Lancashire Care NHS Foundation Trust

Quality Report

Sceptre Point,
Sceptre Way,
Walton Summit,
Preston
Lancashire
PR5 6AW
Tel:01772 695300
Website:www.lancashirecare.nhs.uk

Date of inspection visit: 12-16 September 2016
Date of publication: 11/01/2017

Core services inspected	CQC registered location	CQC location ID
Acute wards for adults of working age and psychiatric intensive care units	The Harbour Burnley General Hospital Royal Blackburn Hospital The Orchard Ormskirk Hospital	RW5Z3 RW5CA RW5X1 RW5Z2 RW5FA
Forensic inpatient/secure wards	Guild Lodge	RW5ED
Child and adolescent inpatient wards	Royal Preston Hospital The Junction	RW5 RW5X7
Specialised community mental health services for children and young people	Sceptre Point	RW5HQ
Wards for older people	The Harbour Burnley General Hospital	RW5Z3 RW5CA
Community mental health services for working age adults	Sceptre Point	RW5HQ
Crisis and health-based places of safety	Sceptre Point The Harbour The Orchard The Scarisbrick Centre Royal Blackburn Hospital Burnley General Hospital	RW5HQ RW5Z3 RW5Z2 RW5FA RW5X1 RW5CA

Summary of findings

Community mental health services for older people	Lytham Hospital Sceptre Point	RW5GD RW5HQ
Community mental health services for people with a learning disability and/or autism	Sceptre Point	RW5HQ
Community health services for adults	Sceptre Point	RW5HQ
Community health services for children and young people	Sceptre Point	RW5HQ
Community health services inpatient care	Longridge Community Hospital	RW5AQ
Community sexual health services	Sceptre Point	RW5HQ

This report describes our judgement of the quality of care at this provider. It is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from people who use services, the public and other organisations.

Summary of findings

Ratings

We are introducing ratings as an important element of our new approach to inspection and regulation. Our ratings will always be based on a combination of what we find at inspection, what people tell us, our Intelligent Monitoring data and local information from the provider and other organisations. We will award them on a four-point scale: outstanding; good; requires improvement; or inadequate.

Overall rating for services at this Provider	Good
Are services safe?	Requires improvement
Are services effective?	Good
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Good

Mental Health Act responsibilities and Mental Capacity Act/Deprivation of Liberty Safeguards
We include our assessment of the provider's compliance with the Mental Health Act and Mental Capacity Act in our overall inspection of the core service.

We do not give a rating for Mental Health Act or Mental Capacity Act; however, we do use our findings to determine the overall rating for the service.

Further information about findings in relation to the Mental Health Act and Mental Capacity Act can be found later in this report.

Summary of findings

Contents

Summary of findings

Overall summary

We rated the trust as 'good' overall because:

- eleven of the thirteen core services we inspected were rated as good overall
- staff treated patients with respect, care and compassion
- staff communicated with patients in a way that was appropriate to patients' individual needs
- patients told us that staff treated them well and were responsive to their needs
- patients had been involved in service development
- despite the staffing challenges the trust faced, there was evidence to demonstrate that services were committed to minimising the impact this had on patient care
- staff completed timely and comprehensive assessments for all patients including risk and physical health needs
- the board had strategic oversight of potential risks which could impact on their ability to deliver services and had actions in place to mitigate these
- the trust had a dedicated team to investigate serious incidents, all of whom had additional qualifications in root cause analysis.
- staff were knowledgeable about their responsibilities in relation to reporting safeguarding concerns including to external agencies
- most care plans were of good quality with evidence of patient involvement
- services were being delivered in line with national guidance and best practice
- the trust was compliant with the workforce race equality standard and was acting to understand and close the gap between treatment of white staff and those from Black and minority ethnic backgrounds
- staff built and maintained good working relationships with agencies and stakeholders external to the trust
- the trust had established systems in place to support the administration and governance of the Mental Health Act and Mental Capacity Act.
- the trust's strategy had been developed with the population's specific health needs in mind
- the trust had a dedicated equality and diversity lead to ensure the protected characteristics of the population were considered
- the trust had identified that some wards did not meet the needs of the patient groups and had plans in place to move these to more appropriate buildings
- arrangements for children and young people transitioning to adult mental health services had improved since our last inspection
- the trust had a clear vision, supported by six values. The trust's strategy was embedded across the four clinical networks
- the trust's board and council of governors understood their responsibilities. There was a clear framework by which the trust was held accountable for its actions
- each clinical network had a clear, effective governance structure 'from board to ward'
- the trust had a number of established methods to promote engagement and communication with staff.

However:

- in community health services for children and young people, not all safeguarding cases were being supervised and the trust safeguarding team was not routinely copied into referrals made to children's social care
- in the community child and adolescent mental health service, not all patients had an up to date and current risk assessment in their care record
- in the acute wards and psychiatric intensive care units, significantly less than 75% of staff were trained in life support

Summary of findings

- the trust policy did not adequately deal with all the requirements of nursing patients in long term segregation in line with the Code of Practice
- staff were not always providing person centred care to patients on a community treatment order
- there were problems with the quality of care plans on Elmridge ward, in child and adolescent community mental health services and in community health services for adults
- compliance with supervision and appraisal was below 75% in some services
- the trust did not notify CQC of applications for Deprivation of Liberty Safeguards in more than 75% of cases between January 2015 and February 2016
- there was a high demand for mental health beds, which meant that some patients were either being placed out of area or requiring intensive support from community teams
- within the community health services for adults, staff did not do all that was reasonably practicable to mitigate the risks of patients developing pressure ulcers on their caseload.

Summary of findings

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

We always ask the following five questions of the services.

Are services safe?

Requires improvement

We rated safe as 'requires improvement' because the following four core services we inspected were rated 'requires improvement' for safe:

- within the community health services for children and young people service, not all safeguarding cases were subject to objective, critical reflection and the trust safeguarding team was not being routinely copied into referrals made to children's social care. This meant that the safeguarding team did not have an accurate picture of safeguarding activity across the trust
- within the community health services for adults, staff did not do all that was reasonable practicable to mitigate the risks of patients developing pressure ulcers on their caseload
- within the community child and adolescent mental health service, not all patients had an up to date and current risk assessment present in their care records which could result in patients receiving care that did not take into account identified risks
- within the acute wards and psychiatric intensive care services for adults; compliance with basic life support and immediate life support training was significantly lower than the national target of 75%. This meant the trust could not be assured there were sufficient numbers of suitability trained staff to respond to patients requiring assistance following a restrictive intervention.

We also found:

- a number of clinic room temperatures were not effectively maintained below the recommended range of 25 degrees
- the trust policy did not adequately deal with all the requirements of nursing patients in long term segregation in line with the Code of Practice
- within the adult community health service, staff did not always ensure that patients had a pressure ulcer risk assessment performed at first contact to the service as per policy
- compliance with mandatory training and supervision was below 75% within some teams across the trust.

However:

Summary of findings

- the trust was committed to reducing restrictive interventions and had significantly reduced the number of restraints in the prone position and the use of rapid tranquilisation
- there was a clear strategy for prescribing and medicines optimisation
- staff completed timely and comprehensive risk assessments for all patients including their physical health needs
- the board had strategic oversight of potential risks which could impact on their ability to deliver services and had actions in place to mitigate these
- all the wards complied with the Department of Health guidance regarding same sex accommodation
- the trust had a dedicated team to investigate serious incidents. Team members had completed a postgraduate certificate in serious incident investigations to support them within this role
- despite the staffing challenges the trust faced, there was evidence to demonstrate that services were committed to minimising the impact this had on patient care
- the trust had implemented a new escalation process for reporting maintenance work which had significantly improved respond times
- clinical areas were clean and well maintained
- staff followed good infection control practices
- the trust had recently implemented a new 'safeguarding vision 2016-2019' which was developed with input from staff and stakeholders. Staff were knowledgeable about their responsibilities in relation to reporting safeguarding concerns including to external agencies
- the trust was compliant with the Duty of Candour requirements.

Are services effective?

Good

We rated effective as 'good' because:

- staff were completing holistic and comprehensive assessments of patients' needs
- most care plans were of good quality, with evidence of patient involvement

Summary of findings

- important information about patients care was accessible to staff who needed it
- patients care and treatment was monitored and reviewed regularly
- the trust had an identified quality and National Institute for Health and Care Excellence lead
- services were being delivered in line with national guidance and best practice, and staff were kept up to date through newsletters, the trust's intranet and each network's governance structure
- there were good procedures in place to monitor and manage patients' physical health needs
- there was an audit programme to measure compliance with guidance. Concerns highlighted through audits were addressed
- services used recognised outcome measures to monitor patients' progress
- the trust had introduced an internal Academy which monitored and managed all aspects of staff training and development. This was working well
- the trust was compliant with the workforce race equality standard and was acting to understand and close the gap between treatment of white staff and those from Black and minority ethnic backgrounds
- the trust had revised and improved its approach to performance management
- staff were supported to access additional training relevant to their role
- overall, compliance with staff supervision and appraisal was good with most services achieving between 75 and 100%
- all teams provided care and treatment within a multidisciplinary model of care
- staff built and maintained good working relationships with agencies and stakeholders external to the trust
- the trust had established systems in place to support the administration and governance of the Mental Health Act and Mental Capacity Act.

However:

- within community health services for adults in the integrated nursing teams:
- there were no pain assessment scoring tools in patient records
- there was no end of life care plan in 18 of 20 records
- staff did not always follow the trust policy and guidelines for prevention and management of pressure ulcers
- within community mental health services for adults of working age, staff did not always ensure that the rights of patients on community treatment orders were protected in line with the requirements of the Mental Health Act.
- in community learning disability services, not all staff had received essential training required for their role
- within community health in-patient at Longridge Hospital:
- staff did not always measure patient outcomes
- there were patients whose treatment was not following current evidence based guidance and standards
- the number of substantive hours of therapy staff was insufficient to provide treatment following best practice guidance.

In addition:

- in wards for older people with mental health problems, acute mental health wards for adults of working age, forensic inpatient/secure wards, community health services for children and young people and community health services for adults, compliance with supervision and/or appraisals was below 75%
- some teams within the community learning disability services had no speech and language therapists and no psychology, which was due to commissioning arrangements
- on Elmridge ward and in child and adolescent community mental health services, the quality of care plans was poor
- the trust did not notify CQC of applications for Deprivation of Liberty Safeguards in more than 75% of cases between January 2015 and February 2016.

We made the decision to deviate from the aggregation tool when rating this domain. This was because the rating for the community health inpatient ward would have had a disproportionate impact on the overall rating for this domain which was not considered to be proportionate due to the small size of this core service.

Are services caring?

Good

We rated caring as 'good' because:

- staff treated patients with respect, care and compassion

Summary of findings

- staff communicated with patients in a way that was appropriate to patients' individual needs
- patients told us that staff treated them well and were responsive to their needs
- staff involved patients and carers in care planning, and most patients had been offered a copy of their care plan
- patients participated in meetings to review their care, and staff listened to their views
- patients had good access to a range of advocacy services
- there were comment boxes available on wards for patients and visitors to leave feedback
- patients had been involved in service development
- the trusts' friends and family test scores for patients who would recommend the trust as a place to receive care were above the England average for mental health care and in line with the England average for community health care.

However:

- within community health for adults teams, discussions were not always documented in care records when patients were approaching end of life
- in community adult mental health teams, staff were not always recording whether they had offered patients a copy of their care plan
- a group of carers told us that they did not feel involved in patients' care and that it was difficult to contact staff.

Are services responsive to people's needs?

Good

We rated responsive as 'good' because:

- the trusts' strategy had been developed with the populations specific health needs in mind
- the trust had a dedicated equality and diversity lead to ensure the protected characteristics of the population were considered
- the trust had identified that some wards did not meet the needs of the patient groups and had plans in place to move these to more appropriate buildings
- the trust was actively involved in the Lancashire and South Cumbria Change Programme
- the trust had good working relationships with commissioners and other stakeholders

Summary of findings

- the trust had identified areas of unmet need in its population and worked with commissioners to develop new services
- most services were meeting target times for assessment of urgent and non-urgent referrals
- arrangements for children and young people transitioning to adult mental health services had improved since our last inspection
- the trust had implemented a clinical bed management hub which had reduced the number of out of area beds being used for mental health service patients
- the trust had recently opened a mental health crisis support assessment unit at Blackburn General Hospital to provide brief interventions for patients in crisis
- the environments in most inpatient and community services were appropriate for patients' needs. Wards at the Harbour were of particular high quality
- there was a good range of therapeutic, occupational, social and educational activities delivered in all the wards we visited
- the quality of food in forensic and child and adolescent mental health wards had improved since our previous inspection
- staff respected patients' diversity, human rights and individual needs
- patients on the wards were easily able to practise their faith should they wish
- interpreting services were accessed appropriately
- the trust had a community health outreach team, which specifically provided care for homeless people or those seeking asylum
- in community mental health services for adults of working age, the restart teams worked to ensure patients' holistic needs were met, promoted social inclusion and worked with hard to reach groups in innovative ways to promote mental well-being.
- most services had disability access and disabled facilities such as toilets and bathrooms. Where there was no wheelchair access in community-based services, alternative appointments were made either at the person's home or a venue close to where they lived
- the trust had developed a specific sexual health training module focussing on the needs of lesbian, gay, bisexual and transsexual patients
- patients had access to information regarding how to make a complaint and staff supported them to do this where required
- the trust dealt with complaints promptly and effectively. Staff shared learning from complaints through the trust's governance structure and forums.

However:

Summary of findings

- in community child and adolescent mental health services, six patients had waited between 18 and 24 weeks to be seen when the target was 18 weeks
- in Preston single point of access, the waiting time for urgent new referrals was eight days when the target was five days. However, Preston was using a telephone triage system to prioritise cases and reduce the risk
- in community health services for adults' integrated nursing services, there were no systems in place to monitor response times
- in community health services for children, referral to treatment target times for occupational therapy and speech and language therapy had not been achieved
- thirty-three of the trust's 42 hospital wards had bed occupancy rates higher than 85%
- there was a high demand for mental health beds, which meant that many patients were either being placed out of area or requiring intensive support from community teams
- at Burnley General Hospital, four wards had shared dormitory bays which did not promote patients' privacy and confidentiality
- seclusion suites on Dutton and Langdon wards were in close proximity to each other, meaning that conversations could be overheard
- there was no screening on the window of the health-based place of safety suite in Burnley General Hospital, which could compromise patients' privacy and dignity
- in the community health services for adults complaints were not reported or monitored if they were resolved at local service level
- complaints forms in community learning disability services had not been fully adapted for patients with learning disabilities.

Are services well-led?

Good

We rated well led as 'good' because:

- the trust had a clear vision, supported by six values. The trusts' strategy was embedded across the four clinical networks
- the trusts' board and council of governors understood their responsibilities. There was a clear framework by which the trust was held accountable for its actions
- each clinical network had a clear, effective governance structure 'from board to ward'

Summary of findings

- the trust had commissioned an external review of the effectiveness of the board assurance framework
- the trust had effectively identified and tracked the progress of all actions following the previous CQC inspection. The majority had been completed and signed off by the board
- the trust had a clear process for escalating risks from the wards and clinical areas to the board. The board had a good oversight of issues within each network
- members of the trust board undertook a visit to a clinical team each month. A report with examples of good practice and recommended actions for improvement was issued to the team afterwards, and escalated to the board where necessary
- teams used 'quality dashboards', which provided them with information on key performance and quality indicators specific to their team
- the trust had embedded reporting structures and policies in place to support staff to effectively manage clinical issues
- the trust had commissioned a programme of work to understand its organisational culture and leadership
- the trust had 'buddied' with a similar trust in the south of England to exchange ideas and explore how to meet challenges
- the trust had recently appointed three heads of nursing to support the director of nursing with the delivery of the trusts' quality agenda and to provide senior clinical leadership within the trust
- the majority of staff told us they felt valued by the trust. Overall morale was good
- the trust had a number of established methods to promote engagement and communication with staff
- the trust had policies and procedures to ensure that effective recruitment checks were in place
- the trust had a strategy for engagement with the public and people who used services. We saw many examples of patient involvement at trust and core service level
- a number of trust services had received national accreditations
- the early intervention in psychosis service and the children and families network had either contributed to or written good practice guidance. They were also involved in a number of research projects.

Summary of findings

However:

- at Longridge Hospital, management of the local risk register was poor. One risk was three years old and no changes to the register had been made
- at Longridge hospital and on child and adolescent mental health wards, staff morale had been negatively affected by uncertainty about future changes in service delivery.

Summary of findings

Our inspection team

Our inspection team was led by:

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

Head of Inspection: Nicholas Smith, Care Quality Commission

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

The team included CQC inspectors and a variety of specialists: consultant psychiatrists, consultant nurses, a dietician, a district nurse, experts by experience who had personal experience of using or caring for someone who uses the type of services we were inspecting, health visitors, junior doctors, Mental Health Act reviewers, mental health social workers, nurses (Registered General Nurses, Registered Mental Nurses, paediatric nurses and Registered Nurses for Learning Disabilities), occupational therapists, pharmacy inspectors, psychologists, a school nurse, senior NHS managers, social workers and consultant psychiatrists and specialist registrars.

Why we carried out this inspection

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

This inspection was planned to assess if the trust had addressed the areas where breaches of regulation were identified at the inspection completed 28-30 April 2015 (published 4 November 2015). At this inspection, the trust was found to be in breach of regulations of the Health and Social Care Act (Regulated Activities) Regulations 2014 in the following core services:

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

- Regulation 17 (good governance)
- Regulation 18 (staffing)

Forensic inpatient and secure wards:

- Regulation 12 (safe care and treatment)
- Regulation 10 (dignity and respect)
- Regulation 17 (good governance)

Child and adolescent mental health wards:

- Regulation 13 (safeguarding service users from abuse and improper treatment)

Wards for older people with mental health problems:

- Regulation 10 (dignity and respect)
- Regulation 12 (safe care and treatment)
- Regulation 18 (staffing)

Mental health crisis and health-based places of safety:

- Regulation 15 (premises and equipment)

Community based mental health services for adults of working age:

- Regulation 12 (safe care and treatment)

Community mental health services for children and young people:

- Regulation 12 (safe care and treatment)
- Regulation 17 (good governance)
- Regulation 18 (staffing)

Community health services for adults:

- Regulation 9 (person centred care)
- Regulation 12 (safe care and treatment)
- Regulation 17 (good governance)

Community health services for children, young people and families:

- Regulation 12 (safe care and treatment)
- Regulation 18 (staffing)

End of life services:

- Regulation 12 (safe care and treatment)

Summary of findings

- Regulation 18 (staffing)

Adult social care:

- Regulation 12 (safe care and treatment)

Since our last comprehensive inspection of the trust in April 2015, the trust had developed a comprehensive 461 point action plan to improve and address the breaches in regulation we found during that inspection. The trust had also actively engaged in monthly quality improvement board meetings which were attended by a range of stakeholders including;

- Care Quality Commission (CQC)
- Healthwatch
- Local authority safeguarding leads
- Monitor
- NHS England
- Clinical commissioning groups

In addition, members of the senior management team engaged on a monthly basis with the CQC inspection manager, CQC inspectors and Mental Health Act reviewer for the trust to continuously review their progress against the action plan.

During this inspection, we found that in the core services we inspected, the trust had met the regulation requirements related to the previous inspection we carried out in line with the Health and Social Care Act.

How we carried out this inspection

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

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

Before visiting, we reviewed a range of information we hold about the trust and asked other organisations to share what they knew. These included: Advocacy, Clinical Commissioning Groups, General Medical Council, Healthwatch, Health Education England, Monitor, NHS England, National Midwifery Council, Overview and Scrutiny Committee, Royal College of Psychiatrists and service user and carer groups.

We held focus groups for the following groups:

- detained patients at the Harbour and Guild Lodge hospital locations
- health visitors
- qualified community nurses and allied health professional (acute)
- school nurses
- unqualified community support assistants and allied health assistants (acute)

We attended 'The Crew' which was a group for young people who were currently or had in the past received services from the trust.

We held two engagement events for staff at the Harbour and Guild Lodge.

We interviewed the following trust members:

- associate director for allied health professionals
- associate director for psychological therapies
- chief operating officer
- complaints lead for the trust
- director of finance
- director of human resources
- network director for acute specialist services
- network director for adult community services
- network director for children and families
- non-executive director for quality and safety
- risk lead for the trust

We left comment boxes at 17 wards and teams.

Summary of findings

During the visit we:

- attended 34 meetings including team meetings, multidisciplinary meetings, handovers and therapy groups
- carried out 17 home visits
- looked at a range of clinical and management records
- looked at 24 staff records
- met with a group of carers from a non-statutory organisation
- met with 538 trust employees
- met with 169 patients who use services who shared their views and experiences of the core services we visited
- observed how patients were being cared for
- reviewed 439 patient care records
- spoke with 30 carers or relatives of people who use the service
- visited all 39 in-patient wards within the trust.

We held focus groups for the following groups:

- administrative staff
- allied health and social care professionals
- approved mental health professionals
- clinic based acute services service managers
- consultant psychiatrists and senior doctors
- independent hospital managers
- junior doctors and doctors in training
- mental health directorate leads
- mental health network service managers
- non-executive directors
- qualified mental health nurses
- student nurses
- trade unions and staff side representatives
- unqualified mental health support workers.

We also interviewed the following trust members:

- board lead for the Mental Health Act
- chief executive officer
- chief pharmacist
- director of nursing and quality
- head of corporate compliance
- Mental Health Act team manager/advocacy lead
- medical director
- network director for adult mental health
- network director for mental health specialist services
- quality academy lead and deputy
- safeguarding lead for the trust
- service manager for children's community services
- the clinical business manager and associate clinical director for acute integrated teams including district nursing
- trust chairman
- two service managers for acute clinic based services
- two service managers for specialist acute community services.

Information about the provider

Lancashire Care NHS Foundation Trust gained foundation trust status in December 2007 and had 14,000 members at time of inspection. The trust provided health and wellbeing services for a population of around 1.4 million people. The trust covered the whole of the county and employed around 7,000 members of staff across more than 400 sites.

The trust had an annual turnover in excess of £340 million. The trust spent £190 million on mental health and secure services, £130 million on community services and £24 million on other services.

The trusts' services were delivered through the following four clinical networks: specialist services, adult community, adult mental health and children and family services.

Summary of findings

Services the trust provided included community services such as health visiting, podiatry, sexual health, dentistry, inpatient and community mental health services, forensic and secures services including prison healthcare.

The trust provided the following 14 core services:

- acute wards for adults of working age and psychiatric intensive care units
- child and adolescent mental health wards
- forensic inpatient and secure wards
- wards for older people with mental health problems
- mental health crisis and health-based places of safety
- community-based mental health services for adults of working age
- community-based mental health services for older people
- community-based mental health services for people with a learning disability or autism
- specialist community mental health services for children and young people
- community health services for adults
- community health services for children, young people and families
- community inpatient services
- community sexual health
- adult social care.

The trust had a total of 503 beds in the following core services:

- acute wards for adults of working age and psychiatric intensive care units: 224 beds
- child and adolescent mental health ward: 16 beds
- forensic inpatient and secure wards (medium, low secure, and step down): 164 beds
- wards for older people with mental health problems: 84 beds
- community inpatient services:15 beds

The trust was registered with the Care Quality Commission to provide the following seven regulated activities:

- personal care
- treatment of disease, disorder or injury
- assessment or medical treatment for persons detained under Mental Health Act 1983
- surgical procedures
- diagnostic and screening procedures
- nursing care
- family planning services.

The trust worked with nine clinical commissioning groups:

- Blackburn with Darwen
- Chorley and South Ribble
- East Lancashire
- Fylde and Wyre
- Greater Preston
- Lancashire North
- West Lancashire
- St Helens

The clinical commissioning groups shared boundaries with Lancashire County Council social services with the exception of Blackburn with Darwen and Blackpool which aligned to their respective unitary authorities.

The trust also worked with NHS England who commissioned all specialist services.

We did not inspect the following services that the trust provided as part of this inspection:

- adult social care
- services to prisons healthcare
- dental services
- eating disorder services
- improving access to psychological therapies.

We inspected the end of life service the trust provided within the community health services for adults as the trust did not have an identified specific end of life core service.

Summary of findings

Lancashire Care NHS Foundation Trust had been inspected under the new methodology of inspection (date of initial publication: 4 November 2015). The inspection was carried out on 28 to 30 April 2015 and overall, the trust was rated as 'requires improvement'.

What people who use the provider's services say

Before the inspection we held two focus groups for detained patients and left comment boxes at 17 wards and teams. During the visit we met with a group of carers from a non-statutory organisation and a group of commissioners.

We received a total of 66 comment cards back from 17 boxes. In total, 39 of these were positive comments, 12 were negative and four were mixed. Eleven were left blank or were illegible. We received the most cards back from the acute and psychiatric intensive care wards with 29, nine of which were positive and eight were negative. The community health for adult's service had the second highest return with 27. Of these, 22 were positive, three were negative and one was mixed.

Feedback from the patients' and carers' focus groups we held was mixed. We received very positive feedback from patients and carers at the Harbour regarding the flexibility of staff on the wards and how they had 'gone the extra mile'. This included arranging for a relative to stay overnight with a patient who was receiving end of life care. We spoke to a separate group of 16 carers, representing a range of trust services. Most were unhappy with the care their relative had received. Carers said that they did not feel listened to or involved. They found it difficult to contact staff and felt that communication generally was inconsistent.

In the core services, most patients and carers said that their experience of using the trusts' services had been positive. Patients told us they were treated with dignity, respect and kindness. They said that staff showed a genuine interest in their wellbeing. Patients and carers at Longridge Hospital and patients within the forensic services were particularly positive about the attitudes of staff and the care they received.

Commissioners told us that they were able to work collaboratively with the trust. Commissioners said that they were invited to reviews of incidents and that they regularly received assurance about the quality of care. They said that the trust had come up with some creative solutions to staffing problems.

Good practice

- community and inpatient child and adolescent mental health services had a dedicated participation group called 'The CREW'. This consisted of young children and parents from across Lancashire who were instrumental in the development of policy and procedure, reducing restrictive practices and staff recruitment. The group had been nominated for local and national participation awards
- two patient groups had been developed in the Lancaster and Morecombe teams for people with a learning disability. Patients provided feedback about services within the trust and their feedback made improvements and changes to services
- the trust had opened a 23 hours crisis support unit which was used as an alternative to hospital admission
- in community mental health services for adults of working age, the restart teams worked to ensure patients' holistic needs were met, promoted social inclusion and worked with hard to reach groups in innovative ways to promote mental well-being
- staff from the Fylde rapid intervention and treatment team were involved in a national randomised controlled trial of assistive technology and telecare with people who were living with dementia

Summary of findings

- the trust had developed a 'safer wandering scheme' and protocol for people with dementia in partnership with the police
- the care home support service team had reduced unnecessary admissions to hospital by implemented a 'hydration kit' for which they had been nominated for an award by the Royal College of Nursing
- in community health services for children and young people, training in newborn behavioural observations was being rolled out to health visiting teams. Newborn behavioural observations is a tool designed to promote positive bonding between parents and children
- speech and language therapists had devised a training and resource pack which had been sold to schools
- the forensic service had established a gardening project within the hospital grounds called "grow your own". The project was available to local schools and community groups as well as patients and staff. Patients had opportunities to gain qualifications and two patients were employed and paid by the trust for their horticultural work
- staff had developed practical guides to treatment pathways for patients within early intervention services which had been published as good practice on the National Institute of Health and Care Excellence website
- the community health services for children and young people had written a good practice statement entitled 'Using Gillick Competence to Gain Consent for Immunisations in the School Setting' which had been submitted to NHS England
- the children and families network were engaged in a range of research projects including how to promote children's language development using family-based shared book reading.

Areas for improvement

Action the provider SHOULD take to improve

- the trust should ensure that all staff receive regular supervision and appraisals and this is evidenced as per trust policy
- the trust should ensure that it continues to implement the recruitment and retention drive to ensure there are enough staff to meet patients' needs
- the trust should ensure that the seclusion policy is updated in line with the Mental Health Act Code of Practice
- the trust should ensure that staff who require essential training receive it in line with trust policy
- the trust should notify CQC of all Deprivation of Liberty Safeguards applications
- the trust should continue with plans to relocate Hurstwood ward and the child and adolescent mental health wards.

Lancashire Care NHS Foundation Trust

Detailed findings

Mental Health Act responsibilities

The trust had established systems in place to support the administration and governance of the Mental Health Act. A team of Mental Health Act administrators were based in each locality and were managed by a mental health law manager. The team provided the central oversight of the administration of the Act within the trust and the link between the clinical networks and the trust governance structure. Each of the four clinical networks had a network mental health law group that ensured compliance with mental health law and best practice within that networks. The mental health law groups reported to the trust mental health law sub-committee which reported directly to the quality committee.

Training on the Mental Health Act was considered essential training for specific staff groups dependent upon their role. However: trust wide, the compliance rate for Mental Health Act level 2 training was 50% with three of the four networks falling below the CQC benchmark of 75%.

Since our last inspection, the trust had fully implemented an electronic system for documenting Mental Health Act records across the trust which was monitored by the Mental Health Act administrators.

During this inspection visit, we found staff were adhering to the principles set out in the Code of Practice and their application of the Mental Health Act was good across all wards. However; we found the following issues within the adult community mental health services in relation to the application of the Act:

- patients on a community treatment order had not been informed of their rights to an independent mental health advocate
- patients had not exercised their rights to appeal and we could not be assured that this was an informed choice
- systems were not in place to ensure that the corresponding legal authority to administer medication to community treatment order patients were kept with the medicine chart and reviewed by nurses administering medication
- staff did not always consider the consent status and scope of parental responsibility when patients came into the service at the age of 16.

Some staff raised concerns that inpatient beds were not always available for patients in the community who were liable to be detained. They reported that this meant some patients who had been assessed as requiring immediate hospital admission under the Mental Health Act, were waiting for long periods to receive the care and treatment they need. As a result, patients were being subjected to multiple assessments as beds became available days later.

There were also some issues raised regarding access to an inpatient bed for patients who had been detained under section 136 of the Mental Health Act and who had subsequently agreed to be admitted informally to hospital. Staff told us that patients detained under section 136 who required a formal admission to hospital were prioritised and usually found a bed within the 72 hour assessment period of the section 136. However: the trust reported 26 breaches where the 72 hour period had lapsed before a patient who had agreed to be admitted informally was

found a bed. This meant that they remained in the 136 suite beyond the 72 hours. Breaches of section 136 were monitored and reported through the trust's governance structure and to the Multi-Agency Oversight Group.

Mental Capacity Act and Deprivation of Liberty Safeguards

The trust had a new system in place to deal with the interface between the Mental Health Act and Deprivation of Liberty Safeguards which included guidance to ensure that patients were not deprived of their liberty without authorisation.

All four networks had a compliance rate above 75% for Mental Capacity Act Level 1 training. Corporate services fell below this benchmark with 55%. The overall compliance rate for the trust was 79%. However: compliance with Mental Capacity Act Level 2 training was much lower trust wide at 40% overall.

The trust made 63 Deprivation of Liberty Safeguards applications between 16 January 2015 and 11 February 2016 across 14 wards. CQC records show that we received 15 Deprivation of Liberty Safeguards notifications from the trust between the same period which equates to less than 25% of the Deprivation of Liberty Safeguards applications the trust submitted during this period. This was because the trust had only submitted applications which had resulted in a Deprivation of Liberty Safeguard been approved rather than all applications in line with the trusts' regulatory duty.

Staff had a good understanding of their responsibilities in relation to the Mental Capacity Act. For example, staff were able to discuss the five principles which underpinned the Mental Capacity Act and give practical examples from their clinical practice. There was evidence of formal best interest meetings when important decisions were taken about a patient who was assessed as lacking capacity to consent to that decision. Staff supported patients to put legal frameworks in place while they still had capacity to help them plan for future decisions before they became more cognitively impaired and unable to do so.

In community health services for adults, we observed staff gaining implied consent from patients however we saw little evidence that consent was documented in the patient record.

Within the services we inspected which provided care to children under the age of 16, staff demonstrated good working knowledge and application of Gillick competence in practice.

Requires improvement

Are services safe?

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

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

Summary of findings

Our findings

Safe and Clean Care Environments

The trust had an estates strategy 'Property strategy-building for the future 2013-2019' which was published in April 2013. Estates strategies are designed to provide trusts with a five-10 year high level plan for the future development of its estate based on the needs and predicted needs of the population it serves. The implementation of the plan was monitored by the infrastructure subcommittee which had senior representation from each clinical network. The subcommittee fed into the trust boards finance and performance committee. All capital expenditure proposals were reviewed and approved by this committee based on priority, sustainability, waste reduction and alignment to the trusts vision and values. The plan identified four key objectives which the trust aimed to achieve:

- reduce overheads by £715k
- reduce the trust's footprint by 16%
- make lease and maintenance savings of £478K
- save £750K by cost avoidance

The director of nursing and quality told us that despite the cost improvement savings the trust were required to make, the trust were committed to making sure that this did not compromise the quality of the services they provided. This was evidenced for example, by the significant building work the trust had completed since our last inspection on Hurstwood ward at Burnley General Hospital to ensure it complied with the Department of Health's guidance regarding same sex accommodation in line with all the other wards within the trust.

The trust participated in annual patient led assessment of the care environment visits. Patient led assessment of the care environment assessments are self-assessments undertaken by NHS care providers and include at least 50% members of the public. They focus on different aspects of the environment in which care is provided including: food, condition and appearance, dementia and disability access, privacy dignity and wellbeing.

The 2016 patient led assessment of the care environment scores for the trust was 96% which is slightly below the England average of 98%.The trust scored one percent below the national average of 94% for condition, appearance and maintenance of facilities. The Junction scored the lowest at 87% followed by Guild Lodge at 90%. The Royal Blackburn Hospital and The Orchard scored the highest with 97%. The other four locations scored between 92 and 95%.

The trust had made improvements in the way that maintenance and repair work was managed since our last inspection. As part of the CQC action plan; the trust had worked with contractors to develop a new way of logging and responding to maintenance and repair works requested which included triaging work based on urgency. Work categorised as urgent was responded to within four hours, emergency within two hours and routine within the same day. Posters were placed on items reported which included the date they were reported. All work was logged electronically. This included the planned date for completion of work and any reasons for delays. Service managers reviewed the logs on a weekly basis to identify any issues which may require escalating. Any issues were monitored through the local network governance groups which sent a monthly report on progress to the finance and performance committee. There was a clear escalation process from ward to board. This meant the board was assured it had oversight of any problems or improvements in the timeliness of maintenance work being completed. Staff told us that since the new escalation process had been implemented, the response to maintenance work had improved significantly. They told us the poster system meant they could see at a glance the date work had been requested which reduced the risk of work not been reported.

Requires improvement

Are services safe?

We found buildings were well-maintained and equipment was checked regularly as per trust policy. However: at Leyland clinic, Chorley Health Centre and the forensic wards at Calder, Hermitage, Greenside and Fairsnape, clinic room temperatures were not effectively maintained below the recommended range of 25 degrees Celsius which could affect the efficacy of medicines or clinical equipment stored in the rooms. The trust was aware of the issues with the clinic room temperatures and had begun issuing thermometers which constantly read the room temperature across these services.

The kitchen at Longridge was in need of a refurbishment which staff told us was planned although no timescale had been set for work to commence.

Of the eight locations assessed, the trust scored above the national average in six for cleanliness. The Platform scored the lowest with 87% and Longridge Community inpatient Ward scored the highest with 100%. The overall trust compliance rate with infection control training was above 90% for all staff. Clinical areas we visited were clean and tidy. Staff had access to infection control and prevention equipment and facilities to support them such as sanitising gels, aprons, gloves and hand wash basins at point of care. There was evidence to demonstrate staff were applying good infection control and food hygiene principles in their clinical practice. The exceptions to this were on Hermitage ward and the seclusion suites on Dutton and Langden wards within the forensic services. Staff were not adhering to good food hygiene standards within these areas. The kitchen area on Hermitage ward was also dirty as were the observation areas within the seclusion suites. The trust took immediate action to make sure these areas were clean.

The trust had escalated onto the strategic risk register that environmental audits and risk assessments did not always take place in all clinical areas as identified during our last inspection.

Within the forensic wards, extensive anti-ligature work had been carried out on Fairsnape, Greenside, The Hermitage and Calder wards since our last inspection. During this inspection, all clinical areas had environmental risk assessments completed including ligature risk assessments. Most ligature assessments were completed fully however: there were some gaps for example on the child and adolescent wards, the laundry rooms were not included in the audit. There were some ligature points at the Hermitage and The Junction which staff managed through the use of observations. Most of the wards had clear lines of sight to enable staff to observe patient areas. Where blind spots were identified for example on three of the forensic wards, staff used mirrors and observations to mitigate risks.

In the crisis team at Blackburn, the interview rooms had desks positioned in the back corner of the room. This meant it would be difficult for staff sitting behind the desk to leave the room if a patient became aggressive.

At our last inspection, the environment in schools where immunisations were carried out did not always promote a calm and safe environment. In response, staff had altered the immunisation sessions to allow more space between, “immunisation stations” and a separate room was identified for children who required a more private environment.

Staff had access to alarms. Emergency and first aid equipment including defibrillators were accessible to staff where appropriate. Evidence of checks were recorded as per trust policy with the exception of Fairoak ward where checks were recorded inconsistently.

Safe Staffing

The trust had experienced significant challenges recruiting and retaining staff over the past two years which had been escalated onto the trusts board assurance framework 2016/17 with a rating of 15 which was classed an ‘extreme’ risk.

The trust employed 6,743 substantive staff at the time of our inspection. Over the previous 12 months, 709 staff left the trust which equated to 10.5% of the workforce. Community sexual health services had the highest staff turnover with 35 out of 64 staff leaving (54.7%). Community mental health services for older people had the lowest percentage with 4.2%. The other core services had rates of between 6.1%-13.5%.

The average staff vacancy rate was 8.12%. The overall vacancy rate for qualified nurses was higher at 17%. The acute and psychiatric intensive care wards had the highest qualified nurse vacancy rate with just under 80 whole time equivalent vacancies which equated to 26%. The trust vacancy rate for nursing assistants was nine percent. Community health services for adults had the highest vacancy rate for nursing assistant at just under 21 whole time equivalent vacancies which equated to 37%.

Requires improvement

Are services safe?

The staff sickness rate was 4.8% which was lower than the sickness rate of 6.3% last year. Wards for older people had the highest sickness rate at just under 11% and community health services for children and young people had the lowest at just over three percent.

We interviewed the director of human resources who had been in post just prior to our previous inspection. They told us they had reviewed and up-dated the trusts' recruitment strategy since our last inspection. At the time of our previous inspection, individual managers placed adverts when vacancies arose within their teams. The director of human resources had identified that the trust was recruiting 700 new members of staff a year, and that it would therefore be more efficient to have a rolling recruitment programme. The new programme included raising the trust's profile through recruitment events and social media. Job descriptions and interviews assessed candidates against the trust values. The director of human resources told us the trust had so far recruited 65 people this way, around 50 of whom were newly qualified.

The trust had also implemented a strategy to improve staffing retention called the 'People Plan'. The People Plan was based on evidence and recommendations from the 2012 Kings Fund review Employee Engagement and NHS Performance. Since our last inspection, executives had spoken to around 800 members of staff to share ideas and help people feel more involved. The most recent results from the national NHS staff survey showed that the score for staff engagement had increased from 3.63 to 3.87, which put the trust in the top 27% of NHS trusts.

The trust had implemented Health Roster and SafeCare across all services since our last inspection. These were online tools used to calculate and manage staffing requirements. There was an action plan in place to support the implementation of this initiative. Health roster was an electronic e-rostering system and SafeCare compared staffing levels with the actual care needs of patients on a shift by shift basis.

Each ward had a SafeCare champion. All staff had access to the Health Roster so they could check their shifts. Only qualified staff had access to SafeCare. This was because the system calculated dependency levels on the wards based on the information staff imputed and produced reports called ward analysers. The reports displayed any deficits in staffing in red for each shift so the nurse in charge could see immediately whether there were enough staff to meet the care needs of the ward. It also showed excess hours rostered.

Shifts could be planned in advance on the system based on the projected needs of patients on the ward. The system was flexible and would reduce or increase staffing levels per shift based upon any changes in patient need which staff inputted into the system.

The director of nursing received daily up-dates regarding staffing levels from each senior manager, which meant they had oversight of any shifts which remained red for each ward. The implantation of the safer staffing action plan was reviewed monthly at the safer staffing group which reported to the quality and safety subcommittee. This provided assurance that the board had oversight of any staffing issues within the trust.

Within the community health services for adult, a review of staffing had been completed since our last inspection. A business case had been developed but this was on hold due to the transformation of community services review which was taking place within the trust. However, all the community teams used weighting tools to inform workforce planning and help staff to prioritise patient's needs.

The trust used a staff bank to cover any deficits in staffing levels and had recently offered bank staff the option to convert to a permanent contract. Eight people had taken up this offer so far. Where possible, staff would block book bank staff to cover shifts to promote consistency of care. Any shifts that remained uncovered would be inputted onto Safe care by the registered nurse and this request automatically went out to the bank for cover. In the event that a shift was not covered, the deficit would be escalated to the senior nurse on duty who had responsibility for prioritising staffing on the unit. All wards had a flow chart which showed what action needed to be taken if a shift was not covered which included contacting agencies to provide cover. Over the previous 12 months, the trust filled 2882 shifts with bank staff and 699 with agency staff to cover sickness, absence or vacancies. The total number of shifts not filled was 505.

The acute and psychiatric intensive care wards had the highest use of bank and agency to cover shifts at 1133 and 207 respectively. They also had the highest number of shifts

not filled at 343. Community health services for adults had the second highest use of bank staff with 309 shifts filled and 31 not filled followed by wards for older people which used bank staff to fill 206 shifts, agency to cover 72 and 50 remained unfilled.

The forensic wards had 25 shifts overall which were not filled and mental health crisis services and health based places of safety had 22. The other core services had between no shifts and six which were not filled.

Despite the staffing challenges the trust faced, there was evidence to demonstrate that services were committed to minimising the impact this had on patient care where possible. Caseloads across community services were manageable and staff were able to respond to patients based on need.

However; at Fylde older people's community rapid intervention team, the hours of operation had temporally reduced due to concerns around safe staffing levels which had been escalated onto the networks risk register. Within the forensic services, patients leave had been cancelled on 73 occasions during the past six months due to low staffing levels. Staff reported this was always re-arranged as soon as possible. Cancelled leave due to staffing issues was monitored and reported through the network governance structures. Staff within the acute mental health wards reported that issues with staffing meant they had to cancel training and supervision at times.

We held two focus groups with junior doctors and consultants within the trust in addition to interviewing the medical director. Overall, they reported that there were no significant issues with the provision of medical cover within the trust. This reflected what staff and patients told us. However: within the community services for patients with a learning disability or autism, the Lancaster and Morecombe teams did not have a psychiatrist commissioned whereas the other five teams did have varied access to a psychiatrist. This inequity in service provision had been escalated onto the trusts' risk register.

The trust compliance rates for the 16 core training courses staff were required to attend were:

- conflict resolution (three yearly) : 67%
- equality and diversity (three yearly) : 96%
- fire safety (annual) : 91%
- health and safety (three yearly) : 95%
- infection control (admin) (two yearly) : 95%
- infection control (clinical) (annual) : 90%
- information governance (annual) : 86%
- manual handling level 1 (three yearly) : 87%
- manual handling level 2 (three yearly) : 70%
- manual handling level 3 (two yearly) :56%
- resuscitation (basic life support) (annual) : 76%
- immediate life support (annual) : 57%
- safeguarding children level 1(three yearly) : 93%
- safeguarding children level 2 (three yearly) : 82%
- safeguarding children level 3 (three yearly) : 73%
- safeguarding vulnerable adults level 1 (three yearly) : 91%

This meant the trust was not achieving 75% compliance with four of the 16 core training courses. Overall, the compliance rate for core training within the trust was 86%. This could be broken down by each network:

- Adult community: 87%
- Adult mental health: 84%
- Children and families: 90%
- Specialist services: 83%

For six of the 16 core training courses, the following networks were not achieving 75% compliance:

Conflict resolution training:

- Adult Community: 65%
- Adult Mental Health: 62%
- Corporate: 51%
- Specialist Services: 60%
- Manual handling level 2:
- Adult Mental Health: 69%
- Corporate: 64%
- Specialist Services: 56%
- Manual handling level 3

- Adult Community: 60%
- Adult Mental Health: 54%
- Children & Families: 0%
- Corporate: 0%
- Specialist Services:60%
- Basic life support:
- Adult Mental Health: 70%
- Corporate: 72%
- Specialist Services: 66%
- Intermediate life support:
- Adult Mental Health: 47%
- Specialist Services: 66%
- Safeguarding children level 3
- Adult Mental Health: 58%

The trust compliance rates for training classed as essential related to specific job roles were:

- Mental Capacity Act Level 1 (three yearly) : 79%
- Mental Capacity Act Level 2 (three yearly) : 40%
- PREVENT Channel (three yearly) :41%
- PREVENT WRAP3 (three yearly) : 26%
- Mental Health Act Level 2 (three yearly) :50%
- Violence Reduction Training (annual) : 63 %
- Safeguarding Vulnerable Adults Level 2 (three yearly) : 38%

This meant the trust were not achieving 75% compliance for six of the seven essential training courses overall. The following core services were not meeting the 75% compliance rate for the following courses:

Mental Capacity Act Level 1

- Corporate: 55%

Mental Capacity Act Level 2

- Adult Community: 42%
- Adult Mental Health: 37%
- Children & Families: 47%
- Corporate: 30%
- Specialist Services: 44%

PREVENT Channel

- Adult Community: 45%
- Adult Mental Health: 35%
- Children & Families: 65%
- Corporate: 16%
- Specialist Services: 44%

PREVENT WRAP3

- Adult Community: 26%
- Adult Mental Health: 19%
- Children & Families: 55%
- Corporate: 9%
- Specialist Services: 22%

Mental Health Act Level 2

- Adult Community: 41%
- Adult Mental Health: 36%
- Specialist Services: 43%

Violence Reduction Training

• Adult Community: 57%

- Adult Mental Health: 72%
- Children & Families: 71%
- Specialist Services: 50%

Safeguarding Vulnerable Adults Level 2

- Adult Community: 46%
- Adult Mental Health: 37%
- Children & Families: 35%
- Corporate: 31%
- Specialist Services: 39%

Low levels of compliance with mandatory and essential training had been escalated onto the trust's strategic risk register in June 2015 with an initial risk rating of 20. The current risk rating was still 20.

Compliance with basic life support and immediate life support training was low within some of the adult acute wards. The average compliance rate with basic life support

was 59% and 41% for immediate life support training. This meant that staff trained in immediate life support might not be immediately able to attend an emergency if restrictive interventions were used.

The Academy lead told us the trust continued to struggle to release staff for face to face training which had been booked such as basic life support, intermediate life support and PREVENT. This was due to staff often cancelling due to staffing issues. They told us they were looking at ways they could deliver this training to front line staff more effectively. They also told us that there was often a time lag between staff completing face to face training and this being inputted onto the system. This was not an issue for on-line training which was captured in 'real time' as soon as the course was completed.

Within the community sexual health services, the service had up-skilled some staff but omitted to ensure they had received level 3 safeguarding in addition to level 2 training required for their new roles and responsibilities. Staff who had transferred to the trust from another provider under TUPE had also not had their training transferred to the trust. This meant the North and East Lancashire teams were reported by the trust as having only 14% of staff trained in safeguarding level 3. However; staff told inspectors they had received this training.

The Academy lead told us the trust was exploring ways they could capture and record training staff had received prior to joining the trust to prevent them having to repeat training which was already valid.

Assessing and managing risk to patients and staff

The trust had a board assurance framework for 2016/17. Board assurance frameworks are used to enable organisations to determine and manage the nature and extent of their strategic risks.

The board assurance framework detailed 13 strategic risks related to the trust which were linked to the following seven strategic priorities as at 1 April 2016:

- Excellence
- a reduction in the use of restraint by 70% by April 2016
- a reduction of inpatient physical violence incidents by 60% by April 2016
- compliance with restraint training of 85%
- a reduction in the use of 'face down' or prone restraint

The trust had a number of policies and procedures to support staff to implement the programme which had all been reviewed in March 2016. These were:

- 'Reducing Restrictive Practices Policy: Management of inpatients who may require use of restrictive practices' – This policy included a visual flow chart of what staff should consider in relation to reducing restrictive practices which was based on national guidance.
- 'Violence reduction procedure for in-patient mental health settings': This document provided guidance on all aspects of violence reduction including de-escalation and de-briefs post a restraint incident.
- 'Violence reduction training procedure for in-patient mental health': This documented training staff were required to complete.

In the NHS Staff Survey 2015, 21% of staff said they experienced physical violence from patients, relatives or the public in the last 12 months. This was six percentage points higher than the national average of 15% for combined mental health, learning disability and community trusts and 10 percentage points higher than the trust scored in 2014.

The trust had recorded 1,166 incidents of the use of restraint between 1 August 2014 to 11 February 2015. A total of 435 of these incidents involved the use of prone restraint and 189 resulted in rapid tranquilisation being used. Rapid tranquillisation is the use of medication (usually intramuscular or, exceptionally, intravenous) to control acute behavioural disturbances exhibited by a patient with the aim of achieving sedation sufficient to minimise the risks posed to the patient or others.

Between 1 December 2015 and 3 June 2016, the trust recorded 1,553 incidents of restraint of which 35 were in the prone position and 16 resulted in the use of rapid tranquilisation being used. The majority of restraints, 957 (62%) took place within the acute adult mental health core service.

The trust was not meeting their set compliance training target of 85% or the target to reduce the incidence of restraint which had increased by 387. However: the trust had significantly reduced the number of restraints in the prone position from 435 to 35 and the use of rapid tranquilisation from 189 to16. The adult mental health network published a completed audit report in March 2016

based on the standards of the National Institute of Health and Care Excellence 'Violence and Aggression Clinical Guidance' NG10 which was published in May 2015. This found that the network was achieving between 83-100% compliance against the standard, 'Prior to the use of rapid tranquillisation have de-escalation techniques been used?' This provided evidence which demonstrated that staff were using less restrictive interventions before considering the use of rapid tranquilisation in line with best practice. Restrictive interventions were kept to a minimum and were appropriate to make sure patients were kept safe.

The trust had a clear strategy for prescribing and medicines optimisation with implementation led effectively by the medicines management team. The strategy supported the effective use of resources, promoting better value through the best use of medicines. There were good medicine management procedures in place for the storage, auditing and disposal of medicines.

Since our previous inspection, the trust had begun roll out of an electronic prescribing and medicines administration system on the in-patient wards. This was almost complete at the time of our visit. Medical, nursing and pharmacy staff we spoke with were very positive about the electronic prescribing and medicines administration system implementation processes and told us that training was good and they were well supported throughout the roll out. As the roll out was not complete, a benefits realisation report was not available. However, staff spoke positively about the clarity of the prescription record, the ability to see a patient prescription record remotely and to prescribe remotely and having electronic links to the British National Formulary. The electronic system also allowed pharmacists to alert prescribers if medication was prescribed outside of National Institute for Health and Care Excellence guidelines.

Track record on safety

We analysed data about safety incidents which had occurred within the trust from the following five sources;

- strategic executive information system: the strategic executive information system records serious incidents and 'never events'. 'Never events' are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented, so any 'never event' reported could indicate unsafe care.) Trusts have been required to report any 'never events' through the strategic executive information system since April 2011
- Serious incidents reported by staff through the trust's own electronic serious incident reporting system
- The national reporting and learning system: since 2004, trusts have been encouraged to report all patient safety incidents to the national reporting and learning system at least once a month. Since 2010 it has been mandatory for them to report all death or severe harm incidents to the Care Quality Commission via the national reporting and learning system
- The two serious case review reports and action plans the trust had completed in the last 12 months. Both of these related to adult mental health services
- Direct notifications the trust submitted to CQC.

The trust reported 118 serious incidents through the strategic executive information system between 2 April 2015 and 27 March 2016. One of the incidents was categorised as a never event. This took place at Burnley General Hospital when a person was seen to have climbed out of a dormitory window. This should not have occurred because the window restrictors should have been sufficient to prevent a person being able to open the window fully.

Thirty five incidents occurred in community based mental health services for adults of working age which is the most for any core service. Twenty five of these incidents were categorised as: 'apparent/actual/suspected self-inflicted harm'.

Community mental health services for children and young people reported the lowest number of incidents with one followed by child and adolescent mental health wards with two. The other core services reported between four and 13 incidents each.

The most frequent incidents reported were:

- Apparent/actual/suspected self-inflicted harm: 46
- Pressure ulcer: 11
- Disruptive/ aggressive/ violent behaviour: eight
- Confidential information leak/information governance breach: seven

Requires improvement

Are services safe?

- Unexpected Death of Community Patient (in receipt of care): five

Fifty seven percent of the trust's incidents reported to the strategic executive information system were closed. The oldest ongoing incident was dated April 2015 and was regarding a death in custody. The trust reported closing these was dependent upon third parties external to the trust completing their own investigations. However: this was an improvement of 27% from last year where we found 30% of incidents had been closed.

The number of serious incidents requiring investigation which staff reported through the trust's reporting system was 118 which correlated with the number the trust reported to the strategic executive information system. Ninety four were categorised as incidents that were unexpected or avoidable death or severe harm of one or more patients, staff or members of the public. Community-based mental health services for adults of working age reported the most of these incident types with 31 followed by Community health services for adults with 13 and Mental health crisis services and health-based places of safety with 11. Five other core services reported between three and five each. Of the 24 remaining, 13 were related to the loss of confidence in the service through adverse media coverage or public concern. The Forensic inpatient/secure wards had the highest with six followed by Acute wards for adults of working age with four. Three other core services had one each. Nine were in relation to a scenario that prevents or threatens to prevent an organisation's ability to continue to deliver healthcare services which were split across seven different services.

CQC received 26 direct notifications from the trust between 1 July 2015 and 3 August 2016 which were:

- Deprivation of Liberty Safeguards applications: seven
- Death in detention: seven (relating to five actual deaths)
- Absentee returns: six
- Admission of a child to an adult psychiatric ward : two
- Unauthorised absence of a detained patient: two
- Serious injury: one
- Abuse or allegation of abuse: one

The trust reported 9,898 incidents to the national reporting and learning system between 1 June 2015 and 31 May 2016. The majority of these incidents 7,606 resulted in no harm. 1,498 resulted in low harm, 751 in moderate harm, 35 resulted in severe harm and eight resulted in death.

The six most frequent incident types reported were:

- Self-harming behaviour: 2,877
- Medication: 1,480
- Access, admission, transfer, discharge (including missing patient): 1,167
- Disruptive, aggressive behaviour (includes patient-to-patient): 1019
- Patient accident: 1041
- Documentation (including electronic & paper records, identification and drug charts): 975

The NHS Safety Thermometer is a national improvement tool for measuring, monitoring and analysing avoidable harm to patients and 'harm free' care. It provides a monthly snapshot of areas of harm including falls, catheter and new urinary tract infection cases and pressure ulcers. The trust reported 124 new pressure ulcers between June 2015 to June 2016. The highest monthly number reported was 17 in January 2016 and the lowest reported number of new pressure ulcers was in December 2015 with four. The trust reported 177 falls with harm during the time specified. The highest monthly number reported was 28 in May 2016. The lowest was in December 2015 with six falls with harm reported. The trust reported 25 catheter and new urinary tract infection cases in the time specified. The highest monthly number reported was four in January 2016 and March 2016. No cases were reported in October 2015 and December 2015.

Reporting incidents and learning from when things go wrong

In the NHS Staff Survey 2015, 97% of staff said that they had reported errors, near misses or incidents witnessed in the last month, which was five percent higher than the national average for combined mental health, learning disability and community trusts. This figure was a five percent improvement on the trust's score for 2014. For staff confidence and security in reporting unsafe clinical practice, and the fairness and effectiveness of procedures

for reporting errors, near misses and incidents, the trust scored higher than the national average and the score achieved for 2014. This indicated the trust had a mature, embedded culture of reporting incidents.

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.

During our previous inspection, we identified issues regarding the consistency in the quality of some of the investigations undertaken by the trust. The trust had implemented an action plan to improve this. This had included the development of a trust-wide 'investigations and learning team' which was responsible for completing all serious incident investigations graded four or five. All the investigators within this team were required to complete a postgraduate certificate in serious incident investigations to support them within this role. Incidents graded level three which required a 72 hour review remained within the networks for senior managers to undertake as did incidents rated as level one and two which required local management reviews. The trust required all managers undertaking level one to three reviews to be trained in root cause analysis and Human Factors training.

We looked at seven investigations the trust had completed following serious incidents. The investigations followed a root cause analysis methodology. The reports were comprehensive and completed within set time scales. Recommendations had been identified which were used to formulate action plans. However: one of the reports we looked at relating to a never event focussed entirely upon the physical environment which meant there was no evidence that clinical issues which may have related to the incident had been considered. Two reports identified some errors but not all which meant that opportunities for further improvement were not considered as part of the investigations; i.e. opportunities for further training in grading of pressure ulcers for example. These reports had been completed before the trust had introduced the new investigation team.

The Chief Coroner's Office publishes the local coroners 'Reports to Prevent Future Deaths' report which 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 future deaths.

The trust received five Regulation 28 notices in the last twelve months which related to deaths which had taken place between June 2013 and January 2015. Two deaths had occurred in two prisons and the other three had occurred in adult mental health services. The trust had developed action plans to address the issues raised by the coroner.

Learning from incidents was disseminated to staff through the governance structure and a number of established forums. The trust held 'Dare to share-Time to shine' sessions which staff across the trust could attend to share learning from incidents and complaints across networks. There were also a number of newsletters and alerts which staff received which included lessons learnt.

The matrons had oversight of all incidents reported in their clinical areas and they met monthly to monitor and review clinical quality issues including incidents. They shared learning from incidents with the team managers through their network governance meetings. Team managers held regular team meetings which included the sharing of lessons learnt.

The medicines management nurses worked with the pharmacy team to promote medicines incident reporting and the sharing of learning across networks and at nursing forums. Information about medicines-related patient safety incidents was shared through the trusts 'Bluelight' and 'Greenlight' e-mail bulletins which were used to raise staff awareness of learning from clinical and medicines-related incidents.

There was an established process for supporting staff following a serious incident. The violence reduction team provided staff de-briefs following a serious incident. This was recorded and monitored on the electronic reporting system. Serious incidents could not be closed on the system until it was confirmed a de-brief had taken place.

Debriefs for less serious incidents were managed at ward level. However; within the forensic wards, there was a lack

of evidence to demonstrate these were always happening. Staff could also access peer supervision, reflective practice meetings and support from a psychologist or occupational therapist if required.

Duty of Candour

The statutory Duty of Candour was introduced for NHS bodies in England from 27 November 2014. The obligations associated with the Duty of Candour are contained in regulation 20 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The key principles are that NHS trusts have a general duty to act in an open and transparent way in relation to care provided to patients. This means that an open and honest culture must exist throughout the organisation. Appropriate support and information must be provided to patients who have suffered (or could suffer) unintended harm while receiving care or treatment.

The trust's Quality Account 2015 – 2016 referenced the trust's commitment to 'achieving a culture of openness and transparency reflected by a constant desire to learn from mistakes, not to conceal them' in line with the Duty of Candour requirements. The trust had a Being Open Policy in place which took into account the statutory Duty of Candour requirements. The policy set out the approach staff needed to take including being open with patients, their relatives and carers when things went wrong and the formal process to comply with the Duty of Candour requirements.

The trust had also updated their incident reporting system to include compliance with the Duty of Candour. Compliance was reported to the quality and safety sub-committee and commissioners.

We looked at copies of the five most recent serious incident reports the trust had completed which met the criteria for Duty of Candour. These provided evidence that the trust had followed the Being Open Policy in relation to these incidents.

Anticipation and planning of risk

The trust had identified and escalated potential risks which could impact on their ability to deliver services onto the strategic risk register dated 3 May 2016. These included risks related to finances, sustainability, the transformation agenda and quality of service provision. The register was monitored by the board.

The trust estates strategy had been developed based on the needs and predicted needs of the population. Consideration of the trusts geographical foot print and the current and predicted key characteristics of the population were included.

The trust had business continuity plans and associated polices to ensure services could respond effectively in the event of an emergency situation or major incident which could impact on service delivery. This included situations such as flooding, bomb scares and pandemics.

Staff were able to provide examples of how they managed anticipated risks to both themselves and patients. These included how they followed the lone working policy to make sure staff were safe and prioritising services during adverse weather conditions for example.

Staff undertook fire drills regularly in the majority of services we visited. However: in seven of the 17 community teams for older people this was not the case.

Good

Are services effective?

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

Summary of findings

Our findings

Assessment of needs and planning of care

The trust used an electronic patient record system across all inpatient mental health wards and adult community mental health teams. This meant that staff had good access to patient records across these services. Community learning disability teams were using paper records which were not easily accessible to other teams within the trust if needed. However; the teams had mitigated this risk by saving patients' crisis plans onto a shared trust computer drive.

Within the community child and adolescent services, care records were visible to other trust staff; e.g. school nurses, as they were using the same electronic system.

The records were not visible to adult mental health services which meant it could be difficult for staff to access information when a young person was transitioning from child and adolescent mental health services to adult mental health services. However: we found there were effective transitional pathways to support patients who were moving between services within the trust including from child and adolescent to adult mental health services. These services had developed a joint protocol to support patients transitioning between their services. This process was supported by the introduction of dedicated transition leads in each locality.

Overall, staff were completing holistic and comprehensive assessments of patients' needs following admission to services. The assessments included the patients' physical, psychological, social, occupational, spiritual and cultural needs. However: within the community health services for adults, there were no pain assessment scoring tools in any of patient's records reviewed in the integrated nursing teams. In addition, not all patients within the community child and adolescent mental health service had an up to date and current risk assessment present in their care records which could result in patients receiving care that did not take into account of their risks.

The quality of the care plans we looked at was good overall and there was evidence of patients' involvement in the development of these. However, on Elmridge ward and in the child and adolescent community mental health services, the quality of the care plans was particularly poor. Staff on Elmridge ward confirmed care plans had been reviewed and completed in the days prior to our inspection with no involvement from patients. In Chorley and South Ribble Integrated Nursing Teams and the treatment room service, there were not always care plans in place for problems that had been identified. We found incomplete assessments, wound evaluation charts not updated at least fortnightly in line with the trust management of wound's policy, and not all entries had the time of entry documented.

Within the community health for adult's service, a new end of life pathway was launched in August 2016 to replace the Liverpool care pathway. This was not embedded in all services. There were different versions available at different bases and some staff thought the end of life care plan had been put on hold. We looked at 20 care records of patients who had died and found there was no end of life care plan in 18 of them. However; risk assessments, symptom control and discussions with the patients' family were clearly documented. The trust identified that of the 349 patients that had died between 1 April 2016 and 30 June 2016 who were on the integrated nursing team caseload, 49.6% did not have an end of life care plan in place.

Patients' care and treatment was monitored and reviewed regularly. Within mental health services, patients' care packages were co-ordinated and provided in line with the care programme approach principles. Care plans were recovery orientated and focussed on providing care in the least restrictive environment. Reviews were completed at least annually for patients in the community. Patients had a care co-ordinator allocated and a named nurse if they were an in-patient. However: within community health services

for adults, where several services were involved in a patients care, it was not clear in the patient record who was the key worker or the person responsible for coordinating the patients care.

Best practice in treatment and care

The trust had an identified Quality and National Institute of Health and Care Excellence lead for the trust. The medical director provided representation at the National Institute of Health and Care Excellence guidance committee. The trust had registered as a stakeholder on all guidelines and so staff could contribute directly to guidelines in development. Staff were informed of changes to guidance and provided with best practice up-dates through newsletters, the trusts' intranet and each networks' governance structure.

Overall, services were delivered in line with the National Institute of Health and Care Excellence guidance and we saw good examples of this in clinical practice across both acute and mental health services. These included guidance on breastfeeding, the use of high dose anti-psychotic medication, long lasting reversible contraception and the provision of psychological interventions in the treatment of psychosis for example. Across the trust, there were good procedures in place to monitor the physical health of patients and ensure patients' physical health needs were being met.

The trust had implemented a number of initiatives in line with best practice which included:

- the community health services for children and young people service had rolled out training in newborn behavioural observations to health visiting teams. This was a tool designed to promote positive bonding between parents and children
- a range of research projects in the children and families network including how to promote children's language development using family-based shared book reading
- speech and language therapists had devised a training and resource pack which had been sold to schools
- the care home effective support service team had implemented a 'hydration tool kit' which had resulted in patients diagnosed as dehydrated being treated at home rather than being transferred to hospital. The toolkit had been nominated and shortlisted for a 2016 Royal College of Nursing award at the time of our inspection
- the Family Nurse Partnership was delivered in the Preston and Burnley areas of the trust. This was a home visiting programme offered to first time mothers aged 19 years and under to improve health, social and educational outcomes
- staff had developed practical guides to treatment pathways for patients within early intervention services which had been published as good practice on the National Institute for Health and Care Excellence website
- the trust has supported over 3,132 patients to stop smoking since the introduction of their no-smoking policy in January 2015. They have recently rolled out access to e-cigarettes in addition to other nicotine replacement therapies for patients to support them to stop smoking
- with community mental health services for older people, the care home liaison staff ensured care staff understood a patient's life story as part of good dementia care.

The trust had an audit committee which fed directly into the trust board. The audit committee linked across the trusts four clinical networks through the network governance structures. An annual audit programme had been developed in line with the trusts' objectives and in line with National Institute for Health and Care Excellence guidance.

The trust participated in 45 clinical audits between October 2015 to June 2016 and eight local audits. These included a number of audits against the National Institute for Health and Care Excellence standards and:

- Quality Standard 43: Smoking Cessation re-audit
- Violence & Aggression – Short Term Management in Mental Health, Health and Community Settings.
- Clozapine Audit
- Consent To Treatment Audit November 2015
- Re-audit of Assessment & Treatment of Lower Limb Ulcers

- Domestic Abuse
- End of Life
- Safeguarding Review
- Enhanced Observation & Therapeutic Engagement

There was an audit programme to assess medicines handling in accordance with the trusts' medicine policies and national guidance. The trust participated in relevant POMH UK (Prescribing Observatory for Mental Health UK) audits to facilitate benchmarking of prescribing practice against other similar trusts and against national guidance. We saw that action was taken to address concerns highlighted through audits. This included the development of a Clozapine Task and Finish Group to promote the safe use of Clozapine in response to a review of incidents and low compliance with audit standards. This was included on the pharmacy risk register.

Where the results of an audit showed standards we not being met, the audit remained on the programme to make sure a re-audit was completed. For example: an audit of compliance with the trusts' 'Enhanced Observation & Therapeutic Engagement Procedure' was conducted within the Inpatient Mental Health Services. This showed compliance with all standards with the exception of 'Patients are involved in therapeutic activity during their inpatient stay' which scored a partial compliance rate of 77%. A re-audit took place in April 2016 which showed 100% compliance against this standard. This evidenced that audits were not removed from the programme until the trust had assurance that standards were met.

There was evidence across services that staff were involved in auditing patient outcomes. Some staff were also involved in research. For example: the Fylde rapid intervention and treatment team were participating in a national randomised controlled trial which aimed to establish whether assistive technology and telecare was an effective way of supporting patients with dementia.

The trust used an electronic outcome measures tool called quality SEEL. This consisted of data collected from a variety of sources and measured 16 quality outcomes related to safety, effectiveness, patient experience and leadership. This required teams to carry out audits of documentation, speak with staff, patients and carers and undertake observations of care provided and the environment. Team leaders had the authority to submit any issues of concerns that were identified through the SEEL audit onto their local risk register. 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.

Teams also used a range of recognised assessment tools to monitor outcomes. There was written guidance and training to support staff to use these tools which included:

- the model of human occupation screening tool
- the Liverpool University neuroleptic side-effect rating scale
- health of the nation outcome scores
- Canadian occupational performance measure
- mental health clustering tool
- children's global assessment scale
- Waterlow assessment tool
- Cornell scale for depression in dementia
- malnutrition universal screening tool
- recovery star
- my shared pathway
- functional assessment measure
- the Addenbrookes cognitive examination tool
- the challenging behaviour scale
- the depression, anxiety and stress scale

However: at Longridge hospital staff were not always following best practice guidance and auditing patient outcomes. Within the community health services for adults, there were no audits performed to determine if patients that had experienced a close death felt supported during and after the death. This resulted in a missed opportunity to learn and improve services for patients and those close to them. We were also not assured staff were always following the trust policy and guidelines for, 'The prevention and management of pressure ulceration'. We found of the 973 pressure ulcers reported during the period 1 September 2015 and 31 August 2016, 59.1% of pressure ulcers developed whilst the patient was in the trust's care. This was not identified as a risk on the community health services for adults risk register.

Good

Are services effective?

Skilled staff to deliver care

During our last inspection, we identified that the trust had experienced difficulties in how the human resource department had functioned which had impacted negatively on the recruitment process, management of staff disciplinary procedures and staff compliance with appraisals, supervision and mandatory training. Since our inspection, the trust had developed an Academy which had been set up to provide a central hub to monitor and manage all aspects of staff training and development. Since the introduction of the Academy, it had:

- developed a new process for induction. Figures showed the number of staff receiving an induction within four weeks of starting had increased from 12.64% in October 2015 to 95% which demonstrated the new induction process was effective
- worked with a local college to provide courses for band 1 to 4 unqualified staff to help them gain the academic qualifications needed to access degree level programmes such as nursing. The trust had in excess of 30 staff in that pipe line at the time of our inspection
- developed a compassionate leadership programme which provided up to 14 master classes for staff coaches who had been allocated to support this programme
- been shortlisted for Apprenticeship employee of the year 2016 for the collaborative work it had done with a local college. The trust had 200 nursing apprenticeships across the patch
- developed a coaching network which was underpinned by a values based framework. Twenty one staff had been identified as cultural ambassadors for the trust
- provided 1000 placements in this year for the non-medical workforce
- supported quality dashboards for each team which showed 'real time' compliance with appraisals, supervision and training
- supported a core medicines education and training package at different levels to provide training appropriate to the roles of staff. In addition, a mixture of face-to-face and e-learning training was available on specific topics including, antimicrobial stewardship, venous thromboembolism, diabetes and mental health medications.

We spoke to a group of team and service managers. Most had been supported by the trust and in some cases Health Education England to complete additional training, including at Masters and Doctorate level. In the NHS Staff Survey 2015, 90% of staff said they believed that the organisation provided equal opportunities for career progression or promotion, which was one percentage point more than the national average. The trust 2015 score was six percentage points more than it was in 2014. However: within community health services for adults, 66.4% of staff identified by the trust as requiring training in relation to pressure ulcer management had not accessed any modules on the trust training tracker in the 12 months prior to September 2016.

The director of human resources described how the team had changed their approach to performance management; intervening early to prevent the need for formal procedures. Staff discipline and grievance had reduced by 34% since our last inspection. We spoke separately to a group of union representatives. The union representatives spoke positively about their relationships with the human resources team and reported they were working together to address problems with staffing.

The workforce race equality standard requires NHS trusts to demonstrate progress against nine indicators of workforce equality. The trust was collecting data using the equality delivery system, analysing and publishing the data, and acting to close the gap between the treatment of white staff and Black and minority ethnic staff. For example, the trust was using a root cause analysis tool to understand why black and minority ethnic staff were more likely to be formally disciplined and report discrimination than white staff. The trust had implemented many strategies to try to improve the experience of black and minority ethnic staff. These included an 'opportunity knocks' equality and diversity conference, equality and diversity training, equality impact assessments for recruitment and targeted communication for development opportunities. The workforce race equality standards report showed that the trust had made progress in some areas since 2015. For example, in 2015, 74% of black and minority ethnic staff said they believed that the trust provided equal opportunities for career progression or promotion. In 2016, this had increased to 92%, which was the same proportion as for white staff.

Good

Are services effective?

Between April 2015 and March 2016, the trust suspended 34 staff pending the outcome of a disciplinary hearing investigation. This meant these staff were not undertaking active duty within the trust during their period of suspension. The director of human resources told us where possible, the trust looked at alternatives to suspending staff where this was assessed as appropriate. The trust had moved 25 staff to alternative duties while an investigation was carried out in this time period. The director of human resources gave an example that a clinical member of staff might be moved to an office based role temporarily while an investigation was conducted. The most instances of suspension / supervision were with band 3 staff with 21 followed by band 5 staff with16.

The acute mental health wards had the highest instance of suspension/supervision with 23. The locations with the most instances were Keats ward with six followed by Byron ward with five. The wards for older people had the highest number of staff who have been moved to alternative duties with seven followed by the acute mental health wards with six.

We reviewed five recently completed staff disciplinary files. We audited the files against the trusts' disciplinary procedure policy. The files contained evidence which demonstrated that the policy and procedures had been followed in each case. We looked at four staff files which contained referrals the trust had made to the Nursing Midwifery Council. Three of the files were all in order however; one of the files did not contain an outcome. This was immediately rectified when we raised this with the human resource manager.

We looked at three staff grievance's which the trust had received in line with the trusts grievance policy dated August 2016. In all cases, the trust had responded to the grievances within 10 working days as per policy. Appropriate actions had been taken to address and resolve the issues raised including the issuing of an apology where a grievance was upheld. We did find however; that two of the files did not contain interview notes relating the parties involved.

The trust provided five staff exit questionnaires which had been completed between March to October 2016. All five had been completed by consultant psychiatrists and were therefore not representative of all staff groups who had left the trust in this time period. The reasons cited for leaving the trust were related to obtaining a promotion or travel issues.

In the NHS Staff Survey 2015, 41% of staff said they had suffered work related stress in the previous 12 months which was three percentage points more than the national average of 38%. However: this was 11 percentage points less than it was in 2014 which is a positive finding.

Seventy two percent of trust staff reported through the survey they had received an appraisal in the past 12 months. The trust scored 3.21 for the quality of appraisals provided against the national average of 3.05. During our last inspection, we reported that there were some inconsistencies across the trust in relation to staff receiving appraisals and the accuracy of the data recorded by the trust. To address this issue, the trust had implemented a new appraisal system in April 2016 based upon the trust's strategic objectives and values. The director of nursing told us that the clock had been re-set at the same time and there was a rolling programme in place to ensure that all staff had received an appraisal under the new system by March 2017 and that this was recorded centrally. The Academy monitored compliance with the new appraisal system.

The figures the trust provided for compliance with appraisals for the 12 months prior to the implementation of the new system showed rates below 75% compliance in some teams within the following core services:

- Wards for older people
- Forensic in-patient/secure wards
- Community health services for children and young people
- Community health services for adults

The trust's overall appraisal rate since the implementation of the new appraisal system in April 2016 for non-medical staff was 32% as at 29 June 2016. Out of 6338 staff, 1998 had received an appraisal and 4340 had not since the introduction of the new system. This meant the trust had exceeded the target it had set for quarter 1 of 2016.

Good

Are services effective?

As at 11 May 2016, 111 of the 116 permanent medical staff had an appraisal in the last 12 months which equated to 96%. This figure included only permanent staff, and not those on short term contracts or trust locums.

The trust reported that 95% of doctors had been revalidated which was based on "100 positive recommendations and five deferrals."

The trust had introduced supervision passports for all staff since our last inspection as the trust had recognised that not all staff were recording all their supervision sessions accurately. Staff told us supervision occurred informally in conversations with senior staff and within team meetings, care reviews and multidisciplinary meetings although this was not always recorded.

Overall, compliance with supervision was good with most teams achieving between 75%-100%.

On the wards for older people, acute wards, forensic wards and community health services for adults, some teams were not achieving this target. However: staff reported they could access support if needed and they felt supported in their roles. Student nurses and junior doctors told us that they received regular, good quality, formal and informal supervision. They felt that the trust induction and local team inductions prepared them well for their roles.

Multi-disciplinary and inter-agency team work

All the teams we visited provided care and treatment to patients within a multidisciplinary model of care. The teams consisted of a range of disciplines, including consultant psychiatrists, doctors, nursing staff, social workers, psychologists, pharmacists, occupational therapists, health visitors and other health and social care professionals depending on the services being received. However: within the community learning disability service, some teams had no speech and language therapists and no psychology which was due to commissioning arrangements.

In the NHS Staff Survey 2015, the trust score for effective team working was 3.94, which was slightly above the national average for similar trusts.

Each team we visited had established regular multidisciplinary meetings which included ward rounds and staff handovers. We attended 34 multidisciplinary team meetings and staff handovers. These were attended by key staff involved in the patients care. The meetings were collaborative and informative. Within mental health services, patients care packages were co-ordinated and provided in line with the care programme approach principles.

Some teams used technology such as skype for meetings if distance was an issue. For example, the community older people teams and wards held joint bed management meetings via skype.

The child and adolescent mental health services had developed a protocol with adult mental health services to support patients transitioning between their services. This process was supported by the introduction of dedicated transition leads in each locality.

Within all the services we visited, there were examples of how staff had built and maintained good working relationships with agencies and stakeholders external to the trust. These included statutory agencies such as the police, social care services and primary care in addition to non-statutory agencies such as voluntary services.

The trust had a multi-agency policy in place for the implementation of section 136 of the Mental Health Act in accordance with the crisis care concordat. This had been jointly agreed by the trust, local police forces and relevant stakeholders. There were excellent working relationships with partner agencies and good attendance at multi-agency meetings.

There was effective joint working between the diabetes service and a local ambulance trust to support diabetic patients on a hypoglycaemia pathway who were at increased risk of falls. The tissue viability and lymphoedema service worked with a specialist podiatrist to run a 'healthy legs clinic' in Darwen twice weekly.

Pharmacists and extended role pharmacy technicians were fully integrated into clinical teams to support and ensure best outcomes for the use of medicines. The non-medical prescribing team provided leadership and governance to primary care non-medical prescribers.

Within the community mental health services older people, staff provided a care home liaison service to give support and advice to patients and care home staff.

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

The trust had established systems in place to support the administration and governance of the Mental Health Act. A

team of Mental Health Act administrators were based in each locality and were managed by a mental health law manager. The mental health law manager informed us the team provided the central oversight of the administration of the Act within the trust and the link between the clinical networks and the trust governance structure.

Each of the four clinical networks had a network mental health law group that ensured compliance with mental health law and best practice within that networks. The mental health law groups reported to the trust mental health law sub-committee which reported directly to the quality committee.

Training on the Mental Health Act was considered essential training for specific staff groups dependent upon their role. As at 23 August 2016, the overall trust compliance rate for Mental Health Act level 2 training was 50%. This could be broken down as:

• Adult Community 41%

• Adult Mental Health 36%

• Children & Families 80%

• Specialist Services 43%

These figures show that three of the four networks fell below the CQC benchmark of 75%.

Since our last inspection, the trust had fully implemented an electronic system for documenting Mental Health Act records across the trust. Overall adherence to the Mental Health Act within each locality was monitored by the Mental Health Act administrators who produced daily ward reports which provided an overview of each detained patient's status. This included information about section 132 rights, consent to treatment dates and information on hospital manager's hearings and tribunals. The daily ward view ensured that staff were clear about the requirements of the Act and the timeframes for the completion of all actions. The trust undertook quarterly audits of consent to treatment to ensure compliance with the Mental Health Act and Code of Practice.

The CQC had undertaken 24 unannounced Mental Health Act reviewer visits between 1 June 2015 and 30 June 2016. The visits focussed on assessing the care and treatment detained patients received in 10 different categories such as leave, security and consent to treatment. Over the 24 visits, there were 147 issues found at locations across the trust. The highest category for issues was purpose, respect, participation, least restriction with 56 issues followed by leave of absence with 25 issues. Mallowdale and Orwell wards both had the most issues in a single visit with nine each. Bronte ward had the lowest number of issues in a single visit with two.

Of the 24 wards visited, 21 had issues identified with purpose, respect, participation, least restriction with Orwell ward having the most with five.

The next three categories which had the most issues identified from the visits were: admission to the ward, leave of absence and consent to treatment. Seventeen of the 24 wards flagged these issues. Patients detained using police powers and assessment, transport and admissions to hospital categories had the least number of issues identified, with 23 of the 24 locations visited not identifying this issue.

During this inspection visit, we found staff were adhering to the principles set out in the Code of Practice and their application of the Mental Health Act was good across all wards. From the evidence we collated relating to the wards, we concluded that:

- patients' care records contained the necessary legal paperwork relating to their detention
- documentation relating to the authorisation of section 17 leave was complete and risk assessments were completed before leave was authorised
- patients were advised of their rights in accordance with section 132 of the Mental Health Act
- patients' capacity to consent to treatment was assessed and documented
- prescribed medication was authorised by a form T2 or T3 in accordance with section 58 of the Mental Health Act copies of which were attached to patients medication charts
- all detained patients were automatically referred to the independent mental health advocacy service unless they had capacity and objected.

However; we found the following issues within the adult community mental health services in relation to the application of the Act:

- patients on a community treatment order had not been informed of their rights to an independent mental health advocate
- patients had not exercised their rights to appeal and we could not be assured that this was an informed choice
- systems were not in place to ensure that the corresponding legal authority to administer medication to community treatment order patients were kept with the medicine chart and reviewed by nurses administering medication
- staff did not always consider the consent status and scope of parental responsibility when patients came into the service at the age of 16.

During a focus group we held with approved mental health professionals, staff raised concerns that inpatient beds were not always available for patients in the community who were liable to be detained. They reported that this meant some patients who had been assessed as requiring immediate hospital admission under the Mental Health Act, were waiting for long periods to receive the care and treatment they need. As a result, patients were being subjected to multiple assessments as beds became available days later. This often resulted in a different approved mental health professional and doctor becoming involved in each new assessment of the patient.

There were also some issues raised regarding access to an inpatient bed for patients who had been detained under section 136 of the Mental Health Act and who had subsequently agreed to be admitted informally to hospital. Staff told us that patients detained under section 136 who required a formal admission to hospital were prioritised and usually found a bed within the 72 hour assessment period of the section 136. However: the trust reported 26 breaches where the 72 hour period had lapsed before a patient who had agreed to be admitted informally was found a bed. This meant that they remained in the 136 suite beyond the 72 hours. Breaches of section 136 were monitored and reported through the trust's governance structure and to the Multi-Agency Oversight Group.

Good practice in applying the Mental Capacity Act

The trust had a new system in place to deal with the interface between the Mental Health Act and Deprivation of Liberty Safeguards which included guidance to ensure that patients were not deprived of their liberty without authorisation. This is in accordance with paragraph 13.61 of the Code of Practice which states; "Hospitals should have policies in place to deal with circumstances where disagreement results in an inability to take a decision as to whether the Act or Deprivation of Liberty Safeguards should be used to give legal authorisation to a deprivation of liberty to ensure that one is selected".

All four networks had a compliance rate above 75% for Mental Capacity Act Level 1 training. Corporate services fell below this benchmark with 55%. The overall compliance rate for the trust was 79%. Compliance with Mental Capacity Act Level 2 training was much lower trust wide at 40% overall. This could be broken down as:

- Adult Community42%
- Adult Mental Health37%
- Children & Families47%
- Specialist Services44%

The trust made 63 Deprivation of Liberty Safeguards applications between 16 January 2015 and 11 February 2016 across 14 wards. The majority of these were made from wards for older people at the Harbour with almost a third (20) made at Wordsworth ward, 10 from Dickens ward and seven from Bronte ward. A further six were made from Hurstwood ward and five from Lytham ward. Longridge in-patient ward submitted five applications. The eight other wards submitted either one or two each.

CQC records show that we received 15 Deprivation of Liberty Safeguards notifications from the trust between the same period which equates to less than 25% of the Deprivation of Liberty Safeguards applications the trust submitted during this period. This was because the trust had only submitted applications which had resulted in a Deprivation of Liberty Safeguard been approved rather than all applications in line with the trusts' regulatory duty.

Staff had a good understanding of their responsibilities in relation to the Mental Capacity Act. For example, staff were able to discuss the five principles which underpinned the Mental Capacity Act and give practical examples from their clinical practice. There was evidence of formal best interest meetings when important decisions were taken about a patient who was assessed as lacking capacity to consent to that decision. Staff supported patients to put legal frameworks in place while they still had capacity to help them plan for future decisions before they became more cognitively impaired and unable to do so.

Good

Are services effective?

Staff understand and where appropriate worked within the Mental Capacity Act definition of restraint.

In community health services for adults, we observed staff gaining implied consent from patients however we saw little evidence that consent was documented in the patient record.

Gillick competence is the term used in British medical law to decide whether a child of 16 years or younger is able to consent to his or her own medical treatment, without the need for parental permission or knowledge. Children under 16 can consent to medical treatment if they understand what is being proposed. Within the services we inspected which provided care to children under the age of 16; staff demonstrated good working knowledge and application of Gillick competence in practice. For example: within community health services for children and young people, a good practice statement had been written entitled 'Using Gillick Competence to Gain Consent for Immunisations in the School Setting'. This described how the use of the Gillick competence assessment was found to be a highly effective process that empowered students to take responsibility in relation to their health needs. This had been submitted to NHS England.

Good

Are services caring?

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

Summary of findings

Our findings

Kindness, dignity, respect and support

The Friends and Family Test was launched in April 2013. It asks patients who use services whether they would recommend the services they have used and give them the opportunity to feedback on their experiences of care and treatment. The trust wide response rate between November 2015 and April 2016 of those eligible was between 1.1% and 2.4%. This meant that between 242 and 523 patients completed the survey each month. This was below the England average of between 2.2% and 2.5%. The response rate for mental health services was generally below the England average during this period apart from November 2015 where it was at 2.4% compared to the England average of 2.2%.

For mental health services the trust scored above the England average for patients who would recommend the trust as a place to receive care apart from April 2016 where they scored just below with 84% compared to 88% nationally. The only month with a higher than average number of patients who would not recommend the trust as a place to receive care was April 2016 which was twice the England average with eight percent.

For community health services, response rates were in line with the national average. The percentage of respondents who would recommend the trust as a place to receive community health services fluctuated between 89% in March 2016 to 96% in April 2016.

We received a total of 66 comment cards back from 17 boxes. In total, 39 of these were positive comments, 12 were negative and four were mixed. Eleven were left blank or were illegible. We received the most cards back from the acute and psychiatric intensive care wards with 29, nine of which were positive and eight were negative. The community health for adult's service had the second highest return with 27. Of these, 22 were positive, three were negative and one was mixed.

The trust received 6,636 compliments during the last 12 months. Community health services for adults received the highest number of compliments with 2,769 and child and adolescent mental health wards received the lowest number with seven.

Throughout our inspection, we spent time observing staff interactions with patients and carers within a range of settings including clinics, patients' own homes and in-patient wards. We also spoke with over 169 patients and 30 carers. All patients we spoke to said that staff treated them well and were responsive to their needs. Staff were respectful, caring and compassionate towards patients and their carers. Staff communicated with patients in a way that was appropriate to the patients' level of understanding and their age.

Staff we spoke with had a good understanding of the individual needs' of the patients they were delivering care to. Patients and carers at Longridge Hospital and patients within the forensic services were particularly positive about the attitudes of staff and the care they received.

Feedback from the patients' and carers' focus groups we held was mixed. We received very positive feedback from patients and carers at the Harbour regarding the flexibility of staff on the wards and how they had 'gone the extra mile'. This included arranging for a relative to stay overnight with a patient who was receiving end of life care. We spoke to a separate group of 16 carers, representing a range of trust services. Most were unhappy with the care their relative had received. Carers said that they did not feel listened to or involved. They found it difficult to contact staff and felt that communication generally was inconsistent.

The staff friends and family test was launched in April 2014 in all NHS trusts providing acute, community, ambulance and mental health services in England. It asks staff whether they would recommend their trust as a place to receive care and whether they would recommend their trust as a

place of work. The trust had a higher staff response rate than the England average (19.1% compared to 11.9%) from 1 January to 31 March 2016 which equated to 1,273 respondents.

The percentage of staff who would recommend the trust as a place to receive care was below the England average at 72% compared to 79%.

The trust scored the same as the national average in relation to privacy, dignity and wellbeing with 86%. The Royal Blackburn Hospital scored the lowest with 80% followed by Guild Lodge at 82%. The Platform scored the highest at 97%. The other five locations scored between 85-88%.

Throughout our inspection, we saw that staff respected patients' confidentiality and privacy.

Involvement of people using services

Patients were orientated to the wards and services on admission. Patients were shown around the ward and introduced to other patients and staff as part of the admission process. Wards had information and welcome leaflets available for patients.

Overall, we found that staff involved patients and their carers in all aspects of their care planning and most patients had been offered a copy of their care plan. However: within the community health for adult teams, discussions were not always documented in care records when patients were approaching end of life. Staff were not always recording whether they had offered patients a care plans within the community adult mental health teams.

At the start of 2015, the CQC sent a questionnaire to 850 patients who had received community mental health services from the trust. The questionnaire asked patients for their views about the care they received, how involved they had been in their care and treatment and their overall experience for example. Responses were received from 216 patients. The trust scored similar to other mental health trusts in all of the ten areas. However, the trust's performance in one question ('do you know how to contact out of office hours when you have a crisis') had declined since 2015.

Family members and carers of patients were involved in care and treatment where this was appropriate and agreed with the patient. This included reviews of patients care through care programme approach reviews and ward rounds. In the meetings we attended, patients were active participants in the discussions and staff listened to the views of patients.

Patients had good access to a range of advocacy services. Information regarding advocacy was available in all clinical areas. Some services also had information on non-instructed advocacy services for patients with significant cognitive impairment such as dementia, acquired brain injury or a learning difficulty where appropriate. Non-instructed advocates work with patients who lack capacity to support decisions in the patient's best interest. Staff actively supported patients to access advocacy if needed.

There were comment boxes available on wards for patients and visitors to leave feedback. The majority of wards held regular patient meetings with the exception of Hyndburn ward. At the Orchard, the patient meeting was run by an ex-patient who was now a volunteer for the trust. Some of the wards also had, 'you said, we did' boards on display. These detailed issues raised by patients and the actions taken by the service in response.

We found several good examples of how services across the trust had supported patients to be involved with and influence how services were developed. These included:

- at the Orchard patients had been involved in choosing a colour scheme and decor for the patient café
- on Dunsop ward, a patient had been involved in completing environmental checks on the ward
- the trust supported patients to be involved in the recruitment of staff at all levels
- at the Junction and Platform there was a well-established participation group in operation which former patients and their carers attended. Attendees told us they felt they had a real influence on decisions made about the service
- patients had been involved in writing the violence reduction training and crisis planning skills training with staff on the forensic wards which they had presented to the board

Good

Are services caring?

- staff on the forensic wards had also supported two patients to teach other patients about how they could develop 'My Shared Pathway'. This is a patient focussed tool which identifies the specific needs of patients and how they would like their care to be delivered by staff
- the trust had invited the parents of a patient who had recently been in seclusion to join a 'seclusion task and finish group' based on feedback they had provided about their experiences
- two patient groups had been developed in the Lancaster and Morecombe teams for people with a learning disability. One of these was a health in action group where patients were fully involved in making decisions about the group and arrangements for speakers to attend. The aim of the group was to encourage independence by accessing different resources in the community and to learn new skills as well as providing health and wellbeing awareness. They also had a co-design experience based project for patients. Patients provided feedback about services and their feedback made improvements and changes to services. This meant that patients were listened to and were consulted with to shape services.
- the trust had worked with the Dean of a local college to develop a 'recovery college' for patients. Staff and patients have been involved in this work which will be run by them. The prospectus had been completed at the time of our inspection.

Good

Are services responsive to people's needs?

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

Summary of findings

Our findings

Service Planning

Public Health England published a report in June 2015 which assessed the health profile of the population of Lancashire against the national average. This included health indicators such as hospital admissions, poverty, life expectancy, academic achievements, incidence of self-harm, alcohol related illness and a range of physical health issues. Overall, Lancashire scored above the national average against over 50% of the indicators. There were also significant health differences within the localities within the trusts' catchment area which ranged from relative affluent areas to some of the most economically deprived areas in the country. The trust had identified three health priorities, which were; starting well, living well and aging well to address some of these issues.

We saw from the trusts' estates strategy 'Property strategy-building for the future 2013-2019' that consideration of the trusts' geographical foot print and the current and predicted key characteristics of the population the trust served were included. The trust had a dedicated equality and diversity lead contact within the estates department to ensure the protected characteristics of the population were considered in any plans. A review of the strategy was included in the 2015/16 internal audit plan which was approved by the audit committee. The review provided assurance to the trust that there were established processes in place to ensure that the estate strategy would include the views of key trust staff and stakeholders. The implementation of the plan was monitored by the infrastructure subcommittee which had senior representation from each clinical network. The subcommittee fed into the trust boards finance and performance committee. All capital expenditure proposals were reviewed and approved by this committee based on priority, sustainability, waste reduction and alignment to the trusts vision and values.

The trust had identified that some wards did not meet the needs of the patient groups and had plans in place to move these to more appropriate buildings. There were limitations to the improvement work the trust could complete on Hurstwood ward at Burnley General Hospital as the building was not trust property. The trust had therefore planned to move the ward to a new building by December 2016. The new building was designed to meet the complex needs' of the patient group. Plans were on track at the time of inspection.

There were also plans to move the Platform and Junction onto one site to provide a more appropriate environment to meet the needs' of young patients. Both moves had been supported and approved by NHS England.

The trust was actively involved in the Lancashire and South Cumbria Change Programme. The programme was set up to support trusts and council organisations to work together to transform current systems to make sure they had the capacity to meet the needs of the population over the next five years and beyond whilst making financial efficiencies.

The trust also 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 good working relationships with commissioners and other stakeholders, including third sector organisations to improve service delivery. We saw some good examples of how the trust had worked with stakeholder to improve services. For example: they had successfully negotiated with the local council and bus company for a more frequent bus service and a zebra crossing to operate at the entrance to Guild Lodge to improve access to public transport and promote the safety for patients using this.

Good

Are services responsive to people's needs?

The trust had also worked with commissioners to open a 23 hour crisis support unit to deliver brief focussed interventions to patients in crisis who would otherwise be admitted to an acute mental health ward.

Within the community health services for adults, a review of the community matron service in Blackburn with Darwin had identified the need for specialist chronic obstructive pulmonary disease services and rapid access of care for patients to prevent hospital admissions. In response, the trust had implemented an intensive home support service that consisted of rapid assessment, intra-venous service, chronic obstructive pulmonary disease service and complex case management. There was evidence of multi-agency working and consultation, and input from patient focus groups to inform delivery of services.

Access and discharge

The trust received 430,000 referrals across all of their services annually and 2.8 million contacts with patients using their services which was very high compared to similar trusts.

The trust operated a single point of access model for access to services including in-patient beds. The target times for the single point of access teams were five working days to see urgent referrals and 14 working days for non-urgent referrals. At the time of our inspection, all the teams were meeting this target with the exception of the single point of access team at Preston which were seeing urgent referrals within eight days. The team had introduced a triage telephone call in order to make initial contact with the patient to assess their level of urgency to meet the target time of five days. This had resulted in a reduction in the waiting time month on month.

Within the community health services for adults, referrals to services were prioritised to ensure patients with urgent needs were seen in a timely manner. This was evidenced by the service meeting the national target of 18 weeks for referral to treatment times. There was easy access to clinic premises and the referral process took into consideration the holistic needs of patients using the services. We saw evidence of flexibility to meet patients' needs which included: rehabilitation services being offered in the workplace. However; within the integrated nursing service, there was a lack of systems in place to monitor response times although the team was over performing against their contract for activity.

The trust had consistently exceeded the days from initial assessment to the onset of treatment time national target of 126 days in all the services provided within this core service. In twelve of the services provided, the actual days from initial assessment to the onset of treatment time was significantly lower than the national target. Rheumatology had the highest actual days with 77.4 and the Rapid Assessment Team had the lowest with 0.7 days.

Within community health services for children's, the trust had consistently exceeded the target of 18 weeks for referral to treatment times for physiotherapy since September 2015. However; the referral to treatment times for occupational therapy and speech and language therapy had not been achieved. The delays in accessing these services had been escalated onto the networks risk register. The service was meeting the initial assessment to onset of treatment national target time of 126 days for, physiotherapy, speech & language therapy and paediatric musculoskeletal services. Children's Speech & Language Therapy had the highest actual days with 92.7 and the paediatric musculoskeletal service had the lowest number of days with 26.1.

The community mental health services for children had waiting lists for patients referred to the service which were monitored through the governance structure. The target time from referral to assessment was 18 weeks. The trust were meeting with target in all teams with the exception of Ellen House which had six patients who had waited over this target up to 24 weeks between March to August 2016.

All teams with the exception of one were meeting the 18 weeks waiting time target from acceptance into the service to allocation of a care co-ordinator. Five patients were waiting over this target at Ellen House.

The community mental health services for patients with a learning disability or autism were achieving the referral to treatment times of 18 weeks for access to speech and language therapy, occupational therapy and physiotherapy.

The early intervention teams had a standard of two weeks target time from referral to treatment. The team were exceeding the key performance indicator set to see 50% of referrals within this time. Overall, patients did not report any significant issues with accessing services, response times or appointments being cancelled within the community teams we visited.

Good

Are services responsive to people's needs?

The podiatry service had access to a vascular consultant who could see patients the same day. The service could request blood tests and x- rays prior to the appointment and gave a letter to the patient to take with them to the appointment which reduced the need for additional appointments.

Staff were following the trusts' policy in relation to actively following up when patients did not attend for appointments.

Since our last inspection, the trust had commissioned an external review of the transition arrangements between children and adolescent mental health services within in trust. This was in response to issues we identified during inspection which had resulted in the trust implementing a new transitions protocol. The review was carried out by an NHS internal audit team external to the trust in the summer of 2016 to assess the effectiveness of the new protocol.

The review included seven patients who were due for transition from children and adolescent.

The audit confirmed that transfer of care documents were available in six out of seven files, evidenced discussion with the transition lead in all but one case and where it was agreed that transition was appropriate a joint meeting was held in 100% of cases. Feedback from patients was positive. This meant that improvements had been made with significant assurance given to the board by the reviewing team. The report made five recommendations for further improvement which senior managers were working to address.

Over 95% of all admissions to the in-patient acute mental health wards were gate kept through the crisis resolution home treatment team. These teams did not have waiting lists so they were able to respond to referrals quickly. The teams ensured that all other options were considered such as providing intensive treatment and support at home, before a hospital admission was agreed as the most appropriate option.

The average bed occupancy rates for each core service between 1 November 2015 and 30 April 2016 were:

- adult acute admission wards: 96%
- forensic/secure wards: 97%
- child and adolescent wards: 92%
- wards for older people: 98%
- community health in patient wards: 90%

The Royal College of Psychiatrists reports that when bed occupancy rates rise above 85%, it can start to affect the quality of care provided to patients and the orderly running of the ward and hospital. Thirty three of the trusts' 42 wards had bed occupancies above 85%. Wordsworth ward had the highest bed occupancy with 112%. The following wards had bed occupancy rates above 100%: Dickens, Austen, Darwen, Orwell, Keats, The Orchard, Scarisbrick, Dutton, Greenside and Marshaw. The high bed occupancy rates within the trust had been escalated onto the trusts' strategic risk register.

The following wards had occupancy rates below 85%: Bronte, Ribble, Mallowdale, Byron, Fellside and the Hermitage. The trust had reduced the occupancy on Fellside due to the planned opening of the women's Low secure unit ward on Fellside East.

The trust provided length of stay data for current inpatients as at 18 May 2016 and for patients discharged between 1 May 2015 to 30 April 2016. Forensic/secure inpatient wards had the highest lengths of stay with eight wards having current lengths of stay over 1000 days the highest of which were Forrest Bank at 1893 days and Fellside at 1804 days. The lowest lengths of stay were at The Platform at 17 days and Longridge at 20 days.

There were 212 readmissions within 90 days reported by the trust between 1 November 2015 and 30 April 2016 across 42 wards. The significant majority of these occurred in adult acute wards and psychiatric intensive care units with 191. Community inpatients had the second highest with 16 and wards for older people reported five.

Between 1 November 2015 and 30 April 2016, the trust reported 244 delayed discharges.

These were broken down by core service:

- Adult acute wards; 124
- Wards for older people; 101
- Child and adolescent wards; 10
- Forensic secure wards; nine

The wards with the highest numbers of delayed discharges were Wordsworth ward with 32, Dickens ward with 28 and Orwell ward with 21.

Good

Are services responsive to people's needs?

The main three reasons for delays in discharging patients from hospital were:

- awaiting residential home placement or availability
- housing: patients not covered by NHS and Community Care Act
- awaiting nursing home or placement or availability

Staff within both the community older people's and adult mental health teams told us that delayed discharges and high bed occupancy levels on some wards meant that staff in these teams were having to work additional hours to manage increased risks in the community because no beds were available for some patients assessed as requiring a bed. Accessing an adult acute bed at the Harbour was identified as a particular issue by staff.

The trust reported 26 incidents in past 12 months where patients were not found a bed within 72 hours following detention under section 136 of the Mental Health Act.

Between March and August 2016, 237 patients had been placed in an out of area bed by the trust. Of these, 183 were acute admission beds and 54 were for psychiatric intensive care beds. The trust had secured a 'one-off' payment from commissioners to develop a clinical bed management hub with the aim of reducing out of bed usage and improving patient flow through the system. Since the implementation of the hub, the trust had significantly reduced the number of out of area beds used. In March 2016, a total of 44 out of area beds had been used. This figure remained stable month on month until August 2016 when there was a significant reduction to 26 out of area beds used. The use of psychiatric intensive care beds fluctuated between seven per month in March 2016 to a high of 12 in June 2016. This meant the reduction was largely in acute admission bed usage which fell from 37 in March 2016 to 18 in August 2016. Commissioners told us they were impressed by the progress the trust had made.

The trust had recently opened a mental health crisis support assessment unit based at Blackburn General Hospital. The aim of the unit was to provide brief interventions for patients in crisis within a safe environment to avoid an admission to an acute ward. The unit enabled patients to stay on the unit for up to 23 hours for assessment and crisis intervention treatment by a range of mental health professional. It was too early to determine if there was a correlation between the opening of the unit and the reduction in acute out of area bed usage.

The Quarterly Mental Health Community Teams Activity return collects data on the number of patients on care programme approach followed up within seven days of discharge from psychiatric inpatient care. The teams have been consistently above the national 95% target from January 2015 to March 2016 for seven day follow ups. Between January and March 2016, the trust scored above 98%.

The facilities promote recovery, comfort, dignity and confidentiality

Within the community services we visited, there was a good range of interview rooms where staff could see patients in private. These were appropriately furnished, clean and tidy. On the wards, patients had access to a range of therapy and activity rooms, family visiting rooms and lounges. Some of these had dual purposes however: the activity room on Fellside east was used as the multidisciplinary meeting room and the family at Burnley General hospital was used as a staff room and not designed for purpose.

Every ward had access to outside space. Three of the adult acute wards were located on the first floor without direct access to the outside space. Some patients required a staff escort to access the outside space and both staff and patients told us there could be a delay in this depending upon staffing levels and ward activity. On Hurstwood ward, there was no dedicated garden area however; staff took patients to the hospital garden on a daily basis.

Most patients had their own bedrooms. However: at Burnley General hospital, four wards had shared dormitory bays which did not promote patients privacy and confidentiality. The trust did not own the building and they had plans in place to relocate these wards to more suitable accommodation. Staff supported patients to personalise their bedrooms with picture and photographs. Patients had access to locked facilities to keep their belongings safe. Where bedrooms did not have en-suite facilities, patients could access nearby bathrooms and toilets. Assisted bathrooms which were fitted with bespoke baths designed to assist less able patients were available.

The seclusion and health based places of safety suites promoted the privacy and dignity of patients with the

Good

Are services responsive to people's needs?

exception of the seclusion suites on Dutton and Langdon wards which were in close proximity to each other so conversations could be overheard. Within the health based place of safety suite at Burnley General Hospital, there was no screening on the window which could compromise patients' privacy and dignity.

There was a good range of therapeutic, occupational, social and educational activities delivered in all the wards and services we visited. The trust monitored all wards to assess if they were meeting the target of providing 25 hours of meaningful activity each week to every patient. Most wards were meeting or exceeding this target. Seven of the forensic wards had not achieved 85% compliance with this target over the past eight months. The lowest rate was on Calder ward with 58% and the highest was on Greenside ward with 83%. However, four of these wards were either admission wards or high dependency wards with a greater acuity of patients.

The facilities and activities at the Harbour were excellent and there were good provisions at Guild Lodge. The ward designs at the Harbour included curved walls that gave the impression of a circular shape allowing patients to move around freely and remain under cover even when outside. The garden space on Wordsworth ward was preceded by a wall mural that suggested a walk in a forest, then on to a beach, before arriving at a purpose built "pub", called Iggy's bar. The bar had seating, an area outside to sit, and a proper bar with beer pumps (disconnected) to give an atmosphere of a real bar. Bronte ward had a similar design, with a purpose built "café" in the garden. Tarnbrook unit provided vocational training including woodwork, metalwork, gardening and a computer suite. There was a therapeutic resource centre which provided pottery, art, library, kitchen and communal areas. Social activities were provided at the Gleadale social club such as cinema nights and pool tournaments. There was a cafe and other social areas to facilitate drop in sessions. Gardening activities, qualifications and employment were available to patients who accessed the 'grow your own' project which was a large gardening project at Guild Lodge.

During our last inspection, we highlighted problems with patients not being able to make phone calls in private within the forensic wards. We found improvements had been made which included: all payphones had a hood or an enclosed booth to provide privacy and patients had access to cordless phones which they could access to make private phone calls from their bedrooms.

In relation to food, the 2016 patient led assessment of the care environment data for the trust was 89% which was one percent lower than the England average. Ormskirk District and General Hospital scored worse than the trust across the three food categories. For ward food, the trust scored below the average of 92% with 87%. The Orchard scored the lowest with 73% followed by Ormskirk District and General Hospital with 74%. Guild Lodge scored 83%. The other five locations scored between 90 - 95%.

At the Junction, patients had raised some issues regarding the quality of food provision. Patients had been involved in developments to improve this which included access to the kitchen facilities so they could cook their own meals. Patients reported this played an important role in their recovery. The food at Guild Lodge had improved since the last inspection. A new menu had been implemented in September 2016 which patients had been involved in developing. All patients described the food as good quality, with better portion sizes and more variations to the menus. Menus were available to cater for those with special dietary needs and a new seclusion menu had also been introduced. Patients could access a hot drink or snack at any time during the day or night. Generally patients reported they were happy with the food provision although patients we spoke with on the acute wards provided mixed views regarding the quality of the food provided.

Meeting the needs of all people who use the service

The trust had an Equality and Diversity Statement of Intent 2015-2020 which outlined how the trust aimed to further develop and improve services to meet the diverse needs of the population it served. This linked with the trusts' strategy and quality vision and described how the trust would measure success. Across the trust, we found that patients' diversity and human rights were respected by staff. Staff were aware of patients' individual needs and tried to ensure these were met. Overall, 96% of staff had attended equality and diversity training in the trust which was a significant increase from 2014 which was 56%.

The trust had extended its network of equality and diversity champions to over 60 across the organisation. Their role involved proactively seeking out opportunities to promote

Good

Are services responsive to people's needs?

inclusive working and celebrate diversity. The equality and diversity project the trust had ran over the past year was due to finish and the equality and diversity lead told us that permanent appointments were due to be made to roles in the equality and diversity team. These included a strategic lead and a post with responsibility for training and advice.

The trust had joined a local multi-faith forum since our last inspection. Patients had access to representatives from different faiths in the inpatient services and access to rooms that could be used for prayer or religious services. The trust had retendered the provision of Halal meals. Three companies had been short-listed by the trust and patients had decided which one they wanted the trust to use.

Pharmacists and the diabetic team offered advice for groups of patients with specific needs, for example patients who were fasting during Ramadan. Staff had access to interpreting services and we found evidence this was accessed appropriately by staff. Leaflets were also available in different formats and languages as required through the trust.

The trust had a community health outreach team, which specifically provided care for homeless people or those seeking asylum.

In community mental health services for adults of working age, the restart teams worked to ensure patients' holistic needs were met, promoted social inclusion and worked with hard to reach groups in innovative ways to promote mental well-being. For example, the restart team had developed a football league called the inclusion league which was developed in conjunction with Lancashire Football Association. Following a small settlement of people displaced from Syria, staff from the recovery service had established links and invited people to attend this local league football team to promote well-being and encourage participation and awareness of services available.

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

There were some good examples within the community sexual health services of how staff actively engaged with patients who were vulnerable and struggled to access services. This included looked after children and those at risk of sexual exploitation. The service had extended and variable opening hours in different sites for example colleges, youth cafes and treatment rooms.

The trust had developed a specific sexual health training module focussing on the needs of lesbian, gay, bisexual and transsexual patients'.

In relation to meeting the environmental needs of patients with dementia, the trust scored lower patient led assessment of the care environment scores than the average of 81% at four of the six locations assessed which were: The Royal Blackburn Hospital, Guild Lodge, Ormskirk District and General Hospital and The Orchard. Longridge Community Hospital and the Harbour scored 80%. The child and adolescent wards were not assessed against this criterion.

For meeting the environmental needs of patients with disability access needs, the trust scored lower than the average of 84% with 73%. The lowest score was at Guild Lodge with 50% followed by The Orchard with 70% and The Royal Blackburn Hospital at 74%. The Platform scored the highest with 100% and the other four locations scored above the national average. However; in the community learning disability and autism services, the form provided for patients to provide feedback about the service was not specifically adapted for this patient group.

Most services had disability access and disabled facilities such as toilets and bathrooms. Where there was no wheelchair access in community-based services, alternative appointments were made either at the person's home or a venue close to where they lived.

The trust had won a number of awards in the past 12 months for the work it had done in relation to equality and diversity including the NHS England Diversity and Inclusion Partner award for 2016/17.

Listening to and learning from concerns and complaints

In all the core services we inspected, staff demonstrated a good understanding of the trusts' complaints procedure. Patients had access to information regarding how to make a complaint and staff supported them to do this where required. Patients were provided with information about advocacy services and the trusts' patient advice and liaison

Good

Are services responsive to people's needs?

service which could also support them in making a complaint. Where possible, staff told us they tried to resolve complaints locally if it was within their power to do so in line with trust policy.

The trust received 1,099 complaints between 1 April 2015 to 31 March 2016. Of these, 271 were upheld and 372 were partially upheld. This figure also included formal written complaints.

In the community health services for adults however, complaints were not reported or monitored if they were resolved at local service level. This meant the figure was higher than the trust data supplied as the trust were unaware of these complaints.

The number of formal written complaints the trust received in 2014/15 was 773 which was an increase of 262 from on the 471 they received in 2013/2014. Of these, the number of upheld complaints also increased from 118 in 2013/14 to 151 in 2014/2015.

Five complaints had been referred to the Parliamentary and Health Ombudsman. Of these, three were not upheld, one was upheld and the other was partially upheld.

For the core services we inspected, community based mental health services for adults of working age had the highest number of complaints with 242 of which 150 were upheld.

Child and adolescent mental health wards community mental health services for people with learning disabilities and autism both received the lowest number of complaints with two each.

The trust received the highest number of complaints relating to nursing, midwifery and health visiting staff for a second year running. This staff group received 39.15% of the total number of complaints which was an increase of 3.48% from 2013/2014.

The top three most common themes in complaints the trust received were:

- all aspects of clinical treatment: 355 (for the second year running)
- attitude of staff : 105
- appointments, delay / cancellation (outpatient): 57

The latter also had the highest percentage of complaints upheld in with 46% (26).

The trust had implemented a rapid resolution process for managing and dealing with complaints 18 months ago. Although the trust reports these as a complaint, they are resolved much more quickly than the timescales for managing a formal complaint.

We reviewed five recent formal complaints which the trust had received against the trusts' complaints policy and procedures criteria for managing complaints. All the complaints had been managed and responded to within the timescales set within the policy. The evidence within the files we looked at provided assurance that the trust had investigated complaints appropriately and resolved them where applicable in line with trust policy. This involved keeping in contact with the complaint in addition to formally writing to the complainant with the outcome of the investigation. This included any actions the trust had taken or intended taking in response to the outcome of the complaint.

The trust had a number of ways staff shared learning from complaints across networks both through the trusts governance structure and forums. These included established initiatives such as the 'Dare to share-Time to shine' forum which provided sessions for staff across the trust to share learning from incidents and complaints across networks.

Locally, teams held regular team meetings which linked into their local governance structure.

Good

Are services well-led?

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

Summary of findings

Our findings

Vision, values and strategy

Since our last inspection, the trust had worked with staff and service users to rearticulate the trust vision within the trusts' strategic planning framework for 2014/19. This was in response to the result of a cultural assessment tool which highlighted that communication with staff regarding the future direction of the trust could be improved. The new overarching vision, 'High quality care, in the right place, at the right time, every time' was introduced in October 2015 and was known within the trust as 'Our vision'.

The trust had the following six values to support the implantation of the trusts' vision;

- Teamwork- share it
- Accountability- accept it
- Integrity- show it
- Respect- earn it
- Excellence- reach for it
- Compassion- offer it

The trust had integrated the following eight quality commitments based on the Department of Health's 6 C's to underpin this vision:

- Choice
- Quality; to provide high quality services
- Outcomes; to provide accessible services delivering commissioned outputs and outcomes
- Excellence; to be recognised for excellence
- People; to employ the best people
- Sustainability; to provide excellent value for money in a financially sustainable way
- Innovation; to innovate and exploit technology to transform.

The trust had four key quality work streams for 2016/17, which focused on providing quality assurance and continuous quality improvement. These were:

Priority 1:

- People who deliver and support the delivery of services are motivated, engaged and proud of the services they provide

Priority 2:

- People who use our services are at the heart of everything we do: all teams will seek the views of service users and carers to inform quality improvements

Priority 3:

- People who use our services are at the heart of everything we do: care will be safe and harm free

Priority 4:

- A quality focused culture is embedded across the organisation: services are well led and we are all working together to always be the best we can be

Each priority had a set target, identified how progress would be monitored and how this would be reported.

The trust created a single page visual presentation of 'Our Vision' which incorporated script and animation to support accessibility. The new trust vision was presented at an Engage event in January 2016 which 300 leaders across the organisation attended. The presentation of the vision and strategy was shared with new staff during the induction process. Posters were displayed in all clinical areas we visited.

The strategy was embedded across the trust's four clinical networks. Staff told us that they had felt involved in the development of the new values. Progress on the delivery of the strategy was monitored by the board through the trust's governance structure.

The trust was financially sustainable and secure.

Good

Are services well-led?

Good governance

The trust had 12 board of directors. This included five non-executive and five executive directors in addition to the chief executive and chair. The board was accountable for the running of the trust and provided the overall strategic leadership to the trust. The trust had a council of governors who provided a link between the communities and board of directors. They understood they held the non-executive directors to account and provided assurance to members, stakeholder organisations and the public on compliance with the provider licence, the delivery of strategic direction and the quality of services. There was representation from the trust governors at board meetings.

The trust had four committees which reported directly to the board which were:

- Quality committee
- Audit committee
- Finance and Performance committee
- Nominations Remuneration committee

The trust had the following four clinical networks:

- Children and families
- Adult mental health
- Specialist services
- Adult community

Each of the four networks had senior management representation at the following sub committees which fed directly into the board committees:

- Corporate governance and compliance
- Business development and delivery
- Mental health legislation
- Quality and safety

In addition, each network had a governance and assurance committee which linked directly into the business development and delivery subcommittee.

During our last inspection, the trust had an embedded governance structure from board to senior management level and was in the process of developing the structure from senior management level to wards and clinical teams. During this inspection, we found the trust had completed this piece of work. Each clinical network had a clear governance structure 'from ward to board'. Each network structure was displayed on a flow chart which provided staff with a visual overview of how their teams fit into the overarching trust governance structure. We saw the flow charts displayed in the clinical areas we visited.

The trust had commissioned an external independent review of its governance arrangements which was completed in July 2016. The commissioning of the report demonstrated that the trust was open to external scrutiny and was committed to improving the quality of services provided. The report was in draft at the time of our inspection.

The review focused specifically upon the following areas:

- effectiveness of the board committees and sub committees in their management of risk and the robustness and consistency of the assurances received.
- effectiveness of property services governance arrangements
- effectiveness of network governance arrangements, in particular the alignment of the network governance structures and arrangements to the corporate structure.

The review provided assurance to the trust that there was a clear connectivity at network level up to corporate level.

The trust commissioned an external audit review of the effectiveness of the board assurance framework which was published in March 2016.

The review assessed whether:

- the structure of the assurance framework met the requirements
- there was trust board engagement in the review and use of the assurance framework
- the quality of the content of the assurance framework demonstrated clear connectivity withthe trust board agenda and external environment

The review concluded that:

- the trusts' assurance framework was structured to meet the NHS requirements
- the assurance framework was visibly used by the board
- the assurance framework clearly reflected the risks discussed by the board

Good

Are services well-led?

We reviewed a sample of trust board minutes including those for closed meetings. The evidence we saw was consistent with the audit findings. The meetings were well attended and covered standing agenda items including; safe staffing, the board assurance framework, the strategic risk

register, financial plan and position, corporate key performance indicators and the trusts' quality improvement Care Quality Commission action plan. There were robust assurance mechanisms in place before the 461 actions on the CQC action plan could be signed off as completed by the board. For each of the actions on the plan, the evidence was reviewed and validated by the relevant clinical director and the safety and quality governance sub-committee group before being presented to the board for approval. The action plan had been up-dated in September 2016 and that majority of actions on the action plan had been signed off by the board as being completed. We saw evidence that progress had been made against the remaining few actions. Some of the remaining actions had been moved to the trust' business plan for monitoring as they were longer term actions. For example, the trusts' plan to move from paper based records to electronic trust wide and the proposed move of some wards.

The trust provided a copy of its full risk register for June 2016. This captured all risks within the trust. Clinical staff could escalate risks onto their own network risk register through their local team and governance meetings. Risks identified on local network risk registers were escalated onto the trusts executive strategic risk register through the sub committees which fed directly into the board. Each network had representation at each subcommittee. This meant the trust had a clear process in place for escalating risks from the wards and clinical areas to the board. The risk manager and director of nursing told us that risks remained on the register until the board had assurance that the risk had been mitigated and there was evidence that this had been sustained. This meant that the level of risk identified on the register did not always reflect action taken to reduce the risk therefore the actual level of risk. Some of the risks on the register did not contain dates of when recorded action had been taken. However: all identified risks had been up-dated in line with trust policy. Compliance with mandatory training, appraisals, supervision and staffing were captured on the register.

Management of local risk registers was good overall however: at Longridge Hospital, this was poor. One risk was three years old and no changes to the register had been made.

The board had good oversight of issues within each network through the governance reporting structure. In addition, members of the trust board undertook a visit to a clinical team each month called, 'Good Practice visits'. Membership included executive directors or their deputies, non-executive directors, governors and clinical commissioning group team members. Feedback from these visits was shared with teams, including recommendations for further development. These recommendations were developed into an action plan, which identified who was responsible for implementing the action and the timeframe for completion. We reviewed the reports from the previous six months. The reports contained recommendations from the team to improve service delivery in addition to recognising good practice. There was evidence that the visiting team escalated issues for consideration at board where these had trust wide implications.

The board received 'board balance score cards' for each clinical network which provided data on a range of key performance indicators such as staffing, training compliance, incidents reported, appraisal rates and complaints/compliments. Information on the score cards could be broken down to each team. The teams used 'quality dashboards' which provided them with information on key performance and quality indicators specific to their team. Teams also used an electronic outcome measures tool called quality SEEL. This consisted of data collected from a variety of sources and measured 16 quality outcomes related to safety, effectiveness, patient experience and leadership. 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. Trends and issues were discussed within local team governance meetings.

The trust had embedded reporting structures and policies in place to support staff to effectively manage a range of clinical issues such as:

- safeguarding
- infection control and prevention
- complaints

- application of the Mental Health Act
- application of the Mental Capacity Act
- medicines management
- staffing issues

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 and linked across the four clinical networks. Audits remained on the programme until compliance against standards was met.

Leadership and culture

The trust had commissioned a programme of work in January 2015 in partnership with The King's Fund to understand the current organisational culture and the extent to which the organisation had the collective leadership capabilities to create the desired culture to deliver the trust's vision for quality called 'discovering our culture; understanding our leadership'. The discovery phase involved reviewing evidence from organisational data already collected e.g. national staff survey and serious incident data and utilising a number of discovery tools including: a cultural assessment tool survey (which 2,066 people completed), collective leadership measure, leadership behaviours analysis, board interview questions and staff discussions**.** This demonstrated that the trust was committed to ensuring a positive culture existed within the trust. The trust had developed a coaching network which was underpinned by a values based framework to support them to achieve this. Twenty one staff had been identified as cultural ambassadors for the trust. In addition, the trust had developed a leadership programme for senior staff.

The trust had buddied a similar trust in the South of England to exchange ideas and explore how they could meet the challenges the trust faced going forward.

The trust had recently appointed three heads of nursing to support the director of nursing with the delivery of the trusts' quality agenda and to provide senior clinical leadership within the trust.

In the NHS Staff Survey 2015, 31% of staff reported good communication between senior management and staff, which was two percentage points less than the national average however: this was five percentage points higher in than it was in 2014. The trust scored higher than the national average for:

- staff motivation at work
- recognition and value of staff by managers and the organisation
- staff being able to contribute towards improvements at work
- staff satisfaction with level of responsibility andinvolvement
- support from immediate managers
- the trust score for staff recommending the organisation as a place to work or receive treatment was 3.70 which was slightly higher than the score for 2014).

The majority of staff told us that they felt valued by the trust and they spoke positively about the support that they had been offered by immediate and senior managers. Overall; staff morale was good within the trust. However: staff morale at Longridge Hospital and the child and adolescent wards had been negatively affected by uncertainty about the future due to proposed service delivery changes to these wards. Within the sexual health service, some staff reported low morale due to them being transferred over to the trust from another provider.

The trust had a number of established methods to promote engagement and communication with staff across the trust. These included:

- The 'big engage event': Over 700 staff were involved in these events which focussed on improving the culture and governance structure within the trust
- 'InTouch' sessions: These sessions were well attended by staff and provided an opportunity for them to raise any issues directly with a member of the trust board
- 'Dear David': This initiative enabled staff to raise any concerns they had quickly and anonymously directly with the chair of the trust. Between March and August 2016, staff had raised 47 issues through this forum
- 'Quality Matters': The director of nursing, quality and governance circulated a briefing paper to staff on a monthly basis. The paper focussed on the quality agenda
- Trustnet: This site provided information and support for staff from the trusts communication and engagement team. Staff could make suggestions regarding information they wanted included on the site

Good

Are services well-led?

- The Pulse: The trust sent all staff an electronic bulletin every week which contained information which was rated red for important, amber for specific teams and green for non-urgent up dates
- 'Bluelight' and 'Greenlight' e-mail bulletins: These were used to raise staff awareness of learning from clinical and medicines-related incidents
- 'Dare to share-Time to shine'. These sessions were attended by staff across the trust and used to share learning from incidents and complaints across networks
- Newsflash: These were trust wide e-mails which were time sensitive or critical up-dates which were sent by the board to all staff
- Team Talk: This was a monthly brief of key messages and up-dates based upon the trust's strategic objectives and aims which was sent to all staff
- Insight: This was a staff magazine which was produced on a monthly basis
- Network newsletters: Each network had its own specific newsletter for staff which was sent out monthly or bi-monthly.

Fit and Proper Persons Test

The fit and proper person requirement is a regulation that has applied to all NHS trusts, NHS foundation trusts and special health authorities since 27 November 2014. Regulation 5 states that individuals who have authority in organisations that deliver care, including providers, board directors or equivalents, are responsible for the overall quality and safety of that care. This regulation is about ensuring that those individuals are fit and proper to carry out this important role and providers must take proper steps to ensure that their directors (both executive and non-executive), or equivalent, are fit and proper for the role. Directors, or equivalent, must be of good character, physically and mentally fit, have the necessary qualifications, skills and experience for the role.

The trust had two policies relating to the fit and proper person requirements: Recruitment and Selection Guidance and the Recruitment and Selection Policy both dated October 2015. The documents set out the main principles the trust had adopted for recruitment, selection and appointment to posts including the fit and proper persons test for the appointment of directors. The director of human resources had overall responsibility for ensuring that there were robust processes and procedures in place to allow for effective recruitment checks and procedures for staff and for providing assurances to the Trust Board of compliance with the procedure.

The process for appointment of directors included:

- pre-employment checks
- determination of specific qualifications and requirements set out within job descriptions and person specifications
- identity checks
- qualification and registration checks
- right to work checks
- disclosure and barring service checks
- references
- search of insolvency and bankruptcy register
- review of full employment history seeking explanation of any gaps in employment
- health questionnaire and occupational health clearance
- interview processes including values based panel interviews.

The trust had had a process for ensuring the continued fitness of directors through:

- the maintenance of a register of declared interests
- a formal appraisal processes
- the completion of an annual self-declaration by all directors
- the introduction of annual checks for credit, bankruptcy and registration.

We reviewed the personnel records of the 14 senior directors in the trust in line with the fit and proper person requirements and found the trust was meeting these requirements.

Engaging with the public and with people who use services

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 trusts' local communities with mental health and learning disability needs. The 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 trusts' engagement strategy formed part of their people plan. It set out how the public, patients, carers and other organisations would be involved in improving service delivery.

The trust issued a quarterly newsletter, 'VoiceNews' for patients, people who had used services and carers. This provided updates on the trust vision and strategy, publicised opportunities for involvement and asked for people's opinions and feedback.

We saw examples of patients, people who had used services and carers developing services at trust and individual level. 'The Crew' was a group of young people who had used the child and adolescent mental health inpatient service. They had attended a session with trust staff, commissioners and other stakeholders to discuss their views on the implementation of the Crisis Care Concordat. These views were integrated into the Crisis Care Concordat Lancashire action plan. We saw that other people who had used services had trained staff in risk assessment, and that a carer group had trained staff in information sharing. Patients were also involved in recruiting new members of staff into the trust.

The trust had also partnered with a local wildlife trust to develop a project, MyPlace, for around 1000 young people at risk of mental health problems. MyPlace offered these young people opportunities to participate in improvements to urban community green spaces.

Quality improvement, innovation and sustainability

- The trust had the following services which had received national accreditations:
  - The Junction and The Platform; Quality Network for in-patient Child and Adolescent Mental Health Services
  - Guild Lodge; Quality Network for Forensic Mental Health Services
  - Royal Blackburn Hospital and Royal Preston Hospital Electro Convulsive Therapy clinics
  - the Royal College of Psychiatrists Electro Convulsive Therapy Accreditation Scheme
  - the children and family health services had received level 3 baby friendly accreditation
  - in July 2016, the sexual health service was awarded the Lancashire Lesbian, Gay, Bisexual and Transsexual Quality Mark
  - the care home effective support service team had implemented a 'hydration tool kit' which had been nominated and shortlisted for a 2016 Royal College of Nursing award at the time of our inspection
  - the trust had won the NHS England Diversity and Inclusion Partner award for 2016/17.

In addition, we found the following areas of good practice:

- staff had developed practical guides to treatment pathways for patients within early intervention services which had been published as good practice on the National Institute of Health and Care Excellence website
- the community health services for children and young people had written a good practice statement entitled 'Using Gillick Competence to Gain Consent for Immunisations in the School Setting' which had been submitted to NHS England
- the children and families network were engaged in a range of research projects including how to promote children's language development using family-based shared book reading.