Lancashire Care NHS Foundation Trust

Quality Report

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Core services inspected	CQC registered location	CQC location ID
Acute wards for adults of working age and PICU	The Harbour Burnley General Hospital Royal Blackburn Hospital The Orchard Ormskirk Hospital	RW5Z3 RW5CA RW5X1 RW5Z2 RW5FA
Wards for older people	The Harbour Burnley General Hospital	RW5Z3 RW5CA
Longstay/ Rehabilitation for adults of working age	Moss View	RW5YL
Forensic inpatient/secure wards	Guild Lodge	RW5ED
Child and Adolescent Mental Health inpatient wards	Royal Preston Hospital The Junction	RW5 RW5X7
Community services for working age adults	Sceptre Point	RW5HQ
Community mental health services for older people	Lytham Hospital Sceptre Point	RW5GD RW5HQ
Specialised community mental health services for children and young people	Sceptre Point	RW5HQ

Summary of findings

Crisis and Health-based places of safety	Sceptre Point	RW5HQ
	The Harbour	RW5Z3
	The Orchard	RW5Z2
	The Scarisbrick Centre	RW5FA
	Royal Blackburn Hospital	RW5X1
	Burnley General Hospital	RW5CA
Community mental health services for people with learning disabilities or autism.	Sceptre Point	RW5HQ
Community health services for adults	Sceptre Point	RW5HQ
	The Minerva Centre	RW5RP
	Barbara Castle Way Health Centre	RW5RG
	Ashton Health Centre	RW5Y8
Community health services for children, young people and families	Sceptre Point	RW5HQ
	St Peter's Primary Healthcare Centre	RW5Y3
Community health inpatient services	Longridge Community Hospital	RW5AQ
Community end of life care	Sceptre Point	RW5HQ
	The Harbour	RW5Z3
Adult social care	Garstang Road, Preston, Learning Disability Supported Living Scheme Ormskirk Hospital	RW5EP RW5FA

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	Requires improvement	🟠
Are Services safe?	**Requires improvement**	🟠
Are Services effective?	**Requires improvement**	🟠
Are Services caring?	**Good**	🟢
Are Services responsive?	**Good**	🟢
Are Services well-led?	**Requires improvement**	🟠

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

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

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

Summary of findings

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Summary of findings

Overall summary

When aggregating ratings, our inspection teams follow a set of principles to ensure consistent decisions. The principles will normally apply but will be balanced by inspection teams using their discretion and professional judgement in the light of all of the available evidence.

We found that the provider was performing at a level that led to a rating of 'requires improvement' overall.

Following consultation with a range of staff and stakeholders, the trust had recently developed a new governance structure from board to senior management level to support the implementation of its five-year strategic plan. The structure was in its infancy and, as such, was in the process of being embedded in practice. It was configured to provide an effective mechanism for senior managers and the trust board to have strategic oversight and an informed understanding of the quality agenda, financial performance, operational issues and risks relating to the trust.

However, the governance structure from senior management level to ward level was in the process of being developed and was still in draft form at the time of our inspection. There was not an effective, existing governance structure in place across the four clinical networks. This had resulted in a disconnect between the four clinical networks which limited opportunities for shared learning across the networks. The trust acknowledged that there needed to be a common approach across the four networks to effect alignment with the refreshed governance arrangements and the assurance requirements of the corporate level structure needed to be clearly articulated to be embedded appropriately.

The lack of a clear structure from senior management level to ward level had also resulted in a disconnect between the board and the four clinical networks. This was shown by the number of environmental issues we found across services that compromised the safety of patients. The board was not aware of these issues, which were not in line with best practice guidance and the Mental Health Act (MHA) Code of Practice (CoP).

These included:

- One older people's ward that breached same sex accommodation guidance.

- A number of seclusion rooms, a health-based place of safety, and the use of 'Extra care Areas' in the adult mental health service and that child and adolescent mental health service (CAMHS) that were not compliant with the Royal College of Psychiatrists' standards and the Mental Health Act Code of Practice.

- A number of maintenance and cleanliness issues in the forensic services and a lack of infection control audits in community CAMHS.

- There were a number of wards and services which had furnishings or fittings that had ligature risks (places to which patients intent on self-harm might tie something to strangle themselves). Some of these ligature risks had not been identified through local audits.

- Many of the children's services were being delivered from locations that were not owned by the trust. These locations were not suitable environments for the services they were delivering.

- The low number of risk assessments for clinic locations and the fact that they were not complete orcomprehensive meant the potential risks were not being clearly identified or addressed.

- Connectivity for IT in the community was hindering a full move to electronic records and creating additional work for the staff converting paper records into electronic ones.

The trust had experienced challenges with staffing levels due to the relocation of some wards to the newly opened Harbour service, which was being proactively managed. However, in some other mental health services, staffing levels were not adequate or staff were not suitably qualified to meet patients' needs.

In the community health services there were challenges including substantive staffing levels not being met in most children's teams, although adult's teams were better staffed. This was due to large case loads, the fluctuating population from seasonal workers and students, and the increased acuity of patients.

Summary of findings

There was a gap in service provision for young people aged 16-18 years old. We identified a number of issues of concern in relation to the child and adolescent mental health services provided by the trust in the community. This included the lack of an appropriate transitional pathway for patients moving from CAMHS to adult services.

In the community health services, service redesign had led to restructuring of teams, which had brought smaller teams together. However, the leadership of these changes appeared to be restricted to band 7 clinical managers with minimal support in some areas from managers above this level. This demonstrated a lack of connection between service delivery and the board. The lack of supervision for band 7 allied health professional (AHP) clinical managers for two years and the lack of visibility of management above service integration managers in the district nursing service further demonstrated a lack of strategic support and control.

We found compliance with compulsory training, appraisals and supervision was inconsistent across all services and the trust was not meeting its own targets.

The trust had introduced a 'smoke free' initiative across all services in January 2015. This was not being consistently implemented, which had led to increased risks in some areas.

The trust was committed to reducing restrictive practices including the use of prone restraint, which was demonstrated by their strategy on this.

The trust was transparent and open in its approach to safeguarding and reporting incidents. We found evidence of the trust's commitment to improve how it responded to complaints. However, we found that learning from incidents, complaints and the sharing of learning needed to be embedded and shared consistently across services.

Adherence to the principles of the Mental Health Act and its associated Code of Practice was good throughout the trust.

Medication management was good, with the exception of one community health services team where we found issues with the storage of vaccines and another team where medication recording issues were identified.

Patients' care and treatment needs were assessed using a holistic approach that included a comprehensive physical health needs assessment. A range of evidence-based assessment tools, outcome measures and adherence to best practice guidance was evident in the care and treatment staff delivered. Care was provided with a multidisciplinary approach.

Staff delivered care in a responsive, caring manner and strived to ensure patients' cultural and diverse needs were met. People had access to translation services.

The trust engaged with people including carers in the planning of service development initiatives.

There were some issues that impacted negatively on how responsive some services were. This was due to long waiting lists and ineffective care pathways. Waiting times were showing an improving trend in children's services. In other community health services waiting times were reasonable except for chronic fatigue service appointments, which were much worse than the expected six weeks, with an average waiting time of 60 weeks.

The trust participated in several internal and external audits to drive improvements, including the quality SEEL (a quality initiative focusing on Safety, Effectiveness, Experience and Leadership).

In the teams, local leadership was generally visible and strong. Most staff understood the trust's visions and values. Executive management visibility in the community health services was low, although staff felt listened to and supported by local managers. Staff clearly expressed the trust's vision and values and portrayed positivity and pride in the work they did.

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?

We rated safe as 'Requires Improvement' because:

- Ward 22 breached same-sex accommodation guidance and the Mental Health Act Code of Practice, which compromised patients' privacy and dignity.

- The health-based place of safety at the Scarisbrick Unit, Ormskirk, compromised patient safety, confidentiality and dignity as it did not meet the Royal College of Psychiatrists' standards.

- Seclusion facilities on Calder, Greenside and Fairsnape wards were poorly equipped and did not afford people privacy and dignity.

- Both of the inpatient child and adolescent wards had an 'extra care area' (ECA) that met the definition of seclusion. At The Platform, this area had been used as a seclusion room in the previous 12 months. However, these areas did not comply with the requirements of the Code of Practice. Records relating to the use of the ECA at The Platform were not completed in line with trust policy.

- In the forensic services, there were a number of maintenance and cleanliness issues that directly impacted on patient care. At Chorley CAMHS community team and Lancaster CAMHS community team, infection control audits were not carried out in line with trust policy.

- At Garstang Road, some medication administration charts had not been up-dated to reflect people's current prescription and medicines needs, which increased the risk of medication errors occurring.

- In the community health services for children, young people and families, we found the cold chain was not always maintained for vaccines (this means it was not possible to be certain that vaccines had been kept cold enough to ensure their effectiveness), and monitoring for adverse reactions was not undertaken.

- There were a number of wards and services which had furnishings or fittings that had ligature risks (places to which patients intent on self-harm might tie something to strangle themselves). Some of these ligature risks had not been

Requires improvement ●

identified through local audits. Where ligature risks had been identified, there was often no action taken to reduce these risks despite risks about ligature points being on the trust's risk register since 4 September 2013.

- Staff found it difficult to access electronic patient records in some trust sites when connectivity was poor and access to paper-based records was variable throughout the trust, meaning that information about people's care and treatment was not always available.

- Learning from incidents and the sharing of learning from incidents was not embedded across all services. There was no established mechanism to record if staff had received a debrief following a serious incident.

- The trust's action plan to reduce acquired pressure ulcers did not include re-audits. Although all the actions on the plan were completed, it was not clear how continued compliance with the action plan would be monitored.

- There were inconsistencies in the provision of clear end of life pathways across the trust.

- The trust was not meeting its target for mandatory training compliance of 85% in a number of services. In the acute wards and psychiatric intensive care units, there was a significant shortfall. Of 193 staff records examined, only 22 (11%) staff had completed the required training.

- The trust's 'Smoke free' initiative was not being consistently implemented across all areas. This had led to increased risks, specifically in areas where staff and patients were not complying with the policy.

- Staffing levels in the community end of life services, ward 22, community health services for children, young people and families, and older people's wards were not always sufficient to meet the needs of patients.

- In the community health services for adults, reception staff were triaging patients on arrival at nurse-led clinics. These staff were not clinically trained and therefore there was a risk that incorrect decisions might have been made.

However:

- The trust's serious incident reporting rate was high, which demonstrated a transparent safety culture.

Summary of findings

- The trust had effective safeguarding processes and procedures, which staff were aware of and were following.

- The trust was committed to reducing restrictive practices, which was shown by a number of documents we reviewed.

- Medicines management was good across the trust, with the exception of recording issues identified at Garstang Road and storage of vaccines in one community team.

- Staff in the trust assessed, managed and reviewed individual patient risks on an on-going basis. Risk formulations were comprehensive and based on the five Ps model (This is a way of assessing risk in mental health based on the 5Ps – Problem, and Predisposing, Protective, Perpetuating and Precipitating factors.)

- The trust had implemented an initiative that enabled staff to contact the chair of the board directly to share any concerns they may have. Action from the feedback was reported to staff through the trust's internal media.

- The majority of staff we spoke with understood the underlying principles of the Duty of Candour requirements and the relevance of this in their work; the exception was the district nursing team staff.

Are services effective?

We rated effective as 'requires improvement' because:

Requires improvement 🟠

- The trust was not meeting its targets for compliance with supervision and appraisals consistently. On some wards there were significant gaps in the training that staff had received in relation to the Mental Health and Mental Capacity Acts.

- Not all the newly recruited staff at The Harbour had received an induction.

- Some community teams had electronic patient records while others had paper-based. This presented a risk by having two systems complicating the process of record-keeping. Electronic patient records were not always accessible when connectivity was poor and access to paper-based records was variable throughout all areas, meaning that information about people's care and treatment was not always available.

- The quality of care plans was variable. In some services, there was little evidence of the direct involvement of patients in the content of care plans.

However:

Summary of findings

- Patients' care and treatment needs were assessed using a holistic approach, which included a comprehensive physical health needs assessment. A range of evidenced-based assessment tools was used to assess patients' needs.
- Across services, there were several examples of how staff had integrated best practice guidance such as the National Institute for Health and Care Excellence (NICE) guidance and the dementia strategy (Department of Health) into their clinical practice.
- The trust participated in several national and local audits to monitor patient outcomes and drive improvement.
- The trust had implemented an electronic outcome measures tool called quality SEEL. This consisted of data collected from a variety of sources and measured 16 quality outcomes.
- There was an effective multidisciplinary team model of care integrated in all teams.
- Staff understood issues in relation to the Mental Capacity Act (MCA) and where needed, best interest meetings were held and included the multidisciplinary team and family members.
- Adherence to the principles of the Mental Health Act was good throughout the trust.

Are services caring?   **Good** ●

We rated caring as 'Good' because:

- Across all of the community health services, mental health services (inpatient and community) and the adult social care homes we inspected, we saw most staff being responsive, respectful, caring and kind when interacting with patients.

- Feedback from focus groups we held was positive in relation to how patients were cared for by staff.

- Staff actively involved patients and their carers in the planning and delivery of the care they received.

- Results from the Friends and Family test was positive across the community health services.

- Each ward had a patient involvement group established, which was facilitated by one of the patient experience and quality improvement team.

- Carers who attended the carers' focus groups we arranged confirmed that they had all been offered a carers' assessments on an annual basis.

Summary of findings

- There were good examples of how the trust had involved patients and carers in service development initiatives.

However:

- On one older people's ward and two adult wards, we witnessed incidents where staff did not treat patients with respect. These incidents were escalated immediately and assurance was provided that appropriate action would be taken to address these issues.
- Young people's confidentiality was not always protected in one clinic we visited

Are services responsive to people's needs?   **Good** ●

We rated responsive as 'good' because:

- At the Minerva Centre, there were excellent examples of how staff engaged with Muslim and Hindu communities, which included regular contact taking place in mosques, community centres, schools and health melas (fairs).

- Staff were trained in equality and diversity, were able to recognise patients' diverse needs and actively tried to meet them. This included access to interpreters and faith leaders, and the provision of information in different formats.

- The trust engaged with people including carers in the planning of service development initiatives.
- The trust had a rapid resolution process for managing and dealing with complaints.

- Some 95% of patients on the Care Programme Approach received a follow up within seven days of being discharged from hospital.
- The trust was meeting the referral target time of 18 weeks from initial assessment to treatment in 15 of their 22 community health based services.

However;

- In seven services the trust was not meeting referral target times. The chronic fatigue service had the longest average wait time of 60 weeks.

- We identified a number of issues of concern in relation to the child and adolescent mental health services (CAMHS) provided by the trust in the community. This included the lack of an appropriate transitional pathway for patients moving from CAMHS to adult services.

Summary of findings

- In the forensic wards, patients' needs were recognised but not always met owing to shortages of staff, which meant access to meaningful activities and leave was inconsistent.

- Of 35 wards, 19 had a bed occupancy over 90%, with three having a bed occupancy of 100% or over.

- Learning from complaints and concerns was not embedded across all teams and clinical networks in the trust. However; the trust recognised this and the issue had been escalated onto the trust's risk register.

Are services well-led?

We rated well led as 'Requires improvement' because:

- The governance structure from senior manager level to ward level was still in the process of being developed. Therefore it was not possible to determine the effectiveness of this in practice. Although most teams discussed governance issues in team meetings, there was no consistent agenda or approach across the trust.

- The trust had experienced significant issues that impacted on the effective functioning of the human resources department. These included length of time to recruit new staff, the recruitment process and managing staff disciplinary procedures in a timely manner in line with trust policy.

- The trust was not meeting its target rate of 85% for attendance of mandatory training.

- There were inconsistencies across the trust regarding compliance with appraisals and supervision.

- In mental health services, there were inconsistencies across the teams, with four out of the 10 core services requiring improvement in the well led domain and five requiring improvement overall.

- Feedback from complaints and incidents was inconsistently provided to staff in the trust. This meant that leaning from complaints and incidents was not fully embedded across all clinical areas.

However:

- The board had a clear five-year plan that set out the vision and strategic objectives for the trust, which most staff were aware of and understood.

Requires improvement ●

Summary of findings

- The trust had developed a good governance structure at board level to senior manager level, with established committees that monitored quality, financial performance and operational issues relating to the trust.

- The trust had action plans to drive service improvements and risk registers to monitor progress.

- The trust had implemented the quality SEEL in each clinical area. Information regarding the outcome of SEEL audits were on team information boards, which were visible and accessible to visitors.

- The trust had experienced difficulties with how the human resources department had functioned, which it acknowledged and was addressing. The trust was meeting the Fit and Proper Person Requirement (to ensure that their directors or equivalent are fit and proper for the role).

- In the teams, local leadership was generally visible and strong.

- The trust had implemented a number of initiatives to improve engagement with staff in the trust.
- Three out of the four clinical networks had received national accreditations.

Summary of findings

Our inspection team

Our inspection team was led by:

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

Head of Inspection: Jenny Wilkes, Care Quality Commission

Team Leaders:

Sharon Marston, Mental Health, Care Quality Commission

Lorraine Bolam, Community Health Services, Care Quality Commission

Mathew Haines, Adult Social Care, 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 and Registered Nurses for Learning Disabilities), occupational therapists, a paediatric nurse, pharmacy inspectors, physiotherapists, podiatrists, psychologists, a school nurse, senior managers, social workers and specialist registrars.

Why we carried out this inspection

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

How we carried out this inspection

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

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

Before visiting, we reviewed a range of information we hold about the trust and asked other organisations to share what they knew. We held listening events at each main hospital location for detained patients. We met with groups of carers prior to the inspection at a number of hospital locations.

We held two focus groups prior to the inspection, facilitated by two voluntary organisations, The Maundy Trust for community health services and Lancashire Mind for mental health services on Friday 10 April 2015.

We carried out announced visits to all core services on 28, 29 and 30 April 2015. The exception to this was an announced visit to Longridge Hospital on 13 and 18 May because it was closed for refurbishment during the planned inspection week. Ward 20 at Burnley General Hospital was closed due to a suspected outbreak of norovirus so we inspected that location on 14 May 2015. We carried out an unannounced visit to The Harbour on 13 May 2015.

During the visit we;

- held focus groups with a range of staff who worked in the service. This included nurses, doctors, psychologists, allied health professionals, and administrative staff.
- met with 755 trust employees.
- met with representatives from other organisations including commissioners of health services and local authority personnel.

Summary of findings

- met with 289 patients who use services who shared their views and experiences of the core services we visited.
- observed how patients were being cared for
- reviewed 272 care or treatment records of patients who use services and 96 medication administration charts. Of these, we case tracked nine.

- spoke with 54 carers or relatives of people who use the service.
- looked at a range of records including clinical and management records.

Information about the provider

Lancashire Care NHS Foundation Trust was established in April 2002 and authorised as a Foundation Trust on 1 December 2007. The trust specialises in inpatient and community mental health services. The trust also provides health and wellbeing services for a population of around 1.5 million people. The services provided include community nursing, health visiting and a range of therapy services including physiotherapy, podiatry and speech & language. Wellbeing services provided include smoking cessation and healthy lifestyle services. The trust specialises in inpatient and community mental health services.

Inpatient beds:

Number of total trust inpatient beds: 514

Number of trust locations providing inpatient beds: 12

Staff Total: 6,650

The trust works with eight Clinical Commissioning Groups:

Blackburn with Darwen

East Lancashire

Greater Preston

Chorley and South Ribble

West Lancashire

Lancashire North

Fylde and Wyre

Blackpool

There have been 20 CQC inspections at sites registered to Lancashire Care NHS Foundation Trust.

These inspections have occurred at ten locations (out of 117 locations in total registered to the trust).

The trust's services were provided through four clinical networks which were;

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

The four clinical networks provided the following core services:

Mental health wards:

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

• Long stay/rehabilitation mental health wards for working age adults.

• Forensic inpatient/secure wards.

• Child and adolescent mental health wards.

• Wards for older people with mental health problems.

Community-based mental health and crisis response services:

• Community-based mental health services for adults of working age.

• Community-based mental health services for older people

• Mental health crisis services and health-based places of safety.

• Specialist community mental health services for children and young people.

• Community mental health services for people with learning disabilities or autism.

Community Health Services:

Summary of findings

- Community health services adult.
- Community health services children and young people.
- Community end of life.
- Community inpatient.

We also inspected the following services that the trust provide:

• Adult social care services.

We did not inspect the following services that the trust also provides:

- Improving access to psychological therapies
- eating disorder services.
- services to prisons.

What people who use the provider's services say

A review of comments placed on the 'patient opinion' and 'NHS choices' websites was conducted ahead of the inspection.

Patient Opinion

The trust had been rated 3.2 stars out of 5 for 'respect' based on 30 ratings. The trust had 3 out of 5 stars for 'listening' based on 30 ratings.

The trust scored 3.1 out of 5 stars for 'involved' based on 29 ratings.

The trust scored 3 out of 5 stars for 'social support' based on 18 ratings.

On the patient opinion website there were 48 positive comments that included:

- Staff are caring, compassionate and respectful.
- Communication with patients and carers.
- Patient involvement in care and treatment.
- Patients treated with dignity and respect.
- Good emotional support given to patients and those close to them

NHS Choices

Royal Blackburn Hospital received 4 out of 5 stars for dignity and respect based on 336 ratings.

Focus Groups

Before the inspection Lancashire Mind held four hosted focus group across Lancashire. These were poorly attended, with three people being the highest number of attendees. This meant we could not identify key themes before the inspection or report on these issues as they might lead to people being easily identified.

Speak Out also hosted a focus group for those patients who had used the community health services. Five people attended.

Before the inspection we spoke with service users and their carers across the trust. We facilitated eight focus groups for detained patients at four hospital locations. During these sessions we heard both positive and negative comments about the trust services. The main themes that emerged were in relation to low staffing levels, low staff morale, high staff turnover and overuse of bank and agency staff. Patients also reported very few activities occurred during the day or the evening.

Inspection

During our inspection we received 182 comment cards completed by service users or carers. Of those, 110 gave positive comments about the way staff behaved and cared for them and about the hospital environments. Thirty nine comment cards gave negative comments that related to a wide range of issues that we were unable to follow up on individually during the inspection. We received 23 comment cards that provided mixed feedback about the trust and the care and treatment received and 10 cards were blank.

Throughout the inspection we spoke with 343 patients and carers who had used inpatient services or were receiving community treatment.

Community health services

All of the people we spoke to said staff were efficient, kind and very helpful. Many of the people we spoke to said there was nothing that could be done to improve the services they received, and that they felt well looked after. They reported that they never feel rushed during their appointments.

Summary of findings

Mental health services

The majority of the patients and carers we spoke to were positive about the care and treatment provided by the trust. Staff were caring and respectful.

However, eight families commented on the long wait to access children and adolescent mental health services. In the trust's forensic services, concerns were raised about escorted leave and activities being cancelled, understaffing, unsafe patient mix on some wards, and the poor quality of food. Patients also complained about the smoking ban and blanket restrictions on mobile technology.

We have reported on the issues raised here in the mental health core service reports.

Good practice

Community-based services for people with learning disabilities or autism

- There was a dementia intervention service being piloted in the East Lancashire district and developed by the Burnley, Pendle and Rossendale Team. The service screened patients with learning disability or Down's syndrome for dementia and offered treatment to patients and support to carers with multidisciplinary input from psychologists, learning disability nurses, psychiatrists, and speech and language therapists.

Mental health crisis teams and health-based places of safety

- The referral system enabled anyone to refer into the service, 24 hours a day, seven days a week, including self-referrals from people or their carers. This meant that people were empowered to access help and support directly when they needed it. Access to crisis care was not delayed; for example, by having to access it through the accident and emergency department.

- All the MHCS carried out home-based clozaril titration. Clozaril titration is usually carried out in hospital because of the level of monitoring required. People did not have to be admitted to hospital when they were prescribed clozaril because staff carried out monitoring in the person's own home. This practice meant people were able to stay in the community.

- The development of the health-based places of safety (HBPoS) and joint working arrangements with the police reduced the numbers of people being assessed in police cells.

Forensic inpatient/secure wards

- The forensic inpatient/secure wards were recognised for patient engagement in service development and improvement, which was extensive. Patients had been involved in delivering control and restraint training to staff. Patients were involved in recruiting staff. Patients had been supported in starting up a car washing business on site. Patients were invited to support work on redesign of care pathways. In 2014, Guild Lodge won an award for patient involvement in designing a new ward and a picnic area. In 2013, Specialist Services won a National Service User Award (Service User Champion Guild Lodge: Risk Assessment).

- The forensic women's service operated a gender-based model of care which offered a holistic approach to care and recovery. Patients and staff collaborated to develop this in accordance with national guidelines on gender informed healthcare, mental health best practice and recovery initiatives. Patients were given a leaflet describing the model of care.

- Forensic inpatient/secure wards worked in partnership with The University of Central Lancashire on research into the involvement of patients and families in violence prevention and management.

Community end of life care

- The trust had an equipment store facility whereby staff had access to equipment patients required. They delivered a seven day service and showed diligence in the provision of appropriate equipment in a timely way.

Community health services for adults

- The Minerva Centre displayed excellent community links with diabetes patients and strived to maintain these through education and care.

Summary of findings

Child and adolescent mental health wards

- The Crew is a Lancashire-wide group for young people, parents and carers (whose family use the service) who have previously used the acute inpatient mental health service. The group works in close partnership with parents, management and commissioners in respect of service development and improvements.

Long stay/rehabilitation mental health wards for working age adults

- Weekly psycho-educational groups exploring thoughts and feelings were held. For example, 'what is anger?' This meeting was open to patients and staff. Patients shared their thoughts with those caring for them, further developing the therapeutic relationship.

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

- The trust had introduced a team information board. These were used throughout inpatient units and during clinical and multi-disciplinary meetings and care programme approach (CPA) reviews. The system linked to a touch screen display, displaying information from the electronic clinical record allowing attendees to view information relating patients. In addition, the system could be used to view information relating to the trust's performance indicators, as well as incidents and lessons learned.

- The Scarisbrick Unit was piloting the alternative therapy intervention project, which was aiming to offer an alternative to hospital admissions by offering daily placements for people in crisis and receiving support from the home treatment team.

- In Burnley, they had developed a clinical practice team which aimed to facilitate clinical assessments and rapid discharges for patients who did not require secondary care mental health services on discharge.

Wards for older people with mental health problems

- We found on Wordsworth ward restrictive care plans were in place to address and meet any identified risks where any 'hands on' intervention or support was needed to provide personal care to patients.

- Dickens ward was piloting an observational baseline and on-going monitoring tool. This was developed for use with patients who had difficulty in self-reporting their anti-psychotic side effects. Its purpose was to help ensure that side effects are recognised and appropriate action is taken.

Areas for improvement

Action the provider MUST take to improve
Specialist community mental health services for children and young people

- Ensure staff complete environmental risk assessments, to minimise risks to young people, children, or staff.
- Ensure staff complete mandatory training. Young people could be at risk because the number of staff who had completed training was below expected standards at both CAMHS. For example conflict resolution was below 70%, and resuscitation (basic life support) 50%.
- Ensure young people who present at the A&E department at Lancaster, Blackpool and West Lancashire hospitals, with self-harm or acute mental health problems receive a prompt assessment of their mental health needs.

- Ensure there is a protocol in place for the transfer of young people from CAMHS to adult mental health services and that this is fully adhered to by staff to ensure the health, safety and welfare of young people.

Child and adolescent mental health wards

- Ensure staff adhere to the Mental Health Act code of practice when secluding patients.

Forensic inpatient/secure wards

- The trust must ensure that ligature risks are removed from Calder ward, Greenside ward, Fairsnape ward and The Hermitage.
- The trust must ensure that seclusion rooms on Calder, Greenside and Fairsnape wards afford patients privacy.
- The trust must ensure timely repair and maintenance of premises and replacement of equipment.
- The trust must ensure that patients have privacy when making telephone calls.

Summary of findings

- The trust must ensure that patients' religious needs are met in a timely and responsive manner.
- The trust must ensure there is timely access to special diets, ensure choice and variety (for example, halal), and improve the range and quality of food.
- The trust must ensure that patients receive escorted leave and activities, in line with their care plans.
- The trust must ensure that staffing deployment across all wards meets the needs of patients (for example, reviewing the staffing establishments of the male medium secure wards and Dutton ward).

Wards for older people with mental health problems

- Ensure that ligature risk assessments are carried out. This is because on ward 22 we identified ligature risks throughout the ward. No ligature assessments had been completed on all the wards we visited to identify and manage any risks to patients using the service.
- Ensure that the privacy and dignity needs of patients are met. This is because on ward 22 we found the Department of Health guidance on same sex accommodation and the Mental Health Act Code of Practice was not being complied with. Access to reach bathroom and toilet areas meant patients had to walk through an areas occupied by either sex in the main ward area.
- Ensure there are a sufficient number of nursing staff on duty at all times and who have received appropriate supervision, training and appraisal to enable them to carry out their duties.

Community based mental health services for adults of working age

- Ensure that there is a protocol in place for the transfer of young people from CAMHS services to adult mental health services and that this is fully adhered to by staff to ensure the health, safety and welfare of service users.

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

- Ensure recruitment and retention of staff at the Harbour.
- Ensure that the high levels of sickness at the Harbour were addressed.
- Ensure a consistent approach across the wards to the smoke free initiative.
- Ensure compliance to mandatory training.

- Ensure that all new staff receive an induction.
- Ensure that episodes of seclusion are recorded and are accurate as per seclusion policy.

Mental health crisis services and health based places of safety (HBPoS)

- Ensure the layout and location of the HBPoS at the Scarisbrick Centre is suitable for the purpose for which it is being used and does not compromise patients' safety, privacy, dignity and confidentiality.

Long stay/rehabilitation mental health wards for working age adults

- Ensure there is a robust and informative ligature audit that follows best practice guidance suggested by The NHS National Patient Safety Agency in Preventing suicide | A toolkit for mental health services. This audit must relate to both the HDRU and the CRU.
- Ensure Moss View is compliant with the Department of Health guidance regarding same sex accommodation to ensure patients privacy and dignity is protected.
- Ensure all qualified nursing staff receive appropriate supervision and all clinical staff have a yearly appraisal in line with trust policy.
- Ensure effective local governance systems are in place and lead to improvements in the quality and effectiveness of the service.

Community end of life care

- Ensure nurse staffing levels, the skill mix and skills of nursing staff are appropriate to meet the needs of patients.

Community health services for adults

- The service must review the triage process for nurse led treatment rooms (formally minor injury units),
- The service must review the requirements for life support skills in treatment rooms (Minor Injuries Unit) and ensure staff are adequately trained to deliver care.
- Review records management to ensure records are managed effectively and all areas of concern are documented. Consideration should be made to minimise duplication and the risk of transcription errors.
- The provider should improve the waiting time for patients in particular the Chronic Fatigue Clinic and podiatry.

Summary of findings

Community health services for children, young people and families

- Ensure appropriate staffing levels and caseload mix is determined to meet the needs of patients using a recognised management tool.
- Ensure the cold chain is maintained for vaccinations used and ensure monitoring for adverse reactions is undertaken and appropriate guidance followed when taking consent.
- Ensure premises are safe to use for their intended purpose.
- Ensure completion of mandatory training and personal development reviews to meet the trust targets.
- Ensure the trusts centralised system for mandatory training is accurate and up to date and reflects the local figures without discrepancies.

Garstang Road Preston Learning Disability Supported Living Services

- Ensure that people are protected against the risks of unsafe care and treatment relating to the safe and proper management of medicines.

Action the provider SHOULD take to improve
Community based services for people with learning disabilities or autism

- Make sure that risk information was consolidated into a single overarching risk assessment and management plan for each individual patient at the Lancaster team. The trust should ensure across other teams that risk assessments contain key patient information such as the date when risks were assessed or reviewed and who completed the risk assessment.

- Review the recording of patient information to optimise the sharing of patient data between staff of differing services and teams.

- Ensure that GPs are up dated with plans specific to patient care including any interventions being delivered and goals achieved and information on patients being discharges from the service.

- Improve attendance at mandatory training to meet its own target of 85% completion target across all 10 mandatory training courses.

- Continue to work with commissioners on the development of the service provision to meet the needs of the local population and prevent variations of service provision in different areas. At present some teams have limited access to psychiatrists, speech and language therapists and occupational therapists.

Specialist community mental health services for children and young people

- Make better use of care pathways. This is so senior managers could ensure there was a consistent approach to treatment and care; and young people had a coherent journey from referral to receiving a timely and relevant service.
- Have a system in place to monitor the uptake of clinical and management supervision of staff. Clinical supervision is an important tool for checking that young people have received the appropriate care and treatment.
- Have an annual appraisal. This is because annual appraisal enables the managers to review staff performance, to check their competency, and develop a training plan to ensure they update or develop their skills.
- Continue to address the initial and internal waiting times for young people at Chorley CAMHS.

Wards for older people with mental health problems

- Make sure that where facilities have items in place to protect patients' privacy, they are used. This is because we saw that blinds and doors on ward 22, were not used and people visiting the ward could see through to where the patients were.
- Review the patient mix on ward 22, and provide more autonomy to the matron to make admission decisions. This is because at the time of our visit the matron on ward 22 was unable to make definitive ward admission decisions. Staff also felt that the patient mix on ward 22 meant that it was not always easy to keep patients safe. Ensure that on ward 22 the risk register is reviewed in relation to the reduced RMN staffing levels and three depleted band three support workers temporarily redeployed.
- Continue to monitor the use of bank and agency staff being used.
- Review, implement and monitor staff training and appropriate supervision and/or appraisals.

Summary of findings

- Review the effectiveness of running bed occupancy rates of over 85% on older people's inpatient wards.

Child and adolescent mental health wards.

- There is a clear action plan regarding the fixed ligature points on the ceiling at the Platform.
- All staff are confident to use the res-q-vac handheld vacuum suction machine.
- Monitoring systems are put in place to ensure the clinic room equipment is regularly checked
- All staff adhere fully to the MHA code of practice and are specifically aware of the approval and agreement for administration of medication, at the Junction.
- All staff assess patients individual needs when deciding whether they can use communal rooms at the Platform or the garden area at the Junction.

Community based mental health services for adults of working age.

- The provider should ensure that all staff receives mandatory training line with trust policy including training on the Mental Health Act and Mental Capacity Act.

- The provider should ensure that people who use the service are offered copies of their care plans and that this is recorded.

- The provider should ensure the full implementation of actions detailed in the CAMHS Transition CQUIN. This will ensure that the adult mental health service is able to meet the needs of young people transferred from CAMHS at the age of 16.

- The provider should ensure on-going consultation and feedback around the community services review. This will help address uncertainty within teams and staffing groups.

- The provider should ensure that annual appraisals take place for staff including non-clinical staff. This will support existing supervision arrangements to ensure staff are appropriately supported and are able to develop professionally.

- The provider should ensure that appropriate KPIs are developed for single point of access services. This will help ensure that the service is running effectively.

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

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

- Consider changes to sleeping arrangements on wards that still had dormitories.
- Continue with the on-going recruitment and retention of staff across the acute and PICU wards.

Mental health crisis services and health based places of safety (HBPoS)

- Monitor and review the impact of the no smoking policy.
- Ensure the premises at Hope House are fit for purpose.
- Ensure that incidents are thoroughly investigated and a root cause established and addressed.
- Ensure that documentation relating to medications is completed consistently.
- Ensure that staffing levels at the Orchard are sufficient to manage the health-based place of safety (HBPoS) safely.
- Ensure that risk assessments completed with the police are undertaken consistently across the HBPoS.
- Ensure that opportunities for learning and sharing are taken across the service.
- Ensure that information recorded at the HBPoS is complete and consistent.
- Ensure that mechanisms for collecting feedback from people are consistent across the teams.
- Ensure the HBPoS at the Harbour does not compromise patients' privacy and dignity.

Long stay/rehabilitation mental health wards for working age adults.

- Ensure staff fully understand the principles of the Mental Capacity Act 2005.
- The restrictive practices are reviewed to make sure they are based upon patients' individual risk assessments. These include kitchen knives being locked away and patients not having a key to their room.

Forensic inpatient/secure wards

- The trust should ensure that care staff have timely access to the electronic care records system.

Summary of findings

- The trust should ensure that all pat downs of patients returning from leave offer patients privacy and dignity.
- The trust should ensure that all staff understand and correctly apply the Mental Capacity Act, and ensure consistency in record-keeping.
- The trust should consider reviewing the blanket policies on access to mobile technology, and night observations in terms of the frequency and method.

Community health services for adults

- Ensure that all clinics offer appropriate access for wheelchair users and that safety measures are adhered to.
- Review the culture of feeling 'supplementary' to mental healthcare provision. In particular, ensure all relevant documentation reflects 'community services' rather than 'mental healthcare' where applicable.

- Review the financial sustainability of the community equipment loans service in its current form.

Community health services inpatient

- Consider making medicine administration a protected activity to ensure staff do not get distracted as this is a recognised cause of medication errors.

Community health services for children, young people and families

- Review records management to ensure records are managed effectively and all areas of concern are documented. Consideration should be made to minimise duplication and the risk of transcription errors.
- Ensure data regarding the completion of mandatory training and personal development reviews are robust

Lancashire Care NHS Foundation Trust

Detailed findings

Mental Health Act responsibilities

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

Where the Mental Health Act 1983 was used, most people were detained with a full set of corresponding legal paperwork. There was one exception to this on the long stay/rehabilitation wards where the original detention papers were not present.

In almost all the care records reviewed relating to the detention, care and treatment of detained patients the principles of the Act had been followed and the Code of Practice adhered to. The exception to this was in The Platform child and adolescent inpatient ward where we found that seclusion was not being recorded as detailed in the Code of Practice.

Treatment was given under the appropriate legal authority. In some cases it was not possible to determine if a patient's capacity had been assessed at the point that medication had first been administered.

There was evidence that patients were advised of their rights in accordance with section 132.

There was an independent mental health advocacy (IMHA) service available to all patients. The trust operated an opt-out system that meant patients would be automatically referred to the IMHA unless a patient with capacity objected. Mental Health Act training was available in the

trust. However, there were clinical staff who had not received training. Despite this, most of the staff we talked to appeared to be knowledgeable about the application of the Act.

Mental Capacity Act and Deprivation of Liberty Safeguards

There was a policy for implementing the Mental Capacity Act (MCA) and obtaining authorisation for Deprivation of Liberty Safeguards (DoLS) dated September 2012. This was supported by an MCA and DoLS managing authority procedure dated November 2014.

The trust had submitted DoLS notifications to CQC in line with the trust's regulatory duty.

(Note: Deprivation of Liberty Safeguards are rules on how someone's freedom may be restricted in their best interests to enable essential care or treatment to be provided to them. The safeguards ensure that the least restrictive option that can be identified to meet a specific need is applied.)

Across services, most staff understood their requirements under the Mental Capacity Act and in obtaining patient consent. The exceptions to this were;

• The long stay/rehabilitation wards for older adults where clinical staff were not confident in their understanding of the Mental Capacity Act or Deprivation of Liberty Safeguards.

Detailed findings

- The children, young persons and families services where staff in the vaccination and immunisation team were not following the trust's consent policy in relation to the Gillick competency and Fraser guidelines. We observed that Gillick competency was not used at all and this resulted in children not being vaccinated or the parents being contacted to give verbal consent.

(Note: Gillick competency involves deciding whether a child of 16 years or younger is able to consent to medical treatment without the need for parental permission or knowledge. The Fraser Guidelines were set out by Lord Fraser in his judgement of the Gillick case in the House of Lords in 1985 and apply specifically to contraception. They are used to decide whether a girl of 16 or under can be given contraceptive advice or treatment without the consent or knowledge of her parents.)

Staff compliance with Mental Capacity Act training was inconsistent across services. In the wards for older people there were significant gaps in the training that staff had received which ranged from 37 to 76% for level 1 training and from 18 to 40% for level 2 training. Records showed that only one member of medical staff had undertaken level 1 training and none had completed level 2 training. However, we saw that patients' capacity to consent was assessed and recorded appropriately. Where possible, patients were supported to make decisions for themselves before they were assumed to lack the mental capacity to make a decision. Where needed, best interest meetings were held and included the multidisciplinary team and family members.

Are services safe?

Requires improvement 🟠

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

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

Summary of findings

We rated safe as 'Requires Improvement' because:

- Ward 22 breached same-sex accommodation guidance and the Mental Health Act Code of Practice, which compromised patients' privacy and dignity.

- The health-based place of safety at the Scarisbrick Unit, Ormskirk, compromised patient safety, confidentiality and dignity as it did not meet the Royal College of Psychiatrists' standards.

- Seclusion facilities on Calder, Greenside and Fairsnape wards were poorly equipped and did not afford people privacy and dignity.

- Both of the inpatient child and adolescent wards had an 'extra care area' (ECA) that met the definition of seclusion. At The Platform, this area had been used as a seclusion room in the previous 12 months. However, these areas did not comply with the requirements of the Code of Practice. Records relating to the use of the ECA at The Platform were not completed in line with trust policy.

- In the forensic services, there were a number of maintenance and cleanliness issues that directly impacted on patient care. At Chorley CAMHS community team and Lancaster CAMHS community team, infection control audits were not carried out in line with trust policy.

Detailed findings

- At Garstang Road, some medication administration charts had not been up-dated to reflect people's current prescription and medicines needs, which increased the risk of medication errors occurring.

- In the community health services for children, young people and families, we found the cold chain was not always maintained for vaccines (this means it was not possible to be certain that vaccines had been kept cold enough to ensure their effectiveness), and monitoring for adverse reactions was not undertaken.

- There were a number of wards and services which had furnishings or fittings that had ligature risks (places to which patients intent on self-harm might tie something to strangle themselves). Some of these ligature risks had not been identified through local audits. Where ligature risks had been identified, there was often no action taken to reduce these risks despite risks about ligature points being on the trust's risk register since 4 September 2013.

- Staff found it difficult to access electronic patient records in some trust sites when connectivity was poor and access to paper-based records was variable throughout the trust, meaning that information about people's care and treatment was not always available.

- Learning from incidents and the sharing of learning from incidents was not embedded across all services. There was no established mechanism to record if staff had received a debrief following a serious incident.

- The trust's action plan to reduce acquired pressure ulcers did not include re-audits. Although all the actions on the plan were completed, it was not clear how continued compliance with the action plan would be monitored.

- There were inconsistencies in the provision of clear end of life pathways across the trust.

- The trust was not meeting its target for mandatory training compliance of 85% in a number of services.

In the acute wards and psychiatric intensive care units, there was a significant shortfall. Of 193 staff records examined, only 22 (11%) staff had completed the required training.

- The trust's 'Smoke free' initiative was not being consistently implemented across all areas. This had led to increased risks, specifically in areas where staff and patients were not complying with the policy.

- Staffing levels in the community end of life services, ward 22, community health services for children, young people and families, and older people's wards were not always sufficient to meet the needs of patients.

- In the community health services for adults, reception staff were triaging patients on arrival at nurse-led clinics. These staff were not clinically trained and therefore there was a risk that incorrect decisions might have been made.

However:

- The trust's serious incident reporting rate was high, which demonstrated a transparent safety culture.

- The trust had effective safeguarding processes and procedures, which staff were aware of and were following.

- The trust was committed to reducing restrictive practices, which was shown by a number of documents we reviewed.

- Medicines management was good across the trust, with the exception of recording issues identified at Garstang Road and storage of vaccines in one community team.

- Staff in the trust assessed, managed and reviewed individual patient risks on an on-going basis. Risk formulations were comprehensive and based on the five Ps model (This is a way of assessing risk in mental health based on the 5Ps – Problem, and Predisposing, Protective, Perpetuating and Precipitating factors).

Detailed findings

- The trust had implemented an initiative that enabled staff to contact the chair of the board directly to share any concerns they may have. Action from the feedback was reported to staff through the trust's internal media.

- The majority of staff we spoke with understood the underlying principles of the Duty of Candour requirements and the relevance of this in their work; the exception was the district nursing team staff.

Our findings

Track record on safety

The Strategic Executive Information System (STEIS) records serious incidents and 'never events'.

(Note: '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 STEIS since April 2011. Between 1 February 2014 and 31 January 2015 the trust reported no never events.

Serious incidents are those that require an investigation. The trust reported 221 serious incidents between 1 February 2014 and 31 January 2015. There were 105 deaths reported in that time through STEIS.

The majority of the STEIS incidents relate to the 'unexpected death of community patient (43 in receipt of care and treatment)' followed by 'admission of under 18s to adult mental health ward' (42) and 'child death' (38). However, the trust informed us that following a local decision by the NHS England area team, the trust reports all deaths of children open to their universal services on STEIS, including those deaths of natural causes with no Lancashire Care NHS Foundation Trust connection.

Twelve of the 105 deaths were 'unexpected death of community patient (not in receipt of care or treatment)'. There were six 'unexpected death of inpatient (in receipt of care and treatment)', three 'unexpected death (general)' and one each for 'maternity services - maternal death', 'unexpected death of outpatient (in receipt)' and 'unexpected death of inpatient (not in receipt)'.

CQC's intelligent monitoring (IM) report about the trust published in June 2015 identified the trust as an outlier in relation to the number of deaths of patients detained under the Mental Health Act. The trust was flagged as an elevated risk for the number of deaths of detained patients due to natural causes among people aged 75 and under during the period 1 January 2014 to 31 December 2014.

The trust also reported eight category 3 pressure ulcers and six category 4 pressure ulcers that were acquired by patients receiving community health services in their own homes. The trust had completed a pressure ulcer audit report dated March 2014, which reported that district nurses were not always completing the appropriate assessment on the first visit and when these were undertaken, not all elements of the assessment were completed. There was an action plan in place to address the recommendations of the report. All the actions on the plan were completed. However, a re-audit was not cited in the action plan. It was therefore not clear how the trust was able to be assured that planned action would be effective in reducing the incidence of pressure ulcers in the future.

Seventy seven percent of the incidents reported were categorised as Grade 1, with a 45-day investigation deadline. Our intelligence monitoring identified that the oldest serious incident on STEIS had been on-going since February 2014 and only 30% of the serious incidents had been closed on STEIS. The trust informed us that they have returned all STEIS reports to commissioners by the required deadline. The delay in closing incidents on STEIS was with commissioners not the trust. We met with commissioners of services during the inspection, who confirmed that this was the case.

The associate director of patient safety and quality governance attended a monthly meeting with commissioners to identify themes from incidents and monitor quality and performance issues. The trust has worked with the lead commissioners to reduce the historic backlog of incidents that have not been closed.

Since 2004 trusts have been encouraged to report all patient safety incidents to the National Reporting and Learning System (NRLS) and since 2010 it has been mandatory for them to report all death or severe harm incidents to the Care Quality Commission (CQC) via the NRLS.

Detailed findings

A total of 9,263 incidents were reported to NRLS between 1 February 2014 and 31 January 2015. There were 20 incidents categorised as deaths during the period, which accounted for 0.2% of all the incidents reported. The majority of incidents resulted in no harm (75%) or low harm (15%) to the patient. Eight percent of incidents resulted in moderate harm and 0.3% resulted in severe harm. The trust took an average of 45 days to report incidents to NRLS.

The most commonly reported incident type was "documentation" with 21% (1,987). This related to electronic and paper records, including medication administration charts. Of the 1,987 incidents reported, 1,982 resulted in no harm; three resulted in moderate harm and two in low harm. The second highest reported incident type was self-harming behaviour with 18%. During our inspection, we reviewed the incident type 'documentation' as this was an unusual report of incidents. In the community health services we found that some staff used electronic records but others used paper records. Electronic patient records were not always accessible when connectivity was poor and access to paper-based records was variable throughout all areas. Staff were reporting many of these as 'incidents' in addition to when the IT service had to be contacted to make amendments that the staff user was not able to do. This explained the high number of 'documentation' incidents reported.

The trust reporting rate was higher than average, which represents a maturing safety culture, and the trust remains in the top percentile of reporters (NRLS 2014) in the current comparable cluster of trusts.

The trust reported that a total of 253 serious incidents that required further investigation occurred between 3 December 2013 and 30 November 2014. The majority (20%) of incidents reported were categorised by the trust as 'suicide (actual)'. 'Failed to return from leave' accounted for 13% and 'suicide (attempted/suspected' and 'unexpected death') accounted for 9% of all incidents reported.

Every six months, the Ministry of Justice publishes a summary of recommendations that had been made by coroners with the intention of learning lessons from the cause of death to help prevent deaths. There were no concerns raised regarding the trust in the most recent report (April 2013 – September 2013).

Learning from incidents

The trust used a Datix electronic system for reporting incidents. Staff were aware of how to use the system to report incidents. Any member of staff could access the system.

The trust incident management policy, which was ratified in May 2015, had clear timescales for reporting incidents. 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 investigation within 72 hours. These were then reviewed by the trusts' executive serious review panel to determine if further investigation was required. All incidents graded below four were investigated locally within seven days.

We looked at a sample of investigations that the trust had completed following a serious incident. The investigations followed a root cause analysis methodology. Overall, they were comprehensive and identified recommendations, which were used to formulate an action plan. The trust had identified issues regarding inconsistency in the quality of some of investigations undertaken and had an action plan in place to improve this that was linked to the trust's risk register. Progress against the action plans was monitored by the matrons and fed up to the trust board through the governance structure.

We held a focus group with the matrons. They told us they met monthly to monitor and review clinical quality issues including incidents. The matrons had oversight of all incidents reported in the clinical areas for which they were accountable. They disseminated learning from incidents to the ward managers and team leaders through established senior managers meetings. This meant that learning could be shared across the trust and in teams. However, we found that there was not an established governance structure in each team with a shared agenda. We requested a sample of team meeting minutes for a range of services in the trust. We received a small number; we did not receive copies of all the minutes requested. This meant it was not possible to determine if learning from incidents was effectively disseminated to all staff through their team meetings.

There was an established process for supporting staff following a serious incident. This included group or individual debriefing sessions and support from a psychologist or the occupational health service if required.

Detailed findings

We attended a debriefing session with staff on Keats ward. This was well managed by the senior nurse. However, staff in some clinical areas told us that they had not always been offered a debrief session following a serious incident. Debrief sessions were not always recorded on the Datix system. This meant the trust could not be assured that all staff involved in an incident had been offered or received a debriefing session following a serious incident. The trust informed us they were aware of this issue and intended to ensure details about debriefing sessions were entered onto the Datix system before an incident could be closed.

The trust used a green light/blue light safety alert system. Alerts were shared with staff via emails. These included learning from incidents across the trust.

Safeguarding

The trust had an identified safeguarding lead for adults and a lead for children. In each clinical area, there were named nurses and specialist safeguarding practitioners. The trust had an up to date safeguarding policy. Staff were knowledgeable about their responsibilities in relation to reporting safeguarding concerns.

CQC had received four safeguarding alerts and 202 safeguarding concerns between 25 February 2014 and 24 February 2015 in relation to the trust against an expected number of 60. Compared to other NHS trusts providing mental health services, the trust was flagged as a risk for the number of safeguarding concerns received by CQC during this period. Blackpool Victoria Hospital, Chorley and South Ribble Hospital and Ormskirk Hospital each received one safeguarding alert. An alert for Burnley General Hospital was received but was downgraded. Concerns raised were regarding staff attitude, care/treatment, sexual abuse and record-keeping.

Guild Lodge had the most safeguarding concerns, with 125 raised between January 2014 and February 2015. The March 2015 patient safety sub-group meeting for Guild Lodge focused on safeguarding. Nursing staff were seen to make the most safeguarding alerts and an action was identified to ensure that medical staff were aware of the procedure.

Overall, 80% of staff in the trust were in date with safeguarding adults training and 86% were in date with safeguarding children training. The trust target for compliance with all mandatory training was 85%.

Whistle-Blowing

The number of whistle-blowing enquiries received by the CQC since March 2014 was eight. Issues raised included poor care, staffing levels, management and leadership and staff training. The trust responded positively to CQC requests to investigate these concerns. In addition to the trust whistle-blowing policy and procedures, the trust had introduced 'Dear Derek' in September 2014.

'Dear Derek' was an online form that had been introduced on the trust intranet to enable any member of staff to raise a concern quickly, effectively and in confidence to the trust's chairman about any wrongdoing or poor practice when they saw it. The link to the 'Dear Derek' form was in a prominent position on the home page of the trust intranet. Feedback on the issues raised and what had been done in response to these was seen in the trust's Quality e-bulletin, which was issued each month.

Assessing and monitoring safety and risk

The trust had a board assurance framework. The board assurance framework was reviewed by a sub-committee of the trust board quarterly and was thereafter reported to the full trust board. There was an executive risk register and we saw a copy dated 5 December 2014. Risks about ligature points dated 4 September 2013 remained open, with a further review date of March 2015. We noted that in total there were four risks that had been opened in 2012 and five opened in 2013 that remained open on the executive risk register. Minutes of the trust board showed that the board reviewed and discussed the board assurance framework where required changes were agreed and actioned. The minutes also confirmed that the executive risk register was reviewed at the same time. Each clinical network had its own risk register, which fed into the executive risk register. We concluded that the management of risk is not always carried out quickly to reduce the level of risk to patients and staff.

There were 21 notifications received in total for the trust. Royal Blackburn Hospital had the most with 12. Out of the 12 notifications received from Royal Blackburn Hospital, 10 were about the admission of a child to an adult psychiatric ward. Half of these notifications were submitted to the Care Quality Commission (CQC) between 12 June and 26 June 2014. The trust informed us that in these circumstances, it was agreed by the multidisciplinary team that it was in the young person's best interests to be cared for on one of the acute admission wards rather than transfer him or her to a

Detailed findings

bed out of the area, which could be several miles away from their local area. The trust considered how long the young person was likely to require an acute bed, the likelihood of a bed becoming available in the trust, and the preferences of the young person and their carers when making such decisions.

Staff in the trust assessed and managed individual risks on an on-going basis. Risk formulation was based on the five Ps model. This was a trust-wide initiative to assist staff in considering risk in a consistent way. There was a policy and procedure for staff to follow that was reviewed in February 2015. However, staff in the specialised community services for children and adolescents were unaware of the trust's policy and local operating procedures.

In the community health services for adults, we found reception staff were triaging patients on arrival at nurse-led clinics. These staff were not clinically trained and therefore there was a risk that incorrect decisions may have been made.

The trust had stopped using the Liverpool care pathway for the dying patient, which was removed nationally in 2014 .However, the replacement care pathway was still waiting to be ratified by the board. This meant there were inconsistencies in the provision of clear end of life pathways across the trust.

Safe and clean environments

The trust participated in annual Patient Led Assessment of the Care Environment (PLACE) visits. The trust scored above the national average for two of the four scores ('Food' and 'Condition, Appearance and Maintenance').

The Avondale unit in Preston and Ridge Lea Hospital scored 100% for cleanliness for January to June 2014. The lowest score was Parkwood Hospital in Blackpool with 96% against the national average of 98%. However this unit has since closed and care was now provided at the new Harbour Hospital in Blackpool.

Ridge Lea Hospital and Longridge Hospital scored 99% and 97% respectively for condition, appearance and maintenance against the national average of 94%, but again Parkwood Hospital had the lowest score of the trust with 92%.

During our inspection we identified that most of the environments were safe and clean, with the following exceptions:

- The health-based place of safety at the Scarisbrick Unit, Ormskirk compromised patient safety as it did not meet the Royal College of Psychiatrists' standards.
- At Guild Lodge, we found that Calder, Greenside, Hermitage and Fairsnape medium secure wards were not safe and there were a number of ligature points identified. (A ligature risk point is a place to which patients intent on self-harm might tie something to strangle themselves.) We also identified a number of maintenance and cleanliness issues at Guild Lodge that impacted on the patients. This included both telephones on Greenside ward being out of order. One had been out of order for three months. A tumble dryer was out of order on Fairsnape ward for three weeks and patients' laundry was sent to another ward. Patients complained that items were lost or not returned to the correct owner. The ward environment was particularly poor on Greenside ward. The ward appeared sparse and uncared for. Décor was tired; windows broken and boarded up and in one patient's bedroom and there were no curtains at the window.

The trust provided us with information on planned improvements to Guild Lodge. It was anticipated that most of the works would be completed by August 2015.

We found the most recent infection and control audit to protect against the spread of infections at Chorley CAMHS community team was July 2011 and Lancaster CAMHS community team had not carried out an audit.

Ligature points were identified at The Platform, the children and adolescent mental health inpatient ward. However, these had not been escalated to the network risk register.

At The Harbour we saw that all the kitchens had hot water taps but because staff were unable to regulate the temperature and there was a 'risk of scalding' patient access to the kitchens and hot drinks was limited.

A full ligature risk assessment had not been completed at the community rehabilitation unit (CRU) at Moss View. The assessment that was completed for the high dependency rehabilitation unit was not specific or comprehensive. For example, the wardrobes at the CRU were fitted with standard hinges rather than the piano hinges they should have had.

Detailed findings

In the specialised community services for children and adolescents, neither service had an up-to-date environmental risk assessment.

In the wards for older people with mental health problems, we found ligature risks on Ward 22 at Burnley General Hospital and the wards at The Harbour. No ligature risk assessments had been done at either of these locations. In addition, patients on Ward 22 were unable to summon help as there was no patient call alarm system.

On Ward 22, we also found that patients had to sleep in dormitory accommodation. There was one male and two female dormitories with four single male bedrooms. However, the patients had to walk through these dormitory areas to reach bathroom and toilet facilities. This is a breach of same-sex accommodation guidance and the Mental Health Act Code of Practice. We observed both male and female patients wandering around the ward in their nightwear and some of these patients were disinhibited and were exposing themselves. This meant that the privacy and dignity needs of these patients were not being met at all times.

Environmental risk assessments were not available in all of the areas inspected in the community health services for children, young people and families. These were locations/clinics not owned by the trust. Those that existed were not comprehensive and had numerous omissions. This meant the potential risks were not being clearly identified or addressed.

Seclusion

There was a seclusion policy dated March 2015 with a review date of March 2018. The seclusion procedure was issued at the same time.

There were 184 incidents of use of seclusion across 15 locations across the trust in the six months 1 August 2014 to 11 February 2015. The majority of incidents were on Charnock Ward where 26 occurred, followed by the Lathom Suite psychiatric intensive care unit (PICU) with 25 and Calder PICU with 21. There were four incidents of long-term segregation, which all occurred at Guild Lodge.

Neither of the CAMHS in patient wards had a seclusion room. However; they both had an area described as an 'extra care area' (ECA). Although the ECA at The Junction had not been used in the previous 12 months, staff at The Platform confirmed they had used their extra care area. The environment was sparse and resembled a seclusion area.

The door to the entrance of the extra care area was lockable, as was the corridor door that led to the entrance of the area. We were concerned that where patients were nursed in the extra care area (ECA), they were accompanied by staff and would be prevented from leaving. This met the definition of seclusion, although this was not being recorded as seclusion at The Platform. There was some confusion amongst the staff members we spoke to about what constitutes seclusion.

(Note: Seclusion is the supervised confinement of a patient in a room, which may be locked. Its sole aim is to contain severely disturbed behaviour likely to cause harm to others.)

The ECA environments were not appropriate environments for secluding patients as they did not comply with the requirements of the Code of Practice (CoP).

Where nursing patients in the ECA was recorded as seclusion, the records we scrutinised were incomplete and did not meet the requirements of the trust's own policy.

Seclusion facilities on Calder, Fairsnape and Greenside ward at Guild Lodge were not appropriate environments. This was identified on the trust executive risk register and remedial work had initially been planned for September 2014 but had not been completed. We were informed that work was to begin in July 2015, with completion by December 2015.

On the two psychiatric intensive care units, Keats and Byron, there were issues regarding the recording of seclusion. On Byron ward we saw evidence that 20 episodes of seclusion had not been entered onto the seclusion log. On Keats ward, there had been inaccurate recording of the seclusion start time and when the mandatory reviews, including medical reviews, had been carried out.

Restraint

In April 2014, The Department of Health published guidance around reducing restrictive practices, "Positive & Proactive Care: reducing the need for restrictive practices". The trust completed a self-assessment against the 142 recommendations set out in the report. This showed that the trust needed to take action to ensure they were fully meeting 91 of the recommendations. The trust presented a paper to the board in December 2014, which was accepted and resulted in a 'reducing restrictive practices programme' being implemented in March 2015. The plan identified

Detailed findings

actions required to reduce the use of restrictive practices including prone restraint. Progress against the plan was monitored through the trust board's governance structure. At the time of our inspection, it was too early to measure the effectiveness of the action plan in reducing the use of prone restraint as it had not been embedded fully.

As a whole, the trust had recorded 1,166 incidents of the use of restraint between 1 August 2014 to 11 February 2015. These occurred on 26 patient wards, units or teams. At 16 locations there were 30 or more incidents of restraint.

Of those 1,166 incidents, 435 patients were restrained in the face down or 'prone' position. Of these incidents, 189 also resulted in rapid tranquilisation being used.

The trust had listed a concern about the high number of restraints being undertaken, including the use of 'prone' or face down restraints onto the risk register in August 2014. The trust had targets, which it had set and agreed with the board, regarding reducing the number of restraints used. These included:

- The trust will commit to a reduction in the use of restraint by 70% by April 2016. This equates to a reduction of restraint usage by 1,900 occurrences per year;
- The trust will commit to a reduction of inpatient physical violence incidents by 60% by April 2016. This equates to a reduction of incidents by approximately 700 occurrences per year;
- The trust will commit to compliance with restraint training of 85%.
- The Datix integrated risk management system will be reviewed and enhanced where necessary to promote the effective collation and analysis of data.

At Guild Lodge, we saw that there was a violence reduction lead nurse. We saw that the wards were introducing advance statements as part of the trust's implementation of positive behavioural approach.

Medicines Management

Overall, we found that medicines management in the trust was good. However; we found at Garstang Road that some people's medication administration charts had not been up-dated to reflect the person's current prescription and

medicines needs. This meant there was a risk that people would not be provided with the medication they were prescribed, which could cause preventable harm to the person.

In the community health services for children, young people and families, we found that medicines were not always managed safely. At a school vaccination session, the storage temperatures were allowed to go over the recommended range. This could affect the cold chain storage of the vaccinations, making them unsuitable for use. This means it was not possible to be certain that vaccines had been kept cold enough to ensure their effectiveness

The trust had a clear strategy for medicines optimisation with key objectives and deliverables supported by the pharmacy and medicines management business plan. Progress against these plans was regularly monitored to help promote the safe and effective use of medicines. The trust had secured funding from the 'The Safer Hospitals, Safer Wards Technology Fund' for the implementation of electronic prescribing and medicines administration (EPMA). A project board had been set up with plans for EPMA implementation across the trust hospitals by October 2016. A complete review of the trust's medicines training had also been completed and a business case was being prepared for board approval.

Pharmacy support was provided across all the trust networks although, as identified in the pharmacy and medicines management business plan, a seven day clinical pharmacy service was not provided. A ward-based pharmacy service was only provided Monday to Friday, with an on-call service provided by local acute trusts during the weekends and out-of-hours. This meant that access to specialist mental health pharmacist expertise was not available out-of-hours and that medicines reconciliation could be delayed for patients admitted at the weekends. There was no support to enable the ongoing monitoring and review of prescribing in the learning disability services but there were plans to recruit further pharmacy support.

In response to a national directive (improving medication error incident reporting and learning, NHS England, March 2014) the trust had revised its medicines governance and incident reporting structure and established a medicines safety group to review medication error incident reports and to improve reporting and learning from medication incidents. 'Bluelight' and 'Greenlight' e-mail bulletins were

Detailed findings

used to raise staff awareness of learning from clinical and medicines-related incidents but strategies for communicating learning across the trust networks were still being developed. A scoping exercise was underway to support the development of a medicines safety dashboard.

A pharmaceutical needs assessment was completed for all in-patients to determine the level of medicines support needed. Following assessment, patients wishing to self-administer medicines were supported to do so. However, this was more easily facilitated on the newer wards at The Harbour where there was dedicated space for patient education and support with self-administration than on older wards, such as those at Burnley Hospital. Patients had the opportunity to speak with a pharmacist about their medicines while in hospital and further written information was provided on discharge. However, the trust was not able to provide an electronic discharge summary to the patient's GP or primary care provider at the point of discharge, instead relying on fax or post.

Safe staffing

In the 2014 NHS Staff Survey the trust performed worse than the national average relating to 'staff feeling satisfied with the quality of work and patient care they are able to deliver', 'work pressure felt by staff', and 'staff working extra hours'. However, they performed better than the national average relating to 'staff feeling pressure in last three months to attend work when feeling unwell'.

In January 2015, Guild Lodge (covering 14 wards) used the most bank / agency staff to fill shifts across the trust, a total of 1,505 shifts out of a total of 1647 were filled.

The early intervention service had the highest number of vacancies for registered nurses and Guild Lodge had the highest number of vacancies for nursing assistants.

We found that Guild Lodge had challenges staffing wards effectively due to the number of vacancies, staffing establishments and staff deployment. Many of the staff were newly qualified band 5 nurses who had little experience of working in a medium or low secure setting. We reviewed ward meeting minutes and those for Marshaw ward in February and March 2015 confirmed that there were staffing issues that impacted on patient care. Leave was cancelled and patients could not take part in planned

activities. Staffing levels at Guild Lodge were recorded on the trust's executive risk register and had plans to review the staffing establishments but there was no planned date identified.

The trust had recently opened The Harbour hospital site. Staff had been relocated to the new site from the wards that had since closed. Some staff had not been able to relocate due to travel issues, which meant that The Harbour had experienced significant staffing issues, including a shortage of medical staff. This had been escalated as a risk on the risk register. The trust had an action plan to improve recruitment to vacant posts, which was monitored by the board. The plans the trust had implemented included allowing ward managers to recruit extra staff when needed. We observed that when patients needed higher levels of observation or support additional staff were bought in to the wards. Staff were available to carry out physical interventions and intermediate life support. This meant that despite the significant shortfalls, staffing levels maintained patient safety at all times.

On Ward 22 at Burnley General Hospital, a ward for older people with mental health problems, we saw that they had identified insufficient staffing levels on their risk register. This risk had been on the risk register since February 2013. They had identified corrective actions but no action had taken place at the time of our inspection. The trust confirmed that they were working on one fewer qualified nurse at night than the two that had been identified for safe staffing levels.

In the community end of life services, we found staffing levels were not always meeting the needs of the patients due to a shortage of nursing staff. The trust had identified the risks and overtime alongside bank and agency staff were used to cover the shortfalls.

Low staffing levels in the community health services for children, young people and families resulted in high caseloads and staff not being able to complete tasks in a timely manner. We were particularly concerned at the low staffing numbers at Avonham Health Centre. This related to health visitor staffing levels which were below the identified staffing levels by 2.5 whole time equivalent. This did not compromise children and young people's safety.

We found nurse staffing levels were not determined using a recognised management tool in end of life services.

Detailed findings

The local end of life strategy (Adults) 2014/15-2016/17 highlighted that NHS Benchmarking outlined that end of life nursing levels should ideally be 2.58 per 100,000 population. Based on the current populations across Chorley, South Ribble and Greater Preston, end of life nursing levels should be 9.96 whole time equivalent (WTE) but staffing levels are currently 7.4 WTE.

A number of the nursing teams reported staff vacancies and recruitment problems, Darwen and North Central teams reported frequent use of bank and agency staff in end of life services.

The trust did not employ its own specialist end of life consultant or doctor

Not all staff had completed mandatory training, which might put patients and staff at risk. The trust had a target of 85% compliance for all mandatory training. We found that in the acute wards and psychiatric intensive care units there was a significant shortfall. Of 193 staff records examined, only 22 (11%) staff had completed the required training. As at January 2015 the trust were below their 85% target rate overall for training – achieving 75%. Acute mental health services achieved 76%, children and family services were 84%, secure and specialist services achieved 69% and adult community services were 74%. It was clear that due to the reduced staffing levels, training was not prioritised and was cancelled when wards were short staffed.

We also found that compliance with mandatory training was variable in the community-based mental health services for adults of working age. However, we saw that actions were being put into place to increase mandatory training compliance.

In the community health services for adults, we found that staff did not have advanced paediatric life support training when working in the 'Minor Injuries Unit' despite offering services to children over a year old. These concerns were raised with the trust at inspection and the trust undertook a full service review.

The trust target was not being met consistently in community services for children, young people and families. Basic life support training was only reaching 64% compliance at the time of the inspection.

The combination of short staffing and lack of training was adversely affecting the quality of care provided and was potentially putting patients at risk.

Blanket restrictions

The trust was working towards reducing restrictive practices and we saw a number of documents that confirmed this approach.

However, we found some blanket restrictions in place at The Harbour. This included the use of plastic cutlery instead of metal on the psychiatric intensive care units.

We also found that at Moss View there were some blanket restrictions on patients having keys to their rooms.

At Guild Lodge, a decision had been taken to search all patients on return from leave irrespective of risk. This was related to the increase in smoking-related incidents.

Potential risks

The trust told us during their presentation at the start of the inspection that they had become a 'smoke free' organisation from January 2015. The trust acknowledged that this had presented challenges and recognised this would be as an on-going process. During the inspection, we found several issues in relation to the 'smoke free' initiative. We observed patients smoking in a number of hospital locations, including The Harbour, which did not open until March 2015. Despite the 'smoke free' policy, some staff were very clear that they would not engage in physical interventions to stop patients from smoking or search patients to remove smoking items. We observed staff lighting cigarettes for patients and keeping them in offices for patients. However, in other locations, staff strictly enforced the 'smoke free' policy. This led to patients asking to be transferred to locations where they were 'allowed to smoke.' We noted on a Datix incident form that there had been a fire following a patient taking a lighter into the ward. Incident reports confirmed that Guild Lodge had experienced an increase in violent incidents, security incidents and increased reporting of patient on staff aggression. Staff on all wards confirmed that they were experiencing incidents related to smoking.

Duty of Candour

The new 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

Detailed findings

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 majority of staff we spoke with understood the underlying principles of the duty of candour requirements and the relevance of this in their work. However, we found district nursing teams delivering care were not aware of duty of candour legislation. One member of the trust board we spoke with was also unclear about the trust's duty in relation to this.

We looked at a sample of investigations the trust had carried out in response to complaints and serious incidents that had occurred. We were satisfied that the trust had

complied with the duty of candour principles' when undertaking investigations. In addition, the trust had responded to and offered appropriate support to people raising a complaint or who had been involved in a serious incident.

Duty of candour was not part of the trust's compulsory training requirement for staff. In the trust- wide magazine 'The Pulse' dated 26 November 2014, there was a link to some external training that staff could apply to attend regarding duty of candour. We were informed that the Quality directorate led the 'Engage' events in January 2015 and delivered a quality themed presentation to approximately 300 senior leaders from across the organisation and a separate cohort of aspirant leaders from both corporate and clinical services. The presentation featured information on duty of candour and the work that the trust is doing to build an open culture.

Are services effective?

Requires improvement 🔴

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

Summary of findings

We rated effective as 'requires improvement' because:

- The trust was not meeting its targets for compliance with supervision and appraisals consistently. On some wards there were significant gaps in the training that staff had received in relation to the Mental Health and Mental Capacity Acts.

- Not all the newly recruited staff at The Harbour had received an induction.

- Some community teams had electronic patient records while others had paper-based. This presented a risk by having two systems complicating the process of record-keeping. Electronic patient records were not always accessible when connectivity was poor and access to paper-based records was variable throughout all areas, meaning that information about people's care and treatment was not always available.

- The quality of care plans was variable. In some services, there was little evidence of the direct involvement of patients in the content of care plans.

However:

- Patients' care and treatment needs were assessed using a holistic approach, which included a comprehensive physical health needs assessment. A range of evidenced-based assessment tools was used to assess patients' needs.
- Across services, there were several examples of how staff had integrated best practice guidance such as the National Institute for Health and Care Excellence (NICE) guidance and the dementia strategy (Department of Health) into their clinical practice.
- The trust participated in several national and local audits to monitor patient outcomes and drive improvement.

- The trust had implemented an electronic outcome measures tool called quality SEEL. This consisted of data collected from a variety of sources and measured 16 quality outcomes.
- There was an effective multidisciplinary team model of care integrated in all teams.
- Staff understood issues in relation to the Mental Capacity Act (MCA) and where needed, best interest meetings were held and included the multidisciplinary team and family members.
- Adherence to the principles of the Mental Health Act was good throughout the trust.

Our findings

Assessment and delivery of care and treatment

In both the mental health services and community health services, we saw that patients were assessed and care delivered using evidence-based practice. Clinical staff had access to national guidelines to help them achieve this. In mental health services the assessment included a physical health assessment.

We saw that there were systems to monitor and review risks to patients. Patients were involved wherever possible in care planning. Care plans were varied in terms of quality. Many that we saw were detailed, personalised and holistic. Others were not as detailed and staff might have found it difficult to meet individual patients' care needs.

Clinical pathways in community health services were developed and referenced with nationally recognised standards. For example, the developmental musculoskeletal pathway in physiotherapy referenced the British Thoracic Society and Association for Chartered Physiotherapists in Respiratory Care.

The trust had developed an integrated end of life framework and was working to ensure care was planned and delivered in line with evidence-based guidance across the community services.

Are services effective?

In the community health services inpatient service, we saw that two patients had been assessed as being at risk of developing pressure sores. They required specialist mattresses and chair cushions and the equipment had been readily provided.

The use of antipsychotics for patients with dementia was being reviewed in the wards for older people as recommended in the Banerjee report 2008. The Malnutrition Universal Screening Tool (MUST) was completed for all patients admitted to the wards and weekly measurements of body mass index and weight were completed.

In the child and adolescent mental health wards all of the care records demonstrated that patients had a full physical health assessment on admission and had evidence of on-going physical health care. In addition, all the qualified staff at The Junction had completed physical health assessment management and escalation (PHAME) training.

Across the crisis teams and health-based places of safety, staff completed assessments quickly. Urgent referrals were seen within four hours. The crisis team based at Hope House had carried out development work around optimising home treatment, reducing or avoiding admissions and out-of-area placements. They had developed an intervention tool kit and defined standards for gatekeeping.

For patients using the community-based services for people with learning disability or autism, care plans were 'easy read' and patients could contribute to the care planning process. Risk was assessed as part of the initial assessment and reflected in care plans. The teams followed relevant pathways based on National Institute for Health and Care Excellence (NICE) guidance and the Winterbourne View report, Transforming Care. Annual health checks took place. During the inspection we observed innovative working in relation to a dementia pathway based on national guidelines from NICE.

Outcomes for people using services

The trust participated in national audit and local audits were also in place. The trust participated in the National Intermediate Care Audit 2014.

The trust had an identified Quality and National Institute of Health and Care Excellence (NICE) lead for the trust. The medical director provided representation at the national NICE guidance committee. The trust had registered as a

stakeholder on all guidelines and therefore staff could contribute directly to guidelines in development. An annual audit programme had been developed in line with the trust's objectives. The annual audit programme included NICE guidelines as a priority. The NICE lead promoted guidelines and quality standards to staff via the trust weekly bulletin and monthly emails and to service users through the trusts voice news publication. The Quality and NICE Lead told us they had twice been asked to promote the trusts work at the national NICE conference, once for work on self-harm and once for work on dementia. Both presentations were made jointly with service users who had supported implementation of the relevant guidelines.

The trust had completed several NICE audits between February 2014 and February 2015. These were:

- The treatment and management of psychosis and schizophrenia in adults (February 2014)
- Drug allergy (September 2014)
- Bipolar disorder (September 2014)
- Antenatal and postnatal mental health (December 2014)
- Anxiety (August 2014 and January 2015)
- COPD (September 2014)
- Depression (August and December 2014)
- Hypertension (August 2014)
- ADHD (December 2014)
- Alcohol dependence (March 2014)
- VTE (June and August 2014)
- PTSD (July2014)
- Self- Harm (February 2014)
- End of Life (February 2015)
- Nutrition (November 2014)

The trust had an audit programme to assess medicines handling in accordance with the trust's 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. The outcome of these audits were shared at the Drugs and Therapeutics Committee and network and ward level governance meetings.

We saw in the community health services for adults that local audits were undertaken and the results were seen as positive. Patient outcomes were reviewed in relation to diabetes and weight management but we were unable to determine if the findings were used to improve services.

Are services effective?

The trust target for the vaccination programme in community health services for children, young people and families was to achieve 90% uptake. However, the actual uptake ranged from 59 to 73%.

We saw that patients identified as requiring end of life care received expert input from specialist respiratory or cardiac care nurses if required.

The Advancing Quality Alliance (AQuA) toolkit was used in the wards for older people to improve the safety and quality of healthcare to patients and this would improve patient outcomes. Wards providing older adult mental health care had completed various audits to inform and improve outcomes for patients.

Staff in the child and adolescent mental health wards used routine outcome measures on admission, after six weeks and on discharge to measure the patients' progress. These included: the patient's strengths and difficulties questionnaire (SDQ), Health of the Nation Outcome Scales - Child and Adolescent Mental Health (HoNOSCA) and the Children's Global Assessment Scale (CGAS). Patients on these wards had access to cognitive behavioural therapy, family therapy and a solution-focused recovery group.

The long stay/rehabilitation wards for working age adults used Health of the Nation Outcome Scores (HoNOS), Recovery Star, Social Functioning questionnaires and the Camberwell Assessment of Needs to measure the effectiveness of the care and treatment.

The occupational therapy team in the forensic/secure services was in the process of adopting the Model of Human Occupation Screening Tool (MoHOST) as this was recommended for secure services.

The crisis teams and health-based places of safety rated severity and outcomes using HoNOS. The information had been collated and scores across the teams showed an average improvement in clinical outcomes of 71%.

The services in the adult mental health network measured outcomes by Payment by Results cluster types. The community services for working age adult teams used a variety of other tools including the recovery star, the Camberwell Assessment of Need and the Questionnaire about process of recovery. There was a clear programme of audits in place but it was not clear how findings and recommendations were fed back to the teams.

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.

Staff skill

The 2014 NHS Staff survey involved 287 NHS organisations in England. Over 624,000 NHS Staff were invited to participate using a self-completion postal questionnaire survey or electronically via email.

The trust saw a negative trend in 2014 when compared to other mental health and learning disability trusts in England for the number of staff who had received an appraisal in the last 12 months. The national average was 88% compliance rate compared to the trust's score of 86% in 2013 and 75% in 2014. This meant that the trust scored 11% less than the previous year. The trust also scored less than the national average for appraisals being 'well-structured'. The national average was 41%, while the trust scored 40% in 2013 and 32% in 2014.

We saw during the inspection that across services rates of appraisal were low. In the wards for older adults, Dickens ward had completed only one appraisal out of 42 staff. Ward 22 identified that nine out of 43 staff had been appraised. The ward with the highest number of staff appraised was Austin ward, with 19 out of 45 staff having received an appraisal. In the child and adolescent mental health wards, the Junction had completed only 18% and The Platform 60%.

Managers of the long stay rehabilitation wards told us that clinical staff had not received an appraisal for over a year. Records confirmed this. In addition, qualified nurses in the community rehabilitation unit were all overdue clinical supervision.

Staff in the crisis teams and health-based place of safety received annual appraisal and we saw evidence of this. We also saw evidence that staff received regular clinical and managerial supervision.

Staff had received modified training in control and restraint in line with the trust's commitment to reducing restrictive practices. Forensic/secure wards had instructors on each ward to support staff with the changes in practice.

Staff working at The Harbour in the acute wards and psychiatric intensive care units did not always have the necessary skills needed to carry out their roles. When the services were moved to The Harbour, the trust lost a

Are services effective?

number of qualified and experienced staff. Many staff were newly qualified or recruited. Of the 193 staff at The Harbour, only 22 had completed all mandatory training while four had not completed any training. Not all the newly recruited staff at The Harbour had received an induction. We were told that dates had been arranged for induction later in the year. Staff on the acute and psychiatric intensive care wards had not received regular supervision, again due to low levels of staffing.

The trust's failure to ensure that staff are appraised regularly means that patient care could be compromised because staff are not up to date with the training, skills and knowledge they need to provide effective care.

Multi-disciplinary working

All the teams we visited worked in a multidisciplinary model of care. The teams consisted of a range of disciplines, including consultant psychiatrists, nursing staff, social workers, psychologists, pharmacists, occupational therapists and other health and social care professionals depending on the services being received.

We attended 25 multidisciplinary team meetings or care programme approach meetings and 12 staff handovers.

In the community health services, multidisciplinary working was collaborative and evident in nearly all the clinics and locations we visited. There were arrangements to ensure regular meetings took place. Individual case reviews and shift handovers were evident. There was an exception at the Buckshaw Village surgery, which was visited as part of the community health services for adults where communication was poor between the teams. Staff were not able to recall the names of staff from other disciplines, which raised questions about how familiar the teams where with each other.

In the mental health services we found that there were regular and effective multidisciplinary meetings taking place. We noted that at The Harbour, wards for older people with mental health problems had developed daily ward 'huddles', where all staff met to discuss issues relating to the ward and patient care. With one exception on Ward 22, patients in the older people's wards were invited to attend meetings that were about their care and treatment.

The child and adolescent mental health wards had good working relationships with the adult crisis teams and the

tier four outreach team. Both wards followed a multidisciplinary collaborative approach to care and treatment, and the teams included teachers, social workers and dieticians.

We heard that the long stay/rehabilitation wards for working age adults had positive relationships with care co-ordinators who were invited to be a part of the multidisciplinary teams and attend ward rounds. In addition, the staff worked in partnership with local GPs to ensure patients physical health care needs were met.

Crisis and health-based places of safety worked to an integrated health and social care model and there was good multidisciplinary working. The teams also worked with acute wards to plan transition between services. There were good working relationships at both strategic and operational level in relation to section 136 of the Mental Health Act.

Information and Records Systems

The trust operated an electronic patient record system in the mental health directorate. However, in the community health services we found that some staff used electronic records but others used paper records. This presented a risk by having two systems complicating the process of record-keeping and could lead to confusion or recording errors. Electronic patient records were not always accessible when connectivity was poor and access to paper-based records was variable throughout all areas. Electronic templates had not been set up for all the specialities, which meant staff continued to maintain paper records, which could not be accessed across other specialities. In children's services issues were raised in relation to "Red Books", which were not always fully completed with names and address of the children and the "Flimsies" in the red books were inconsistently completed and we saw evidence of poor quality of scanning of these 'flimsies' making them illegible.

Guild Lodge had implemented a new electronic records management system. Access and navigation was time-consuming. The issue had been escalated to the executive risk register and an action plan had been developed.

Records relating to section 136 episodes were in paper format. This meant the information was readily available.

Are services effective?

However, we found that the information was not fully completed. This meant the trust could not fully audit the information and learn lessons to improve outcomes for people.

(Note: The police can use section 136 of the Mental Health Act to take you to a place of safety when you are in a public place and you appear to have a mental illness and be in need of care. A place of safety can be a hospital or a police station. The police can move you between places of safety.)

Consent to care and treatment

There was a policy for implementing the Mental Capacity Act (MCA) and obtaining authorisation for Deprivation of Liberty Safeguards (DoLS) dated September 2012. This was supported by a MCA and DoLS managing authority procedure dated November 2014. This procedure was to assist staff in a managing authority (inpatient) setting in relation to the DoLS process.

The trust recorded 17 DoLS applications from 8 August 2014 to 27 January 2015. Five DoLS notifications had been received by CQC in line with the trust's regulatory duty.

Across the community health services staff understood patient consent and when it should be obtained, with the exception of some staff in the children, young persons and families services. Staff in the vaccination and immunisation team were not following the trust's consent policy in relation to the Gillick competency and Fraser guidelines. These are used to decide whether a child is mature enough to make decisions. The trust policy stated that children in school year 10 (aged 15-16) could give consent if they were deemed to be Gillick competent. We observed that Gillick competency was not used at all and this resulted in children not being vaccinated or the parents being contacted to give verbal consent.

(Note: Gillick competency involves deciding whether a child of 16 years or younger is able to consent to medical treatment without the need for parental permission or knowledge. The Fraser Guidelines were set out by Lord Fraser in his judgement of the Gillick case in the House of Lords in 1985 and apply specifically to contraception. They are used to decide whether a girl of 16 or under can be given contraceptive advice or treatment without the consent or knowledge of her parents.)

Staff told us and records demonstrated that where required, a template was used to complete details regarding mental capacity. Checklists were available to support staff in this task. Staff were also aware of their requirements under the Mental Capacity Act and could tell us when a DoLS application might need to be made.

In the mental health services, most staff understood consent and knew where to find the trust policy. We found that in most core services, patient's capacity to consent was assessed on admission and it was recorded. In the wards for children and adolescents we saw that capacity to consent was discussed at every review meeting. However, on the long stay/rehabilitation wards for older adults, clinical staff were not confident in their understanding of the Mental Capacity Act or DoLS. Despite this, we saw evidence in multidisciplinary team meetings and patient notes that staff had considered patients capacity to consent.

Records indicated there were two levels of Mental Capacity Act training for all staff. In the wards for older people, we saw that there were significant gaps in the training that staff had received. The percentages of staff across all five wards who had received level 1 training ranged from 37 -76%. Level 2 training ranged from 18 – 40% across all staff. Records showed that only one member of medical staff had undertaken level 1 training and none had completed level 2 training. However, we saw that patient's capacity to consent was assessed and recorded appropriately. Patients were supported where possible to make decisions for themselves before they were assumed to lack the mental capacity to make a decision. Where needed, best interest meetings were held and included the multidisciplinary team and family members.

In the community health services for children, young people and families, we found appropriate guidance was not always followed when taking consent for the administration of vaccines.

Assessment and treatment in line with Mental Health Act

The trust had a Mental Health Legislation sub-committee. A review of the minutes identified current issues, which included; accuracy of section 17 leave forms (this is a form that must be completed in order that a patient who is detained may leave the hospital grounds), performance management/late reports, no escalation of urgency, lack of designated places of safety for young people under 16 or 16-18; out of hours assessment and no budget for Mental Health Law training.

Are services effective?

During our visits to the wards, we found that where patients were detained under the Mental Health Act 1983 (MHA), the necessary legal paperwork was present in the patient's files. In most cases this also included a copy of the approved mental health professional (AMHP) report, although this was not always present for patients who had been detained for some time.

There was evidence that patients were advised of their rights in accordance with section 132. We saw that patients were reminded of their rights at three-monthly intervals. However, we found that where patients had not understood their rights, further attempts to explain them were not always happening in a timely manner on some wards. Patients confirmed that they were aware of their rights and were able to operate their right of appeal effectively.

There was an independent mental health advocacy (IMHA) service available to all patients. The trust operated an opt out system that meant patients would be automatically referred to the IMHA unless a patient with capacity objected.

Documentation relating to the authorisation of section 17 leave was well completed and risk assessments were completed before leave was authorised. Old and superseded leave forms were available in the patient files on one ward, which could lead to some confusion about what leave was currently authorised.

(Note: If someone is detained in hospital under the Mental Health Act, it is against the law for them to leave without specific permission granted by the responsible clinician. Permission to leave the hospital grounds – to visit their family, for example, or for a trial visit home prior to discharge – can be given under Section 17.)

We found that informal patients were routinely and consistently restricted from leaving on some acute wards. There was no information about an informal patient's right to leave displayed at Moss View.

There were inconsistencies across services with staff compliance with MHA training. The trust target of 85% was not being met.

In relation to section 58 (see note below), we found that all prescribed medication was authorised by a form T2 or T3. However, we were concerned about the inconsistent recording of the responsible clinician's (RC) assessment of a patient's capacity. In some cases it was not possible to determine if a patient's capacity had been assessed at the point that medication had first been administered. On one ward there was no evidence of a discussion relating to the capacity to consent at the point at which a T2 or T3 had become necessary.

(Note: Section 58 of the Mental Health Act sets out the circumstances in which medication or treatment can be given to patients without their consent. Form T2 is a certificate of consent to treatment completed by a doctor to record that a patient understands the treatment being given and has consented to it. Form T3 is a Certificate of second opinion completed by a doctor to record that a patient is not capable of understanding the treatment he or she needs or has not consented to treatment but that the treatment is necessary and can be provided without the patient's consent.)

The quality of care plans was variable. In some there was little evidence of the direct involvement of patients in the content of care plans. Some care plans were written from a nursing perspective and contained language that would not be easily understood by the patient.

On Greenside ward, patients did not have direct access to hot drink making facilities and needed to ask staff when they wanted a hot drink.

The trust had developed a new electronic system for documenting Mental Health Act (MHA) records, which it hoped would lead to an improvement in performance information and, more importantly, flag when issues need to be addressed in relation to the administration of the MHA. The system was still to be implemented across the trust.

Are services caring?

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

Summary of findings

We rated caring as 'Good' because:

- Across all of the community health services, mental health services (inpatient and community) and the adult social care homes we inspected, we saw most staff being responsive, respectful, caring and kind when interacting with patients.

- Feedback from focus groups we held was positive in relation to how patients were cared for by staff.

- Staff actively involved patients and their carers in the planning and delivery of the care they received.

- Results from the Friends and Family test was positive across the community health services.

- Each ward had a patient involvement group established, which was facilitated by one of the patient experience quality improvement team.

- Carers who attended the carers' focus groups we arranged confirmed that they had all been offered a carers' assessments on an annual basis.

- There were good examples of how the trust had involved patients and carers in service development initiatives.

However:

- On one older people's ward and two adult wards, we witnessed incidents where staff did not treat patients with respect. These incidents were escalated immediately and assurance was provided that appropriate action would be taken to address these issues.

- Young people's confidentiality was not always protected in one clinic we visited.

Our findings

Dignity, respect and compassion

The Patient Led Assessment of the Care Environment (PLACE), England 2014 identified that the trust scored 94% for the privacy, dignity and well-being element of the assessment against an England average of 88%. There was PLACE information available for 12 locations.

Feedback from the 'Patient Opinion' website showed the trust had been rated 3.2 stars out of 5 for 'respect' based on 30 ratings. The trust had 3 out of 5 stars for 'listening' based on 30 ratings.

Before the inspection, Lancashire Mind hosted a focus group. The group fed back that staff were caring and kind and that patients and carers were always respected. However, they also commented that staff were very busy and that they didn't have time to care on top of all the other processes that happen.

Across all of the community health services, mental health services (inpatient and community) and the adult social care homes we inspected, we saw most staff being responsive, respectful, caring and kind when interacting with patients.

There was one exception on Ward 22, a ward for older people, when we observed staff placing aprons around patients. Staff did not explain what they were doing or ask if the patient would like an apron. This meant that patients were not respected. However, we also used the short observational framework for inspection (SOFI) tool on Bronte ward and observed patient engagement and interaction. We observed staff being warm, encouraging and supportive with patients.

(Note: The Short Observational Framework for Inspection tool is used by CQC inspectors to capture the experiences of people who use services who may not be able to express this for themselves.)

Two other exceptions took place on the acute wards for working age adults and psychiatric intensive care units. They involved the same member of staff who we observed blocking a patient's attempt to enter the ward office without explanation and by physically pushing the patient

away from the door. Later we saw that staff member and two others pulling a patient by the arms. This was reported immediately to the nurse in charge, who told us they would take immediate action.

In the community health services we saw a care worker supporting a patient to elevate their legs on a footstool and staff replace a patient's identity bracelet to make them more comfortable. Staff spoke with patients in private to maintain confidentiality. However, we also observed that in the vaccination clinic, young people who could not roll up their shirtsleeves had to wear a gown to protect their modesty whilst in view of other young people. Female students were also asked if there was any chance of pregnancy in an open hall without due consideration for their privacy.

Results from the Friends and Family test were positive across the community health services. This test is used nationally to capture how patients felt about the care they received. The results were displayed in services so that patients and relatives could see them.

Overall for the trust, on average 97% of respondents said in the Friends and Family Test between January and March 2015 that they would be either extremely likely or likely to recommend the trust as a place to receive care most of the time or all the time. Community mental health services for working age adults also used the Express Your Experience – Achieve Change Together tool (EYE-ACT).

In the supported living services, people enjoyed a high level of privacy and dignity as they were living in their own homes.

Involvement of people using services
We saw that on the Patient Opinion website, the trust scored 3.1 out of 5 stars for 'involved' based on 29 ratings.

On NHS Choices we saw that there were concerns about lack of communication, and patients and those close to them not being heard.

In the CQC Community Mental Health Patient Experience Survey (2014) the trust scored 8.2, which is above average compared to other trusts, for the question 'Were you involved as much as you wanted to be in deciding what treatments or therapies to use?' This translated into an above average score of 7.8 for the overall section on treatments.

Care records showed that in nearly all cases patients were actively involved in care planning and that the plans were person-centred. In addition, in the community health services it was evident that those closest to patients had been involved in patient care.

The trust had a patient experience and oversight group. The purpose of the group was to seek assurance on behalf of the Council of Governors that the duty to engage with the public, including service users and carers, and to learn from the patient experience, thereby continuously improving services, is being met by the trust. Minutes of this group demonstrated that there was oversight of engagement with Healthwatch, implementation of the Friends and Family Test, and compliments and complaints.

The governors told us in their focus group that they had engaged with the public through the use of questionnaires and public meetings. However, response rates were poor.

Each ward had a patient involvement group, which was facilitated by one of the Patient Experience Quality Improvement Team.

The Quality and NICE lead told us that some service users were involved in some specific staff training e.g. personality disorders and understanding self-injury. Minutes of meetings confirmed that both patients and carers were involved in recruitment at different levels across the trust.

At The Harbour we were told that patients and carers had been involved in the development and design of the building. In addition, with a local community arts project, they had created the signage and key pieces of art work. A group of carers reported positively on this work at a focus group meeting. Staff told us that there was good access to interpreters where required.

On the children and adolescent wards, staff had involved patients in the day–to-day running of the ward. Patients stated that they felt involved in decisions about the ward.

Patients and relatives in the forensic/secure services were engaged in all aspects of life at Guild Lodge. Patients had designed the service guide and had set up a car-washing business on site.

Emotional support for people
In the community health services, staff were sensitive to the needs of patients who were seriously ill and recognised the impact this had on those close to them. Recently bereaved relatives spoke about the support they received. In the

Are services caring?

community health services inpatient service we saw that there were leaflets available in the day room, which included various signposting to different agencies. Chaplains from the local community were available to provide emotional support.

Carers who attended the carers' focus groups we arranged confirmed that they had all been offered carers' assessments on an annual basis.

In the mental health services, wards displayed leaflets and posters so that patients knew how to access both Independent Mental Health Advocacy and general advocacy services.

At The Harbour we saw there was a dedicated room for contemplation/prayer. The room is designed as a multi-faith room and had a Quibla indicator to identify the direction of prayer for Muslims. There were information leaflets explaining how to access this room in all of the wards.

We also saw that there were information leaflets available about drop-in groups, meetings and local community groups. Information to support patients, relatives and carers about treatments was freely available.

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

We rated responsive as 'good' because:

- At the Minerva Centre, there were excellent examples of how staff engaged with Muslim and Hindu communities, which included regular contact taking place in mosques, community centres, schools and health melas (fairs).

- Staff were trained in equality and diversity, were able to recognise patients' diverse needs and actively tried to meet them. This included access to interpreters and faith leaders, and the provision of information in different formats.

- The trust engaged with people including carers in the planning of service development initiatives.
- The trust had a rapid resolution process for managing and dealing with complaints.

- Some 95% of patients on the Care Programme Approach received a follow up within seven days of being discharged from hospital.
- The trust was meeting the referral target time of 18 weeks from initial assessment to treatment in 15 of their 22 community health based services.

However;

- In seven services the trust was not meeting referral target times. The chronic fatigue service had the longest average wait time of 60 weeks.

- We identified a number of issues of concern in relation to the child and adolescent mental health services (CAMHS) provided by the trust in the community. This included the lack of an appropriate transitional pathway for patients moving from CAMHS to adult services.

- In the forensic wards, patients' needs were recognised but not always met owing to shortages of staff, which meant access to meaningful activities and leave was inconsistent.

- Of 35 wards, 19 had a bed occupancy over 90%, with three having a bed occupancy of 100% or over.

- Learning from complaints and concerns was not embedded across all teams and clinical networks in the trust. However; the trust recognised this and the issue had been escalated onto the trust's risk register.

Our findings

Planning and delivery of services

All admissions to the trust's inpatient acute mental health wards were through the Crisis Resolution Home Treatment Team (CRHTT). The trust has consistently performed below the England average of 99% for the proportion of admissions to acute wards via the CRHTT team, reaching 95% of admissions in October to December 2014/15. However, the trust informed us that the figure for quarter four between January to April 2015 was 98%. The trust told us it had improved in this area through increased scrutiny of admissions.

Between 1 July 2014 and 31 December 2014 Talbot Ward, Lytham Hospital, had the highest number of delayed discharges with 32. Ward 20 at Burnley General Hospital had the highest number of readmissions within 90 days with 57.

We met with carers from across the localities before the inspection. Carers who attended a focus group at The Harbour told us that there was good consultation and engagement with carers regarding the planning stage and move to The Harbour. This included plans being available for them to review and they were invited to site visits and tours of the building.

Staff side representatives we met with confirmed that staff had been actively encouraged by the trust to be involved in consultations regarding the move.

Are services responsive to people's needs?

The trust had recognised that the move to The Harbour might mean it was difficult for some people to visit their relative due to the location. In response to this, the trust had purchased a caravan that could be used by relatives to stay overnight at no cost.

There was also evidence to show that the trust had proactively engaged with people regarding the review of adult community mental health services.

Diversity of needs

Overall, Lancashire had 17 health indicators worse than the national average. However, in Blackpool and Blackburn, these increased to 23 and 21 respectively.

Deprivation in Lancashire was higher than national average, with 18.2% (38,700) children living in poverty. Life expectancy for both men and women was significantly lower than the national average. There was also a difference in life expectancy between the most deprived areas of Lancashire in comparison to the least deprived (9.9 years for men and 7.6 years for women). Incidences of smoking, alcohol-related illnesses, violent crime, self-harm and infant mortality were higher than the national average.

The trust had identified three health priorities, which were; starting well, living well and aging well to address some of these issues. In January 2015, the trust introduced a no-smoking policy, which meant that patients would no longer be allowed to smoke in the trust's grounds, including the outdoor areas. Patients were offered assistance to stop smoking, with the use of nicotine replacement therapies. Despite this, we found attitudes towards the no-smoking policy varied throughout the trust. In some areas, staff actively enforced the policy and in other areas, we found evidence which showed that staff took a more relaxed approach. This lack of consistency meant that some patients had requested transfers to areas where staff took a more relaxed approach.

The trust had an equality strategy called; 'Transformation and Equality', which sets out how the trust is working strategically to meet the needs of the diverse population it serves. This includes making sure that equality and diversity issues are integrated in each network business plan to ensure progress is monitored by the board twice a year. The number of people from a black and minority ethnic (BME) background who have received services from the trust was 7% from a local population of 9.6%. The largest minority group of staff was Asian/British Asian with

4.84% of the workforce. Overall, the workforce split by ethnicity was representative of the population served by the trust. Across the trust, we found that patients' diversity and human rights were respected by staff. Staff working in the trust were aware of patient's individual needs and tried to ensure these were met.

At the Minerva Centre, there were excellent examples of how staff engaged with Muslim and Hindu communities, which included regular contact taking place in mosques, community centres, schools and health melas. Patients were encouraged to attend clinic and classes were offered using translators.

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. However, in the forensic wards, access to religious facilities was inconsistent.

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.

The trust scored above the national average for food as assessed through the patient led assessment of the care environment (PLACE) visits. The trust provided food to meet patients' special dietary needs. A choice of meals was available, with efforts made to ensure the cultural and spiritual needs and preferences of patients were met on most wards. However, on the forensic wards, with the exception of Fellside (which held its own budget); both patients and staff raised concerns about the food, describing it as poor quality, tasteless, lacking in choice and not fresh.

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.

We held a focus group with local stakeholders. The group informed us that the trust had worked extremely hard to develop the gender identity services and psychosexual team, which they regarded as "excellent".

Are services responsive to people's needs?

Overall, 86% of staff had attended equality and diversity training in the trust, which was above the trust's target of 85%.

Right care at the right time

The aggregated total for bed occupancy rates for Lancashire Care NHS Foundation Trust had been consistently higher than the England average for mental illness beds during the past 12 months. For quarter three (September to December 2015) the trust's aggregated occupancy was 92%. Of 35 wards, only seven had a mean bed occupancy under 85% between July and December 2014. Nineteen of these had a bed occupancy over 90%. Darwen, Pendleview, Bowland Unit and the Latham suite had a bed occupancy of 100% or over. On these wards, patients returning from a period of leave would occasionally have to move to other wards because a bed was not available in the ward they were on leave from. This was flagged as a risk on the trust's risk register.

It is generally accepted that when 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. The trust was meeting the referral target time of 18 weeks from initial assessment time to treatment in 15 of their 22 community health based services. In services where the trust was meeting the targets, the average wait times varied between 0.2 weeks (rapid assessment team) to 9 weeks (continence service).

The seven services that were not consistently meeting target times across the trust were CAMHS Tier 3, learning disability services, occupational therapy, physiotherapy, speech and language, child psychology and the chronic fatigue service. Of the seven services, the chronic fatigue service had the longest average wait time of 60 weeks (ten times the six-week target).

The learning disability service was the closest at meeting the target of 18 weeks with an average wait of 17 weeks. However, the trust included the patient's initial assessment as their first treatment session for all services.

We identified a number of issues of concern in relation to the child and adolescent mental health services (CAMHS) provided by the trust in the community. The trust's community service model meant that when a young person reached the age of 16 they were transferred from the community CAMHS service to the adult community mental health service.

Concerns identified included:

- CAMHS staff were unavailable outside of normal working hours, to assess young people with mental health problems at Lancaster, Blackpool and West Lancashire A&E departments as this is not currently commissioned to be provided by Lancashire Care. This meant that young people might wait as long as three days to be seen by a specialist at a weekend.
- Long waiting times for appointments to access services especially in Chorley and South Ribble and West Lancashire.
- External stakeholders informing us in a focus group that vulnerable 16 and 17-year-olds were not able to access community adult services in a timely manner, with waits of several months.
- Gaps in service provision for young adults with autism who were transferred from CAHMS to the adult community mental health teams. There was a lack of an appropriate pathway. This had resulted in deterioration in some individuals' health and the need for them to access the crisis team service.

However, the trust had recognised these issues and was being proactive in addressing them. Actions had been agreed and a CQUIN target (payment for improving quality) was associated with the delivery of the action plan.

In the forensic wards, patients' needs were recognised but not always met owing to staffing issues or a lack of transport. The most recurring theme from patients was in regard to home leave, community leave and activities being cancelled or re-arranged because there were not enough staff available to provide escorts. There were inconsistencies across the service in relation to the amount of meaningful activity provided on the 14 wards. This fluctuated between as little as 90 minutes a week on Dutton ward to 25 hours a week on Forest Beck ward.

We held a focus group with carers' of patients who had or were accessing services in the trust. They told us that their relatives had experienced some difficulties re-accessing services once they had been discharged.

Delayed transfer of care

In the first six months of 2014, the trust had an average of 28 delayed transfers each month. This dropped to an

Are services responsive to people's needs?

average of 11 delayed transfers in the final six months. 'Housing – patient not covered by NHS and Community Care Acts' was the most common reason for both delayed days and delayed patient transfers in 2014.

In the forensic services on Fairsnape ward, patients were admitted for an assessment period of 12 weeks. However, some had been on the ward for up to seven months. While some extended stays were based on individual needs and circumstances, we found there were also delays in transfers to other wards. This meant that for some patients, the ward they were staying on had a higher level of security than was required based on their individual risks. Common barriers to discharge that caused delay and frustration on the forensic wards included the availability of appropriate accommodation, funding approval, and Ministry of Justice approval.

In relation to discharge follow-up within seven days for patients on the Care Programme Approach, the trust had been slightly below the England national average of 97% at 95%.

Learning from concerns and complaints

Six hundred formal complaints were made to Lancashire Care NHS Foundation Trust in the 12 months ending January 2015, of which 322 were upheld. This figure of over 50% is much higher in comparison to similar trusts. The associate director of quality and experience told us this figure included complaints that were partially upheld in addition to those that were wholly upheld, which accounted for this high percentage. Of the 600 complaints received, four were referred to the Parliamentary and Health Service Ombudsman (PHSO). Complaints are referred to the Ombudsman when the complainant is not satisfied with the investigation of their complaint or its outcome. None of these four complaints were upheld by the Ombudsman.

The top three most common themes in complaints the trust received were lack of respect from staff, issues relating to care received, and lack of or poor involvement in care. The specialist services and adult mental health services received the highest number of complaints.

The trust had implemented a rapid resolution process for managing and dealing with complaints six months ago. 373 complaints had been managed through this process. Although the trust reports these as a complaint, they are resolved much more quickly than the timescales for managing a formal complaint.

The associate director of quality and experience told us the trust had a development plan in place to improve the way the trust responded to and managed complaints. The plan included reviewing the skills staff needed to investigate each complaint and reviewing how the trust assesses and grades complaints as level 1 or 2.

Learning from complaints and concerns was not embedded across all teams and directorates in the trust. The trust had recognised this and had strengthened the focus on listening to the experiences of people by realigning the customer care team with the quality improvement and experience portfolio. This had supported the strengthening of the 'Dare to Share - Time to Shine' model which gave an opportunity for staff across the trust to come together to share learning.

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

We rated well led as 'Requires improvement' because:

- The governance structure from senior manager level to ward level was still in the process of being developed. Therefore it was not possible to determine the effectiveness of this in practice. Although most teams discussed governance issues in team meetings, there was no consistent agenda or approach across the trust.

- The trust had experienced significant issues that impacted on the effective functioning of the human resources department. These included length of time to recruit new staff, the recruitment process and managing staff disciplinary procedures in a timely manner in line with trust policy.

- The trust was not meeting its target rate of 85% for attendance of mandatory training.

- There were inconsistencies across the trust regarding compliance with appraisals and supervision.

- In mental health services, there were inconsistencies across the teams, with four out of the 10 core services requiring improvement in the well led domain and five requiring improvement overall.

- Feedback from complaints and incidents was inconsistently provided to staff in the trust. This meant that leaning from complaints and incidents was not fully embedded across all clinical areas.

However:

- The board had a clear five-year plan that set out the vision and strategic objectives for the trust, which most staff were aware of and understood.

- The trust had developed a good governance structure at board level to senior manager level, with established committees that monitored quality, financial performance and operational issues relating to the trust.

- The trust had action plans to drive service improvements and risk registers to monitor progress.

- The trust had implemented the quality SEEL in each clinical area. Information regarding the outcome of SEEL audits were on team information boards, which were visible and accessible to visitors.

- The trust had experienced difficulties with how the human resources department had functioned, which it acknowledged and was addressing. The trust was meeting the Fit and Proper Person Requirement (to ensure that their directors or equivalent are fit and proper for the role).

- In the teams, local leadership was generally visible and strong.

- The trust had implemented a number of initiatives to improve engagement with staff in the trust.

- Three out of the four clinical networks had received national accreditations.

Our findings

Vision, values and strategy

The trust had a strategic planning framework for 2014/19 that included six clear visions:

- To provide high quality services
- To provide accessible services delivering commissioned outputs and outcomes
- To become recognised for excellence
- To employ the best people
- To provide excellent value for money in a financially sustainable way
- To innovate and exploit technology to transform care.

Underpinning these visions, there were six trust values;

- Teamwork
- Accountability
- Integrity
- Respect

Are services well-led?

- Excellence
- Compassion

The strategy was embedded across the trust's four clinical networks. However, there was no local vision or strategy for community services for adults.

The trust was financially sustainable and secure.

Good governance

The trust board of directors were accountable for the running of the trust. They provided the overall strategic leadership to the trust. There was also a council of governors who provided a link between the local communities and the board of directors. The council of governors held the non-executive directors to account for the performance of the board. The trust had recently implemented a new governance structure. Four committees fed directly into the council of governors.

These were:

- The standards and assurance committee, which seeks assurance on behalf of the council of governors that appropriate standards of healthcare are being met by the trust.

- The patient experience and oversight group, which seeks assurance on behalf of the council of governors that the duty to engage with the public, including service users and carers, and to learn from the patient experience, thereby continuously improving services, is being met by the trust.

- The council of governors nomination/remuneration committee, which makes recommendations for ratification to the council of governors, for the appointment, removal and remuneration, allowances and other terms of office of the chairman and non-executive directors of the trust.

- The membership and governance committee which seeks assurance on behalf of the council of governors that the membership of the trust remains representative of the service users and public served by the trust and that the membership engagement strategy is effectively delivered by the trust. The committee also supported the effectiveness and governance of the council of governors, making recommendations to the council of governors where appropriate.

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

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

Underneath these committees, there were the following nine sub-committees;

- Corporate governance and compliance
- Operational delivery and performance
- Business planning and transformation
- Finance
- Estates
- Health informatics
- Quality and safety
- People
- Mental health legislation

These committees ensured there was a robust structure to monitor quality, financial performance and operational issues relating to the trust, which directly linked to the trust board. This meant the board maintained a strategic oversight of key issues and performance indicators in the trust. Each of the committees had developed terms of reference for the groups.

The trust had corporate action plans to monitor progress against areas where improvements needed to be made, which were monitored by the board. Each directorate held their own risk register. Risks could be escalated from these to the corporate risk register by senior managers.

The trust was developing a new governance structure from senior management level to the wards and clinical teams. This was in draft form at the time of our visit. We were told that this was 'phase 2' of the process, for the middle tier to be consistent in the governance structures across and down the organisation. This meant it was not possible to determine the effectiveness of the new structure as this had not been implemented.

Matrons in the trust met monthly to monitor and review clinical quality issues. The matrons met regularly with ward managers and team leaders to discuss quality issues.

We saw evidence that in most clinical environments, staff teams did discuss governance issues in team or governance meetings. However, the governance structures in some areas were not embedded at local level and there

Are services well-led?

was no consistent agenda or approach across the trust. This meant that important issues could have been missed and communication between teams and the trust could be negatively affected. The NHS staff survey results shows the trust scored lower than the national average in 2013 and 2014 regarding the number of staff who felt that there was good communication between senior management and staff (the national average being 30% and the trust scoring 27% for each year).

The trust saw a negative trend in 2014 when compared to other mental health and learning disability trusts in England for the number of non-medical staff who had received an appraisal in the last 12 months. The national average was 88% compliance rate compared to the trust's score of 86% in 2013 and 75% in 2014. The trust also scored less than the national average for appraisals being 'well-structured'. The national average was 41%, while the trust scored 40% in 2013 and 32% in 2014.

As at January 2015, the trust were also below their 85% target rate overall for training, achieving 74.9%.This indicated that the action plan the trust had in place to improve these scores had not been effective. In addition, there were inconsistencies across teams regarding adherence to the trust's supervision policy.

The trust had implemented the Quality SEEL self-assessment tool in each clinical team across the trust two years ago. The tool focusses on assessing and monitoring a team's compliance with the Care Quality Commission regulatory requirements and covers the key quality areas of safety, effectiveness, experience and leadership. This requires 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.

The percentage of permanent staff sickness overall was 6.3% between February 2014 and January 2015.

For nursing staff, between January and December 2014, there were a total of 50,596 sick days out of 777,655 available days, giving a rate of 6.5%.

Leadership and culture

We attended both the public and private board meeting that took place during our inspection and reviewed minutes of previous board meetings. Both meetings were well attended and conducted efficiently by the trust chair. Each board meeting was opened by the sharing of a 'patient story'. This was introduced by the chief executive to ensure the meetings remained firmly focussed on the delivery of patient care. Members of the board made well informed and relevant contributions to discussions. It was clear they had oversight of the key issues and challenges facing the trust. The risk register was reviewed and amended as part of the board meeting.

The governors' focus group identified that the CEO was quick to respond to any issues they raised. They found the briefing sessions they had with the CEO to be a good, effective mechanism for keeping them informed of information they needed to be aware of in relation to their role and the trust. In addition, they were able to discuss any concerns or issues they had as a group directly with the CEO. They reported that the trust had an open and transparent culture in which learning and development was promoted.

However, they also reported that they felt the trust board needed to place more trust in the governors. Governors also reported that when they were involved in 'Good Practice' visits, they were restricted to talking with senior staff and not patients, which they used to do.

In the teams, local leadership was generally visible and strong. However, some staff reported feeling that the community services were supplementary to mental healthcare services in the trust. The trust recognised this and had raised awareness of smaller departments (such as dietetics and smoking cessation) by hosting a 'niche services day'.

We held a focus group with staff representatives. They told us that the trust had not dealt with disciplinary procedures in a timely manner in the past two years, which has caused a great deal of distress to staff involved. They also stated that the trust target ward-based staff rather than managers when things go wrong. The trust acknowledged that they had experienced problems with how the human resources department had functioned and this had been escalated onto the trust's risk register. The trust had recently appointed a new director of human resources who had an action plan in place to address the issues of concern. These

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included length of time to recruit new appointees and the recruitment process, mandatory and personal development review compliance and managing staff disciplinary procedures in a timely manner in line with trust policy.

Fit and Proper Person Requirement

The fit and proper person requirement (FPPR) is one of the new regulations that applied to all NHS trusts, NHS foundation trusts and special health authorities from 27 November 2014. Regulation 5 says 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, and be able to supply certain information (including a Disclosure and Barring Service check (DBS) and a full employment history).

We reviewed the personnel records of the 14 senior directors in the trust in line with the FPPR. Some of the directors had been in post for several years. Only one director had been appointed since the new regulation was introduced.

Nine records showed that DBS checks had not been carried out on initial appointment. Some of these were not completed until several years after the person's appointment, the longest being a person appointed in October 2006 not having a DBS completed until 2011. However; we found that the trust had completed the necessary DBS, health screening and solvency checks for each person to meet the requirements of the new regulation.

We found that 12 out of the 14 files had no photo ID which should be there.

There were no application forms or evidence of how the interview process had been adhered to in any of the files we saw. In nine of the files there were references but we

found that in five files there were no references. This meant that it was not possible to determine that the interview process had been followed for these appointments in line with trust policy.

We held a focus group meeting with governors with 10 attendees. In the group there was concern expressed about the board's proposed procedure to appoint to the lead governor post which did not involve the council. The governors' council were unhappy with this process of recruitment and expressed their concern to the board. They told us the board did involve the council in the recruitment of the lead governor in the end.

Engagement with the public and with people who use services

The trust holds regular 'In Touch' sessions with staff, which are facilitated by senior members of the trust board. Between March and April 2015, 265 staff across the trust attended these sessions. The sessions are an opportunity for staff to raise any issues directly with a member of the trust board.

The trust has recently introduced the 'Dear Derek' initiative. The initiative enabled staff to raise any concerns they may have quickly and anonymously directly with the chair of the trust. Issues raised and progress made are reported to staff through the 'quality matters' briefing paper, which the director of nursing, quality and governance sends to staff on a monthly basis.

Members of the trust board undertake a 'Good Practice' visit to a clinical team each month. Members include executive directors or their deputies, non-executive directors, governors and clinical commissioning group team members. Feedback from these visits is shared with teams, including recommendations for further development. These recommendations are developed into an action plan, which identifies who is responsible for implementing the action and the timeframe for completion.

Senior members of the trust board, including the chief executive officer, also carry out three to four 'walkabouts' a month where they visit different clinical teams or wards. However, there was no documented evidence to show what the outcome of these visits was or how the outcomes were monitored to drive improvements.

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Quality improvement, innovation and sustainability

The trust had three clinical networks that had received national accreditations. These were;

Child and Adolescent Mental Health Services (CAMHS).

The Junction; Quality Network for in-patient CAMHSBlackburn with Darwen CAMHS; Baby-friendly accreditation

Adult Community Service.

Memory Assessment Service, Lancaster, Fylde and Wyre, Blackpool ; Memory Service National Accreditation Programme (MSNAP) - Excellent

Adult Mental Health

Bowland Unit; Accreditation for Inpatient mental health wards (AIMS**)**

Electro-Convulsive Therapy (ECT) Accreditation scheme

In January 2014, Guild Lodge successfully completed the self and peer review parts of the Quality Network for Forensic Mental Health Services annual review cycle.

The dietetics service had received an award for its training model.

An audit programme was in place to assess medicines handling in accordance with the trusts medicine policies and national guidance. The trust participated in relevant prescribing observatory for mental health UK) audits to facilitate benchmarking of prescribing practice against other similar trusts and against national guidance. The outcome of these audits were shared at the drugs and therapeutics committee and network and ward level governance meetings.

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment **How the regulation was not being met** The location and layout of the HBPoS at the Scarisbrick Centre, Ormskirk General Hospital, was not suitable for the purpose for which it was being used. It compromised patient safety, privacy, dignity and confidentiality. The toilet and washing facility had ligature points and did not meet fundamental standards in the good practice guidance of the RCP to assure against the risks of unsafe or unsuitable premises. There was a potential risk of self-harm and ligature risks to people who use the service. The toilet and washing facilities were not an integral part of the suite but located across a corridor that was open to the public and ward traffic. People were escorted to toilets through the reception area. This meant their privacy, dignity and confidentiality were compromised and the practice could put the patients or other people at risk. The entrance to the suite was located in the public reception area. The suite was visible from reception and the ward entrance. The suite did not conform to national best practice as it breached Royal College of Psychiatrists' standards and Health Building Note 03-01: Adult acute mental health units. The physical environment of Calder and Greenside wards was in poor condition, including significant damage. There were ligature risks on Calder, Greenside, Fairsnape and The Hermitage wards. Seclusion facilities on Calder, Greenside and Fairsnape wards were poorly equipped and did not afford people privacy and dignity.

Regulation 15(1)(c)(f)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Nursing care Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing How the regulation was not being met: People who use the service and staff could be at risk because the number of staff who had completed mandatory and required training was below expected standards. This included compliance with training around the Mental Health Act 1983 and Mental Capacity Act 2005. At ward 22 Burnley General Hospital we found high amounts of bank and agency staff being used with 807 requests from January 2015 to April 2015 and 118 of shifts not being filled. The risk register also highlighted lack of RMN cover and staff redeployment. We found staff had not always received supervision and or appraisals. The trust also confirmed that there was only one RMN covering at night when there should have been two. Ward 22 had insufficient levels of nursing staff on duty during the day against the trust figures provided for the period of January 2015-March and Bronte, Wordsworth, Dickens in March 2015 also. Young people could be at risk because the number of staff who had completed training was below expected standards at both Chorley and Lancaster CAMHS. We found low staffing numbers in some community health services for children, young people and families teams. This resulted in high caseloads and staff not being able to complete all the required tasks in a timely manner. The team at Avonham Health Centre and Preston area had particularly low numbers. In community health services for children, young people and families we found the trusts centralised system for mandatory training and supervision was not always accurate and up to date and did not reflect the local figures

This section is primarily information for the provider
Requirement notices

We found nurse staffing skill mix in end of life community health services did not always meet the needs of the patients as the caseloads had increased but recruitment was challenging and some teams reported frequent use of bank and agency staff.

At Guild Lodge, patients frequently experienced cancellations to escorted leave and activities.

There were not sufficient numbers of suitably qualified and experienced staff working on acute wards.

Staff did not receive appropriate levels of support to access mandatory training.

Staff did not receive regular supervision and appraisal.

Nurses working on the CRU at Moss View did not have regular clinical and managerial supervision in line with trust policy. Clinical staff from across both units did not have appraisals in place.

Regulation 18(1)(2)(a)(b)

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care

How the regulation was not being met :

There was a gap in service provision for young adults aged 16-18 with a diagnosis of autism who were transferred from child and adolescent mental health services to adult mental health community services. This meant that individuals were unable to access services that meet their needs.

Care and treatment did not meet service users needs as the waiting time for Chronic Fatigue Service appointments was an average of 60 weeks. In a podiatry clinic at Leyland Clinic, demand for appointments exceeded the number available and waiting times for appointments were long. This had resulted in several patients on a daily basis being referred or turned away. One patient reported waiting five months for a podiatry appointment. Despite this, our intelligence showed that patients were usually seen within 6 weeks which was better than the target of 18 weeks.

Requirement notices

Regulation 9 (1) (3) (b)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Nursing care Personal care Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment How the regulation was not being met : At ward 22, Burnley General Hospital, and the older adult wards at The Harbour, we found no ligature risk assessment had been completed to identify and manage any risks to persons using the service. We saw there were many identified ligature risks throughout the ward areas. There were no call alarms fitted on ward 22 in patient areas to allow patients to summon assistance if needed to ensure their care and treatment was provided in a safe way. We found that the transfer of young people to adult mental health services was not working effectively. There was no current protocol for staff to follow and inconsistency in practice. The triaging of patients upon arrival at nurse led clinics was not by suitably qualified staff. Life support skills in treatment rooms classed as Minor injuries Units, did not meet the levels expected. We found risk assessments were not available for all areas we inspected, staff were not always aware and therefore not mitigating the risks. They were poorly written and assessed and the premises used by the service provider were not always are safe to use for their intended purpose. in community health services for children, young people and families. At Garstang Road, Preston, Learning Disability Supported Living Scheme, the registered person had not ensured people were protected against the risks of unsafe care and treatment with regard to the safe and proper management of medicines. In the community health services for children, young people and families, we found the cold chain was not always maintained for vaccines, monitoring for adverse reactions was not undertaken, and appropriate guidance was not always followed when taking consent.

The physical environment of Calder, Greenside and The Hermitage wards was in poor condition, including significant damage, and did not provide a safe environment.

Greenside and Calder wards were not clean and hygienic.

There were ligature risks on Calder, Greenside, Fairsnape and The Hermitage wards.

Seclusion facilities on Calder, Greenside and Fairsnape wards were poorly equipped.

On the CRU at Moss View the ligature points had not been identified on the risk register. There was no ligature risk assessment in place for the CRU. The ligature risk assessment in place for the HDRU was of poor quality and did not adequately identify or manage the risks recorded.

We found breaches in compliance with the Department of Health guidance on same sex accommodation at Moss View.

At the time of our visit male and female patient bedrooms were located next to each other on the HDRU.

On the CRU, the communal IT equipment was located in a female pod, male and female patients freely accessed each other's pods without supervision and there was no separate female only lounge.

Regulation 12 (1)(2)(a)(b)(d)(I)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect How the regulation was not being met: At ward 22, Burnley General Hospital, we found breaches in compliance with the Department of Health guidance on same sex accommodation (SSA) and the Mental Health Act (MHA) Code of Practice (CoP), which could compromise the dignity and privacy of patients because access to bathroom and toilet areas meant patients had to walk through communal areas occupied by either sex which opened out onto the main ward communal area.

At Guild Lodge, all wards with the exception of two wards, had public phones with hoods situated in open communal areas. The phone in The Hermitage did not have a hood. Phones were not always in working order owing to damage or faults. Both phones on Greenside ward were out of order.

Regulation 10 (1) (2) (a)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment **How the regulation was not being met:** We found that staff had not adhered to the MHA Code of Practice or followed their own policy regarding seclusion at The Platform. Staff described secluding patients in the extra care area but we found they had not followed the MHA Code of Practice on seclusion. One seclusion record out of the five reviewed had no evidence of who started and who ended seclusion. Three records did not have 15-minute recordings of the progress of the patient. Medical reviews were evident in some records but it was difficult to ascertain who was independent and when the medical review took place. Regulation 13(7)(b)

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **How the regulation was not being met:** Neither CAMHS community team had an up-to-date environmental risk assessment to ensure the environments posed no potential risks to young people or children. Seclusion records were not complete and records on Keats were missing. Staffing levels on acute wards were not appropriate for the level of care required by some patients.

In September 2013 the CQC asked the trust to review the environment of the seclusion room shared by Whinfell and Bleasdale wards. At the time of the inspection the building works had finally commenced. We noted delays in responding to maintenance and cleanliness on the Calder, Greenside and The Hermitage wards.

The trust used both an electronic records system and a paper based system. In the electronic system it could take 2 hours to complete ECR details. ECR entries had to be transferred to other systems increasing the risk of errors and created extra work for staff. Incorrect entries on the electronic system could not be amended by the author and had to be amended by the information technology staff which complicated the process for record completion. This could explain why Trust figures for reporting documentation issues was high. Staff used computerised 'tablets' enabling them to source or store information when visiting patients which although useful and speeded up processes when connectivity was poor contemporaneous notes could not be made. On one occasion, patient visit lists could not be accessed. This issue had been added to the trust's risk register which showed it had been identified as problem.

At Moss View, there was no effective method for ensuring staff received timely feedback and lessons learned from incidents/complaints. The service was not working to any key performance indicators and audits being undertaken were in their infancy.

17(1)(2)(a)(b)(c)