool.

However, on reviewing the register at the Blackpool decision unit, in May 2019, there had been 18 patients who had stayed longer than 23 hours, out of a total number of admissions of 31 patients. This would be a 58% breach rate. Of these, one patient had stayed within the unit for 10 days, two patients for seven days, 2 patients for five days and 2 patients for four days.

Staff working within decision units described pressure to accept patients who were not suitable for the service or who were waiting for beds. They also felt within the trust and amongst other staff that the function of the units was not well understood.

The trust monitored patients waiting for inpatient beds via a bed management hub. Mental Health decision units and number of chairs available was recorded alongside inpatient and out of area placements available. Findings at this inspection suggest that the decision units have lost their focus as crisis support and were now used as admission lounges.

All of the patients that were resident in decision units when we visited during this inspection were awaiting inpatient admission.

Home treatment teams

The service had clear criteria to describe which patients they would offer services to. None of the teams had waiting lists.

The trust set and the service met the target times for seeing patients from referral to assessment and assessment to treatment. Patients were seen within set timescales depending on the urgency of the referral.

Staff saw urgent referrals quickly and non-urgent referrals within the trust target time.

The teams did not have staff available to assess patients immediately 24 hours a day seven days a week. All teams had staff available by phone overnight but there was no capacity for face to face assessments or home visits after 9pm. Several teams did no visits after 7.30pm.

The team responded quickly when patients called. We had mixed feedback regarding this from patients, with some noting they were called back quickly if they left a message and others saying they had to repeatedly ring to speak to staff.

The teams tried to engage with people who found it difficult, or were reluctant, to seek support from mental health services.

The team tried to contact people who did not attend appointments and offer support.

Patients had some flexibility and choice in the appointment times available. Appointments could be made for times that worked for patients. In some teams, there was flexibility to offer evening medical appointments. Medical staff in Blackpool would see patients at home. None of the teams had medical cover at the weekend.

Staff worked hard to avoid cancelling appointments and when they had to they gave patients clear explanations and offered new appointments as soon as possible. Patients told us appointments were rarely cancelled and if practitioners were running late they let patients know.

Appointments ran on time and staff informed patients when they did not.

The service used systems to help them support patients. All teams had either boards or spreadsheets to monitor patient risks. These included referrals and gatekeeping of patients in the community awaiting inpatient admission. Gatekeeping arrangements were not always made with a home treatment team assessment, and monitoring of these patients was often over the phone rather than face to face.

Staff supported patients when they were referred, transferred between services, or needed physical health care. Whilst this was positive, in two teams in particular the number of patients remaining on caseload whilst awaiting assessment or acceptance from community mental health teams was high. In Lancaster and Leyland there were patients waiting for up to 12 months for transfer, which affected the teams' abilities to work more proactively, for example, in seeing patients on wards to facilitate early discharge or admission avoidance work. Only one team was attending inpatient facilities regularly; the team in Blackpool were visiting the decision unit each day to discuss whether patients were suitable for discharge with home treatment. We saw admissions during May where patients had appropriately accessed the decision unit in crisis and had then been discharged with home treatment support.

In Blackpool, an approach called Psynergy had been piloted for six months, whereby a mobile team consisting of police, paramedics and mental health staff could attend to individuals out of hours presenting in crisis and provide immediate support. This was a joint approach between the trust and local ambulance and police services. Feedback for this was that there had been an impact on positive joint working, there was a reduction of barriers between services, development of closer linked working, education around each other's roles and that providing rapid response had reduced attendances at A&E and 136 usage. There had been positive feedback from the local acute trust as well as police and ambulance services. A recent presentation to board had been well received and further funding had been secured.

The facilities promote comfort, dignity and privacy

Section 136 suites

There were issues with the suites at The Harbour and Chorley in terms of access to shower facilities. This would not necessarily be an issue generally for patients detained for up to 24 hours under section 136, but patients in both locations had been detained routinely for days so access to washing facilities was an issue. At Ormskirk, the full screening of the panel for observation meant staff had to keep the door open for observation, particularly at night.

Mental Health decision units

We were concerned at the lack of privacy and poor environment of the decision units. These units were intended for short stay, under 23 hours, but were now routinely being used as additional wards. The accommodation was not designed for this and patients sleeping in reclining chairs in shared lounges for many days on end is highly undignified. At a time when there is a focus on eliminating dormitory accommodation within mental health care these units appear to have become dormitories and waiting lounges.

Aside from a lounge with reclining chairs, there were no private rooms. We were particularly struck by this when patients described getting dressed and changed in the bathrooms. Patients also told us there was no storage and staff told them they were responsible for their own possessions.

Patients told us arrangements for food were poor, choice of food was poor and meals were generally ready meals for re-heating. There were often no snacks available and whilst staff had ordered daily provisions as there would be for a ward, these were sometimes overlooked and not delivered, leaving the unit without supplies of bread and milk. Staff incident reported these and we saw one incident report from May 2019 noting, "patients have had no supper this evening due to having nothing to offer them".

Patients told us they were given blankets for bedding. There were no arrangements for linen and there was no access to pyjamas or toiletries for those admitted in an emergency. Staff at Blackpool had started to make up toiletry bags for patients.

Patients told us sleeping in the chairs was uncomfortable, they felt they were not safe or stable and liable to tipping up. In Blackpool, staff had acquired screens to place between chairs in an evening to try to offer some privacy.

Home treatment teams

The teams we visited had a full range of rooms and equipment to support treatment and care.

Interview rooms in the service had sound proofing to protect privacy and confidentiality, although the team in Ormskirk avoided using three interview rooms because of soundproofing issues.

Patients' engagement with the wider community

Staff supported patients with activities outside the service, such as work, education and family relationships.

Within home treatment teams staff made sure patients had access to opportunities for education and work, and supported patients.

Staff helped family and friends to visit when patients were staying in 136 suites. Patients in decision units were free to leave the units to see family or visit home.

Staff in all services encouraged patients to develop and maintain relationships both in the service and the wider community.

Meeting the needs of all people who use the service

The service met the needs of all patients – including those with a protected characteristic. Staff helped patients with communication, advocacy and cultural and spiritual support.

The service could support and make adjustments for people with disabilities, communication needs or other specific needs. We saw that there had been times when services had worked with patients with learning disabilities with support from specialists.

The service had a designated 136 suite at Preston specifically for children under 18. When a child was detained in the suite, staff from the child and adolescent mental health ward were expected to attend and support. In practice, the inpatient unit was a considerable distance away and from incident data there had been times when staff were not available from the inpatient unit to support. The trust were aware of this at the time of an earlier CQC section 136 review and had discussed possible changes in location for this suite, but no changes had been made at this inspection.

We were concerned that the criteria for the decision units included provision for 16 – 18 year olds, with the proviso that patients under 18 would require continuous observation for safeguarding. This practice of managing children in crisis alongside adults in the environments described is unsafe.

In the last 12 months data from the trust was that 13 children under 18 years old were admitted to mental health decision units, although three children are noted as multiple events so the figure is higher. Nine children stayed over 24 hours and four children stayed for two days.

Home treatment teams were working with patients from the age of 16 and this seemed to be working well.

Staff made sure patients could access information on their rights and how to complain. Within 136 suites patients' rights were discussed with them promptly. Patients in decision units understood their rights in relation to free movement. As noted previously, when patients were assessed as lacking capacity to consent to remain in hospital and recommendations were for detention under the Mental Health Act, staff used leaflets designed by the trust to explain their understanding of the legal position to patients.

The teams could access information in a variety of accessible formats so the patients could understand more easily. All services had access to information leaflets available in languages spoken by the patients and local community. Managers made sure staff and patients could get hold of interpreters or signers when needed and we saw records where this had happened.

Listening to and learning from concerns and complaints

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and wider service.

Patients we spoke with knew how to complain or raise concerns. Some patients told us they did not feel that making a complaint achieved any actions.

Staff understood the policy on complaints and knew how to handle them.

This service received 58 complaints between 1 February 2018 and 31 January 2019. The themes are set out in the table below.

Twenty of these complaints related to care in 136 suites or decision units. Themes from complaints in relation to both 136 suites and decision units relate to prolonged waits for admission, sleeping arrangements and use of chairs in decision units, unsafe discharge arrangements and unlawful detention. Several complaints were made by other agencies on behalf of patients or due to concerns about arrangements.

Actions in relation to complaints were often recorded as an apology being offered or expectations managed, but no evidence of investigation of systemic issues and wider changes.

Managers within these teams did not thoroughly investigate complaints and identify themes.

Complaints within home treatment teams included themes around staff members, wanting to change workers, lack of support whilst awaiting inpatient admission and issues around ringing teams and calls back.

There had been one complaint about transition from child and adolescent services.

Team name	Total Complaints	Communications	Access to treatment or drugs	Appointments including delays and cancellations	Admissions, discharges and transfers excluding delayed discharge due to absence of care package	Clinical Treatment	Consent to treatment	Other	Privacy, dignity and wellbeing	Staff	Waiting times	Facilities	Patient Care including Nutrition / Hydration
L6078 ATT -HTT Chorley & South Ribble	14	3	2	4		1	1		2	1			
L3298 Towneley Unit	9	1			2	3			1	2			
L4082 ATT - HTT Hyndburn, Rossendale & Ribble Valley	8		2	1				3		2			
L5036 Crisis Resolution Home Team Blackpool	5	2			3								
L5090 Harbour - 136 Suite	4				4								
L4081 ATT - HTT - Burnley & Pendle	4	1				1		1					1
L1089 ATT - HTT - Greater Preston	4		1		2				1				
L1005 Mental Health Decisions Unit	3				1					1		1	
L7080 ATT - HTT	2		1								1		
L7012 Mental Health Inpatients - Scarisbrick - 136 Suite	2			1				1					
Q0002 Burnley 136 Suite	1							1					
L5203 MHDU North	1		1										
L3076 Blackburn 136 Suite	1										1		

Team name													
	Total Complaints												
	Communications												
	Access to treatment or drugs												
	Appointments including delays and cancellations												
	Admissions, discharges and transfers excluding delayed discharge due to absence of care package												
	Clinical Treatment												
	Consent to treatment												
	Other												
	Privacy, dignity and wellbeing												
	Staff												
	Waiting times												
	Facilities												
	Patient Care including Nutrition / Hydration												
Core service total	58	7	7	6	12	5	1	6	4	6	2	1	1

This service received 1250 compliments during the last 12 months from 1 February 2018 and 31 January 2019, which accounted for 17% of all compliments received by the trust as a whole.

Home treatment team managers fed back compliments and thank you cards to staff within team meetings or via emails.

Is the service well led?

Leadership

Managers we met with understood the issues and challenges faced across the acute care pathway. They had been involved in recent reviews of service provision.

However; the issues within this core service relating to extreme pressures and demand for inpatient beds, coupled with delays in discharge from other services and teams, were felt to be entrenched and unresolvable at that level.

Staff told us there had been visits to their teams recently by senior leaders within the organisation.

Vision and Strategy

There was currently no higher level, longer term strategy to tackle the extreme levels of demand for inpatient admission beds across the trust. This, coupled with delays in discharge at all points within this core service, meant that none of the services were operating as they were intended to.

However, the trust was working on a strategy and plans with all relevant stakeholders, following an in-depth review of this care pathway. We saw that some actions were in progress, for example, the recruitment of dedicated staffing for section 136 suites.

Culture

Staff generally felt respected and supported, although some felt their work was not valued within the wider trust. They felt the service promoted equality and diversity, and provided opportunities for career development. They could raise concerns without fear.

Staff within the teams we visited felt supported and valued by their immediate managers and their colleagues. Many staff, particularly in decision units and home treatment teams, described feeling that there was little understanding of the function of their team/service and other pressures impacted on service delivery.

Some staff told us they felt positive about the changes at board level and that this already felt positive in terms of a focus on providing quality care.

Some staff felt concerned about a constant pattern of short-term changes within the trust. In home treatment teams, there were concerns that staff had not been consulted clearly about a move to full 24 hour working.

Governance

Leaders did not ensure there were structures, processes and systems of accountability for the performance of the service. Staff at all levels were not clear about their roles and accountabilities. They did have regular opportunities to meet, discuss and learn from the performance of the service, but these meetings and the overall governance within the service was not effective.

Management of risk, issues and performance

There was inadequate management of risk, issues and performance.

Section 136 suites

In terms of performance, the 136 suites were not operating as per the policy, and patients were frequently detained with no legal framework for their continued detention. The oversight of how often this was happening appeared to be piecemeal, with incomplete information captured from

incident forms and the bed management hub not always aware of patients arriving at 136 suites or remaining. Trust oversight of section 136 was via the multi-agency oversight group, which previously met quarterly.

The meetings were chaired by Lancashire Constabulary and the last recorded meeting on 22 November 2018 stated that the Chief Inspector (Mental Health lead - police) would meet with the Head of Operations (Mental Health network) to discuss the need for the locality meetings to be invigorated and for agencies to re-engage to ensure multi-agency working. The terms of reference required refreshing to ensure that all themes and issues were captured. The multi-agency oversight group had not met since November 2018.

We were told about a 'frequent attender's group which also met to look at reducing presentations to emergency departments and 136 suites by a small group of patients. There had been two meetings in February and March 2019, with poor attendance at both and little evidence of actions. It appeared the terms of reference of the group had not yet been agreed. This group would also reassess the multi-agency oversight group.

We were concerned that rather than try to address the issue of patients remaining restricted in 136 suites past the section expiry times, the trust had advised staff to use alternative legislation (the Mental Capacity Act) to continue detention. This had been discussed previously with CQC as used in exceptional circumstances, but it was clear during this inspection that this was now routine practice. Patients were detained with no legal framework for this detention and no right of appeal. The publication of rights leaflets underlines how routine this practice is.

Mental Health decision units

In terms of performance, the decision units were not operating as per the policy, and patients were frequently waiting within these units for days waiting for an inpatient bed to become available. It is telling that at this inspection, all patients resident within these units were awaiting inpatient beds. This had become such routine practice that chairs available were recorded within the bed management hubs. Managers told us they were told to admit patients, even if they felt they were not clinically appropriate or too high risk for the unit. We could see from incident reporting that there had been incidents of violence and aggression within these units, and episodes of self-harm that the units were not well equipped to deal with. Because the units were classed as community placements, there were difficulties in accessing other services or resources when needed, for example in relation to prescribing or urgent physical health care.

The trust had designated two of the units as single sex. We were told this was following sexual safety incidents. One unit remained as mixed sex provision. Regardless of this, the issue of having people sleeping together in a lounge as a crisis arrangement is risky and difficult to manage. We were also concerned about the admission of patients under 18 years old into these environments. There appeared to be no oversight of the safety or risks of these units or the lack of privacy and dignity they afforded.

Home treatment teams

Home treatment teams varied vastly in terms of performance and fidelity to the operating policy. Because of both the pressure for inpatient beds and the delays in discharge to other services, their ability to provide care traditionally associated with home treatment was compromised.

This included a lack of effective gatekeeping, where home treatment teams accepted assessment by others for an admission bed to be sought. Patients awaiting beds in the community were on home treatment team caseloads and assessed on a daily basis. However, this appeared to be

generally a phone call with no reassessment of the need for an admission or whether more assertive home treatment was appropriate. Best practice guidance emphasises these daily reviews should be face to face, and these patients were likely to be at high risk of harm if needing inpatient admission.

None of the teams we visited had any in reach role to their local admission wards to facilitate early discharge. They were reliant on inpatient staff informing them of discharge meetings and arrangements. There were also delays in discharging patients to other services. Two teams in particular had patients referred to community mental health teams who they were still seeing whilst they waited. Both teams had patients who had been waiting for up to 12 months when we visited. This created an unrealistic impression of what home treatment was and also ensured less capacity for new referrals into teams.

We were told of local governance arrangements in terms of home treatment managers' meetings and community teams meetings but these seemed to be largely ineffective in managing the issues facing the teams.

Information Management

The service did not collect reliable information to understand performance or to enable staff to make decisions and improvements.

We were not assured that the trust was collecting meaningful data to understand the scale of the issues apparent across this core service.

Key data from the trust incident reporting in relation to breaches of section 136 was not complete. We were not assured that the bed management records were accurate. Similarly, the scale of breach of the 23 hour timescale in mental health decision units was not being captured. There had been no breaches reported from the Blackpool unit, and the only incident data had been completed by the liaison team. We were not assured that this unit could access or was using the trust system.

Engagement

The service did not engage well with patients, staff, equality groups, the public and local organisations to plan and manage appropriate services.

There were not effective, multi-agency arrangements to agree and monitor the governance of the mental health crisis service and the health-based places of safety. Managers of the service did not work actively with partner agencies (including the police, ambulance service, primary care and local acute medical services) to ensure that people in the area received help when they experienced a mental health crisis; regardless of the setting.

As noted above, we saw some evidence of effective local partnership working. However, the trust oversight had previously been via a multidisciplinary group, which was largely ineffective, poorly attended and was now not happening at all.

Learning, continuous improvement and innovation

The synergy approach being piloted in Blackpool was an example of creative multiagency innovation to meet patients' needs within the trust.

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.

There were no accreditations for this core service.