Lancashire & South Cumbria NHS Foundation Trust

Inspection report

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Ratings

Overall trust quality rating	Good
Are services safe?	**Requires Improvement**
Are services effective?	**Requires Improvement**
Are services caring?	**Good**
Are services responsive?	**Good**
Are services well-led?	**Good**

Our findings

Our reports

We plan our next inspections based on everything we know about services, including whether they appear to be getting better or worse. Each report explains the reason for the inspection.

This report describes our judgement of the quality of care provided by this trust. We based it on a combination of what we found when we inspected and other information available to us. It included information given to us from people who use the service, the public and other organisations.

We rated well-led (leadership) from our inspection of trust management, taking into account what we found about leadership in individual services. We rated other key questions by combining the service ratings and using our professional judgement.

Overall summary

What we found

Overall trust

Lancashire and South Cumbria NHS Foundation Trust provides a wide range of specialist mental and physical health services to a population within Lancashire and South Cumbria. The trust has 25 registered locations which provide inpatient and community care. The trust has approximately 949 inpatient beds across 57 wards and serves a population of around 1.8 million people.

The trust employs approximately 7,000 members of staff and had an annual operating income of over £500 million for 2022-23.

The trust provides the following core services:

- Acute wards for adults of working age and psychiatric intensive care units (PICU's)
- Long stay/rehabilitation mental health wards for working age adults
- Forensic inpatient / secure wards
- Wards for older people with mental health problems
- Community-based mental health services for adults of working age
- Mental health crisis services and health based places of safety
- Specialist community mental health services for children and young people
- Community-based mental health services for older people
- Community mental health services for people with a learning disability or autism
- Community Dental Services
- Child and Adolescent Mental Health wards
- Community Health Inpatient services

Our findings

- Community Health Services for adults
- Community Health Services for Children and Young people
- Community End of life Care

We carried out unannounced inspections of wards for working age adults and psychiatric intensive care units and 2 short notice (24 hour) inspections of the community based mental health services for adults of working age and the crisis and health based places of safety core service provided by this trust.

We also inspected the well-led key question for the trust overall.

- We inspected 18 wards for working age adults and psychiatric intensive care units across all 7 inpatient sites and 5 locations of the community based mental health services for adults of working age. We visited these services because we had concerns about the pathway of care including waiting times to access community based mental health teams, risk management of community based mental health patients and access to working age adults and intensive care unit inpatient beds.
- We inspected the crisis and health-based places of safety. During this inspection we visited 5 home-based treatment teams, 2 mental health liaison teams, 2 mental health urgent assessment centres, 2 health-based places of safety, 2 Initial response services and 1 street triage team. We inspected this core service because at our last inspection in 2020 we rated the service as inadequate overall and needed to ensure the quality of care had improved.
- We did not inspect long stay rehabilitation mental health wards for working age adults or wards for older people with mental ill health which are also rated requires improvement, because we have not been in receipt of information of concern since our last inspection of these services.
- We did not inspect community health services for adults because we have not been in receipt of information of concern since our last inspection of these services.

We are monitoring the progress of improvements to these services and will re-inspect them as appropriate. All other core services provided by the trust were rated good at the time of our inspection.

Overall, we rated safe and effective as requires improvement and caring, responsive and well-led as good.

Our rating of trust improved. We rated it as good because:

- We previously rated 10 of the trust's core services as good overall and 5 as requires improvement. We previously rated 14 of the core services as good in the caring key question with one service rated as outstanding. We previously rated 14 of the core services as good in the responsive key question. Although we found some areas for improvement in leadership and management within some of the services we inspected, we were sufficiently assured of the trust's overall leadership, management and culture following our trust-wide well-led inspection.
- The Crisis service and health-based places of safety had significantly improved since our last inspection in 2020 where we had rated the service inadequate. Following transformation of this core service the crisis service had improved to good.
- Leaders were experienced, visible and approachable. Leaders had implemented improvements since our last inspection. The trust had implemented a transformation programme which was planned across the adult mental health acute care pathway.

Our findings

- Executives and non-executives were passionate about the trust's delivery of safe, high-quality care, they were aware of the trust's challenges and risks. An improvement plan which included an increase to bed capacity had already begun and a model of care to increase community support was in progress.
- The trust had a clear vision and strategy, understood by all staff and driven by the executive team. We were able to see progression towards the trust's achievement of its strategic goals. Staff demonstrated the trust's values in the care they provided.
- The trust had a strong freedom to speak up process which staff spoke about positively. Staff equality networks had been successful implemented and supported staff through development initiatives. A 'flex' system had been introduced to enable individuals to work flexibly, this supported staff retention and showed value of the workforce.
- The trust had made improvements to its information management systems this included the implementation of DIALOG+ to support patient-centeredness, care planning and goal-based outcomes. A significant financial investment had been ringfenced to implement a patient record system within community health services, this also supported partnership working with other stakeholders such as GP's.
- The trust had implemented a recognised Quality Improvement methodology with a clear and embedded approach to quality improvement which involved staff at all levels, we were able to see examples of where quality improvement approaches had been used to make improvement at both services and trust-wide level. Quality improvement was part of the mandatory training programme.
- System wide work with partner organisations was evident with a shared health and care approach. This included work to support both the workforce and the care and treatment of those accessing services.
- The trust commissioned an external well led review in 2022 and have implemented an action plan to drive improvement.

However:

- Since our last well led inspection in 2019 the trust had reviewed and implemented new clinical models and had developed transformation programmes to support this. This was still in the implementation stage and was not yet fully operational.
- At this inspection we rated 2 of the 3 core services we inspected requires improvement overall and one of the core services as good overall this was an improvement from inadequate at our last inspection. In rating the trust, we considered the current ratings of the 12 core services we did not inspect this time.
- The trust did not always have enough suitably trained staff to deliver safe care in all services. This was due to high vacancy rates, high but improving sickness rates and significant reliance on temporary staff in some services. However, there were clear plans with evidence of delivery in increasing the number of Care Hours Per Patient Day in inpatient wards and increasing the establishment and recruitment to this new establishment in Community Mental Health Teams and Home Based Treatment Teams.
- There was low compliance with supervision and annual appraisals although this was improving. Overall, the trust had a supervision compliance rate of 76% including staff on long term sick and new starters and an overall appraisal compliance rate of 80%. There was a clear and structured approach to supporting staff through a newly-introduced Appraisal Cascade approach, which ensured that individual objectives aligned to trust objectives. At the time of the inspection, the roll out of Appraisals since April had reached 80.2% against a target of 80%.
- People continued to wait too long to access some services. Waiting times for Community based mental health services for adults of working age had improved since the last inspection however there was not enough nursing and multidisciplinary staff in some teams, and this impacted on service delivery such as waiting for a care coordinator.

Our findings

Current bed capacity within the trust meant there were high risk individuals who had been deemed appropriate for admission but were unable to access an inpatient bed. There were also significant waiting times in specialist community mental health services for children and young people including access for neurodevelopmental assessments. The trust was working with the integrated care board to improve access to services.

- The capacity in acute wards for adults of working age and psychiatric intensive care units was lower than the demand, which had led to higher than expected out of area placements and an increase in demand for community based mental health services for adults of working age. This may have impacted upon the experience of those in community services.

How we carried out the inspection

Before the inspection visit, we reviewed information we held about the trust. During the inspection visit, the inspection team:

- visited all 18 of the trust's acute wards for adults of working age and psychiatric intensive care units across all 7 inpatient sites.
- visited 5 out of 13 community based mental health teams for adults of working age.
- visited 5 home-based treatment teams, 2 mental health liaison teams, 2 mental health urgent assessment centres, 2 health-based places of safety, 2 initial response services and 1 street triage team.
- spoke with 118 members of staff.
- spoke with 52 people using the trust's services.
- spoke with 23 carers or relatives of people using the trust's services.
- reviewed 143 care records including medicines administration charts.
- observed several meetings including multi-disciplinary team meetings, safety huddles, multi-service calls and a multi-agency call and handover of care meetings.
- conducted 10 observations of direct practice.
- observed 1 sub-committee of the board as well as 1 board meeting.
- held 10 focus groups with staff and governors.
- spoke with 30 members of the trust's leadership team including members of the board, the chair, and the chief executive.
- sought feedback from a range of stakeholders including health watch and the integrated care board.
- reviewed the trust's process for fit and proper persons employed.

You can find further information about how we carry out our inspections on our website: www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

What people who use the service say

Community- based mental health services for adults of working age

Our findings

Patients we spoke with told us staff had warm and friendly attitudes towards them and most patients said staff were responsive.

Patients felt they were well informed in relation to their diagnosis, treatment, and care plans. Patients we spoke to confirmed they felt involved in their care.

Patients said they felt they trusted staff and they had a good rapport with their care coordinators. Patients described staff as lovely, polite, helpful, and well organised.

Feedback from friends and family was overall very positive. There were a small number of negative comments relating to poor communication and waiting too long to access the service.

We also spoke specifically to patients who had experienced being on the unallocated waiting list. Most patients said they were not contacted regularly by the service; telephone calls were not returned and they did not have care plans or crisis plans to refer to.

Mental health crisis services and health-based places of safety

We spoke with 11 patients who used the service. Patient feedback was generally positive. Patients viewed staff as kind, caring and considerate. Patients told us that the service was generally responsive and had helped them when they needed it.

Acute wards for adults of working age and psychiatric intensive care units (PICU's)

Most described staff positively and said they were caring and supportive and treated them with dignity, kindness, and respect. They described being able to speak to staff about any issues that were troubling them and being afforded privacy to do this.

Patients told us they were offered a copy of their care plans and given information about their care and treatment.

Patients said there were generally enough staff around, but they were always very busy, with three patients saying there were not enough staff. One patient told us their leave had been cancelled and one patient told us that activities were cancelled due to a lack of staff.

Most patients were happy with the activities, food, and ward environment.

Trust wide

Integrated Care Board

Feedback from the integrated care board (ICB) noted a significant change to the trust leadership and culture. The integrated care board felt the trust had developed into a transparent and honest organisation which had developed positive relationships with the ICB team and key stakeholders including local authorities, police, voluntary sector, ambulance and acute colleagues. The ICB felt they were promptly informed of any emerging risk and that relationships were good.

Our findings

The ICB was aware of the shortfall in inpatient bed numbers but felt that following the opening of the new wards based at the Whalley site the shortfall would be considerably reduced. The ICB confirmed their support for a move away from an acute delivery system model to a community system.

Health Watch

During our well led inspection we held a focus group with representatives from Healthwatch they told us that feedback was a main driver at the trust and they were Inviting positive and negative feedback. They described been invited to quality visits on the inpatient units and feeling listened to when providing feedback.

They felt the change was on the back of the new leadership team.

We heard some concerns regarding the crisis line and some patients experience of using this.

Outstanding practice

We found the following outstanding practice:

Mental health crisis services and health-based places of safety

The urgent care pathway was going through a programme of transformation. The transformation programme had been designed and was being delivered in collaboration with partner agencies. The programme of transformation was aligned to national standards and best practice. For example, the programme had seen the introduction of the Initial Response Service and the development of strong multi-agency partnerships, including the formation of Street Triage teams which were run with local Police. Staff we spoke with were positive about the transformation programme and felt new services such as the Initial Response Service were having a positive impact. Data provided by the trust showed there had been a reduction in referrals to Home-based Treatment teams in the areas where the Initial Response Service had been rolled out and embedded.

Areas for improvement

Action the trust MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is because it was not doing something required by a regulation, but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the trust MUST take to improve:

We told the trust it must take action to bring services into line with 14 legal requirements. This action related to 3 core services.

Community- based mental health services for adults of working age

- The trust must ensure staffing meets the requirements of the teams to ensure safe care and treatment for patients. (Reg 18)
- The trust must ensure patients on the unallocated waiting list are contacted as per policy. (Reg 12)

Our findings

- The trust must ensure staff are supervised and appraised in line with the trust policy. (Reg 18)
- The trust must ensure care plans are up to date for all patients and that they contain comprehensive information relating to mental and physical health needs.
- The trust must ensure children do not share waiting room areas with adults. (Reg 12)
- The trust must ensure governance processes identify concerns and that plans are quickly enacted to promote prompt improvement. (Reg 17)
- The trust must ensure inpatient admissions are not unduly delayed and that patients receive the appropriate care promptly. (Reg 12)

Mental health crisis services and health-based places of safety

- The trust must ensure staffing meets the requirements of the teams to ensure safe care and treatment. (Reg 18)

Acute wards for adults of working age and psychiatric intensive care units (PICU's)

- The trust must ensure physical health recording always takes place after the administration of rapid tranquilisation. (Reg 12)
- The trust must ensure a Venous Thromboembolism (VTE) risk assessment takes place and is recorded within 24 hours of a person being admitted as per hospital policy. (Reg 12)
- The trust must ensure clozapine monitoring is always completed. (Reg 12)
- The trust must ensure staff receive regular supervision and an annual appraisal in line with trust policy. (Reg 18)
- The trust must ensure staff are up to date with all areas of mandatory training, including the mental capacity act. (Reg 18)
- The trust must ensure there are patient alarms in bedrooms so that patients can alert staff to their need for urgent support. (Reg 12)

Action the trust SHOULD take to improve:

Trust wide

- The trust should ensure that they continue their work with system partners to support the community model of care, supporting appropriate discharge from inpatient wards.
- The trust should ensure they continue the work at pace on transformation of the community services to strengthen the mental health teams ensuring its new model of care is fit for purpose.
- The trust should ensure that disciplinary and grievances are completed within the timeframe stated in the trust's policy.

Community- based mental health services for adults of working age

- The trust should ensure that alarms systems within each location are utilised by staff as required.
- The trust should ensure medicines are managed within the trusts own policy and agreed guidelines.
- The trust should ensure all patients have good quality safety plans and that these are embedded into practice.

Our findings

- The trust should ensure all staff are suitably trained.
- The trust should ensure they share safeguarding information in a prompt and transparent manner.
- The trust should ensure ligature risk assessments are completed for all locations.
- The trust should ensure all patients have access to a copy of their care plan and crisis plan.
- The trust should ensure that they continue to monitor recruitment and training to support timely patient access to physical health monitoring.
- The trust should ensure timely access to psychological therapies.
- The trust should ensure the electronic care record system is easily accessible to all staff.

Mental health crisis services and health-based places of safety

- The trust should ensure patients receive a physical health assessment.
- The trust should ensure risk assessment documentation is updated as needed.
- The trust should ensure care plans are comprehensive and up to date.
- The trust should ensure that records clearly record whether or not service users have been offered a copy of their care plan and whether or not they accepted it.
- The trust should ensure patients do not exceed 12 hour stays in the Mental Health Urgent Assessment Centres.
- The trust should ensure they share safeguarding information in a prompt and transparent manner.

Acute wards for adults of working age and psychiatric intensive care units (PICU's)

- The trust should ensure that the monitoring and reviewing arrangements to ensure medicines with a minimum dosage interval are administered as prescribed and that the requirements of the pregnancy prevention programme are met.
- The trust should communicate with all carers where patients have given permission for this to happen.
- The trust should ensure staff understand the procedure for maintaining fridge temperatures and know what action to take if temperatures are not within the appropriate range.

Is this organisation well-led?

Our rating of well-led improved. We rated it as good.

Leadership

The trust board had the appropriate range of skills, knowledge and experience to perform its role. The executive team comprised a Chief Executive, Chief Medical Officer with the additional role of Deputy Chief Executive, Chief Nurse and Quality Officer, Chief operating Officer, Chief Strategy and Improvement Officer, Chief People Officer and Chief Finance Officer. The Chief Nurse was an interim post at the time of our inspection, the trust had recently interviewed for this post and was in the process of an offer.

Our findings

The Chief Executive Officer had been in post since April 2023 following a period of interim Chief Executive from October 2022. Before taking on this role, they had worked in the role of Chief Operating Officer and Deputy Chief Executive since July 2020.

Since our last well led inspection in 2019 the trust had appointed a new Chair who brought over 30 years of leadership experience from health services. The trust also had 7 Non-Executive Directors including the Deputy Chair and a Senior Independent Director.

During our well led inspection we held a Non-Executive Directors focus group, all had a full understanding of the trust and were able to provide examples of when they had needed to provide challenge to the executive team, we were told that when this happened, they were thanked for their insights. They described the trust as a values led organisation where the values and inclusivity were evident throughout the trust.

The trust had a lead for child and adolescent mental health, learning disability and autism and a named doctor for safeguarding children and adults, there was also a professional safeguarding lead, and the medical director was the lead for mortality. During our inspection we interviewed the leads for learning disabilities, safeguarding and mortality. All the leads had an in-depth knowledge of their area and were able to describe strong leadership, governance and learning for their specialism.

The trust board and senior leadership team worked well together on an ongoing basis. The board were made up of 12 voting members, there were 4 female executive members and no black and minority ethnic member. The Non-Executive board included 3 women and 1 black and minority ethnic member.

Prior to the well led inspection we observed a trust management meeting which was the operational meeting chaired by the Chief Executive Officer and the board meeting of all the Executive and Non-Executive Directors chaired by the Chair. We observed that discussion, scrutiny of information shared, and challenge was encouraged by the Chair. We saw thoughtful questioning and checking of the attenders understanding of information. We heard some discussion regarding waits for Care Coordinators within the Community Mental Health Teams and improvements in wait times since 2022. The recruitment of new staff which may impact on the reduction of wait times was also discussed. Waiting times to access inpatient beds was discussed during the trust management meeting at different points. There was a benchmark conversation which identified the demand for inpatient beds, and it was acknowledged that bed capacity was below this benchmark. However, the focus around this moving forward was to: 'focus on rehab nearer to home, improve gatekeeping, and see it as an opportunity to develop community ventures'.

The trust planned board development sessions throughout the year. Prior to our inspection we attended part of one of these sessions. The topic was staff engagement and staff were invited to attend. The board had also received some facilitated sessions from an external leadership organisation.

The trust had 27 governors made up of elected members of the public, staff and people that had been nominated by partner organisations. During our well led inspection we held a focus group with the governors they told us they were empowered to hold non-executive directors to account, they described a positive relationship which encouraged challenge.

Fit and Proper Person checks were in place. During our well led inspection we reviewed 5 personnel files of directors. We were able to see all files had appropriate checks in place. This included checks regarding disqualified directors list, disclosure and barring service, professional body registration and proof of qualifications and references.

Our findings

When senior leadership vacancies arose the recruitment team reviewed capacity and capability needs. During the 12 months prior to our well led inspection a review of executive director portfolios was undertaken due to some movement in the senior leadership team. Roles were reviewed bringing together responsibilities and portfolio to align to the new structure.

The trust reviewed leadership capacity and capability on an ongoing basis. The board and council of governors Nominations and Remuneration Committee monitored the skills and experience of the board and ensured succession planning was in place. **We could see how succession planning was in place across the trust.** Since our last well led inspection in 2019 the deputy Chief Nurse and Quality Officer had moved into an interim Chief Nurse role whilst recruitment was taking place, and the Deputy Chief Executive Officer took up an interim role before successful appointment to Chief Executive Officer in April 2023. We were also able to see that external candidates were also successful in taking up leadership roles.

The trust leadership team had a comprehensive knowledge of current priorities and challenges and took action to address them. Leaders were sighted on the key risks on the board assurance framework and corporate risk register. They were aware of their responsibilities to monitor and mitigate risks for defined actions. The Chief Executive Officer and the directors were well sighted on the challenges which the trust faced and talked openly with us about these. There were clear governance and performance monitoring processes to ensure accurate and up-to-date data.

At our last well led inspection in 2019 we found trust leaders had failed to address the failings within the acute care pathway despite being aware of these issues. Senior managers had not identified and improved the quality of the service. There were significant problems with the performance of the governance framework throughout the pathway. This was a breach of Regulation 17. We told the trust they must ensure the acute care pathway operated effectively.

At this inspection we found the acute care pathway still had significant problems which impacted on patients access to care and treatment both within the community mental health teams and access to acute inpatient beds. However, the leadership team were aware of the issues, had put plans in place to address the concern and were monitoring the progress through their governance processes. Transformation work to address the pathway issues was in progress and where transformation had completed, we could see improvements.

The trust had worked with commissioners and local partners to increase bed capacity over the last 18-months including creating more mental health rehabilitation beds. The Trust had opened or refurbished:

- Wesham Rehabilitation Unit - 17 new beds opened March 2022
- Skylark Unit – newly refurbished 11 bed, an older adult female ward. Opened February 2023
- Kentmere ward - 12 acute mental health beds (10 re-opened and 2 additional new beds). Opened September 2022
- Whalley site - 32 new beds due to open in the financial year 2022/23. These beds will support the treatment and recovery of those requiring enhanced mental health support and will comprise of both male and female wards.

The trust had also undertaken work to reduce demand for inpatient beds including the development of alternatives to admission. This included Mental Health Urgent Assessment Centres, Crisis Houses and programmes of intensive psychological therapies delivered by the crisis team. The trust provided data showing that the volume of admission demand and admission volume was now at or below the NHS Benchmark in three localities. It was above the national average in the Fylde Coast locality.

Our findings

The trust implemented the initial response service in January 2022 and had rolled this out across its localities throughout an 18-month period. This service supported people accessing the right care, at the right time, in the right place. The trust identified that although there had been an increase of people accessing mental health services there was a clear reduction of people accessing A&E liaison teams and the home treatment team.

The trust had established a bed hub who managed access to beds. The bed hub was clinically led and staffed 24 hours a day. The service was led by nurses with medical input. The trust had a patient flow manager and patient flow practitioners within each of its four localities. Flow practitioners were available seven days a week.

There were a series of multi-disciplinary and multi-agency calls to provide management and escalation of risk. There were twice- daily calls with each locality's flow lead and community service managers to escalate risk and discuss prioritisation. Community teams held daily safety huddles to discuss risk, including amongst those awaiting admission and these fed into the bed hub calls. In addition, there were twice-weekly huddles with local Approved Mental Health Professionals (AMHP's) and safeguarding teams.

The Bed Hub used a clinical risk prioritisation tool to identify priority admissions. The clinical risk prioritisation tool was detailed and provided a focus on the service user 'here and now'. It also included a review of early warning signs, such as Impulsivity, engagement levels, treatment concordance, depressive or psychotic symptoms, physical health and environmental factors. The prioritisation tool was completed twice daily for each service user awaiting admission.

The Bed Hub had access to up-to-date data through the trust's Nerve Centre, this was the live data system that teams and wards had access to and received a daily report from the adverse incident team detailing any incidents in the community that indicate an increased risk and any breaches occurring in A&E departments or 136 suites.

Community services held daily huddles to discuss caseloads and risk. There were clear escalation pathways where required. However, we found that staffing capacity meant teams were not always able to see service users awaiting admission face to face on a daily basis. Where demand exceeded staffing capacity risk was discussed within the team and service users prioritised.

Both the adult community mental health and mental health crisis services had been through a redesign process and had been through or in the process of going through transformation This had included safer staffing reviews for each team and the development of new services such as Street Triage and the Immediate Response Service (including a 24/7 crisis line).

The trust had also implemented programmes of work to improve flow including introducing SAFER (red to green). The programme focused on ensuring internal process for inpatients were standardised and designed to be able to deliver the SAFER and Red 2 Green patient flow bundle.

In the March 2023 the trust identified the limitations of its data gathering as at the time there was no specific criteria on their incident reporting system to identify that a patient was awaiting admission. The trust implemented a new incident reporting system as part of the patient safety work in April 2023 which included a field to report other factors influencing the incident, such as waiting for admission. The new incident reporting system also had a patient search function linked to the electronic patient system, which improved identification of incidents where patients were waiting for admission.

Our findings

The trust was now producing a quarterly report for the Board to capture incidents and monitor trends. Changes had been made to ensure more accurate reporting and it had been agreed that future reviews would also include a review of complaints for related concerns as well as the development of tools to assess the impact on family members and carers who were supporting patients awaiting admission in the community.

There was a Multi-agency Oversight Group which met monthly and included all relevant trust services as well as partners such as local safeguarding teams, Approved Mental Health Professionals, Ambulance Services, and the Police. This meeting was used to review and address concerns and identify improvements. Local safeguarding authorities were presenting data to the group about the need for double or multiple MHA assessments.

Delayed discharge was an area impacting on patient flow. The trust had identified they had a high number of delayed discharges due to external factors such as housing availability. They had addressed this through the integrated care board as they believed a system wide approach needed to be taken to support discharge from hospital. Discussions regarding availability of housing was part of those discussions. We talked to the ICB about this during our well led review. Although no firm plans were in place, opportunities were discussed. There was support for the development of Whalley site, with long-term opportunities on what could happen. There was discussion of having specialist supportive housing available.

The ICB confirmed support for the community model of care favoured by the trust describing a wish to see a shift from an acute delivery system to a community system. Discussions were taking place with Lancashire Place, the Chief Executive Officer and the Registered Social Landlords.

Bed occupancy

Bed occupancy rates were generally high across inpatient wards, with the majority of acute adult wards reporting bed occupancy above 85%.

There had not been a significant difference in the bed occupancy in the latest month (August 2023) compared to the most comparable month last year (July 2022), with most of the wards showing similar occupancy rates.

While there had been an increase in trust bed capacity towards the NHS Benchmark average level, the

trust had not reached this national average level of beds. Trust bed occupancy had therefore remained high.

However, the increase in trust bed capacity meant that there were fewer people waiting at any time for admission to a bed, the trust were able to demonstrate that people were not staying longer in their beds.

The increase in community alternatives to admission had meant fewer short ‘crisis’ admissions had been needed. While there were fewer admissions, this did mean that the average Length of Stay for those people admitted has increased.

System partners and the trust recognised that the issue of very long stays was a system issue, requiring capacity in long-term placements or specialist support.

The number of open ward stays had been relatively stable since July 2022.

The percentage of delayed discharges for adult mental health patients had remained stable in 2023.

Our findings

Other key challenges included waiting time for Child and Adolescent Mental Health Services, out of area placements and workforce.

The trust had recognised that long waiting times to access the Child and Adolescent Mental Health Service was impacted on by young people waiting for attention deficit hyperactivity disorder/autism spectrum disorder assessment, partnership working with 3rd sector organisations was negotiated, with funding of 1.3 million to support this work. The trust forecast that no individual would wait longer than 65 weeks (national goal) by March 2024.

The trust had out of area placement agreements in place. At the time of our inspection, they contracted 155 beds from the independent sector. There was an out of area practitioner post in place to support work in this area. A bed reconfiguration plan was in progress with an increased bed base to support the demand. The trust also contracted rehabilitation beds through collaborative commissioning. The Development of Mental Health Urgent Assessment Centres supported access to alternatives to hospital admission. The trust was working with system partners within the local authorities and Place Directors regarding patients who were medically fit for discharge but required support from the social sector. There was planned discussions through the Integrated care board, Mental Health Learning Disability and Autism workstream to look at this, if successful this would impact on bed capacity.

There was an increase in the number of out of area placements from February 2023 to April 2023. This may have been because of the capacity issues within local inpatient services.

Between Apil and May 2023 there were 20 out of area placements. This had reduced to 15 by June 2023.

Workforce was on the trust Board Assurance Framework and corporate risk register with the highest risk rating of 20. We were told during our inspection that such a high rating had been assessed due to the impact workforce had on all lines of business across the trust. During our inspection we were told about a number of initiatives in place to support and retain staff. We heard about the 'flex' and hybrid approaches to work which supported staff to work flexibly. This was happening in all roles across the trust including inpatient areas. Apprenticeship schemes were in place to support a 'grow your own' model.

Recruitment continued to be a national challenge however the trust had a number of initiatives in place to support this process. These included career engagement through schools, community and colleges. International recruitment and had a recruitment team in place to oversee improvements in the recruitment process for example length of time to hire, recruitment approach and attraction campaigns.

Investment in the electronic patient record for Community Health services had recently been made to improve the process regarding sharing patient information and documentation. We could see from the trust board papers we reviewed that discussion relating to both mental and physical health were on the agenda and patient stories for both sectors was shared.

There was a programme of board visits to services, staff fed back that leaders were approachable. During our core service inspections of the community based mental health services for adults of working age and the Crisis and health based places of safety service in July 2023 staff told us senior leaders visited the teams regularly and team managers felt they could easily escalate issues and receive the necessary support and advice. We saw a programme of director engagement visits which had taken place over the 12 months leading up to our inspection. These included visits to a range of both clinical and non-clinical services provided by Networks across the trust.

Our findings

We were told about board members visiting services on an evening to ensure they spoke with night staff. These were targeted visits as night staff could sometimes feel isolated. The Chief executive had a 'Contact Chris' avenue which was communicated to all staff so they knew they could contact him if they wanted to share their thoughts or concerns.

Leadership development opportunities were available, including opportunities for staff below team manager level. The trust had an internal leadership programme called Connect. This was aimed at those new to leadership and included management skills and knowledge underpinned by the trust values.

There was opportunity for individuals to apply for the Mary Seacole programme which is aimed at those wishing to progress in leadership roles and the trust was running 'TED' which was an opportunity for high performing team managers to develop skills improving engagement and performance.

The executive directors and directors of the trust all had access to coaching to support their development.

The trust ran an apprenticeship scheme this ranged from level 2 qualifications to Level 7 (master's degree) in a range of clinical and non-clinical subjects.

Vision and Strategy

The trust had a clear vision and set of values with quality and sustainability as the top priorities. The trust's overarching vision was: 'To provide the best mental health, learning disability, autism and community-based services for the populations we serve.' To achieve this vision the trust had identified the quadruple aim which included 4 key areas:

1. Improving Health
2. Value for Money
3. Joy and Pride in Work
4. Best Possible Care

These goals were underpinned by a set of values and behaviours:

We are Kind

- We are approachable and show compassion
- We actively listen to what people need and proactively offer our support
- We pay attention to our own wellbeing and the wellbeing of others
- We celebrate success and provide feedback that is sincere and genuine

We are Respectful

- We are open and honest, ensuring people receive information in ways they can understand
- We support different perspectives and views
- We put service users at the heart of everything we do, proactively seeking feedback
- We take pride in our work, and take responsibility for our actions

Our findings

We are always learning

- We seek out opportunities to learn so we are supported to reach our potential
- We set high standards, and are open and flexible to change, and improvement
- We value appraisals, supervision and learning opportunities
- We speak out if the safety of our service users is compromised

We are a team

- We take personal and team accountability, to deliver the highest standards of care
- We work in partnership with our service users to ensure co-production, engagement and learning.
- We actively build trusting relationships, and take time to celebrate success
- We work in collaboration with others outside of the Trust, ensuring excellent outcomes for service users and carers.

The trust also had quality priorities which were developed with service users and carers these were:

- To deliver safe Care
- To be person centred
- To prevent ill health and
- To ensure our services are accessible to all

The quadruple aim had only recently been implemented at the time of our inspection and was replacing the Six S's previously in place. Following discussion with stakeholders both internally and externally a decision was made to review the objectives and update to the aim. Staff we spoke with described that they found the Six S's hard to engage with but were able to identify with the quadruple aim. There was a plan to commence a roadshow to showcase the quadruple aim to help embed this into practice.

There was a robust and realistic strategy for achieving trust priorities and developing good quality, sustainable care. The trust had a 5-year strategy plan which ran from 2021 to 2026 this plan supported both national and local priorities. The trust 's annual work plans supported delivery of the strategy with each area of work led by an Executive Director. Progress of these annual work plans were reviewed by the board on a quarterly basis. The quadruple aim was linked to the board assurance framework which aligned each aim to a strategic priority and identified risks against each aim. All risks were given a risk score, this was presented to the board through the trust performance report.

The strategy had been developed following work with people who use services, carers, staff and system partners.

Staff knew and understood the trust's vision, values and strategy and how achievement of these applied to the work of their team. During our inspection of the core services in July 2023 staff we spoke with were able to talk about the trust's vision, values and strategy and understood how their role impacted on achieving these.

We saw the trust's vision and values were discussed in team meetings during our inspection of the community based mental health service for adults of working age. Staff were regularly reminded about attitudes and behaviour and the vision and values were also revisited during staff appraisal meetings.

Our findings

The trust embedded its vision, values and strategy in corporate information received by staff. We were able to see information around the trust sites which displayed the vision, values, and strategy. We also saw this in the team briefs which went out to all staff.

The trust aligned its strategy to local plans in the wider health and social care economy and had developed it with external stakeholders. There was active involvement in sustainability and transformation plans. The trust engaged closely with the local integrated care system and the Chief executive officer sat on the integrated care board. The trust had a number of partnership initiatives which supported people who use services. This included work to support the Child and Adolescent Mental Health Service with 3rd sector organisations and work with a provider collaborative. The provider collaborative included 5 provider NHS trust across the Lancashire & South Cumbria footprint.

The trust had planned services to take into account the needs of the local population. The Initial Response Service which was part of the Crisis team offer was a 24-hour mental health service made up of call handlers and triage practitioners. This team was set up to support those in the community needing help and worked closely with carers, GP's, police and other community agencies.

The leadership team regularly monitored and reviewed progress on delivering the strategy and local plans.

The trust had 6 board committees each of these were linked to a strategic priority and aligned to a board assurance framework risk. This supported the implementation of the overarching strategic plan. Progress reports from each of the committees were presented to the board in advance of the board meetings where they were discussed and reviewed. We saw an example where the quality committee Chair's report, linked to the 'safe' strategic priority had identified an increasing trend in substance misuse deaths. Work was taking place with families and Place directors to co-design substance misuse strategies to foster a more cohesive preventative approach.

The board assurance framework identified key risks in relation to delivering the trust strategy and actions to mitigate these. Owners of each action was identified and a due date in place. The board members were aware of the progress made and areas where further work was required to ensure the strategic priorities were met.

There was a robust and realistic strategy for achieving the priorities and developing good quality, sustainable care across all sectors. We could see from a review of board papers that both mental and physical health was on the agenda with both sectors linked to the strategic priorities and quadruple aim.

It had been agreed that from April 2024 the 0-19 health visitor and school nursing service in Blackburn with Darwen which was provided by the trust at the time of our inspection, would be provided by a neighbouring acute trust following a formal tender process.

Prior to our well led inspection we held a focus group with local Healthwatch teams, they told us about the development of the health facilitation team, they described this team as 'great' and how they were providing training to GPs regarding annual health checks and making sure the quality of these improved. They stated that this team had made a positive difference and had people with lived experience also on the team.

Culture

Staff felt respected, supported and valued. Staff and managers, we spoke with during our core service inspections told us that culture and morale was good and improving. Staff we spoke with generally felt respected, supported, and

valued. Staff were positive about their colleagues and felt they worked collaboratively to manage demand and workload. Staff discussed the impact of staffing pressures but acknowledged planned recruitment and the work that was being done to fill vacancies. Results from staff surveys echoed this feedback with questions around morale generally scoring positively but questions around capacity, work pressure and staffing scoring lower.

The National Staff Survey was the trust's primary method of measuring organisational culture and provided an overall picture of employee's experience across the organisation. Out of a sample of 7,160, the trust received 3,008 responses this was a response rate of 42%. The trust had seen improvements in the current year across 2 themes 'we work flexibly' and 'we are always learning' and declines in 2 themes 'staff engagement' and 'we are recognised and rewarded'.

The Staff Engagement theme had the highest percentage of positive comments across any theme and could be broken down into two sub-themes of advocacy and motivation. Advocacy is how likely colleagues were to recommend the organisation, there were 8 positive comments within this section. Colleagues felt the trust was a "fabulous," "fair and honest organisation" and they had been able to pass some of this positive feedback "onto friends who have recently joined the trust too." Of the 6 negative comments within this sub-theme, 3 referred to issues across the NHS more generally feeling they "would not recommend the NHS as an employer to anyone, regardless of trust." However, other people felt that "patients are not getting the best care," and would not recommend this organisation to "family and friends who might need treatment [due to] long waiting times".

When compared to the benchmarking group the trust was below average for 3 themes 'we each have a voice that counts', 'we are always learning' and 'staff engagement'. The other 6 areas remained compatible with peers. When compared to national results the trust sat favourably in all 9 elements.

The staff survey was linked to the strategic priority 'staff' and aligned to the Board Assurance Framework risk Failure to recruit and retain a diverse and talented workforce, due to a national workforce shortage and the scale of required transformation and service development, which may impact on the continuity of care provided to patients.

Following review of the 2022 National Staff Survey the trust identified 4 priority areas:

- **We each have a voice that counts:** continued focus on building security and confidence that concerns both general and clinical will be addressed by the organisation.
- **We are recognised and rewarded:** giving colleagues, teams and leaders, tools and resources to recognise and reward positive practice at local level alongside Trust wide recognition schemes.
- **Cultural development:** Leadership and team development: supporting our teams and leaders to grow, building a culture of QI, high colleague engagement, compassion and inclusion.
- **Valuing and supporting our bank staff:** Improving the experience of bank staff at Lancashire and South Cumbria Foundation Trust through proactive engagement and development of our bank improvement programme.

Each locality network was also asked to identify 2-3 priority areas to influence local change that was most pertinent to their teams.

Our findings

The trust had offered staff the opportunity to be entered into a prize draw with a chance to win £250 for completing the 2023 staff survey. Data from the survey although confidential could be broken down to locality level, this meant managers could see how their team rated their experience of the people promise, staff engagement and morale. Changes could then be identified which would make the biggest impact on teams. Following the 2022 staff survey the trust introduced their flexible working campaign and increased the opportunities for different staff groups to access this.

The trust's strategy, vision and values underpinned a culture which was patient centred. The trust described their vision as 'inspired by learning, driven by compassion and powered by the people who use our services'. There was a service user and carer strategy which set out priorities to achieve over a 5-year period. This included:

We will put service users at the heart of all we do, supporting effective care, recovery and wellbeing.

The strategy had 6 enabling components which supported achieving the overarching aim. The strategy was developed with the involvement of service users, carers and staff. An annual work plan was in place to deliver the strategy and was co-ordinated by the Patient Experience Sub-committee, which provided progress reports to the Service User and Carer Council and Quality Committee. The Chair of the Service User and Carer Council was Chaired by a carer who also attended board meetings. An annual service user and carer event was planned to share progress and receive feedback on the priorities.

The trust had a patient experience lead who we interviewed during our well led inspection they told us they had monthly meetings with Healthwatch where they were able to discuss patient feedback. They described a positive working relationship. During our well led inspection we held a focus group with representatives from Healthwatch covering the Lancashire and South Cumbria area. They said there had been a focus on service user engagement over the last 1-2 years with the trust listening and inviting both positive and negative feedback.

Staff felt positive and proud about working for the trust and their team. During our well led inspection everyone we spoke with was positive regarding the leadership team, people described an energy within the work environment and described it as a happy place to work. We heard some examples of people who had not previously wanted substantive posts or had considered a change of job but had changed their mind due the direction in which the trust was moving.

The trust recognised staff success by staff awards and through feedback. The trust held an annual staff awards ceremony. In October 2022 the 'Time to Shine' event was held to acknowledge successes and achievements of staff. Following this event, the trust launched an internal magazine 'Shine' which was published quarterly and in both paper and digital format. During our well led inspection we held a focus group with the network leads and were told that two of these leads had both been nominated for a time to shine award at the coming event for projects they had led.

The trust had a colleague and team of the month programme. Each month a different network was identified and an individual and a team were highlighted for work they had been involved in which had a positive impact. The identified team and individual were announced in the monthly team brief to celebrate their contribution and share good practice.

In the 12 months prior to our inspection the trust had launched a new appraisal process this was aligned to the trust values and objectives. The trust had a compliance target of 80% for staff appraisals at the time of our well led inspection they were at 79%.

The trust worked appropriately with trade unions. We held a focus group with the trade unions who were established within the trust and raised issues on behalf of staff. The unions attended monthly meetings with the Chief Executive and network directors. We were told that in recent experience, with the Chief Executive, they felt safe to raise concerns and

be supported, listened to and responded to. Overall, they felt there was a willingness from the leadership team to take on issues. They identified that there were recruitment challenges but good initiatives in place to retain staff such as flexible and hybrid working. They also highlighted the carers events, wellbeing passports and carers passports which were in place and addressed changes in individuals caring responsibilities.

The unions confirmed there had been a change to the appraisal process and felt this was positive with more focus on individuals.

The unions did speak of some challenges faced by staff particularly less experienced staff who sometimes felt pressure from senior managers to admit patients onto wards when they believed it to be an Inappropriate referral. There was high use of bank and agency staff in community settings and inpatient wards and ward managers covering clinical work due to staff shortages.

Managers addressed poor staff performance where needed. The trust had relevant policies and procedures in place in relation to managing poor staff performance. During our well led inspection we reviewed a sample of 5 staff disciplinaries and 5 staff grievances all of these followed the trust's disciplinary/ grievance policy, included thorough investigations, and an outcome letter.

The trust had appointed a Freedom To Speak Up Guardian and provided them with sufficient resources and support to help staff to raise concerns. The freedom to speak up guardian was part of a regional network and attended national meetings and conferences to support them in their role. The freedom to speak up guardian reported directly to the director of strategy and improvement who was the executive lead for Freedom to Speak up. Quarterly reports were submitted to the quality committee in addition to an annual report which went to board. We interviewed the Freedom to Speak up Guardian during our well led review. They described a positive speak up culture, identifying a year-on-year increase to the communication they received from staff. They described making speak up accessible to all by placing an app on all trust devices which gave direct access to the speak up guardian. Screen savers on trust laptops included a picture of the guardian and well placed promotional posters of speak up were placed around the trust including toilet doors and cupboards where cups were kept so staff could see the guardians image at those times when they may be having a break. We heard that the Guardian had done service visits late at night to ensure they were meeting both night and agency staff. They described a culture where staff would make contact sometimes just for advice not necessarily to discuss a concern.

The trust had 65 speak up ambassadors across the different localities, who promoted speaking up, and were a local contact for staff to speak to if they had a concern.

At the time of our inspection the trust was in the process of appointing an additional full time Speak up Guardian. The Current Guardian had initially worked full time in this role but was currently spending approximately 2 days a week on this, although this could be flexed when needed. The Guardian had access to good data to support their role which included a dashboard of information, highlighting contacts and themes. They were also able to look wider comparing concern and incident data to see if there was a bigger picture of concern present.

There were other avenues available for staff to raise concerns, people were encouraged to speak with their managers or senior leaders, report incidents on the electronic system, talk with Speak up Ambassadors or contact the Chief Executive Officer through the 'contact Chris' avenue.

Our findings

Staff felt able to raise concerns without fear of retribution. During our core services inspections staff told us they felt able to raise concerns and knew how to access policies to support them to do this. Staff knew how to use the whistle-blowing process and about the role of the Speak Up Guardian.

The trust applied Duty of Candour appropriately. The trust had a Duty of Candour policy and procedure. We reviewed 5 incidents which met the duty of candour threshold and found the trust had followed their policy appropriately on all cases. T**he trust took appropriate learning and action as a result of concerns raised** offering apologies when mistakes had been made.

The Chief pharmacist and medicine safety officer told us they were aware of the 'duty of candour' and could give us an example of when this had happened. They told us pharmacological incidents were reported and reviewed with learning shared appropriately. Any safety incidents were discussed at a safety summit.

All staff had the opportunity to discuss their learning and career development needs at appraisal. The trust had an appraisal policy. This process had been reviewed and updated since our last inspection. Appraisals had been aligned to the trust values and objectives and we were told that it was more focused on individuals. However, the trust compliance rate for appraisals sat at 79% which was below the 80% trust compliance target. There were 2 core service outliers with the acute wards for adults of working age and psychiatric intensive care units holding a 70% compliance rate and the children and adolescent mental health wards with a 66 % compliance rate.

The medicine management team described a supportive culture. There was a rolling cycle of appraisal and 1:1s. Pharmacy staff were above trust target for appraisal.

Staff had access to support for their own physical and emotional health needs through occupational health. The trust had a Health and Wellbeing programme in place which was supported by Health and Wellbeing Champions across all networks. The trust worked in partnership with external organisations and internally to promote access to lifestyle activities to improve health and wellbeing. There was an employee assist programme offering confidential counselling services this was offered on a formal and ad-hoc basis.

Sickness and absence figures were outliers with the second highest sickness rate in the Northwest region. This included 5 other mental health trusts. The most recent sickness rate for all staff was 7.1%. After decreasing from 8.8% in December 2022 to 5.9% in April 2023 the sickness rate had recently increased to 7.1% in July 2023.

Sickness rates (rolling 12 months) for 'All staff' had been worse than expected from August 2022 to February 2023, and consistently higher than the sector average from August 2022 to July 2023.

Sickness rates for All staff, Nursing staff and Allied Health Professionals in particular were worse than expected.

The top reason for staff sickness was due to 'anxiety/stress/depression'.

Sickness rates for 'anxiety/stress/depression' had been increasing from December 2022 to July 2023, where 36% of sickness was due to this reason.

We made a possible link with high staff sickness rates and low supervision and appraisal rates. This may be an area for consideration.

Our findings

The turnover rate for the latest month (July 2023) was 7.8%. Turnover rates for 'All staff' had been lower than the sector average from August 2022 to July 2023.

Turnover rates for All staff, Nursing staff, Allied Health Professionals and Healthcare Assistants were predominantly categorised as 'better than expected'. The trust had the lowest overall turnover rate in the North West over the same period (out of five MH trusts).

Staff felt equality and diversity was promoted in their day-to-day work and when looking at opportunities for career progression. The Workforce Race Equality Standard (WRES) became compulsory for all NHS trusts in April 2015. Trusts must show progress against nine measures of equality in the workforce.

The WRES indicators showed statistically significant differences between BME and white staff (negatively impacting BME Staff) in the following areas:

- Proportion of non-clinical staff in senior roles, band 8a+
- Proportion of shortlisted candidates being appointed to positions
- Staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months
- Staff believing that the trust provides equal opportunities for career progression or promotion
- Staff experiencing discrimination at work from a manager / team leader or other colleague.

The trust had a 2023 workforce race equality standard report which was linked to the trust's strategic priorities and aligned to the board assurance framework. The WRES alongside the trust's Workforce Disability Equality Standard (WDES) and the Annual Inclusion and Belonging Report had been approved by the People and Culture Committee and reviewed at the Inclusion Council in September 2023. The reports were due to go to Board in October 2023 before being published on the trust website.

The Annual Report showcased all the work that had happened and was taking place across the trust and wider system.

The trust's race equality transformation programme priorities were approved by trust Management Board in February and formed the 2023 WRES action plan, the priorities were:

- Board and Leadership Development and Accountability
- Civility, Respect and Safety
- Recruitment and career progression
- Communications and Engagement

Progress with objectives within the plan were reported through the People and Organisational Development governance processes with assurance to the Board through the People and Culture Committee and the Inclusion Council which was chaired by the trust's Chief Executive Officer. Objectives were incorporated into the Inclusion and Belonging consolidated plan which included objectives across all equality strands, and race specific actions.

Our findings

The trust had a 'We Do More Campaign': as part of this the trust lunched a recruitment drive in November 2022; they used visual diversity, language and context to support them to attract diverse talent. As a result, the number of Black/ Black British applicants had increased from 525 to 808 and the number of applicants from Asian/Asian British had increased from 342 to 651. This increase in applicants' numbers occurred from October 2022 to June 2023. The number of applicants from mixed backgrounds doubled from 39 to 80.

The trusts leadership programme 'Connect' was also aligned to the diversity agenda including allyship and flourish as core modules. Inclusive and compassionate leadership was a theme throughout the programme. There were also programmes available on: civility and respect at work, compassionate leadership and emotional intelligence. A 2-hour diversity and inclusion training session for team leaders was in development to bridge the gap between core skills training and the full leadership programme.
Staff networks were in place promoting the diversity of staff. During our well led inspection we held a focus group with the network leads. We were told they all had an executive sponsor who supported them in their work. All the leads were positive about the work they were doing and the support the leadership team gave them to drive forward this work. We were given examples where network members had identified learning needs related to their specific requirements and training had been provided to support this. We were also told of a piece of work the women's network lead was completing across the trust to provide a safe, private, and comfortable room for breast feeding mums. All spaces were provided with a fridge to store milk.

We did receive some feedback from this focus group identifying that access to mandatory training could be improved to support different learning styles and neurodiversity. The trust clarified that it introduced a Reasonable Adjustment at Work Policy in May 2022 which included a Reasonable Adjustments Passport to enable disabled staff to only have to talk about the adjustments they need once. The trust's Mandatory Training and Continuous Professional Development noted that "Where staff have any disability that may impact upon their ability to participate in mandatory training or continuous professional development, then in accordance with the Equality Act 2010, reasonable adjustments will be made."

Mandatory training compliance for Equality and Diversity across the trust was 97%.

Teams had positive relationships, worked well together and addressed any conflict appropriately. Staff felt equally respected, supported and valued across all sectors. teams reported they felt supported by their immediate managers, within their teams and they worked well together. Teamwork scored well in the 2022 staff survey and was compatible with peers and national results.

Governance

The trust had effective structures, systems and processes in place to support the delivery of its strategy including sub-board committees, divisional committees, team meetings and senior managers. Leaders regularly reviewed these structures. The trust had commissioned an external review of its governance arrangements which had provided a number of recommendations for the trust and enabled them to focus on specific areas of work through an improvement plan. Progress against this plan was monitored through the trust improvement board with assurance provided via the audit committee. Through our well led inspection we could see the improvements from this plan which the trust had implemented. This included work around visibility of board, network leads and a review of the trust strategy.

The trust had 6 committees which reported directly to the board which were:

- Quality Committee

Our findings

- Nominations and Remuneration Committee
- Finance and Performance Committee
- Audit Committee
- People and Culture Committee
- Charitable Funds Committee.

Each of these committees had a strategic plan that was aligned to support the implementation of the overarching strategic plan. There was a Mental Health Law Sub-Committee which reported to the Quality Committee.

Non-executive and executive directors were clear about their areas of responsibility. Non- executive directors chaired identified committees and were able to talk to us about the challenge they provided and how they were able to hold the executive board to account. Prior to our well led review we observed a management board meeting and was able to see that challenge was in place and welcomed by the executive team.

The executive directors all held a portfolio of work and provided strategic leadership within the trust.

The trust had a Council of 27 Governors with 5 Public Governor vacancies. The Governors provided a link between the communities the trust served and the board of directors. The governors met monthly and reported they met regularly with the Chief Executive and Chair of the board. During our well led inspection we held a focus group with the Governors and heard about positive improvement in the trust particularly regarding staff engagement, visibility, and a bottom-up approach to leadership. They described a positive relationship with the leadership team which was open and transparent. They understood their role in terms of holding the non-executive members of the board to account and described feeling empowered to do this.

Papers for board meetings and other committees were of a reasonable standard and contained appropriate information. Prior to and during our well led inspection we attended both a trust management board meeting and Executive Management team meeting and reviewed a range of minutes from the board and committee meetings. Papers to inform the meetings were circulated in good time and contained clear, relevant information. The board received a monthly trust performance report which included data at both network and trust wide level. Data was presented as both a RAG rating and in the form of a statistics chart. The data in these reports include quality, workforce, and operational data.

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

Medicines optimisation within the trust was well-led. There were good systems of accountability from pharmacy management to support governance and management of medicines throughout the trust. We saw medicines safety was well integrated into the governance structure for the trust. All medicines incidents were reported via the incident reporting system. Incidents were investigated and any relevant learning shared with all staff. The trust also worked closely with other trusts and healthcare organisations in the area to ensure consistency in medicines related decisions.

The Medical Director held board level responsibility for trust medicines optimisation with strategic, governance and clinical support from a pharmacy team.

Our findings

The trust's medicines optimisation strategy 2023 to 2026 was updated in 2023 and was aligned with trust strategy. Priorities are reviewed annually.

There was a 5-year workforce strategy with priorities identified. A workforce paper, including actions was presented to the trust Board.

The key committee was the Drugs and Therapeutic group (DTG), this had a clear line of reporting to the board via the Clinical Standards Group. The trust's Controlled Drugs Accountable Officer ensured that the required controlled drugs quarterly reports were submitted to the Local Intelligence Network. Appropriate governance arrangements were in place for non-medical prescribing. The trust had several service level agreements for medicines supply, performance was reviewed monthly to help ensure the quality of these services was maintained.

Appropriate governance arrangements were in place in relation to Mental Health Act administration and compliance. During our well-led inspection, we carried out interviews and focus groups with senior leaders and staff groups to understand how well the Mental Health Act 1983 and Code of Practice 2015 was implemented.

There was a large Mental Health Act (MHA) Administration Team compromising 19 staff and led by the head of mental health law. The MHA Administration Team had robust MHA systems and processes in place to ensure compliance with the legislation and Code of Practice 2015. The responsible clinicians we spoke with felt they were well supported by the Mental Health Act team and were given regular e-mail reminders regarding their responsibilities.

At the time of inspection, there were sufficient numbers of Hospital Managers (32) and there had been recent recruitment. They were occasions when managers would be requested to undertake a hearing at short notice when they could not be easily covered but we heard that this was rare.

We heard the mental health law lead and their team had made efforts to recruit knew managers from ethnic minorities and from a working age population. They had some success with this by advertising more widely and had managed to recruit 4 managers from ethnic minorities at the last recruitment drive.

Newly recruited associate hospital managers were allocated a mentor and received annual appraisals. There were 4 associate managers who had been trained to take on the role of peer appraisers. Hospital managers were provided with opportunities to observe and shadow hearings as well as more formal training. They were due to attend training on "Cultural Allyship" face to face in November 2023.They also received equality and diversity training.

Associate hospital managers attended a quarterly forum attended by the medical directors and the non-executive director.

The Chief Medical Officer had executive oversight with the mental health committee meeting quarterly, feeding into the executive team through the Quality Committee.

Information collated around the MHA was pulled from the clinical systems and scrutinised by the MHA Law team. There were weekly reports identifying hotspots such as 132 rights and advocacy. There was some work been undertaken to complete weekly reports around 'missing persons.'

Overall trust compliance with MHA training was 88%. E-learning was completed on the MHA and was refreshed every three years. Preceptorship nurses and junior doctors were trained through the MHA administration team or the ward managers. Ad-hoc training was provided to non-executive directors, governors, and non-clinical staff.

Our findings

We heard from staff, we spoke with, and the mental health law lead that if there was relevant new case law it would be disseminated to staff via e-mail. Updates in caselaw meant staff training would be updated on the internal training electronic system to ensure that staff were aware of changes.

At our last well led inspection in 2019 we found that trust policies relating to the Mental Health Act and the Mental Capacity Act did not reflect all current legislation. This was a beach of regulation 17 and we issued a 'must' do action. 'The trust must ensure that the trust policies relating to Mental Health Act and the Mental Capacity Act reflect current legislation.' (Regulation 17) At this inspection we reviewed all the trust policies relating to the Mental Health Act and the Mental Capacity Act and found all policies were in date. There were some minor conflicts found within some policies however we brought this to the trust attention, and they immediately reviewed and updated these.

At our well led inspection in 2019 we had significant concerns about patients being detained in the health-based places of safety past the expiry of the section 136. Patients were subject to restrictive interventions without the appropriate legal safeguards in place. This practice had become routine. Due to our concerns, we used our powers to take immediate enforcement action. We issued the trust with a Section 29A warning notice for this core service. At this inspection this had improved and the trust were no longer in breach of this regulation. Patients were no longer routinely detained in this area past the expiry of the section 136. Data provided by the trust showed there had been 34 breaches of the 12-hour limit between January 2023 and June 2023. This was a significant improvement from our previous inspection where, for example, we identified 118 breaches of the 23-hour limit in November 2018 alone.

The majority of the 12-hours breaches within the Mental Health Urgent Assessment Centres did not extend beyond 24 hours. Between January 2023 to June 2023 there were 5 breaches which extended beyond 24 hours.

During our well led inspection we spoke with local authority staff and Approved Mental Health Practitioners (AMHP). They described ongoing concerns around the section 135/136 process and the ability to admit in a timely manner. They told us patients regularly spent long periods of time in A and E and places of safety, with section 136-time scales being breached. They said it was rare that an AMHP would do an assessment and that a bed would be available on the day. From Jan to June (inclusive) there had been 34 incidents across all the Mental Health Urgent Assessment Centres where patients had stayed over 12 hours. Of these 5 (15%) extended beyond 24 hours and 85% were resolved within 24 hours.

The trust informed us they had wrote to Place stakholders and raised with the ICB regarding the need to ensure flow out of hospital beds in order to have capacity to admit to, and requesting whole system support to address high number of people stranded in acute mental health beds, including those requiring a Local Authority-funded placement or package of care.

A clear framework set out the structure of ward/service team, division and senior trust meetings. Managers used meetings to share essential information such as learning from incidents and complaints and to take action as needed. The trust had 5 triumvirate and clinical networks which were:

- Bay
- Central and West
- Fylde
- Pennine
- Specialist

Our findings

Each of the triumvirates included a Medical Director, Director of Operations and a Director of Nursing. This model provided support and leadership at network level ensuring a strong relationship with teams and understanding of each geographical area. We held a focus group with representatives from the triumvirates. They told us about daily situation reports they received to review different metrics including harm incidents in both inpatient and community settings. Demand and capacity was described as their highest risk, there was enhanced work to support people in the community in place and they told us of the expanding bed base which was in progress with more beds becoming available over the coming months.

The trust had an organisational structure chart for each of the 5 networks, which provided a clear visual overview of the management structure and the services each network provided. This enabled staff to see how their teams fit into the network but could also see the overarching trust governance structure.

A monthly performance report was produced for each network. This showed performance for each area against the metrics reported in the trust performance report. If any areas identified a need for improvement, then they were presented to the executive team via the performance review meeting which the triumvirates attend.

There was a weekly performance heat map which showed any areas of concern for each network to monitor.

The triumvirates sat on a number of management and leadership meetings including trust management board. At this meeting members were able to consider issues such as service development, escalate risk, consider feedback from stakeholders and operationalising the implementation of trust strategies. Trust management board fed into the Executive Management team meeting.

Staff at all levels of the organisation understood their roles and responsibilities and what to escalate to a more senior person. There was a governance model which allowed for escalation of issues. Local teams had team meetings, with team managers attending care group and directorate management meetings. During our core service inspections in July 2023 staff told us they felt managers were approachable and supportive.

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

The trust was part of a provider collaborative which included 5 neighbouring NHS providers agreeing joint priorities and how to deliver them to the local population.

During our core service inspection, we heard about the Initial Response Service which was a 24-hour mental health offer working closely with police, GP's, Carers and other external professionals to provide support to people in crisis.

There were a number of multi-agency policies and protocols in place which the trust had developed in partnership with other organisations to ensure collaborative working an example of this was a service level agreement with the local acute trust to support Mental Health Act administration and clinical functions when detained patients needed physical care.

Our findings

The trust had a provision of psychiatric liaison services with appropriate governance arrangements. The service worked closely with partnership agencies offering advice and support to the acute trusts improving communication between the accident and emergency department, mental health services and other departments within the acute trust hospital.

They also ensured appropriate signposting or referral to relevant statutory and non-statutory agencies and liaised with other stakeholders involved in individual's care.

Management of risk, issues and performance

The trust had systems in place to identify learning from incidents, complaints and safeguarding alerts and make improvements. The governance team regularly reviewed the systems. The trust had recently implemented a new electronic system for reporting incidents which any member of staff could access. This new system performed better at capturing data and analysing deaths. The trust incident reporting and response policy had clear flow charts for staff to understand incident responses and learning in the event of different types of incidents. The policy had clear timescales for reporting incidents. All incidents were required to be reported within 24 hours. Incidents were graded in severity from 'no harm' to 'Death' and designed to reflect all harm which occurred because of the incident. This included harm which was financial and/or reputational and both physical and psychological harm. Managers were required to complete an initial investigation for all incidents. The "Review" section of the incident report for no harm and low harm incidents was completed in 10 working days for unexpected inpatient deaths a rapid learning review took place within 2 working days and within five working days for all other incidents with harm.

Incidents were reviewed daily by the patient safety team. Rapid learning review were reviewed weekly at the Trust Safety Summit. There was a monthly serious incident review panel which was attended by non-executive and executive directors. The purpose of the panel was to review a selection of serious incident reports, recommendations, and action plans to test, share and challenge learning. The Trust had a Mortality review process to support learning of patient deaths.

During our core service inspection of the acute wards for adults of working age, we saw that the trust had begun a programme of work to change all the bedroom door tops to anti-ligature to minimise patient risk. We were aware of a serious incident which had occurred at the Harbour Unit in October 2022. The Trust investigated this incident and there was identified learning and actions taken because of this. As part of the safety improvement programme environmental work was identified, policy reviews had taken place and training was developed for staff.

The trust used Patient Safety Incident Responses (PSIRF) as a framework to support learning from incidents. This framework allows organisations to review safety incidents relevant to their context and the populations they serve rather than only those that meet a defined threshold. PSIRF is considered as a learning and improvement framework with the emphasis placed on a culture that supports continuous improvement. The trust had a Patient Safety Incident Response Plan (PSIRP) which set out how the trust should respond to patient safety incidents reported by staff and patients, families and carers as part of their work to improve Patient Safety Incident Investigations.

We analysed data about safety incidents from the Strategic Executive Information System (STEIS)

Reporting a Serious Incident must be done by recording the incident on STEIS. This system facilitates the reporting of Serious Incidents and the monitoring of investigations between NHS providers and commissioners.

STEIS data often reflects commissioning decisions about what should be investigated and reported.

Our findings

NHS England and NHS Improvement recommend that:

Serious incidents and Never Events are reported as indicative of a good reporting culture.

STEIS data should not be used to apportion blame to individuals or organisations, benchmark or rank organisations, monitor trends.

Lancashire & South Cumbria NHS Foundation Trust reported 138 incidents to STEIS from 1 September 2022 to 31 August 2023. July 2023 had the highest number of incidents, reporting 19, whilst January 2023 saw the lowest number reported with 4.

Of these 138 incidents, reporting period 1 September 2022 to 31 August 2023, 105 had a reason for reporting as 'unexpected/potentially avoidable death', 24 as 'unexpected/potentially avoidable injury causing serious harm', 7 as 'unexpected/potentially avoidable injury requiring treatment to prevent death or serious harm', and 2 as 'actual / alleged abuse'.

We reviewed 5 serious incident reports during our inspection. This included 1 incident which related to a person who had a learning disability. All reports had terms of reference, we could see that where appropriate. The patient, family and carers had been involved in the terms of reference. The reports all included a thorough investigation and looked for improvements. The reports all identified a way to share learning from the incident.

The trust had an effective system in place to manage complaints. There were processes to resolve complaints informally at a local level and individuals wishing to raise a complaint had access to a Patient Advice and Liaison service and the trust complaints team. There was a comprehensive policy in place to support staff in the management of complaints. The trust governance structure provided forums to review complaints and identify trends and themes.

In the period 1 September 2022 to 31 August 2023 the trust received 2,518 concerns, issues or complaints. Of those, 1,769 were managed by the Patient Advice and Liaison service and 1,729 were resolved. 14 were unresolved and 26 had an unknown outcome. In the same period, 744 formal complaints were raised with the trust complaints team. Of these, 121 were upheld, 291 were partially upheld and 246 had not been upheld. 27 complaints were currently ongoing, and 29 complaints had an unknown outcome. 30 complaints had been withdrawn. In total five complaints had been referred to the Parliamentary and Health Services Ombudsman.

We reviewed 5 complaints during our well led inspection. These included an informal complaint and complaints rated as level one, level two and level three in accordance with the trust policy. All five complaints had been acknowledged and responded to by either the Patient Advice and Liaison service or trust complaints team within three working days as stipulated in the trust complaints policy.

Complaints had been subject to an appropriate investigation by individuals who had received relevant training. Each case file included an outcome letter that was sent to the complainant detailing the findings of the complaint investigation and where relevant learning and next steps were identified. Complainants were advised that if they were not satisfied with the process or outcome of their complaint then they could contact the Parliamentary and Health

Our findings

Service Ombudsman. Details of the role of the Ombudsman and how to contact them were included in complaint outcome letters. We reviewed one complaint that had been referred to the Ombudsman who had taken no further action. Where a complainant was unsatisfied with the outcome of a complaint the trust's Head of Complaints and Patient Advice and Liaison Service also reviewed the complaint case file.

Between 1 September 2022 and 31 August 2023, the trust recorded 2882 compliments on their electronic system. A breakdown of compliments by Network are:

- Pennine 1345
- Specialist Services 711
- Central and West 528
- Fylde Coast 123
- The Bay 85
- Director of Operations 77
- Ad-hoc 13

The compliments data was shared as part of the trust Performance Reports and was used to inform the 'Time to Shine' quality visits. Compliments were reported annually in the Annual Complaints Report which went to the Quality Committee and the Board.

The trust had effective systems in place in relation to safeguarding and identifying learning. Staff at all levels understood their responsibilities in relation to safeguarding. The trust had a safeguarding group Chaired by the Interim Chief Nurse who held safeguarding adults and children on their portfolio. The group meet on a bi-monthly basis and reported to the quality committee. The Executive Team received an annual report on safeguarding. The Trust had a nominated Named Doctor and the Chief Nurse who was the named nurse for Safeguarding, there were 6 named safeguarding nurses and a Sudden and Unexpected Death in Children Nurse, there was also a named nurse for children in care. The trust had a safeguarding and protecting children and adults' policy in place and training in safeguarding was mandatory. Compliance across the trust for safeguarding, level 2 training was 90% and Safeguarding level 3 at 79 % compliant. 'Think Family' was a trust wide approach and Integrated into the training modules. Lessons learned were taken from Child Safeguarding Practice Reviews, Adult Safeguarding Reviews, Domestic Homicide Reviews and Child Death Reviews.

There was a safeguarding strategy dated 2022- 2025. The Strategy described how the trust would meet both local and national requirements by working in partnership with external agencies and the community to safeguard and protect children, young people and adults. There was a schedule of objectives in the strategy which the trust wanted to achieve over the 3-year period. During our well led inspection we talked with the trust safeguarding lead who told us about the partnership work the trust was involved in and external partnership boards they attended.

During our core service inspection, we spoke with local authority representatives, we were told there had been some delays in one of the local authorities receiving safeguarding information from the trust. We discussed this with the safeguarding lead. They were aware of the issue and described some work which had happened to strengthen the system to ensure any delays were minimised. They informed us meetings had taken place with the local authority discussing this issue and an improving relationship with them.

We reviewed 5 safeguarding adult and 5 safeguarding children referrals during our well led review.

Our findings

We could see that all were appropriate referrals and had followed the trust safeguarding policy.

Senior management committees and the board reviewed performance reports. Leaders regularly reviewed and improved the processes to manage current and future performance. The trust had a monthly performance report which went to board. This report had been reviewed since our last well led inspection and new metrics had been added. The report was submitted for validation to the performance team and the service leads. Each of the metrics were measured against national targets where they existed or local benchmarking. Two reports were produced each month, the full report included all of the 194 metrics and a focused report which included metrics where a need for improvement had been identified in the 6-month period prior to the report, it also included the metrics which had shown improvement during that time. This meant the board could see areas of concern and where assurance had been provided.

There was a monthly performance report for the trust senior leaders which included operational and workforce performance at both service level and across the trust overall. Each of the metrics had been aligned to an objective from the trust Single Accountability Framework, to a CQC reporting domain and to a Board Assurance Framework risk.

Each of the networks received a local, daily situation report and weekly hot spot reports. Network leads could easily see any metrics which highlighted concern and was able to monitor this. Monthly reports were produced showing performance against the board report metrics, where areas for improvement were indicated this was discussed at the network performance review meeting.

Leaders were satisfied that clinical and internal audits were sufficient to provide assurance. Teams acted on results where needed. There was a robust audit programme in place to monitor compliance against trust policies and best practice guidance which was managed through the trusts audit committee with oversight from the Board. Audits included topics relating to mental health, dental and community health services. There was also an audit on consent to treatment and a number of audits relating to the Child and Adolescent Mental Health Service.

There were 42 planned audits:

- 10 National Audits
- 5 related to CQUIN
- 8 Baseline audits
- 15 Re-audits
- 4 Deep Dives

The trust participated in Prescribing Observatory for Mental Health (POMH-UK) and the prescribing national programme. This allowed benchmarking audits of prescribing against national standards to identify good practice and areas for development.

The trust had started planning for 2024/25 a clinical audit programme and was talking to both clinical networks and corporate services to identify a programme of work.

Staff had access to the risk register either at a team or division level and were able to effectively escalate concerns as needed. During our core service inspections in July 2023 staff we spoke with told us they could escalate risks onto local risk registers and felt confident doing so. There was a clear process for escalation of risks from networks to the trusts risk

register. Each team had a local risk register where they recorded their risks and management of these. Risks at team level were given a risk rating of 9 or below. If risks could not be managed locally and had a risk rating of 10 to 12, they were escalated to team leaders for support. Any risk rated 12 or above was placed on the locality risk register and was overseen by the Risk Management Group along with the corporate risk register. The board had quarterly oversight of the corporate risk register which detailed trust wide risks, operational risks which scored 15 and above that may inform the Board Assurance Frame (BAF) and the BAF. **Staff concerns matched those on the risk register.** Any concerns we heard from staff, external stakeholders and union representatives were captured on the network and corporate risk register where appropriate.

There was a separate pharmacy risk register with actions and deadlines. Pharmacy risk with a risk rating of 12 and above were subject to multidisciplinary review and were discussed at Drug and Therapeutics Group. There was an action plan aligned to the risk register which was electronically managed with a clear process of regular review.

The trust board had sight of the most significant risks and mitigating actions were clear.

All the risks on the board assurance framework were linked to the trusts' strategic priorities. Within the board assurance framework, any risk which scored 15 or higher according to the Risk Rating Matrix was classified as red on the RAG rating status, this indicated that the identified committee was not satisfied the current risk was mitigated. The trust had 6 overarching risks which were rated as 'red' and 2 rated 'amber'. Of the risks rated red, 3 related to value for money, 2 to quality of care and 1 to workforce.

Each strategic risk had identified actions and a due date. There was an Executive Director and Board Committee lead that were responsible for the reviewing and monitoring of the risks on a quarterly basis via the relevant committee. The BAF was presented to the board on a quarterly basis.

We were assured the trust had good oversight of the risks and that progress had been made through the transformation of the urgent care service and some of the Community Mental Health Teams, however not all risk had been mitigated in the short term due to the timeline of the transformation programme. We were concerned the 'continuing gaps in control' were still a risk whilst transformation continued for the Community Mental Health teams and inpatient services. The trust's long-term plan to provide a predominantly community-based model supporting people to stay at home did not yet have all the resources in place to be fully implemented.

There were plans in place for emergencies and other unexpected or expected events. For example adverse weather, a flu outbreak or a disruption to business continuity.

Where cost improvements were taking place, they did not compromise patient care. Cost improvement plans proposed were subject to a quality and equality impact assessment which considered the impact on patient care, protected characteristics, and sustainability. All staff we spoke with during our well led inspection told us that the trust placed quality before finance.

Information Management

The board received holistic information on service quality and sustainability this included data on a range of key performance indicators such as incidents reported, staffing, training compliance, restraint and seclusion, care planning, discharge and detention, wait for treatment data, safeguarding alerts, appraisal rates and complaints/compliments. **Information was in an accessible format and identified areas for improvement** using a red, amber, green rating. **This data fed into a board assurance framework.** The reports linked to the trusts' values, strategic objectives and the CQC

key questions. Each of the networks received a daily situation report and weekly hot spot reports. Network leads could easily see any metrics which highlighted concern and was able to monitor this. **Team managers had access to a range of information to support them with their management role. This included information on the performance of the service, staffing and patient care.** Managers and staff had access to a live performance dashboard through the Nerve Centre system. This provided information on a range of performance indicators including the number of referrals, waiting times, contacts with no outcome recorded, completion of the electronic care plan and the risk register. Data could be viewed at locality, team, individual staff member or individual patient level.

In addition, there was an Urgent Care pathway dashboard at locality level. This formed part of a performance pack presented to trust executives each month. The dashboard captured the performance of each service against key national standards. This included compliance with the Mental Health Act and any breaches of detention timescales within Health-based Places of Safety, performance against 1, 4 and 12-hour assessment targets within the Mental Health Liaison teams, performance against the maximum 12-hour stay target in Mental Health Urgent Assessment Centres and 3 and 7 day follow ups. The report also provided an overview of staffing across teams and the performance of the Initial Response Service against urgent and routine referral response targets.

The trust had an electronic prescribing system which was rolled out across all Mental Health inpatient services and physical health service. There was dedicated staff who could draw down data from this system. The trust had paid for an additional enhanced reporting module.

Key Performance Indicators were regularly audited at ward level with a medicine management audit.

The system interfaced with other providers to support the safe use of medicines. The Trust was part of a system wide group to introduce a unified medicine record and implement the discharge single record.

The trust had a Chief Digital and Infrastructure Officer who was the senior information risk owner. There was a separate Caldicott guardian. The trust had a Digital Strategy dated 2021 – 2026 which was aligned to the NHS long term plan and 'Our Digital Future' strategy which was developed by Lancashire and South Cumbria Integrated Care System to support Healthier Lancashire and South Cumbria. The Digital Strategy was focussed on 3 key priority areas:

• To build understanding on how data is used and the potential for data-driven innovation, improving transparency so the public has control over how we are using their data.

• To make appropriate data sharing the norm and not the exception across health, adult social care, and public health, to provide the best care possible to the citizens we serve, and to support staff throughout the health and care system.

• To build the right foundations – technical, legal, regulatory – to make that possible.

The strategy had a plan of work which it aimed to achieve, each aim had identified areas to focus on and described how success would be measured.

During our well led inspection we were told about the use of new technology being piloted in wards for people living with dementia across the trust, The system helped staff to visually confirm a patient was safe, by monitoring their pulse and breathing rates, without having to disturb their sleep. The main purpose of this technology was to support the reduction of falls. All patients involved in this pilot had their capacity assessed and carers were also involved in capacity and consent relating to the use of this technology.

Our findings

The Data Security and protection toolkit is an online self-assessment tool which allows organisations to measure their performance against the National Data Guardian's 10 data security standards. All NHS organisations who have access to patient data and systems must complete this toolkit. This provides assurance that they have good data security and are handling information correctly. The trust had completed the toolkit in June 2023 and received substantial assurance.

Leaders used meeting agendas to address quality and sustainability sufficiently at all levels across the trust. Staff said they had access to all necessary information and were encouraged to challenge its reliability. The trust had a monthly performance report which went to board. The report was submitted for validation to the performance team and the service leads before submission. **Board and senior staff expressed confidence in the quality of the data and welcomed challenge,** staff talked to us about triangulation of information which was used to provide assurance that data was reliable. Data was taken from the electronic reporting system, learning systems and qualitative and quantitative data.

We looked at a sample of meeting agendas from across the trust and saw quality and sustainability was regularly discussed we saw issues such as learning from deaths, continuous improvement experience and engagement as well as issues such as staffing, finance and transformation work.

IT systems and telephones were working well, and they helped to improve the quality of care. The trust had invested in a number of new systems to support care. They had implemented a new electronic patient record, a care planning system which was person centred and goal focused and an incident reporting system. Financial investment had also been ringfenced to implement a patient record system within physical health care, this would provide the opportunity to use a joint up system with external partners such as GP's. The Initial Response team, telephone service had been shortlisted in the 'Driving Efficiency through Technology' category at this year's HSJ Awards.

During our well led inspection we had feedback from NHS England regarding an initiative within the Child and Adolescent Mental Health Service at The Cove. They described the use of a digital interface used to interact with patients who struggled with communication. Positive feedback had been received from young people. It had helped people in their daily interactions by practicing communication in virtual reality.

Staff had access to the IT equipment and systems needed to do their work. The trust supported hybrid working and was continuing to invest in IT equipment to support staff working in this way.

The trust had a good track record of submitting **notifications to external bodies as required**. We could see this was stated in appropriate policies where notifying organisations such as CQC was a requirement.

Information governance systems were in place including confidentiality of patient records. Information governance training compliance across the trust was at 94%.

The trust learned from data security breaches. We were told that when this had previously happened, it had related to information been sent to the wrong person. We were told work was taking place to ensure that wrong information could not be inputted into the system.

Engagement

The trust had a structured and systematic approach to engaging with people who use services, those close to them and their representatives. There was a patient experience lead and strategy to support the work. The strategy was co-produced with the service users, carer's council and members of the public. The strategy supported the overall

trust strategy placing 'patients at the heart of everything we do'. The cares council was chaired by a carer who also attended board meetings. However, there was also 5 smaller, locality service user and carer councils to ensure good coverage of each area. The service user council also had 'Youth Voice' this was people up to the age of 25 years to provide a voice for young people accessing services and understand the challenges they faced.

The ward/service team and division had access to feedback from patients, carers and staff and were using this to make improvements. The Friends and Family Test (FFT) asks people whether they would recommend the NHS service they have received to friends and family who need similar treatment or care. Everyone is offered the opportunity to complete the FFT questionnaire when they are ready to be discharged from care or at other points during their care pathway. The trust had a 90% response rate from staff at the time of our inspection and had an average response rate of 2200 per month from patients. There was an average 90% positive feedback rate from the friends and family test. Feedback from this supported teams to make improvements to care through the 'you said we did' process. The trust also used responses from the friends and family test to support the progress on the service user strategy. During 2023 the Patient Experience and Engagement Team planned a monthly roadshow event. They visited all community services within the networks and provided feedback from the previous 6 months Friends and Family Test. This was to generate ideas about increasing Friends and Family Test responses (previously inpatient wards have been focused on) this resulted in a number of visits to team meetings across the networks to provide information on available resources and best practice examples. The use of iPads to collect feedback in an Older Adult team had been successful, with the team twice achieving their network community 'most improved' title. The team were struggling to increase feedback numbers, but after engaging with the Experience Team and highlighting Friends and Family Test as a priority, they had improved their responses. The trust had a Learning Lessons Programme which was delivered monthly. This was a space for staff to reflect and learn. The sessions were informed by patient experience either by a patient story or by using patients' feedback from surveys or Friends and Family Test in addition to sharing the patient's journey through services or an incident. There was a quarterly Learning Lessons bulletin which was circulated to all staff.

Communication systems such as the intranet and newsletters were in place to ensure staff, patients and carers had access to up to date information about the work of the trust and the services they used. There was a monthly team brief available to all staff, this could be accessed through the intranet or in paper format. The Experience and Engagement Team hosted monthly roadshow events, which provided opportunity to visits key sites and talk to staff, service users and carers about work which is taking place. The team give out information and ask for feedback on improvements.

The trust offered public Governors training on appointment. They were actively involved in the operation of the trust. The trust had a Council of 27 Governors The two main responsibilities of Governors are to represent the interests of members of the public and staff, and to hold the non-executive directors to account for the performance of the board. Governors were required to attend an induction when taking up the role and a programme of development sessions were produced each year. The sessions focused on topics, either linked to the Council's statutory duties or areas of education/training. We held a focus group with the trust Governors. They told us there had been positive changes with board over recent years. They described the board spending time engaging with staff both in person and through technology for example podcasts, with easy access to senior leaders. The governors described an open and transparent culture which they felt part of. They were involved in recruitment, received trust reports for review and attended board. The Chief executive officer and directors regularly attended the council of governors meeting and the governors described feeling 'kept in the loop'. The governors had active involvement in the development of the new sites to increase bed capacity, the new Learning Disability site and changes in the physical health services.

Our findings

The trust had a structured and systematic approach to staff engagement. The trust had an inclusion council led by the Chief People Officer which involved staff from across the trust. The staff networks reported into the Inclusion Council sharing good practice and challenges which need escalation. Staff networks were involved in developing policy, raising staff awareness, and supporting social movements such as LGBTQ+ badge scheme.

The staff networks were:

- Woman's
- Race Equality
- LGBTQ+
- International
- Medics Race Equality
- Disability and Long Term Conditions
- Equality, Diversity and Inclusion Champions

Staff were involved in decision making about changes to the trust services The trust had an Improvement and Culture strategy. To support this the trust held engagement events for example 'big conversations'. This event provided an opportunity for all staff to share ideas on improvements and how change was delivered. Other engagement events were held to ensure the views of people working at the trust could be heard.

Division leaders/middle managers, on behalf of front line staff, engaged with external stakeholders such as commissioners and Healthwatch. Healthwatch visited inpatient areas and provided feedback from each visit. During our inspection we talked with specialised commissioning and Healthwatch both described having a relationship with the trust and regular engagement. A representative from commissioning told us the trust was open and transparent and described the Children and Young People service as good, doing innovative work. They told us how the trust had developed and driven a non-inpatient service for crisis. They believed the trust to be well led having gone through a cultural journey.

The trust was actively engaged in collaborative work with external partners, such as involvement with sustainability and transformation plans.

There were mainly positive and collaborative relationships with external partners recognising and understanding challenges within the system and the needs of the local population. There was both informal and formal relationships across the geographical area. This included other NHS trusts, voluntary sector organisations, councils, and charities.

The trust engaged well with stakeholders and partners and was a partner in several system wide groups including but not limited to:

- Provider Collaborative
- Lancashire and South Cumbria Integrated Care Board
- The trust Initial response service
- Recovery Colleges
- Lancashire and South Cumbria Wildlife Trust and the Eden Project

Our findings

We spoke with the Integrated Care Board (ICB) and were told the trust was a 'team player' and a 'unified board'. We heard that as a system the trust was working well and fully participated with the provider collaborative. The Chief Executive Officer of the trust was a partner member on the ICB, and they were developing a recovery transformation board workstream, with mental health being an important area of focus. This was something the trust were pleased to be part of. In relation to acute health care, the trust was helping to relieve pressure on A&E by appropriate sign posting and processes. The ICB also told us of improved relationships with the local government.

Learning, continuous improvement and innovation

The trust actively sought to participate in national improvement and innovation projects. Leaders and staff strived for continuous learning, improvement, and innovation this included participating in and leading research projects and were part of recognised accreditation schemes.

The trust had received 15 external accreditations across its services and were working towards a further 12. The trust also had its inhouse inpatient accreditation system and had accredited 20 wards bronze, 16 wards silver and 8 wards gold.

The 15 external accreditations were:

- Quality Network for Perinatal Mental Health Services - Ribblemere Mother and Baby Unit (19/04/2023)
- Lived Experience Charter - Reconnect and Liaison & Diversion Services (26/03/2023)
- ECTAS – ECT Accreditation Service - Community MH - Blackburn ECT Clinic (15/03/2021)
- UNICEF BFI Gold Accreditation - Blackburn With Darwen 0-19 Universal services (13/02/2023)
- ECTAS – ECT Accreditation Service - Royal Preston Hospital ECT Suite (26/06/2023)
- NHS Finance Leadership Council - Towards Excellence Accreditation, at level 1 - Finance Department (10/05/2023)
- BS EN ISO/IEC 27001:2017 Provision of NHS Information Management & Technology to the Lancashire and South Cumbria NHS Foundation Trust, inclusive of Infrastructure Management, Service Desk Support, Project Management, Development and Testing, and Information Governance - Digital Services (20/12/ 2022 expiry Date: 04/ 10/ 2024)
- DCB1596: Secure email This information standard defines the minimum non-functional requirements for a secure email service, covering the storage and transmission of email, including where email is used for the sharing of patient identifiable data. The standard includes:

the information security of the email service

transfer of sensitive information over insecure email

access from the Internet or mobile devices

exchange of information outside the boundaries of the secure standard - Digital Services (February 2023)

- DSPT – Data Security and Protection Toolkit - Digital Services (2023/24)

Our findings

- GDE – Global Digital Exemplar Lancashire and South Cumbria NHS Foundation Trust was the first mental health trust to receive its Global Digital Exemplar (GDE) accreditation. Lancashire and South Cumbria NHS FT celebrates GDE accreditation (digitalhealth.net) - Digital Services (2023/24)
- HIMSS – INFRAM – HIMSS (Healthcare Information and Management Systems Society) - Digital Services (Assessed as Stage 4)
- Pastoral Care Award (International Recruitment) - Employment Services (July 2023)
- Disability Confident Employer - Employment Services (2022)
- Gold Employers Recognition Scheme (Armed Forces) - Employment Services (October 2022)
- Veteran Awareness - Employment Services (June 2022)

The trust had a planned approach to take part in national audits. The trust Clinical Audit Programme contained 42 audits that were undertaken, 10 were national audits, 5 related to CQUIN, 8 baselines audits, 4 deep dives and 15 were re-audits. Some of the national audits included:

- National Clinical Audit of Psychosis
- National Audit of Care at the End of Life
- National Parkinson's Audit
- Prescribing Observatory in Mental Health: 1h &3e Prescribing high-dose and combined antipsychotics
- Prescribing Observatory in Mental Health: 20b Valproate prescribing in adult MH services

The annual internal audit plan was approved by the Audit Committee and reviewed quarterly. An annual report on the effectiveness of the programme was provided to the committee and was also presented to the council of governors.

The trust was actively participating in clinical research studies. There was an Associate Director of Research and Development and a research and development strategy. The research strategy was aligned to the trust vision and strategic objectives. Lancashire & South Cumbria NHS Foundation Trust had 8 research grants and 5 submissions awaiting a decision.

Of the 8 grants 5 were related to mental health studies and 3 to social care.

Staff had training in improvement methodologies and used standard tools and methods. The trust has invested in a recognised Quality Improvement methodology and had rolled out training for staff in this model. All services had been involved in quality improvement work and we heard from staff during our core service inspection of this work. Quality improvement methodologies had been used to look at topics such as reducing restrictive practice, falls reduction, and direct care. Work looking at reducing restrictive practice showed significant improvements to practice which was recognised nationally and shortlisted for a number of Health Service Journal awards, winning the Patient Safety Team of the year award.

Effective systems were in place to identify and learn from unanticipated deaths. The trust had a Mortality review process to support learning of patient deaths. The mortality review group met monthly and had a multidisciplinary presence including a representative from the suicide prevention group. The trust included carer/family feedback in this process and were able to triangulate information which may also be connected from complaints or the PALS team. The group completed a thorough review of the death and identify learning.

Our findings

We spoke with the mortality leads for the trust who told us about different ways the trust shared learning from these reviews. They told us about e-postcard feedback which was split into a summary of good practice and learning and identified action which were then sent to relevant teams, 1-page summaries, videos, and educational films.

There was monthly online learning lessons events which were open to all staff, the events were themed and included patient stories.

The trust was part of a Northan Alliance, multi organisational group who met to share learning, look at national guidance, capturing data and consider staff support and feedback to staff. The trust had a Chair role at this meeting which it shared with another neighbouring trust.

Staff had time and support to consider opportunities for improvements and innovation and this led to changes. During our well led inspection we were told about the 'listening into action' workstream driven by patients and carers. This workstream developed a booklet 'take care' that allowed patients to record what they want as an outcome from medicines, what medicines work well for them and what medicines do they not want to take again. This work was shared across the organisation and could be used by patients who wanted involvement in decision making regarding treatments.

External organisations had recognised the trust's improvement work. Individual staff and teams received awards for improvements made and shared learning. The trust won Employer of the Year at the NHS Health and Social Care Apprenticeship Awards and was named Best Employer for Nurses by the Nursing Times. This was in recognition of the trust's continued commitment to learning and progression. The trust's Apprentice Team and apprentices were shortlisted 13 times with a trust Nursing Associate winning the Clinical Apprenticeship of the Year Award, having used the apprentice route to move from being a Healthcare Assistant to almost qualified Mental Health Nurse. Two apprentices were highly commended in the Above and Beyond category and a Registered Nursing Associate in the Team Player Award category.

Individual staff were recognised, with a trust nurse winning The Sun's 'Who Cares Wins' award, a senior Occupational Therapist winning the Early Researcher Award, a senior nurse named on the Nursing Times NHS 75 impact list, and trust Doctors winning Trainer of the Year and SAS Doctor of the Year at the North West RCPsych Awards. The trust was recognised for improvements in clinical care, with an RCN Nursing Award for the Scarisbrick Ward's 'Bus Stop' project, and North West Research Award for the Trainee Associate Psychological Practitioners (TAPPs) project, and an HSJ Patient Safety Award for the 'Advocacy for autistic people in mental health inpatient settings' pilot.

Additionally, the Trust was successful in :

- Reducing restrictive Practice – HSJ award for Patient Safety Team of the Year – reflecting reduction in restrictive practice by 49%
- Accreditations
- Equality and Diversity innovations recognised by National Lead (staff networks, WRES/DES)
- Freedom to Speak Up team were finalists in the Changing Culture Award at the HSJ Patient Safety Awards 2022
- National exemplar in the use of Data and Analytics within Mental Health, showcased at national GIRFT workshop
- Development of The Script, an innovative means of providing engaging data analysis
- Establishing a Quality Improvement Fellowship with Lancaster University

Our findings

- Development of library of Apps in collaboration with Orca
- Digital Innovation exemplified by the development of avatar therapy
- Establishment of the Trust's Service User & Carer Council, with Board attendance
- Integrated Commissioning Team shortlisted for HSJ Partnership Award

Key to tables

Ratings	Not rated	Inadequate	Requires improvement	Good	Outstanding
Rating change since last inspection	Same	Up one rating	Up two ratings	Down one rating	Down two ratings
Symbol *	➔➔	↑	↑↑	↓	↓↓

Month Year = Date last rating published

* Where there is no symbol showing how a rating has changed, it means either that:

- we have not inspected this aspect of the service before or
- we have not inspected it this time or
- changes to how we inspect make comparisons with a previous inspection unreliable.

Ratings for the whole trust

Safe	Effective	Caring	Responsive	Well-led	Overall
Requires Improvement ➔➔ Jan 2024	Requires Improvement ➔➔ Jan 2024	Good ➔➔ Jan 2024	Good ↑ Jan 2024	Good ↑ Jan 2024	Good ↑ Jan 2024

The rating for well-led is based on our inspection at trust level, taking into account what we found in individual services. Ratings for other key questions are from combining ratings for services and using our professional judgement.

Ratings for a combined trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Mental health	Requires Improvement	Requires Improvement	Good	Good	Requires Improvement	Requires Improvement
Community	Requires Improvement	Requires Improvement	Good	Good	Good	Requires Improvement
Overall trust	Requires Improvement ➔➔ Jan 2024	Requires Improvement ➔➔ Jan 2024	Good ➔➔ Jan 2024	Good ↑ Jan 2024	Good ↑ Jan 2024	Good ↑ Jan 2024

The rating for the well-led key question is based on our inspection at trust level, taking into account what we found in individual services. Ratings for other key questions take into account the ratings for different types of service. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Rating for acute services/acute trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Ormskirk Hospital	Good Oct 2015	Good Oct 2015	Good Oct 2015	Good Oct 2015	Good Oct 2015	Good Oct 2015
Overall trust	Requires Improvement ➔➔ Jan 2024	Requires Improvement ➔➔ Jan 2024	Good ➔➔ Jan 2024	Good ↑ Jan 2024	Good ↑ Jan 2024	Good ↑ Jan 2024

Ratings for the trust are from combining ratings for hospitals. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Rating for Ormskirk Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Overall	Good Oct 2015	Good Oct 2015	Good Oct 2015	Good Oct 2015	Good Oct 2015	Good Oct 2015

Rating for mental health services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Acute wards for adults of working age and psychiatric intensive care units	Requires Improvement ➔🡐 Jan 2024	Requires Improvement ➔🡐 Jan 2024	Good ➔🡐 Jan 2024	Good 🡅 Jan 2024	Requires Improvement ➔🡐 Jan 2024	Requires Improvement ➔🡐 Jan 2024
Wards for older people with mental health problems	Requires improvement Jul 2021	Good Jul 2021	Good Jul 2021	Good Jul 2021	Requires improvement Jul 2021	Requires improvement Jul 2021
Long stay or rehabilitation mental health wards for working age adults	Requires improvement Oct 2015	Requires improvement Oct 2015	Good Oct 2015	Good Oct 2015	Requires improvement Oct 2015	Requires improvement Oct 2015
Forensic inpatient or secure wards	Good May 2018	Good May 2018	Good May 2018	Good May 2018	Good May 2018	Good May 2018
Child and adolescent mental health wards	Good Sep 2019	Good Sep 2019	Good Sep 2019	Good Sep 2019	Good Sep 2019	Good Sep 2019
Community-based mental health services of adults of working age	Requires Improvement ➔🡐 Jan 2024	Requires Improvement ➔🡐 Jan 2024	Good ➔🡐 Jan 2024	Requires Improvement ➔🡐 Jan 2024	Requires Improvement ➔🡐 Jan 2024	Requires Improvement ➔🡐 Jan 2024
Mental health crisis services and health-based places of safety	Requires Improvement ➔🡐 Jan 2024	Good 🡅🡅 Jan 2024	Good 🡅🡅 Jan 2024	Good 🡅🡅 Jan 2024	Good 🡅🡅 Jan 2024	Good 🡅🡅 Jan 2024
Community-based mental health services for older people	Good Jan 2017	Good Jan 2017	Good Jan 2017	Good Jan 2017	Good Jan 2017	Good Jan 2017
Community mental health services for people with a learning disability or autism	Good Jan 2017	Requires improvement Jan 2017	Good Jan 2017	Good Jan 2017	Good Jan 2017	Good Jan 2017
Specialist community mental health services for children and young people	Requires improvement Jan 2017	Good Jan 2017	Good Jan 2017	Good Jan 2017	Good Jan 2017	Good Jan 2017
Overall	Requires Improvement	Requires Improvement	Good	Good	Requires Improvement	Requires Improvement

Overall ratings for mental health services are from combining ratings for services. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Rating for community health services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community health services for adults	Requires improvement Jan 2017	Requires improvement Jan 2017	Good Jan 2017	Good Jan 2017	Good Jan 2017	Requires improvement Jan 2017
Community health services for children and young people	Requires improvement Jan 2017	Good Jan 2017	Good Jan 2017	Good Jan 2017	Good Jan 2017	Good Jan 2017
Community health inpatient services	Good May 2018	Good May 2018	Good May 2018	Good May 2018	Good May 2018	Good May 2018
Community end of life care	Good Oct 2015	Requires improvement Oct 2015	Good Oct 2015	Good Oct 2015	Good Oct 2015	Good Oct 2015
Community dental services	Good Sep 2019	Good Sep 2019	Outstanding Sep 2019	Good Sep 2019	Good Sep 2019	Good Sep 2019
Overall	Requires Improvement	Requires Improvement	Good	Good	Good	Requires Improvement

Overall ratings for community health services are from combining ratings for services. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Mental health crisis services and health-based places of safety

Good ↑↑

Is the service safe?

Requires Improvement →←

Our rating of safe improved. We rated it as requires improvement.

Safe and clean environments

All clinical premises where patients received care were generally safe, clean, well equipped, well furnished, well maintained and fit for purpose.

The physical environment of the Health-based Places of Safety met the requirements of the Mental Health Act Code of Practice. Mental Health Liaison Teams had access to appropriate assessment rooms within accident and emergency departments.

Staff completed and regularly updated thorough risk assessments of all areas and removed or reduced any risks they identified. Each service we visited had an annual fire risk assessment in place as well as ligature risk assessments which were reviewed every 6 months in partnership with the Trust Health and Safety team. Staff we spoke to were aware of ligature risks within their environment and could describe the steps taken to mitigate these.

Staff using interview rooms within community settings had access to alarms. In some instances these were hard wired alarms built into interview rooms and in other services staff had access to portable personal alarms. Staff we spoke with were aware of alarm systems and response procedures.

Services we visited were clean and well maintained. Cleaning records were up to date. We saw domestic staff cleaning areas during our visit. Domestic staff we spoke with reported they had access to the equipment and resources they needed for their job. Staff followed infection control guidelines, including handwashing.

Staff made sure equipment was well maintained, clean and in working order. Where required staff completed regular checks of equipment including completing calibration. Equipment was clearly labelled with details of the last test date and the next due date.

STAFFING

The service did not always have enough staff, who received basic training to keep people safe from avoidable harm. The number of patients on the caseload of the mental health crisis teams, and of individual members of staff, was not too high to prevent staff from giving each patient the time they needed. However, caseloads in some teams were high.

Nursing staff

Mental health crisis services and health-based places of safety

The service had high vacancy rates. Vacancy rates varied across teams and service types. Across the urgent care pathway, the vacancy rates for qualified nursing staff and unqualified support workers (including call handlers within the Initial Response Service) was 23%. The vacancy rates across different service types was:

Home-based Treatment teams – 23% (46.26 wholetime equivalent vacancies out of 202.33 wholetime equivalent posts)

Initial Response Service – 22% (37.02 wholetime equivalent vacancies out of 164.98 wholetime equivalent posts)

Mental Health Liaison Teams – 12% (14.74 wholetime equivalent vacancies out of 119.62 wholetime equivalent posts)

Health-based Places of Safety – 36% (30.39 wholetime equivalent vacancies out of 85.37 wholetime equivalent posts)

Street Triage – 43% (6 wholetime equivalent vacancies out of 14 wholetime equivalent posts).

The service managed the impact of vacancies through the use of bank, agency and cross-team working. For example, in Lancaster and Morecombe services the Home-based Treatment team and the Mental Health Liaison team worked together to help manage demand. In addition, support was provided by other professionals within teams such as psychologists and occupational therapists.

In the 12 months prior to our inspection (June 2022 to July 2023) the 25 teams in the urgent care pathway had used bank, agency and temporary staffing to fill 23,869 shifts. Of these, 714 shifts were covered by agency, 18,036 shifts were covered by bank staff and 4,849 shifts were covered by temporary staffing.

Managers made sure all bank and agency staff had a full induction and understood the service before starting their shift. Managers utilised regular bank and agency staff to promote consistency. Bank and agency staff that we spoke with told us they felt integrated into teams and demonstrated a sound knowledge of both the team and the patient base.

Managers used a recognised tool to calculate safe staffing levels. The Trust had completed safer staffing reviews for the Home-based Treatment, Mental Health Liaison and Health-based Places of Safety services as part of the urgent care pathway transformation programme. Staffing levels and skill mix had been considered for the Initial response and Street Triage services as part of the business cases developed for their implementation. Staffing reviews considered national guidance, benchmarking data and local factors that impacted on demand. The reviews utilised the Telford Model to ensure a consultative approach and interviewed clinicians and managers as part of the process. In addition to identifying required nursing and support staff levels the reviews also identified new posts within the wider multi-disciplinary team such as psychologists and occupational therapists.

Although vacancy rates were high, they were reducing. The trust had an ongoing recruitment programme in place and a protected budget for vacant staffing posts. The trust had also initiated new recruitment and retention initiatives including welcome bonuses and enhanced carer development pathways. Recruitment and retention strategies were in part informed by leaving interviews conducted with staff who were leaving their post.

The service had varied turnover rates. These had been impacted by staff movement during the urgent care pathway transformation programme and the small size of some teams where one staff member leaving post had an increased impact on the staff turnover percentage. Average staff turnover in June 2023 across the urgent care pathways was 10.7%. However, this included the Barrow 136 health-based place of safety where one staff member leaving post resulted in a 100% turnover rate. The average turnover rate excluding the Barrow health-based place of safety was 7%.

Mental health crisis services and health-based places of safety

Levels of staff sickness were reducing. Staff sickness, including long-term sickness had fallen in the 6 months prior to our inspection from 12.7% in January 2023 to 10.4% in June 2023. Managers supported staff who needed time off for ill health. Advice and assistance was available from the trust occupational therapy and staff support services.

The service had effective systems in place to monitor and respond to staffing demands. Community-based services in each locality had daily huddles to review clinical activity and staffing positions. Where required staff could be redeployed to support other teams. Staffing levels and activity for 136 suites were considered in daily calls within their inpatient location.

Managers within Home-based Treatment teams monitored staff caseloads. Caseloads were reported on weekly and discussed in team meetings and supervision sessions. At the time of our inspection the highest team caseload was in the central Lancashire Home-based Treatment team (103). The lowest was in the west Lancashire Home-based Treatment team (21). As part of the urgent care pathway transformation programme the service had introduced the Initial Response Service. This had resulted in a reduction in referrals to Home-based Treatment teams within the Pennine and Central localities. The Initial Response Service within the Bay locality (including Lancaster) had been launched in March 2023 and the service was hoping to see a similar reduction in referrals to Home-based Treatment teams in the area.

Other services within the urgent care pathway did not carry caseloads. The Trust did provide figures for the number of weekly referrals per wholetime equivalent staff member within the Mental Health Liaison teams. The highest referral rate was in Pennine Mental Health Liaison team (3.2). The lowest was in the Furness Mental Health Liaison team (3.2).

In the 12 months prior to our inspection (June 2022 to July 2023) the urgent care pathway had reported 42 incidents related to staffing levels. The Initial Response Services reported the highest number of incidents with 25. The central and west Home-based Treatment teams reported 8 incidents and the central and west Mental Health Liaison team reported 5 incidents. Incidents were primarily related to staff missing breaks due to pressures. The Initial Response Service also reported 14 incidents were appointments had to be rearranged.

Staff we spoke with acknowledged that staffing could be stretched. Staff concerns about staffing levels were highest in Home-based Treatment teams. In addition to staff missing breaks we also saw that in teams with higher vacancy rates that although care was being managed some paperwork and documentation was not always up to date. This was primarily a concern in Barrow teams. However, we found that in general staff and teams worked well together to manage demand and had the systems and processes in place to support this.

Mental Health Urgent Assessment Centres and Health-based Places of Safety had dedicated staffing establishments.

Medical staff

The service had enough medical staff to keep patients safe and meet need. Each team had access to medical staff and could access a psychiatrist quickly when they needed to. Staff we spoke with told us medics were generally available when required.

Managers could use locums when they needed additional support or to cover staff sickness or absence. Managers made sure all locum staff had a full induction and understood the service.

Mandatory training

Mental health crisis services and health-based places of safety

Staff had mostly completed and kept up to date with their mandatory training. The Trust had an internal compliance target of 95%. At the time of the inspection compliance with mandatory training across the services we visited was 88%. However, there were two services where compliance was below 75%. These were the Morecambe and Lancaster Home-based Treatment team and the Pennine Street Triage service.

There were four courses within the mandatory training programme where compliance across the core service was below 75%. These were the Positive and safe programme (58%), safeguarding level three (71%), manual handling (61%) and clinical risk assessment level three (STORM) training (44%). At the time of our inspection the Trust was in the process of commissioning an alternative risk management training course as a replace for the STORM training.

The mandatory training programme was comprehensive and met the needs of patients and staff. The programme included training programmes covering equality and diversity, basic life support, conflict resolution, risk management, autism awareness and personality disorder.

Managers monitored mandatory training and alerted staff when they needed to update their training. Managers had access to an electronic database to monitor training compliance, identify gaps and prompt staff to complete training when it was due.

Assessing and managing risk to patients and staff

Staff assessed and managed risks to patients and themselves. They responded promptly to sudden deterioration in a patient's health. When necessary, staff working in the mental health crisis teams worked with patients and their families and carers to develop crisis plans. Staff followed good personal safety protocols.

Assessment of patient risk

Staff generally completed risk assessments for each patient on admission / arrival, using a recognised tool, and reviewed this regularly, including after any incident. We reviewed 64 care records. We found that in general patients had up to date risk assessments in place. However, we reviewed 35 records across Home-based Treatment teams and found that 7 out of 35 did not have an up-to-date risk assessment. We found that the risk assessments were being reviewed weekly but not always after every appointment. However, high risk patients were discussed in daily multi-disciplinary huddles and in some cases updates had been included within daily note entries and safety plans.

Staff used a recognised risk assessment tool. Depending upon the service type staff used a combination of the health and social needs assessment and risk assessment and an enhanced risk assessment tool.

Staff could recognise when to develop and use crisis plans and advanced decisions according to patient need. We saw examples of safety plans within the records that we reviewed.

Management of patient risk

Staff generally responded promptly to any sudden deterioration in a patient's health. Staff continually monitored patients on waiting lists for changes in their level of risk and responded when risk increased.

Patients were reviewed daily in team huddles. There were clear pathways to escalate concerns and to refer patients to other teams or for inpatient admission. Community-based services operated a dynamic patient risk register where patients were rated as either red, amber or green. Patients rated as red were deemed to be the highest risk and require

more frequent contact and input. Patient ratings on the risk register were reviewed daily. Following learning from a previous incident the policy around patient rating was changed to mean that an individual staff member could now raise a patients rating without discussion in the wider multi-disciplinary team. However, a patients rating could only be lowered following agreement by the multi-disciplinary team.

However, in some teams staffing levels meant that staff weren't always able to see patients face to face. Teams in Lancaster and Barrow reported that they did not always have the capacity to complete face to face visits. Patients rated as red on the dynamic risk register were prioritised and seen daily as stipulated. However, staff reported that sometimes patients rated as amber or green were not always seen face to face for each contact.

Where staff capacity was an issue protocols were in place to ensure that appropriate amber and green rated patients were prioritised for face-to-face contact. Where face to face contact was not possible staff still maintained contact with patients at the stipulated frequency, but this could be by phone contact or through a different team member. In response to staffing pressures within the Lancaster Home-based Treatment team the trust completed an audit of incidents related to delayed assessment, treatment or clinical care since April 2023. There had been 30 incidents related to delays. 19 of the incidents were graded as no harm and 11 of the incidents were graded as low/minimal harm. None of the incidents had cause significant harm.

Current bed capacity within the trust meant that there were high risk individuals who had been deemed appropriate for admission but were unable to access an inpatient bed. Community crisis services had some involvement in managing these patients along with community mental health teams. The Trust provided data that showed in the 12 months from August 2022 to July 2023 there had been 28 incidents of harm to patients in the community who were awaiting admission. This was out of 2345 admissions to inpatient wards. 24 of the incidents had resulted in low harm and two had resulted in moderate harm. Two incidents resulted in death or catastrophic harm.

The Trust had identified these concerns through their internal assurance processes. The Trust now produced a quarterly report for the trust board detailing incidents of harm to patients in the community who were awaiting admission. Changes had been made to incident reporting and recording to ensure accurate data. Work was ongoing to also understand and report on the impact on families and carers who were supporting patients in the community whilst they awaited admission.

Staff followed clear personal safety protocols, including for lone working. There was a lone worker policy in place which detailed appropriate actions and risk mitigation.

Safeguarding

Staff understood how to protect patients from abuse. Staff had training on how to recognise and report abuse and they knew how to apply it. However, the service did not always work effectively with other agencies.

Staff received training on how to recognise and report abuse, appropriate for their role. Staff mostly kept up to date with their safeguarding training. Across the core service compliance with safeguarding level one training was 97% and compliance with safeguarding level two training was 86%. However, compliance with safeguarding level three training was 71%.

Staff we spoke with were knowledgeable about safeguarding and related issues. Staff knew how to recognise adults and children at risk of or suffering harm. They knew how to make a safeguarding referral and who to inform if they had

concerns. Staff had access to support from a Trust-wide safeguarding team and local safeguarding champions. There were appropriate safeguarding policies in place for further guidance. Safeguarding concerns were discussed daily in safety huddles and within other multi-disciplinary meetings. Records we reviewed included relevant safeguarding information and evidence of ongoing management of concerns.

Staff we spoke with reported positive relationships with local safeguarding authorities. We spoke with safeguarding practitioners in three local councils (Blackburn with Darwen, Blackpool Borough and Lancashire County). Safeguarding staff described positive day to day relationships and good liaison work in relation to safeguarding. However, they reported difficulties in obtaining information and feedback on instances of serious harm. They felt the trust took too long to respond and conclude those processes.

Managers took part in serious case reviews and made changes based on the outcomes.

Staff access to essential information

Staff working for the mental health crisis teams kept detailed records of patients' care and treatment. Records were clear, up-to-date and easily available to all staff providing care.

Care records were in both electronic and paper form. Patient notes were generally comprehensive and all staff could access them easily. The Trust had transitioned to a new electronic records system in 2021. Some staff we spoke with told us they were uncertain where to record some information on the system. This meant that some teams recorded information in different ways or in different places on the system. However, staff we spoke with knew where to find relevant information. These concerns had been raised within the Trust and there was a monitoring and improvement programme called the Core Mental Health Record Optimisation Programme working to develop the records system and promote consistency.

Some staff we spoke with told us they could struggle to access the care records system due to poor WI-FI or internet signal. This was primarily in the South Cumbria services.

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

Records were stored securely. Electronic records were password protected and paper records in locked rooms or cupboards.

Medicines management

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

Staff followed systems and processes to prescribe and administer medicines safely. Medicines prescription and administration cards were stored securely and clearly completed. Summary care record was used to confirm people's current medicines and clinic letters were sent electronically to GP's.

Staff reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines. The trust offered patient's access to information about mental health conditions and medicines on a national website. Paper materials were also shared in clinic. We saw posters with the QR code to enable easy access to the website. Staff completed medicines records accurately and kept them up to date.

The service ensured people's behaviour was not controlled by excessive and inappropriate use of medicines. Staff reviewed the effects of each patient's medicines on their physical health according to NICE guidance.

Staff learned from safety alerts and incidents to improve practice. The trust had recently led on discussions exploring the safe use of clozapine across both acute and mental health trusts to promote wider sharing and learning from incidents.

Track record on safety

The service had a good track record on safety.

Reporting incidents and learning from when things go wrong.

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

Staff knew what incidents to report and how to report them. Incidents were reported on an electronic reporting system. Staff we spoke with told us that they reported all incidents and near misses in line with the trust policy. They were able to give examples of the type of incidents they would report, explain how the reporting system worked and give examples of instances where they had used it.

Adverse incidents were reviewed by team managers, senior management within localities and by the trust patient safety team. Staff received feedback where appropriate. There were governance processes to monitor incident reporting, identify trends and share learning.

Managers investigated incidents thoroughly. There were different levels of investigation triggered depending on the nature or severity of the incident. Managers completed 72-hour reviews, concise investigations and full investigations. Managers at team and locality level had received training in the investigation process and in the use of techniques such as root cause analysis. Support was available from the trust patient safety team. Staff, patients and their families were involved in investigations.

Managers shared learning from incidents in daily huddles, team meetings and supervision. There were also weekly patient safety updates and quarterly lessons learnt documents circulated to staff via email and discussed in team meetings. Staff could also access an electronic learning library where previous updates and lessons learnt were stored. We reviewed the last three patient safety updates. There were examples of identified learning relating to mental health services in general and crisis services specifically. These included learning around the completion of risk assessments within Home-based Treatment teams and prescribing within Mental Health Liaison teams. Staff we spoke with were aware of these documents and confirmed they had discussed lessons learnt within their teams. In addition, some staff had attended trust learning events ether in person or on-line.

Mental health crisis services and health-based places of safety

We saw evidence that learning had led to changes including the reviewing and updating of standard operating procedures and the introduction of a shift leader within Home-based Treatment teams.

Managers debriefed and supported staff after any serious incident. There were processes and policies in place to support staff debriefs and access to reflective practice sessions, complex case group supervision and specialist support services.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong. Managers and staff were aware of the principles of the duty of candour and when they applied. The electronic reporting system captured whether duty of candour was applicable for each incident that was submitted. Staff we spoke with were able to give examples where duty of candour processes had been followed.

Is the service effective?

Good ↑↑

Our rating of effective improved. We rated it as good.

Assessment of needs and planning of care

Staff assessed the mental health needs of all patients. Staff working for the mental health crisis teams worked with patients and families and carers to develop individual care plans and updated them when needed. Care plans reflected the assessed needs, were personalised, holistic and recovery oriented.

Staff completed a comprehensive mental health assessment of each patient. The Initial Response Services completed an assessment and triage tool to identify patient need and the right pathway or referral for their treatment. We reviewed 69 care records and found that all patients had a completed and updated assessment of need.

Staff did not always make sure that patients had a full physical health assessment. We reviewed 35 care records from Home-based Treatment teams and found that 12 did not have clear evidence of a physical health assessment. Recording and monitoring of physical health was inconsistent across records. We raised this with team managers who confirmed that this had been identified through trust assurance processes and case note audits. As part of their response, the Trust had rolled out the Lester physical health tool across services in January 2023 and embedded it in the care records. The Lester tool helps staff to make assessments of cardiac and metabolic health.

The Trust was also rolling out Physical Health in Mental Health training to community services. At the time of our inspection the average compliance rate for the 7 Home-based Treatment teams was 67%. Additional accelerator sessions were being arranged for Home-based Treatment teams to improve this compliance rate. During the inspection we observed that physical health concerns were being considered by staff and saw examples of liaison with relevant specialists within case notes. Staff were trained to carry out physical health procedures such as electrocardiograms and blood tests.

Staff generally developed a comprehensive care plan for each patient that met their mental and physical health needs. Staff generally reviewed and updated care plans when patients' needs changed.

Mental health crisis services and health-based places of safety

We reviewed 64 care and treatment records during the inspection. We found that the majority of these contained care plans that reflected the assessed needs and in general were personalised and holistic. However, we reviewed 35 records across Home-based Treatment teams and found that 11 out of 35 did not have up to date or comprehensive care plans. Managers had identified this concern through the trust assurance processes and were working to improve this.

As part of the move away from care coordination towards key working and community hubs the trust was rolling out a new person-centred assessment tool called Dialog+. The tool used a collaborative approach with the patient to care planning and asked the patient to rate how they felt on a scale of one to 7 across 11 domains. These domains included 8 life domains covering areas such as physical health, accommodation, occupation and friendships and three treatment domains covering satisfaction with medication, the help the patient was receiving and the meetings they had with staff.

Staff we spoke with told us that the migration to the new system was impacting on the completion and updating of care plans. Training was being rolled out at the time of our inspection. Staff were also being provided with tablets to support patients to complete the tool in the community. Dialog+ had already been rolled out within inpatient units and some other community services. Feedback from staff and patients had been positive. Staff from teams where staffing was more stretched also reported that sometimes capacity was an issue in updating care plan records.

Information around patients, patient needs and care plans was discussed and shared within daily team huddles.

Best practice in treatment and care

Staff working for the mental health crisis teams used recognised rating scales to assess and record severity and outcomes. Staff working for the crisis teams and in the health-based places of safety participated in clinical audit, benchmarking and quality improvement initiatives.

Staff delivered care in line with best practice and national guidance. Each service had a Standard operating procedure document which referenced relevant national guidance including guidance from the National Institute for Health and Care Excellence. Staff provided a range of care and treatment suitable for the patients in the service. Crisis services and the urgent care pathway had been through a transformation programme. This included the development of Mental Health Urgent Assessment Centres and the Initial Response Service in line with best practice. In addition, the transformation programme included the development. introduction or strengthening of roles such as psychology, occupational therapy, associate practitioners, counsellors and support time and recovery workers to ensure patients had access to a range of care and treatment.

Patients had access to psychologists and psycho-social interventions where appropriate. Staff within community-based teams had completed training in psycho-social interventions including solution focused therapy and cognitive behavioural therapy for suicidal ideation. The Home-based Treatment team in Preston had developed a skills group for patients with emotionally unstable personality disorder. Patients who were not under the Home-based Treatment teams could access a six-session psychology programme. Patients with the Initial Response Service could also access counselling.

Staff generally made sure patients had support for their physical health needs, either from their GP or community services. Although we found that not every record included a physical health assessment or physical health care plan there was evidence of liaison with GPs around required blood tests and monitoring. Staff had access to relevant equipment to complete monitoring where appropriate. Staff had been trained in the use of relevant equipment.

Mental health crisis services and health-based places of safety

Staff supported patients to live healthier lives by supporting them to take part in programmes or giving advice, for example around smoking cessation or healthy eating.

Staff used recognised rating scales to assess and record the severity of patient conditions and care and treatment outcomes. Services used the Health of the Nation Outcome Scale. The service was also in the process of introducing Dialogue Plus as part of its care planning approach. Dialogue Plus included a patient led progress rating scale.

Staff used technology to support patients. Staff had access to a nerve centre with live information around waiting times, risk levels and prompts around appointments and physical health checks. The service was in the process of implementing a new care planning process called Dialogue Plus. This focused on ensuring the patient voice was at the centre of the care planning process. To support this the service was rolling out tablets for patients to use.

Staff took part in clinical audits, benchmarking and quality improvement initiatives. Managers used results from audits to make improvements. Audits undertaken in the 12 months prior to our inspection included a Commissioning for quality and innovation Biopsychosocial assessment in Mental Health Liaison teams audit and a promoting engagement and access to mental health services audit in the Blackpool Home-based Treatment team. This was a re-audit from the previous year and showed a 12% increase in compliance from 83% to 95%.

Skilled staff to deliver care.

The mental health crisis teams included or had access to the full range of specialists required to meet the needs of patients under their care. Managers made sure that staff had the range of skills needed to provide high quality care. They supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.

The service had access to a full range of specialists to meet the needs of the patients. The staff and skill mix varied between different service types and teams. The trust had identified the required staff and skill mix through safer staffing reviews of each service. Home-based Treatment teams included medics, psychologists, nurses, occupational therapists, social workers and support time and recovery workers. Mental Health Liaison teams included medics, nurses, mental health practitioners and healthcare assistants. The Initial Response Service teams included medics, psychologists, mental health practitioners and call handlers. Street Triage services were staffed by mental health practitioners.

Managers ensured staff had the right skills, qualifications and experience to meet the needs of the patients in their care, including bank and agency staff. Managers gave each new member of staff a full induction to the service before they started work. There were induction programmes in place which ensured new staff were orientated to the service and service user population. New staff were able to shadow existing staff as part of their induction. Staff we spoke with, including agency and bank staff had received an induction.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Training needs were identified through training needs analysis, through learning from incidents and audits and from conversations in supervision. Staff we spoke with had completed additional training in areas including psychosocial interventions, mental state examinations and suicide prevention. Teams also invited other services and external agencies to deliver training and awareness sessions to staff. For example, a non-profit lived experience organisation had delivered sessions around trauma informed care to some services. Staff also provided training to other services and organisations. For example, medics at the Blackburn Mental Health Urgent Assessment Centre had delivered mental health awareness training to staff at a local acute hospital.

Managers supported staff through regular, constructive appraisals of their work. Managers supported staff through regular constructive supervision. Supervision compliance across the crisis core service was 95%. Staff we spoke with told us they felt supported and could access support and advice from clinical leaders and team managers when they needed to. In addition to one-to-one supervision sessions, services offered staff a range of group reflective practice sessions to discuss complex cases and best practice. Appraisal compliance across the crisis service was 74%

Managers made sure staff attended regular team meetings or gave information from those they could not attend. Team meetings were held regularly within each service although the frequency varied and could be impacted by demand. Team meetings had standard agenda items including risk, safeguarding and lessons learnt. Meetings were minuted and key messages were circulated via email.

Managers recognised poor performance, could identify the reasons and dealt with these. Managers could access support from the trust human resources department.

Multi-disciplinary and interagency teamwork

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

Staff held regular multidisciplinary meetings to discuss patients and improve their care. Teams had daily multi-disciplinary meetings to discuss and review patients, consider referrals and assessments and ensure the day's activity was covered. We attended four of those meetings across different services. Meetings had a clear agenda and promoted information sharing and risk escalation. Staff from different disciplines attended the meetings. Staff who couldn't attend in person were able to attend via video or phone. Staff made sure they shared clear information about patients and any changes in their care, including during transfer of care.

Ward teams had effective working relationships with other teams in the organisation. There was a clear structure throughout the urgent care pathway to promote integrated care and joined up working. There were a regular huddle meetings between services within the urgent care pathway and within the wider trust including the bed hub. Meetings were used to discuss patients, escalate risk and prioritise patients for referral, transfer and admission. Staff reported positive relationships with other teams.

Ward teams had effective working relationships with external teams and organisations. The transformation programme for the urgent care pathway and crisis services had been developed collaboratively with external stakeholders including local NHS bodies, third sector organisations and external services including local police forces and ambulance services. We saw evidence of effective working relationships with external organisations to deliver care. For example, Street Triage teams worked alongside local Police and hosted a liaison officer. We spoke with staff at the Blackburn Street Triage service and they reported good relationships and evidenced positive feedback from the Police service around their joint working.

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

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice.

Mental health crisis services and health-based places of safety

Staff received and kept up to date with training on the Mental Health Act and the Mental Health Act Code of Practice and could describe the Code of Practice guiding principles. Staff completed an Introduction to Mental Health Law training module as part of their mandatory training programme. Average team compliance with training across the urgent care pathway was 85%.

Staff had access to support and advice on implementing the Mental Health Act and its Code of Practice. Staff knew who their Mental Health Act administrators were and when to ask them for support. Staff were supported by a trust-wide Mental Health Law team and local Mental Health Act administrators. The service had clear, accessible, relevant and up-to-date policies and procedures that reflected all relevant legislation and the Mental Health Act Code of Practice. The trust had relevant policies in place. These were referenced in Standard Operating Procedures where relevant and were available to staff on the trust intranet.

Patients had easy access to information about independent mental health advocacy. Advocacy services were advertised within community bases. Staff we spoke with were aware of advocacy services and how to refer patients.

Staff completed regular audits to make sure they applied the Mental Health Act correctly. Compliance with the Mental Health Act was considered as part of case note reviews and Mental Health Act administrators supported regular reviews of Mental Health Act paperwork where appropriate. There was effective monitoring of patients in Health-based Places of Safety and a weekly review meeting to discuss patients and any breaches of 136 sections. Patients in 136 suites requiring admission were discussed in daily calls with the bed hub.

Good practice in applying the Mental Capacity Act

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

Staff received, and were consistently up to date, with training in the Mental Capacity Act and had a good understanding of at least the 5 principles. However, training in the Mental Capacity Act was not delivered in a standalone course. Instead training around the Mental Capacity Act was incorporated within Mental Health Law training and in both level two and level three safeguarding modules. Across the urgent care pathway average team compliance with Mental Health Law training was 85%. Average team compliance with safeguarding level two training was 86%. However, average compliance against safeguarding level three training was 71%.

There was a clear policy on the Mental Capacity Act, which staff could describe and knew how to access. Staff knew where to get accurate advice on Mental Capacity Act. There were policies on the Mental Capacity Act and the Deprivation of Liberty Standards available on the trust intranet and additional support available from the Trust Mental Health Law team.

Staff assessed and recorded capacity to consent each time a patient needed to make an important decision. However, we found that although capacity was recorded, where it was recorded on the record system was inconsistent. Not all teams were utilising the mental capacity tab on the records system and some were recoding capacity discussions in daily notes or care planning documents.

Mental health crisis services and health-based places of safety

Staff gave patients all possible support to make specific decisions for themselves before deciding a patient did not have the capacity to do so. When staff assessed patients as not having capacity, they made decisions in the best interest of patients and considered the patient's wishes, feelings, culture and history. We saw examples of mental capacity assessments and best interest meetings within care records we reviewed, including a patient who had refused medications but was deemed to have capacity to make that decision.

The service monitored how well it followed the Mental Capacity Act and made changes to practice when necessary. Staff audited how they applied the Mental Capacity Act and identified and acted when they needed to make changes to improve. Compliance with the requirements of the Mental Capacity Act were considered as part of case note audits and in reviews completed by the trust Mental Health Law team.

Is the service caring?

Good 

Our rating of caring improved. We rated it as good.

Kindness, privacy, dignity, respect, compassion and support

Staff treated patients with compassion and kindness. They respected patients' privacy and dignity. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.

Staff treated patients with compassion and kindness. We spoke with 11 patients during the inspection. Patients we spoke with were generally positive about staff. They described staff as friendly, considerate and helpful. They told us that staff treated them well and behaved kindly.

Staff and patient interactions we observed during the inspection were respectful and conducted in a caring manner. Staff were discreet, respectful, and responsive when caring for patients. We observed 7 contact calls within the Initial Response Service. Staff dealing with the calls were calm, reassuring and supportive.

Staff understood and respected the individual needs of each patient. Patients we spoke with told us that they felt staff were interested in them as an individual and considered their specific circumstances, goals and strengths. Staff we spoke with were able to discuss individual patients and displayed a good knowledge of their individual circumstances and risk.

Staff supported patients to understand and manage their own care treatment or condition. For example, patients told us they were aware of their diagnosis and their care and safety plans. Staff directed patients to other services and supported them to access those services if they needed help.

Staff felt that they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients and staff. Staff we spoke with told us they would be confident to challenge such behaviour and to raise it with

managers. Staff followed policies to keep patient information confidential. Electronic paper records were password protected. Paper records were stored securely in locked rooms or cupboards. Staff completed information governance, including confidentiality as part of their mandatory training programme. At the time of our inspection average team compliance with information governance training across the service was 93%.

Involvement in care

Staff in the mental health crisis teams involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided. They ensured that patients had easy access to advocates when needed.

Staff informed and involved families and carers appropriately.

Involvement of patients

Staff involved patients and gave them access to their care plans. We spoke to 11 patients during the inspection. Patients were generally aware of their care plan and safety plan. They reported being involved in developing them and identifying goals, strengths and support. However, we reviewed 64 care and treatment records and found it was not always clear whether patients had been offered a copy of their care plan or if the offer had been rejected and why.

The service was rolling out a new person-centred assessment and care planning tool called Dialog+. The tool used a collaborative approach with the patient to care planning and asked the patient to rate how they felt on a scale of 1 to 7 across 11 domains. These domains included 8 life domains covering areas such as physical health, accommodation, occupation and friendships and three treatment domains covering satisfaction with medication, the help the patient was receiving and the meetings they had with staff.

Staff made sure patients understood their care and treatment (and found ways to communicate with patients who had communication difficulties). Staff had access to interpreters if patients needed them. Staff and patients had access to additional specialist support from trust level teams and clinical leads for patients with autism or learning disabilities.

Patients could give feedback on the service and their treatment and staff supported them to do this. There was a friends and family survey that patients could access. Patients were given information on how do so and QR codes linking to the survey were included on leaflets and posters within services. Patient feedback was captured and analysed monthly in a specific report. In the month of June 2023, the Urgent Care Pathway received 72 friends and family test responses across services. 63 responses rated the service as very good, 5 responses rated the service as good, one response rated the service as neither good or poor and one respondent rated the service as poor. No respondents rated the service as very poor and 2 respondents stated they did not know.

Staff made sure patients could access advocacy services. Advocacy services were advertised within services. Staff we spoke with were aware of the advocacy services and how to refer patients to them.

Involvement of families and carers

Staff informed and involved families and carers appropriately.

Staff supported, informed and involved families or carers. Home-based Treatment teams were engaged with the Triangle of Care programme. The Triangle of Care is a model of carer inclusion and support that is promoted by the

Carers Trust. Service had completed self-assessments and achieved accreditation. Actions that had been taken as part of the Triangle of Care programme included carers workshops, the identification of carers champions in each team, the development of carers information packs, a dedicated carers page on the trust website and a review of carers paperwork. This was supported by a trust level service user and carer enabling strategy.

We spoke with 2 carers during the inspection. They were positive about staff and the service their loved one had received. They told us that staff were responsive but on occasion weren't able to respond to calls or queries immediately.

Staff helped families to give feedback on the service. Families and carers could access the trust friends and family survey. Carers were given information on how do so and QR codes linking to the survey were included on leaflets and posters within services.

Staff gave carers information on how to find the carer's assessment.

Is the service responsive?

Good

Our rating of responsive improved. We rated it as good.

Access and discharge

The mental health crisis service was available 24-hours a day and was easy to access – including through a dedicated crisis telephone line. The referral criteria for the mental health crisis teams did not exclude patients who would have benefitted from care. Staff assessed and treated people promptly. Staff followed up people who missed appointments.

The service provided a range of access routes to encourage engagement, both through self-referral and referral from other medical professionals. These included through the Initial Response Service and through multi-agency initiatives such as the Street Triage service. Crisis teams had skilled staff available to assess patients immediately 24 hours a day 7 days a week.

Each service within the urgent care pathway had clear criteria to describe which patients they would offer services to. These were outlined within the Standard Operating Policy for each service. Staff we spoke with knew and understood those criteria.

The crisis teams had skilled staff available to assess patients immediately 24 hours a day 7 days a week. The team responded quickly when patients called. Staff in the Immediate Response Service and home-based treatment teams saw urgent referrals quickly and generally saw non-urgent referrals within the trust target time. Staffing pressures in some teams meant that urgent referrals were prioritised. Urgent referrals within community services were reviewed within 4 hours and seen within 24 hours. Non-urgent referrals were seen within 5 days.

The service used systems to help them support patients. There was a dynamic patient risk register in community teams that rated patients as red, amber or green and helped prioritise contacts and engagement.

Mental health crisis services and health-based places of safety

Staff tried to engage with people who found it difficult, or were reluctant, to seek support from mental health services. Staff tried to contact people who did not attend appointments and offer support. There were policies and procedures in place to guide the management of patients who did not attend appointments. Teams attempted contact by telephone and through engagement with other stakeholders. Where the level of risk required staff carried out home visits and welfare checks.

Patients had some flexibility and choice in the appointment times available. Staff offered patients flexibility in the times and locations of appointments. Where patients needed an alternative, the teams were responsive and were able to offer this.

Staff worked hard to avoid cancelling appointments and when they had to, they gave patients clear explanations and offered new appointments as soon as possible. Staff we spoke with told us that appointments were not regularly cancelled. Staff within and across teams worked together to avoid this where possible. Teams held daily huddles to review planned appointments and ensure capacity. Appointments ran on time and staff informed patients when they did not.

Staff supported patients when they were referred, transferred between services, or needed physical health care. There was good cross service working within the urgent care pathway and the wider trust.

Facilities that promote comfort, dignity and privacy

The design, layout, and furnishings of treatment rooms supported patients' treatment, privacy and dignity.

The service generally had a full range of rooms and equipment to support treatment and care. Community-based teams had reception areas and access to interview rooms. Interview rooms had sound proofing to protect privacy and confidentiality.

In response to an NHS England directive during the COVID-19 pandemic the trust had established Mental Health Urgent Assessment Centres aligned with hospital Accident and Emergency departments. The Mental Health Urgent Assessment Centres provided an alternative space to assess and manage patients who presented at Accident and Emergency departments with mental health concerns. The Mental Health Urgent Assessment Centres were not designed to be an inpatient facility and had a 12-hour maximum stay.

The trust had previously operated Mental Health Decision Units that had been intended to service a similar purpose. These had been closed following a previous CQC inspection which identified serious concerns with the environments, promotion of privacy and dignity, staffing and length of stay. The Mental Health Decision Units were single rooms with reclining chairs for patients. There was no direct access to shower and toilet facilities. There was no dedicated staff for the units and minimal clinical input. Patients in the Mental Health Decision Units routinely breached the 23-hour timescale and there was insufficient governance and monitoring around this.

The Mental Health Urgent Decision Units provided a far better environment and had been designed for purpose. Due to the 12-hour limit the units did not offer beds and still utilised reclining chairs. However, individuals in the Mental Health Urgent Assessment Centres now had access to individual spaces rather single communal areas to better protect privacy and dignity. There was access to toilet facilities within the units and the provision of drinks and snacks. Meals were either provided by the adjoining hospital or brought in by staff. However, there were no shower facilities within the units.

Mental health crisis services and health-based places of safety

Data provided by the trust showed that there had been 34 breaches of the 12-hour limit between January 2023 and June 2023. This was a significant improvement from the previous Mental Health Decision Units where, for example, we identified 118 breaches of the 23-hour limit in November 2018 alone.

The majority of the 12-hours breaches within the Mental Health Urgent Assessment Centres did not extend beyond 24 hours. However, we found one instance where an individual had stayed for 9 days in the Preston Mental Health Urgent Assessment Centre. This was one of only two instances of extraordinary stays in MHUACs in the previous 12 months. The individual was informal, and they told us that it was their decision to remain on the unit. However, they had to sleep in a reclining chair and access showers from the acute hospital. Although there was private space to undress, dry and dress before returning to the unit the individual reported that this impacted upon their privacy and dignity. In addition, the Preston Mental Health Urgent Assessment Centre was the only Urgent Assessment Centre that was not located next to the hospital Accident and Emergency Unit. The Centre was located on the other side of the hospital site and a 15-minute walk away.

Meeting the needs of all people who use the service.

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

The service could support and make adjustments for disabled people and those with communication needs or other specific needs. Community teams were able to meet patients at locations that best met their needs, including at home addresses. The service had access to translation services and provided information leaflets in languages spoken by the service user and local communities. Managers made sure staff and patients could access interpreters and signers for face to face, phone or video engagements.

Staff made sure patients could access information on treatment, local service, their rights and how to complain. Information was available in poster, leaflet and electronic formats. The service provided information in a variety of accessible formats so the patients could understand more easily. Information was available in other formats upon request.

Listening to and learning from concerns and complaints

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

Patients, relatives and carers knew how to complain or raise concerns. The service displayed information about how to raise a complaint within each premise and on the trust website. Information on how to contact the trust's patient advice and liaison service was also displayed.

Staff understood the policy on complaints and knew how to handle them. Some staff we spoke with gave examples of when they had advised or supported patients who had wanted to raise a concern or complaint. Staff could access support from the trust complaints team.

In the 12 months prior to our inspection (June 2022 to July 2023) there were a total of 527 concerns or complaints raised in relation to the urgent care pathway. Of these, 271 were managed by the Patient Advice and Liaison service. In the

same period, there were 256 formal complaints made of which 22 were considered level 1 complaints, 215 were considered level 2 complaints and 16 were considered level 3 complaints. Of the 527 concerns and complaints raised, 257 were recorded as resolved, 38 had been upheld, 111 had been partially upheld and 85 had not been upheld. 13 complaints had been withdrawn and 9 were ongoing. 14 were recorded as an unknown outcome or as unresolved.

Staff protected patients who raised concerns or complaints from discrimination and harassment. Patients we spoke with had not had reason to raise a formal complaint but told us they would be confident to do so if they felt it necessary.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. Managers shared feedback from complaints with staff in daily huddles, team meetings, supervision and ad-hoc sessions. Learning was used to improve the service. The service used compliments to learn, celebrate success and improve the quality of care.

Is the service well-led?

Good 

Our rating of well-led improved. We rated it as good.

Leadership

Leaders had the skills, knowledge and experience to perform their roles. They had a good understanding of the services they managed and were visible in the service and approachable for patients and staff.

Leaders had the skills, knowledge and experience to perform their roles. Managers we spoke with were confident in their role. Managers had been supported to undertake leadership and management courses and to develop their skills.

Managers we spoke with demonstrated a good understanding of their service and patient base. They were able to describe how services worked together to deliver care and understood the challenges and risks the service faced. Managers were involved in ongoing transformation work.

Managers were visible within the service and approachable for patients and staff. Staff we spoke with told us that managers operated open door policies and were available to speak to. Staff knew who senior managers within the pathway and locality were. Senior managers regularly visited services and team managers reported they felt supported.

Vision and strategy

Staff knew and understood the provider's vision and values and how they (were) applied to the work of their team.

Staff were aware of the Trust's values and displayed these in their work. These values were also displayed on posters and leaflets within services. Vision, values and objectives were discussed as part of supervision and appraisal.

Mental health crisis services and health-based places of safety

Crisis services had been through a transformation programme. Staff we spoke with knew about and were able to discuss the transformation work, changes that had been made and ongoing work. They understood the objectives and aims of the transformation programme.

Culture

Staff felt respected, supported and valued. They said the trust promoted equality and diversity in daily work and provided opportunities for development and career progression. They could raise any concerns without fear.

Staff and managers we spoke with told us that culture and morale was good and improving. Staff we spoke with generally felt respected, supported and valued. Staff were positive about their colleagues and felt they worked collaboratively to manage demand and workload. Staff discussed the impact of staffing pressures but acknowledged planned recruitment and the work that was being done to fill vacancies. Results from staff surveys echoed this feedback with questions around morale generally scoring positively but questions around capacity, work pressure and staffing scoring lower.

Staff told us that they were well supported by local team managers and by senior management within localities. Staff told us that managers were approachable and visible within the service. Staff were generally positive about the urgent care pathway transformation programme and the improvements that had been made.

Staff we spoke with told us they felt able to raise concerns without fear. Staff knew how to escalate concerns and how to use the whistle blowing process. They understood the role of the Freedom to Speak Up Guardian and described an open and honest culture.

Equality and diversity was embedded into daily practice. Standard Operating Procedure documents for each service and supporting policies had been impact assessed. Staff completed equality and diversity training as part of their mandatory training programme. Average team compliance with equality and diversity training was 97%. Staff considered factors around equality, diversity and protected characteristics as part of the assessment and care planning processes.

Governance

Our findings from the other key questions demonstrated that governance processes operated effectively at team level and that performance and risk were managed well.

Our findings from the other key questions demonstrated that governance processes generally operated effectively. There were processes to identify, understand, monitor and address current and future risks. Leadership at service and locality level demonstrated a good understanding of the issues and challenges faced by the service. Teams had action plans in place to address concerns that had been identified through assurance processes such as audit. For example, the Lester tool had been introduced and physical health training was being rolled out to improve the quality of physical health care. Improved monitoring of adverse incidents awaiting admission to an inpatient unit had been introduced.

Managers and staff that we spoke with discussed improvements that had been delivered by the urgent care pathway transformation programme, for example the development of the Initial Response Service. They were able to identify ongoing work within the transformation programme. We spoke with staff and managers who were part of task and finish and working groups. The transformation programme itself had clear governance and structure as well as appropriate trust oversight.

Mental health crisis services and health-based places of safety

Staff had access to a suite of policies, procedures and operational guidance to support them in the delivery of care. Staff could access further support from trust level teams and specialists where required.

Management of risk, issues and performance

Teams had access to the information they needed to provide safe and effective care and used that information to good effect.

Managers and staff had access to performance reports which supported them in their awareness of risks and in understanding areas requiring improvement.

Managers and staff had access to a live performance dashboard through the Nerve Centre system. This provided information on a range of performance indicators including number of referrals, waiting times, contacts with no outcome recorded, completion of Dialogue Plus and the community dynamic risk register. Data could be viewed at locality, team, individual staff member or individual patient levels.

In addition, there was an Urgent Care pathway dashboard at locality level. This formed part of a performance pack presented to trust executives each month. The dashboard captured the performance of each service against key national standards. This included compliance with the Mental Health Act and any breaches of detention timescales within Health-based Places of Safety, performance against 1, 4 and 12-hour assessment targets within the Mental Health Liaison teams, performance against the maximum 12-hour stay target in Mental Health Urgent Assessment Centres and three and seven day follow ups. The report also provided an overview of staffing across teams and the performance of the Initial Response Service against urgent and routine referral response targets.

The trust also operated a Governance and Performance Portal which was an online database of workforce information. It included reports on planned establishment levels, current vacancies, bank and agency use, turnover and sickness rates. The portal also provided managers with current information on training, supervision and appraisal compliance.

There was a clear structure and framework of meetings where performance and risk were discussed. These included meetings at locality and pathway levels as well as multi-agency meetings with external partners such as the Police and ambulance services. There were clear pathways and processes to escalate risk.

The service had a risk register in place. Risk was captured at pathway, locality and individual team levels. Risks had been identified through assurance processes such as serious incident investigations, performance monitoring and the findings of external reviews. The risk register reflected the risks and pressures identified by staff we spoke with and that we identified during the inspection. Identified risks had identified actions to mitigate, reduce or remove the risk.

The service had business continuity plans in place to support managers and staff to plan for emergencies.

Information management

Staff collected analysed data about outcomes and performance and engaged actively in local and national quality improvement activities.

Staff discussed performance and performance data in team meetings and supervision sessions. There were a range of governance meetings covering service types. localities and the urgent care pathway where data on performance and outcomes was reviewed and analysed and best practice shared. A monthly performance pack was presented to Trust executives.

Services had Commissioning for quality and innovation targets in place that were agreed with commissioners.

Engagement

Managers engaged actively with other local health and social care providers to ensure that an integrated health and care system was commissioned and provided to meet the needs of the local population. Managers from the service participated actively in the work of the local transforming care partnership.

The trust was delivering a transformation programme across the urgent care pathway. This had been designed and was being delivered in collaboration with commissioners, local healthcare providers, third sector organisations and other external agencies. The transformation programme had seen the redesign of services and the development of the Initial Response Service.

Feedback from external stakeholders was generally positive. The integrated care board reported good relationships with the trust and noted an honest and transparent culture. Crisis services worked with external bodies such as the Police and ambulance services to deliver care.

There were effective, multi-agency arrangements to agree and monitor the performance and governance of services. However, we also spoke to social workers from local authorities who felt they did not always get timely responses.

Learning, continuous improvement and innovation

The service was committed to learning, continuous improvement and innovation. There was evidence of learning identified through governance processes such as audit and incident reviews. For example, a monthly dual diagnosis meeting had been established within localities with local substance misuse services in response to identified themes within serious incidents. Staff we spoke with told us that managers were open to ideas for improvement.

The service had a clear plan in place to improve crisis pathways through its transformation programme. There were ongoing task and finish and working groups to further embed change and learning. We reviewed the improvement plan for Home-based Treatment teams as part of the inspection. The plan was detailed and included a brief, desired outcomes, a benefits analysis, risk register and lessons learnt log. As part of this the Home-based Treatment teams were going through the process of securing accreditation from the Royal College of Psychiatrists Hone Treatment Accreditation Scheme. There was a working group overseeing this process and services had completed self-assessments.

The service was involved in research projects. Mental Health Liaison teams were involved in a project related to function replacement in repeated self-harm and the standardising of assessment and related therapy. Home-based Treatment teams were involved in research around the clinical and cost effectiveness of online integrated bipolar parenting interventions and also the use of cognitive behavioural therapy with young adults at high risk of developing bipolar disorder.

Community-based mental health services of adults of working age

Requires Improvement ➔➔

Is the service safe?

Requires Improvement ➔➔

Our rating of safe stayed the same. We rated it as requires improvement.

Safe and clean environment

Not all clinical premises where patients received care were safe. Health and safety inspection checklists and ligature risk assessments were not in place at all locations. However, premises were clean, well equipped, well furnished and well maintained.

Staff did not always complete and regularly update thorough risk assessments of all areas and remove or reduce any risks they identified.

The trust procedure for each community location was to have the following documents completed:

- Health and safety inspection checklist
- Efficacy checklist
- Fire risk assessment
- Ligature risk assessment

We found that the health and safety inspection checklist, efficacy checklist and fire risk assessments documents were completed for the Chorley, Preston and Blackburn locations. However, these were not completed for the Barrow and Kendal location. Ligature risk assessments were not completed for any of the locations. However, fire risk assessments were supplied for the Barrow and Kendal location during the factual accuracy process.

All interview rooms had alarms or access to portable alarms and staff available to respond. The interviews rooms had either an integrated alarm system or personal alarms for staff to use. However, we noted that at the Preston and Blackburn locations these were routinely not being used by staff. Staff were issued with individual alarms which they only utilised when seeing higher risk patients. The Barrow site had alarms on the wall. However, the position of the alarms meant they were difficult to reach and activate.

All clinic rooms had the necessary equipment for patients to have thorough physical examinations. All clinic rooms were clean and tidy. Equipment had been checked and calibrated. The clinic room temperature had not been monitored in Blackburn. No action had been taken when the temperature had been noted to be 27.7 degrees.

All areas were clean, well maintained, well-furnished and fit for purpose. The premises were observed to be clean. We saw domestic staff cleaning areas during our visit. Furniture appeared in a good state of repair.

Staff made sure cleaning records were up-to-date and the premises were clean.

Staff followed infection control guidelines, including handwashing. There were handwashing facilities and alcohol hand gel as needed.

Staff made sure equipment was well maintained, clean and in working order. All equipment had been checked and calibrated. There were stickers advising of the next checking date.

Safe staffing

The service did not have enough staff, who knew the patients and received basic training to keep them safe from avoidable harm. The number of patients on the caseloads of individual members of staff, was not too high to prevent staff from giving each patient the time they needed. However, team caseloads were high in some teams.

Nursing staff

Some teams did not have enough nursing and support staff to keep patients safe. The Preston team had a high number of vacancies, sickness and turnover. This meant there were not enough suitably skilled staff to meet the needs of the service. Trust figures for vacancies for registered nurses per team were:

Pendle 50 %

South Lakes 45 %

Preston West 42 %

Rossendale and Hyndburn 36 %

Furness 30 %

Lancaster and Morecambe 26 %

Burnley 29 %

Flyde and Wyre 24 %

Blackpool 23 %

Preston East 22 %

Darwen 15 %

South Ribble 8%

Chorley 5 %

Blackburn 2 %

West Lancs (-10% over recruited)

Community-based mental health services of adults of working age

There were minimal vacancies throughout the teams for support workers with some over-recruitment. Teams with higher vacancy rates for support workers were Barrow 33% and Lancaster and Morecambe 29%.

There were also minimal vacancies for multidisciplinary (MDT) staff such as psychologists and occupational therapists throughout most of the teams. This was with the exception of Fylde and Wyre 30%, Blackpool 29% and Lancaster and Morecambe 29%vacancies for MDT staff.

Staffing issues had been on the risk register since April 2021. There were initiatives to increase recruitment and retention rates in the Bay area by offering a welcome bonus to new staff.

The service had reducing vacancy rates. Although registered nurse vacancy rates were high in some teams such as Preston West, recruitment was ongoing. The vacancy rate was sometimes perpetuated by increased investment. Newer posts had been created which were yet to be recruited into. Managers felt that recruitment and retention rates were better for teams that were further along into the transformation process such as Blackburn.

The service were utilising bank and agency nurses in some teams. The following figures show bank and agency usage per team over the last 12 months:

- Furness 13 shifts covered by bank staff. No agency usage.
- Preston West 165 shifts covered by bank staff. 101 shifts covered by agency staff
- Preston East 187 shifts covered by bank staff. 606 shifts covered by agency staff
- Chorley 25 shifts covered by bank staff. 532 shifts covered by agency staff
- Blackburn 29 shifts covered by bank staff. No shifts covered by agency staff
- Darwen 45 shifts covered by bank staff. 28 shifts covered by agency staff

No data was supplied for the Kendal team.

The service did not use any bank or agency support workers.

The number of shifts not filled by bank or agency cover per team were:

- Barrow 6
- Preston East 722
- Preston west 303
- Chorley 103
- Blackburn 2
- Darwen 48

The trust did not supply any data for the Kendal team.

Managers made arrangements to cover staff sickness and absence. Some staff absence was covered by bank and agency cover.

Managers limited their use of bank and agency staff and requested staff familiar with the service.

Managers made sure all bank and agency staff had a full induction and understood the service before starting their shift. There were induction policies and procedures in place for both permanent and temporary staff. Staff told us they had been inducted into the service.

The service had varied turnover rates. The Barrow and Preston teams had experienced high turnover rates. The Chorley team had only one staff leaver in the last 12 months.

Managers supported staff who needed time off for ill health.

Sickness levels were reducing in most teams visited. Sickness levels were reducing in Furness, Preston West, Chorley and Blackburn over the last 12 months. Sickness levels had rose in South lakes, Preston East and Darwen. Current sickness levels per team in May 2023 were:

- Furness 3%
- South Lakes 7%
- Preston East 6%
- Preston West 2%
- Chorley 4%
- Blackburn 0%
- Darwen 11%

Managers used a recognised tool to calculate safe staffing levels. Staffing levels had recently been considered as part of the trust's transformation programme. New staff roles had been developed to deliver a psychological programme and care-coordinator roles had been expanded.

The number and grade of staff matched the provider's staffing plan. In teams with a full staff establishment and low sickness such as Chorley and Blackburn, staffing matched the needs of the service. This was reflected in the lack of an unallocated waiting list in both Chorley and Blackburn.

Medical staff

The service had enough medical staff. The service employed enough psychiatrists to meet the needs of the service.

Managers could use locums when they needed additional support or to cover staff sickness or absence.

Managers made sure all locum staff had a full induction and understood the service. There was an induction policy for temporary staff to follow.

The service could get support from a psychiatrist quickly when they needed to. We looked at averages waits for routine appointments to see a consultant psychiatrists which were:

- Furness four weeks
- South Lakes four weeks

- Preston East eight weeks
- Preston West two weeks
- Chorley four weeks
- Blackburn three weeks
- Darwen three weeks

We also looked at average waits for patients for urgent appointments with a psychiatrist which were:

- Furness one week
- South Lakes one week
- Preston East one week
- Preston West three days
- Chorley two days
- Blackburn two days
- Darwen two days

Staff and patients we spoke with confirmed that access to outpatient appointments for medication reviews was good.

Mandatory training

Staff had mostly completed and kept up-to-date with their mandatory training. Overall compliance rates for mandatory training for each team visited was between 87 and 96%. Modules that fell below the trusts target of 95% were:

Furness

Information governance 84%

Basic life support 76%

Safeguarding level three 68%

Physical health in mental health 79%

South Lakes

Safeguarding level two 71%

Physical health in mental health 78%

Preston East

Safeguarding level three 64%

Manual handling 69%

Prevent 71%

Medication management 70%

Administration of medicines 60%

Controlled drugs 0%

Learning disability 79%

Clinical risk assessment 0%

Physical health in mental health 58%

Preston West

Information governance 94%

Blackburn all compliant

Darwen

Fire safety 78%

Information governance 89%

Medicines management 75%

Administration of medicines 75%

Chorley

Information governance 87%

Safeguarding level three 79%

WRAP 85%

Physical in mental health 77%

The mandatory training programme was comprehensive and met the needs of patients and staff.

Managers monitored mandatory training and alerted staff when they needed to update their training. There was an electronic system in place that allowed team managers to have oversight of their staff teams training record which flagged any outstanding modules staff needed to complete. Managers were then able to prompt staff to complete the outstanding modules. Managers explained this was often a time consuming process.

Assessing and managing risk to patients and staff

Staff assessed and managed risks to patients and themselves well. They responded promptly to sudden deterioration in a patient's health. When necessary, staff worked with patients and their families and carers to develop crisis plans. Staff mostly monitored patients on waiting lists to detect and respond to increases in level of risk. Staff followed good personal safety protocols.

Assessment of patient risk

Staff completed risk assessments for each patient on admission, using a structured risk assessment process in line with best practice, and reviewed this regularly, including after any incident.

All patients had risk assessments that were comprehensive within the care records that we reviewed.

At the last inspection in June 2019, we found that the quality of risk management plans was poor. Risk management plans did not include detailed information relating to the management of patients risks. Risk management plans did not match information highlighted within risk assessments and other documents.

At this inspection we found all patients had a risk assessment and a risk management plan. However, the risk management plans within the risk assessment document continued to be too brief. However, we found risk management information within other documents such as the safety plan. In instances where safety plans had been completed, they were of a good standard.

The trust said that this was due to moving to a new system called dialogue plus which aims to better capture patients voice.

We reviewed 32 care records. Risk Management plans were present in all cases but very brief. We noted one patient on a Community Treatment Order recall had a brief risk management plan and no safety plan in the Preston team. This patients' risks were increasing as they had been waiting for an inpatient bed for nine days. Staff were attempting to escalate their concerns for the patient to the bed management hub.

Staff did not use a recognised risk assessment tool. Staff used standard and enhanced risk assessments. These risk assessments had been developed by the trust.

Staff could recognise when to develop and use crisis plans and advanced decisions according to patient need. In most instances, staff with patient input, had developed safety plans that were detailed and personalised.

Management of patient risk

Staff were not able to respond promptly to any sudden deterioration in a patient's health. For patients experiencing mental health decline who required inpatient admissions there were lengthy delays due to a lack of inpatient beds.

On 5 July 2023 data provided to us during the onsite inspection demonstrated that there were approximately 50 patients trustwide waiting for admission to hospital but there were no beds available for them. These patients were a mixture of informal admissions and patients deemed to be detainable under the Mental Health Act.

Community-based mental health services of adults of working age

During the onsite inspection, we noted six particular examples of patients waiting excessive lengths of time for inpatient beds. Some patients had been recommended for detention under the Mental Health Act, some were being recalled from Community Treatment Orders and others had agreed to informal admissions. These patients had been waiting between five and 43 days for their inpatient beds.

On 5 July 2023 in the Chorley location, there were two patients waiting for inpatient beds. One patient was deemed to be detainable under Section 2 of the Mental Health Act and was waiting for a bed in the Section 136 suite and had been waiting for two days. Another patient in Chorley was waiting for an informal admission and had been waiting for over a week for a bed. This patient remained in the community.

On 6 July 2023 in the Blackburn location there were three patients waiting for a bed. One patient was being recalled from their Community Treatment Order and had been waiting five days and remained in the community. Another patient had also been waiting for approximately five days for a bed. The third patient had been waiting 43 days.

On 13 July 2023 there were 40 patients waiting for a bed across the trust. One patient had been waiting 29 days for a bed. This patient remained in the community.

We found that the excessive delays in accessing inpatient beds was having a serious and untoward impact on patients. Between July 2022 and May 2023, we noted specific examples of harm that patients had suffered whilst waiting for an inpatient bed. This included, patients taking overdoses of medication, committing criminal damage and threatening behaviour, assaulting their families, ingesting objects, and dying as a result of walking into motorway traffic. Some of these patients had been assessed and deemed detainable under the Mental Health Act on up to four occasions.

To mitigate this risk patients (where safe to do so,) were provided with daily visits from a combination of community mental health team staff and staff from crisis and home treatment teams.

This meant that patients who had been assessed as requiring 24 hour hospital care were not provided with this and their risks were unable to be managed safely in the community.

We spoke to three patients and three carers specifically in relation to their experience of their admission to a mental health hospital being delayed.

Patients and carers said that they waited approximately two weeks before beds were found for them or their loved ones. Some patients had been assessed under the Mental Health Act and a section two was deemed appropriate for them. Other patients retained capacity and had been able to agree to informal admissions. Some patients remained at home in the community and others patients remained on medical assessment units.

Patients and carers were able to describe risks become increasingly worse whilst they waited. This included, presenting with unpredictable behaviour, neglecting their self-care and using threatening behaviour involving weapons.

All patients and carers felt that their mental health had to get to crisis point before a bed could be located. Patients and carers also felt that admissions to mental health inpatient wards were longer than usually required as the relapse had been left untreated for so long and required longer to recover.

Community-based mental health services of adults of working age

Contact from mental health teams varied. Three patients received daily visits from a combination of community mental health team staff and crisis and home treatment team staff. One patient said they received visits every other day and telephone calls inbetween which they did not find beneficial. One patient said they received two daily telephone calls from community mental health team staff and received face to face visits at weekends only.

Only one patient said they had a copy of their care plan and crisis/safety plan. Two patients/carers said that they had care plans and crisis/safety plans, but they were out of date and not helpful. One carers said they did not have any documents but were given appropriate contact numbers. Two patient/carers said they were not given any documents or contact numbers.

Carers expressed their distress and sense of hopelessness regarding the situation and needing to take sick leave from work which impacted on their well-being.

Staff and patients confirmed that when patients experienced mild to moderate relapse signatures, there were options available to prevent further decline and avoid crisis. For example, medication reviews with consultant psychiatrists were prompt to access. Staff could refer patients to crisis and home treatment teams.

Staff did not continually monitor patients on waiting lists for changes in their level of risk and responded when risk increased. We reviewed three patient care records who were on the unallocated waiting list in Preston. All patients had risk assessments. Two patients did not have safety plans. Risk management plans were very brief. Two of these patients had not received their regular contact to check on their welfare and review any risks.

However, data provided by the trust demonstrated that there were significant gaps in monitoring and responding to patients on the waiting list. The trust informed us following the inspection, that they were working on ensuring all care plans were completed for patients on the unallocated waiting list and that extra weekly audits of the Preston unallocated waiting list would be put in place.

Staff followed clear personal safety protocols, including for lone working. There were boards for staff to sign in and out of. Staff were provided with mobile telephones. There was a lone worker policy for staff to follow.

Safeguarding

The service did not work well with other agencies to protect patients and share lessons learnt. Staff understood how to protect patients from abuse. Staff had training on how to recognise and report abuse and they knew how to apply it.

Staff received training on how to recognise and report abuse, appropriate for their role. Staff mostly kept up-to-date with their safeguarding training. Safeguarding training was mandatory for all staff. Teams that fell below the trust target were:

Furness

Safeguarding level three 68%

South Lakes

Safeguarding level two 71%

Community-based mental health services of adults of working age

Preston East

Safeguarding level three 64%

Chorley

Safeguarding level three 79%

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

Staff knew how to recognise adults and children at risk of or suffering harm. Staff we spoke to were able to give examples of safeguarding concerns they had raised. Staff explained the process to follow which they knew well.

We spoke to safeguarding staff employed by Lancashire County Council, Blackpool Borough Council and Blackburn with Darwen council. These local authority staff expressed their concern regarding the difficulties they had in receiving safeguarding outcomes from the trust in instances of serious harm. Local authority staff gave examples of waiting for approximately 12 months in some cases. Staff felt that these outcomes were only shared after local authority staff were persistent in pursuing this information.

The Trust took some corrective action following the inspection to improve their internal processes including establishing an interface meeting with the local authority to begin to address the issues.

Local authority staff stated that relationships with the trust in respect of lower level safeguarding concerns were much better. Local authority staff said that they had good liaison links with safeguarding leads and ward managers who shared information well in instances involving less serious cases.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff were able to describe examples of safeguarding incidents and both internal and external processes they would follow.

Managers took part in serious case reviews and made changes based on the outcomes. Serious case reviews were completed in respect of safeguarding concerns. Reviews contained information recommending that changes were implemented to safeguard individuals and prevent future occurrences.

Staff access to essential information

Staff working for the mental health teams kept detailed records of patients' care and treatment. Records were clear, up-to-date and easily available to all staff providing care.

Patient notes were comprehensive, and most staff could access them. There was an electronic care record system in place.

At the last inspection in June 2019, we noted that the electronic care record system often froze which caused delays in staff accessing or inputting information.

At this inspection, we found that this problem persisted in some teams who struggled with accessing the care record system due to poor Wi-Fi signals. The team based in Barrow had very slow access to the electronic system. Other teams reported the system mostly worked well.

We noted that the electronic care record system was not always utilised consistently. Teams had adopted different ways to store information within the system. However, staff we spoke to knew where to find the information required.

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

Records were stored securely. The electronic patient care record system had the appropriate password protection protocols in place.

Medicines management

The service had systems and processes to prescribe and administer medicines safely. There was evidence of review and learning from incidents, shared across the wider system. There was a focus on collaborative working with GP's and acute trusts to promote the safe care of patients prescribed mental health medicines. Protocols for the handling of trust held individually prescribed medicines were not in place, resulting in inconsistent practice across community teams. The trust was taking prompt action to address this.

Staff followed systems and processes to prescribe and administer medicines safely. Medicines prescription and administration cards were stored securely and clearly completed. Summary care record was used to confirm people's current medicines and clinic letters were sent electronically to GP's. Where patients had a CTO that referenced medicines, these were kept with the medicine's cards.

Procedures were in place to support clozapine community titration, although capacity to deliver this was limited in the Bay network area. The trust had been selected to work with AQuA (Advancing Quality Alliance) focusing on optimising clozapine use in treatment resistant schizophrenia to support patient's treatment and recovery.

A data base had been set up to provide additional oversight of patients prescribed Valproate, to promote completion of the annual risk assessment for safer prescribing.

Staff reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines. The trust offered patient's access to information about mental health conditions and medicines on a national website. Paper materials were also shared in clinic. We saw posters with the QR code to enable easy access to the website. The trust was rolling out point of care testing at clozapine clinics (~85% complete). Patient's physical health was also monitored at each appointment.

The trust pharmacy team was working collaboratively with GPs to support uptake of 'shared care', which was not well adopted in some areas. Shared Care enables patients to access their medicines closer to home and helps to ensure relevant ongoing monitoring takes place.

Staff stored and managed all medicines and prescribing documents safely. The trust did not have a procedure for managing trust held supplies of named patient injections that were no longer required. However, the trust took prompt action to review current processes and to gather evidence to support drafting a trust policy for re-purposing of long-acting antipsychotic medication in community mental health services.

Community-based mental health services of adults of working age

Community mental health teams showed good compliance with the trusts 'safe and secure handling of medicines audits' (>90% Q1 2023/24). Should any shortfalls arise, action plans were in place, overseen by the pharmacy team.

Staff learned from safety alerts and incidents to improve practice. The trust had recently led on discussions exploring the safe use of clozapine across both acute and mental health trusts to promote wider sharing and learning from incidents. Additionally, following a review of incidents a Lithium register had been implemented to monitor compliance with testing and physical health monitoring according to NICE guidelines (CG185). There was a focus on ensuring patients and carers were given information about taking lithium, including signs of toxicity.

Staff reviewed the effects of each patient's medicines on their physical health according to NICE guidance. However, capacity to complete physical health monitoring for patients prescribed antipsychotics was on the trust risk register (Risk 12, June 2023). This was in part due to vacancies, adverts for recruitment had been placed. The trust was also focusing on increasing community mental health compliance with physical health training, monitored through staff supervision.

Track record on safety

The service had a good track record on safety.

Reporting incidents and learning from when things go wrong

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

Staff knew what incidents to report and how to report them. The service had an electronic incident reporting system. Staff were aware of the system and how to use it. Staff were able to describe incidents that they would report, and the processes taken.

Staff raised concerns and reported incidents and near misses in line with trust policy. We saw evidence of incidents being reported appropriately. There was a policy for staff to follow.

Staff reported serious incidents clearly and in line with trust policy. There were 27 serious incidents reported via the strategic executive information system in the last 12 months. There were approximately between one and four per team. Team managers stated these were mostly deaths of patients and these continued to be under investigation. Any immediate learning was fedback to the teams via team meetings, supervision and email bulletins.

The service had no never events.

Staff understood the duty of candour. They were open and transparent, and gave patients and families a full explanation if and when things went wrong. Managers and staff were aware of the principles of the duty of candour and when this may apply. Staff were able to give examples of situations when the duty of candour was considered and enacted.

Managers debriefed and supported staff after any serious incident.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations. Managers completed several reviews of incidents, depending on the severity. The process included contacting families and carers to apologise for any gaps in service provision that may have contributed to the incident as per the duty of candour policy.

Community-based mental health services of adults of working age

Staff received feedback from investigation of incidents, both internal and external to the service. Incident reports and investigations contained detailed learning and actions for staff to implement.

Staff met to discuss the feedback and look at improvements to patient care. Staff we spoke with confirmed that information was shared with them during team meetings and on trust bulletins that were emailed to them.

There was evidence that changes had been made as a result of feedback. Staff and managers were able to describe examples of actions taken following feedback from investigations. This included changes made following a patient suffering lithium toxicity and changes following patient deaths.

Is the service effective?

Requires Improvement 

Our rating of effective stayed the same. We rated it as requires improvement.

Assessment of needs and planning of care

Staff assessed the mental health needs of all patients. However, they did not always work with patients and families and carers to develop individual care plans and updated them as needed. Care plans did not clearly reflect the assessed needs, or were personalised, holistic and recovery-oriented.

Staff completed a comprehensive mental health assessment of each patient. All patients had assessments in place which described their needs.

Staff did not always make sure that patients had a full physical health assessment and know about all physical health problems. We reviewed 32 care records and considered whether patients physical health needs had been considered as part of the assessment process and whether clear ongoing physical health issues were identified and documented in care plans. We found that 22 patients had their physical health needs identified and care planned. However, for 10 patients the quality of this information was poor. We noted that some patients with complex physical health needs did not have physical health care plans.

Staff did not always develop a comprehensive care plan for each patient that met their mental and physical health needs. Staff did not always regularly review and updated care plans when patients' needs changed. Care plans were not personalised, holistic or recovery-orientated. Care plans were of a mixed quality. We reviewed 32 care plans. Of these care plans:

- Eight were not up to date
- 11 were not personalised
- 22 were not holistic
- 21 were not recovery orientated
- 11 patients had not been offered a copy of their care plan.

Missing information from care plans included pertinent information such as physical health needs and being at risk of sexual violence.

Community-based mental health services of adults of working age

Best practice in treatment and care

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

Staff provided a range of care and treatment suitable for the patients in the service. Patients had access to consultant psychiatrists to review medications and consider diagnoses. Patients could access this promptly. Waiting between one and seven days for urgent appointments and between three days and eight weeks for routine appointments. Patients had access to psychologists to meet any therapy needs they may have. We reviewed internal figures for patients waiting for psychological input per team. This was between two and 37 patients. Staff within the teams coordinated care to meet individual circumstances. Teams had recently introduced a new structured clinical treatment for patients with trauma related issues. This was delivered by care coordinators who had received specialist training. This was more embedded in teams who had this role better established. Teams also had access to occupational therapists. Social workers were employed as care coordinators within the teams. For external social work input, staff could refer to social workers within the local authority for care assessments and funding applications. In the Blackburn and Darwen teams, social workers had remained integrated within the teams.

Staff delivered care in line with best practice and national guidance (from relevant bodies such as NICE). Staff confirmed they received updates on changes to NICE guidance via an email bulletin and during team meetings.

Staff did not always make sure patients had support for their physical health needs, either from their GP or community services. We found that ten out of 32 patients we reviewed did not have clear physical health care plans. This made it difficult for staff to highlight any issues with GP's or specialist services.

Staff supported patients to live healthier lives by supporting them to take part in programmes or giving advice. Teams employed support workers to oversee the role of physical health monitoring and completing the Lester tool. These staff were able to advise patients about healthier living and refer to third sector organisations for support where necessary. This included smoking cessation and community projects such as walking groups.

Staff used recognised rating scales to assess and record the severity of patient conditions and care and treatment outcomes. There were two patient progress rating scales currently in use. Health of the Nation Outcome Score was being used. The new electronic care planning system, (Dialogue Plus), also included a patient progress rating scale.

Staff used technology to support patients. The service were in the process of moving to a new electronic patient care record system. The new system was focused on ensuring the patient voice was at the centre of the care planning process. To enable this, electronic tablets were available for staff to utilise with patients. Patients views could be typed directly into the care plan templates and other documents.

Staff took part in clinical audits, benchmarking and quality improvement initiatives. Nurses completed medication audits. Team leaders completed monthly community safety audits which included checking the quality of patient care records. Other audits were completed as a response to serious incidents as required.

Managers used results from audits to make improvements. Results from community safety audits were shared with staff during team meetings and during individual supervision sessions to consider ways to improve quality.

Community-based mental health services of adults of working age

Skilled staff to deliver care

The teams included or had access to the full range of specialists required to meet the needs of patients under their care. Managers made sure that staff had the range of skills needed to provide high quality care. Managers provided an induction programme for new staff. However, they did not always support staff with appraisals, supervision and opportunities to update and further develop their skills.

The service had (access to) a full range of specialists to meet the needs of each patient. Teams consisted of care coordinators (mostly mental health nurses but some employed with social work backgrounds), support workers, psychologists, consultant psychiatrists, occupational therapists and admin workers. Teams also had access to health and wellbeing workers who were employed by the local authority who worked directly into the teams. The Blackburn and Darwen teams had local authority social workers integrated into the teams. The teams had trained some care coordinators to deliver structured clinical management. Structured clinical management was aimed at supporting patients with trauma related issues to manage their symptoms better. Structured clinical management was in high demand in some teams. This was due to it being newly rolled out and sickness in some teams. Managers were hopeful that once established, the demand would be steadier.

Managers made sure staff had the right skills, qualifications and experience to meet the needs of the patients in their care, including bank and agency staff. Teams employed staff with suitable specialisms to meet the demand of the service. Some teams had delays to access psychological therapy. For example, in Chorley the wait for one to one psychology was 41 weeks. This was due to vacancies within the team. However, a new psychologist had been employed and was due to start work in two months' time. In Lytham St Annes the wait for psychological therapies was 171 weeks.

Problems recruiting psychologists in the Blackpool and Fylde and Wyre areas had been on the risk register since October 2020.

Managers gave each new member of staff a full induction to the service before they started work.

Managers supported staff through regular, constructive appraisals of their work. Most teams were providing regular appraisals to staff. The average appraisal rate was 88% across the teams. Teams with low appraisal rates were:

- South Ribble 71%
- Pendle 67%
- Blackpool 50% (staff were booked to complete their appraisals in July 2023)

Managers supported permanent medical staff to develop through yearly, constructive appraisals of their work.

Most managers supported non-medical staff through regular, constructive clinical supervision of their work. The average supervision rate for June 2023 was 69%. Teams with low supervision rates were:

- Furness 72%
- South Lakes 60%
- Lancaster and Morecambe 60%
- Preston East 43%
- Darwen 67%

- Burnley 50%
- Pendle 17%
- Rossendale and Hyndburn 64%
- Blackpool 62%

However, staff we spoke to felt they received enough supervision and that they felt supported.

Managers supported medical staff through regular, constructive clinical supervision of their work.

Managers made sure staff attended regular team meetings and gave information to those who could not attend. There was evidence of monthly staff business meetings taking place in each team. Risk issues were discussed, and actions taken such as recruitment problems. We also reviewed monthly managers meetings (operational and governance meetings). There was no evidence relating to delayed admissions to inpatient beds and community teams caring for high risk patients on the agendas. We could not see how this risk was being escalated from staff to senior leaders. Meetings with managers from the trust bed hub, demonstrated that individual cases were escalated and prioritised.

Meetings were recorded and shared with staff via email.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Training needs of staff was discussed during supervision and appraisal meetings.

Managers made sure staff received any specialist training for their role. There was specialist training available to enhance staff roles. This included structured clinical management training. However, the trust did not have any centrally held figures for this training.

Other specialist training included venepuncture training which eight staff within the community mental health teams trust wide had completed.

Physical health in mental health training had become part of the mandatory training modules and was being rolled out.

Dialogue plus training which included therapeutic interventions, solution focused therapy and trauma informed care had been completed by between 11 and 32 staff in each team.

One staff member in the Preston west team had completed a post graduate certificate in psychological trauma.

Two staff had completed professional nurse advocate training.

There were 15 staff completing, or had completed, non-medical prescriber training.

There were various courses relating to sexual health and LGBTQ+ transgender awareness courses.

Team managers also said staff had completed compassion focussed therapy and bipolar and psychosis training.

Managers recognised poor performance, could identify the reasons and dealt with these. Managers were able to give examples of staff who were unable to perform and how this was addressed. Managers had access to a HR department for advice and guidance. There were policies in place for staff and managers to follow.

Multidisciplinary and interagency team work

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

Staff held regular multidisciplinary meetings to discuss patients and improve their care. We observed multidisciplinary meetings which were balanced and productive. Staff of different disciplines such as occupational therapy and psychology were able to input into patient care. The discussions were professional and effective at progressing complex cases. There were various forums available to staff to seek multidisciplinary advice. There were daily huddle meetings, referrals meetings and clinical decisions meetings.

Staff mostly made sure they shared clear information about patients and any changes in their care, including during transfer of care. There were some care plans that did not contain pertinent information.

Staff had effective working relationships with other teams in the organisation. Managers and staff described relationships with crisis and home treatment teams to have been strained at times but that this had improved. Staff and managers recognised that staffing pressures in all community teams had impacted on working relationships. To rectify this, managers had worked together to iron out any issues and staff now feel that referrals and joint working was better managed. In the Blackburn and Darwen teams, the crisis and home treatment teams were co-located so informal discussions between practitioners supported better understanding of roles.

Staff had effective working relationships with external teams and organisations. Staff had developed links with primary care, housing departments, drug and alcohol services, social care providers and debt management providers. There was also a designated child and adolescent mental health transition worker.

However, local authority staff employed by Blackpool Council, Lancashire County Council and Blackburn with Darwen Council as Approved Mental Health Practitioners (AMHP's) and safeguarding officers were critical of the service. Stating that joint working relationships were strained due to delayed admissions, the requirement for repeat assessments under the Mental Health Act and that care assessments were requested too close to inpatient discharge dates causing blockages within the local mental health system.

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

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice.

Staff received, and kept up-to-date, with training on the Mental Health Act and the Mental Health Act Code of Practice and could describe the Code of Practice guiding principles. Staff we spoke to were knowledgeable regarding the Mental Health Act and understood this is accordance to their role. Staff confirmed they received and were up to date with Mental Health Act training.

All teams had good compliance with Mental Health Act law training with the exception of the following teams:

- Lancaster and Morecambe 44%

- Pendle 70%

The average compliance with this module was 81%

Staff had access to support and advice on implementing the Mental Health Act and its Code of Practice. Staff knew who their Mental Health Act administrators were and when to ask them for support. Staff knew who the local Mental Health Act administrator was and could contact them for advice if required. Staff knew how to request Mental Health Act assessments.

Staff followed clear, accessible, relevant and up-to-date policies and procedures that reflected all relevant legislation and the Mental Health Act Code of Practice. There was a Mental Health Act policy dated March 2022 for staff to follow and refer to. There was also a consent to treatment under the Mental Health Act procedure dated July 2021.

Patients had easy access to information about independent mental health advocacy. There were independent mental health advocacy providers in Cumbria, Blackpool and Lancashire. Information regarding these advocacy services were available on posters and leaflets and on request. Staff were aware to promote advocacy services for patients who were on Community Treatment Orders. Staff knew how to refer and signpost patients.

Staff explained to each patient their rights under the Mental Health Act in a way that they could understand, repeated as necessary and recorded it clearly in the patient's notes each time. We reviewed the care records of patients who were subject to Community Treatment Orders and noted that their rights under the Mental Health Act had been clearly explained to them and documented.

For patients subject to a Community Treatment Order, staff completed all statutory records correctly. At the last inspection in June 2019, we found that patients on Community Treatment Orders were not always given information on their rights under the Mental Health Act at regular intervals. This included when patients had declined their rights. Also, the legal authority relating to service users on Community Treatment Orders was not always kept with medicine cards.

At this inspection we found that all paperwork relating to Community Treatment Orders was present and correct.

Care plans clearly identified patients subject to the Mental Health Act and identified the Section 117 aftercare services they needed.

Staff completed regular audits to make sure they applied the Mental Health Act correctly. The Mental Health Act administrator completed regular quality checks of the Mental Health Act paperwork. The Mental Health Act administrator was able to prompt staff when patient's rights were due or overdue.

Good practice in applying the Mental Capacity Act

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

Staff received, and were consistently up-to-date, with training in the Mental Capacity Act and had a good understanding of at least the five principles. Staff had a good understanding of the Mental Capacity Act relevant to their role. Staff and

managers confirmed staff received training in the Mental Capacity Act. However, Mental Capacity Act training was incorporated within other modules such as safeguarding level two, safeguarding level three and Mental health Law training. There was no separate Mental Capacity Act training. There were seven teams with good compliance. Compliance with these three modules was low in the following teams:

Safeguarding level two

- South Lakes 71%
- Burnley 50%
- Pendle 75%
- Ribble Valley and Hyndburn 75%

Safeguarding level three

- Furness 68%
- Preston East 65%
- Chorley 79%
- Burnley 62%
- Pendle 50%
- Fylde and Wyre 76%

Mental Health Law

- Lancaster and Morecambe 44%
- Pendle 70%

There was a clear policy on the Mental Capacity Act, which staff could describe and knew how to access. There was a Mental Capacity Act 2005 Policy and Deprivation of Liberty Safeguards Procedure in place dated October 2021.

Staff knew where to get accurate advice on Mental Capacity Act.

Staff gave patients all possible support to make specific decisions for themselves before deciding a patient did not have the capacity to do so. We saw examples in the patient's care records that patients were supported to make decisions as much as possible.

Staff assessed and recorded capacity to consent clearly each time a patient needed to make an important decision. There was a mental capacity assessment and best interests meeting form to support staff with clear documentation.

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

The service monitored how well it followed the Mental Capacity Act and made changes to practice when necessary.

Community-based mental health services of adults of working age

Staff audited how they applied the Mental Capacity Act and identified and acted when they needed to make changes to improve. The trust completed a Mental Capacity Act baseline audit in October 2019 with an action plans based on these results in June 2022.

Is the service caring?

Good

Our rating of caring stayed the same. We rated it as good.

Kindness, privacy, dignity, respect, compassion and support

Staff treated patients with compassion and kindness. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.

Staff were discreet, respectful, and responsive when caring for patients. We observed staff interacting with patients in a professional and caring manner. Patients we spoke with confirmed staff had warm and friendly attitudes towards them. Most patients said staff were responsive, however, one patient said they were not allocated to a care coordinator and therefore did not receive a consistent approach.

Staff gave patients help, emotional support and advice when they needed it. Staff were available to support patients when required.

Staff supported patients to understand and manage their own care treatment or condition. Patients were well informed in relation to their diagnosis, treatment and care plans. We observed multidisciplinary meetings where patients were given information and choices about care options.

Staff directed patients to other services and supported them to access those services if they needed help. Staff made referrals to external agencies on behalf of patients when required.

Patients said staff treated them well and behaved kindly. Patients said they felt they trusted staff and that they had a good rapport with their care coordinators. Patients described staff as lovely, polite, helpful and well organised.

Staff understood and respected the individual needs of each patient. Staff were able to describe at length individual patients needs and treatment. Staff spoke in a respectful manner regarding any difficulties.

Staff felt that they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients and staff. All staff stated they trusted their team managers and that they could raise any concerns directly with them. If necessary they would speak with alternative senior managers or the freedom to speak up guardian.

Staff followed policy to keep patient information confidential. All patient information was stored on a secure electronic care record system. Staff had received training regarding confidentiality and there was a policy in place.

Involvement in care

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

Community-based mental health services of adults of working age

Involvement of patients

Staff involved patients and gave them access to their care plans. There was a new care planning system being rolled out which focused on ensuring patients were involved in their care plans. Electronic tablets were available so that staff and patients could input information directly into the care plan together. There was an emphasis on ensuring the patient voice was captured in all aspects of completing the care plan and other related documents. Patients we spoke to confirmed they felt involved in their care.

However, we reviewed 32 care plans and noted that 11 patients had not been offered a copy of their care plan.

Staff made sure patients understood their care and treatment (and found ways to communicate with patients who had communication difficulties). We reviewed one care plan of an autistic patient . They had a new care plan completed in June 2023, but this was not fully completed. There were areas such as physical health that did not contain enough information despite the patient experiencing weight gain and being prescribed an antipsychotic medication. However, there was a very detailed autism care plan on the old system which covered all areas of mental health. It was clear from examining this document that the patient understood their care plan and it was written in language they would understand. It was discussed with staff that this information needs to be duplicated into the new model.

Staff involved patients in decisions about the service, when appropriate. The teams were in the process of transforming into newer ways of working. The outcome model was based on services being based in one place to improve integration. This hub model would include mental health services, physical health needs and social needs being co-located for ease of access for patients. This model was based on feedback from patients.

Patients were due to be involved in the redecoration of the interview rooms and corridors within the Garburn House building utilised by the South Lakes team.

Patients could give feedback on the service and their treatment and staff supported them to do this. Patients were given information regarding the friends and family test during their initial appointment. Feedback from friends and family tests was overall very positive. Most patients commented that staff were supportive and that the service they were receiving was meeting their needs. There were a small number of negative comments relating to poor communication and waiting too long to access the service.

Other feedback from patients was accessed via the complaints process and patient advice and liaison service which was advertised to patients, families and carers via posters in CMHT settings and on information cards.

Staff supported patients to make advanced decisions on their care. We reviewed one care record where a patient had requested a do not attempt cardio pulmonary resuscitation (DNA CPR). However, the information in the care record was out of date and had not been reviewed.

Staff made sure patients could access advocacy services. Independent mental health advocates and independent mental capacity advocates were available for staff to refer patients to. There were posters explaining the role of advocates and how to contact them. Staff we spoke with understood to automatically refer to advocate for patients lacking capacity or detained under the Mental Health Act. There were other generic advocate services available in the community that staff were aware of.

Community-based mental health services of adults of working age

Involvement of families and carers

Staff supported, informed and involved families and carers. Most carers and family members spoke very highly of the service and that they felt involved in their loved ones care. They were invited to pertinent meetings and involved if any significant decisions were required to be made. However, five carers commented that their loved ones waited too long to access the service or internal departments such as psychology and psychiatry. One carer stated their relative waited weeks for an inpatient bed. When one was eventually found it was out of area..

Staff helped families to give feedback on the service. Families were invited to complete friends and family surveys to provide feedback about their experience.

Staff gave carers information on how to find the carer's assessment. Staff were aware of the local provision to signpost carers for carers assessments to be completed.

Is the service responsive?

Requires Improvement 

Our rating of responsive stayed the same. We rated it as requires improvement.

Access and waiting times

The service was not always easy to access. Its referral criteria did not exclude patients who would have benefitted from care. There was a wait to access the service in some teams. Staff followed up patients who missed appointments.

The service had clear criteria to describe which patients they would offer services to and offered patients a place on waiting lists. There was an admission policy for staff to refer to, named Community Mental Health Team Procedure dated July 2023 which outlined the process for new referrals.

The service met trust target times for seeing patients from referral to assessment and assessment to treatment. There were low number of patients waiting for assessments in most teams. There were higher number of patients waiting in teams in the Bay area. The number of patients waiting per team were:

- Chorley 3
- Preston East 4
- Preston west 15
- South Ribble 0
- West Lancs 14
- Blackpool 8
- Fylde and Wyre 6
- Blackburn 0
- Darwen 0

- Hyndburn and Rossendale 0
- Hyndburn and Ribble Valley 0
- Furness 34
- Lancaster and Morecambe 57
- South Lakes 11

Staff saw urgent referrals quickly and non-urgent referrals within the trust target time. Urgent referrals could be prioritised and assessed sooner.

At the last inspection in June 2019, we found that there were problems with patients waiting to access to the service. This included, patients waiting to be assessed, allocated to a care coordinator, and for appointments to see a psychiatrist.

At this inspection, we found that waiting times to be assessed and to see a consultant psychiatrist had improved but that waiting to be allocated to a care coordinator remained problematic in some teams.

There were significant delays in accessing the service in most areas following assessment. There were 1124 patients waiting to be allocated to a care coordinator trust wide. However, 706 of these patients were receiving care from another aspect of the service such as attending regular depot clinics. The number of patients waiting for a care coordinator per team were:

- Preston East 42
- Preston west 113
- South Ribble 125
- Burnley 37
- Darwen 3
- Hyndburn and Rossendale 182
- Hyndburn and Ribble Valley 169
- Pendle 73
- Furness 112
- Lancaster and Morecambe 183
- South Lakes 85
- West Lancs 0
- Blackpool 0
- Fylde and Wear 0
- Blackburn 0
- Chorley 0

Community-based mental health services of adults of working age

The longest wait (in weeks) to access a care coordinator per team was:

- Preston East 5
- Preston west 50
- South Ribble 24
- Burnley 4
- Darwen 0
- Hyndburn and Rossendale (data not supplied)
- Hyndburn and Ribble Valley 22
- Pendle 21
- Furness 36
- Lancaster and Morecambe 44
- South Lakes 37
- West Lancs 0
- Blackpool 0
- Fylde and Wear 0
- Blackburn 0
- Chorley 0

Some patient waiting times were exasperated by patients being out of the country or requiring only a highly specialist therapy.

Teams with high numbers of patients waiting had experienced staff vacancies, staff sickness and high staff turnover. Teams with low numbers of patients waiting had full staff teams and were further along the transformation process than others. For example, the Blackburn team were fully staff and had been delivering the structured clinical management programme for two years.

There was a policy in place for staff to follow to support the management of the number of patients not allocated to a care coordinator. This policy was called the unallocated cases procedure and dated January 2023. The procedure states that patients should have a care plan devised whilst they are waiting for treatment to begin explaining to the patient the level of contact to expect and how to contact the service. All unallocated cases should be reviewed weekly and a monthly audit should take place.

We saw evidence of two patients who were on the unallocated waiting list in Preston not being contacted as stated in their care plans. We reviewed the audits for the unallocated waiting lists in the Bay area (Furness, South Lakes and Lancaster and Morecambe) and Central and West areas (Preston East, Preston West and South Ribble) and found compliance with regular contact was low.

Community-based mental health services of adults of working age

The number of unallocated patients was on the risk register since April 2021. For the Burnley, Pendle and Rossendale and Hyndburn teams a staffing review was required as staffing was not meeting demand, despite being fully staffed. This was due to be completed by August 2023.

The service used systems to help them monitor waiting lists/support patients. Data was collated into a dashboard to allow managers to review trends over time. We reviewed the Bay area dashboard which demonstrated that over the last 6 months:

- 24% of unallocated patients had not been contacted at all in the last three months.
- 37% had not been seen face to face in the last three months.

In the Central and west areas over the last six months:

- 22% of unallocated patients had not been contacted at all in the last three months.
- 38% had not been seen face to face in the last three months.

Also, in the Central and west area, 57% of unallocated patients did not have a care plan and 85% of patients did not have an up to date risk management plan.

The figures did not represent an improving trajectory. The trust were aware of the issues and an action plan was in place to improve recruitment and retention of staff.

Unallocated patients not being contacted monthly was on the risk register since April 2021 for the Barrow, Kendal and Lancaster and Morecambe teams due to capacity issues.

We spoke to seven patients who were on unallocated waiting lists. Four patients confirmed that they did not receive any regular contact from the service and that their telephone calls were not always returned. Three patients said they did not have a care plan, crisis plan or safety plan.

The trust provided data that showed that between February 2023 and July 2023 there were 41 community harm incidents across the trust known to have involved patients who were awaiting allocation of a care coordinator or named key worker.

These were of the following categories:

- Low Harm 37
- Severe Harm 1
- Death / Catastrophic Harm 3

Staff tried to engage with people who found it difficult, or were reluctant, to seek support from mental health services.

Staff tried to contact people who did not attend appointments and offer support. There was a policy and protocol in place to contact patients by telephone if they failed to attend appointments.

Patients had some flexibility and choice in the appointment times available. For initial appointments, patients were contacted by telephone to arrange a suitable time. Patients said that care coordinators were flexible in their times and locations of appointments.

Staff worked hard to avoid cancelling appointments and when they had to they gave patients clear explanations and offered new appointments as soon as possible. Staff stated they rarely cancelled appointments, and this would be a last resort. Staff claimed they would always seek to re-arrange appointments rather than cancel.

Appointments ran on time and staff informed patients when they did not.

Staff supported patients when they were referred, transferred between services, or needed physical health care. Teams had child and adolescent mental health (CAMHS) transitional workers to support children and adults who were moving into the service from CAMHS.

The service followed national standards for transfer.

The facilities promote comfort, dignity and privacy

The design, layout, and furnishings of treatment rooms supported patients' treatment, privacy and dignity.

Most teams had a full range of rooms and equipment to support treatment and care. There were an adequate number of interview rooms at the Barrow, Kendal, Preston and Blackburn sites. However, the interview rooms in Kendal were within Garburn House, next to Kentmere ward (inpatient MH ward). This location was 10 minutes walk away from the community mental health team base. Staff told us that patients felt uncomfortable attending the Garburn House site as this is co-located with the inpatient ward. Staff said patients were put off by the inpatient fixtures and fittings and reminded them of previous admissions. Staff also felt that time was wasted moving between two buildings.

The CMHT at Chorley was based within a busy health centre. Interview rooms to see patients in were limited. There were three interview rooms and one clinic room. Staff reported not having enough rooms and opted to see patients in their own homes as much as possible. There was not enough staff or patient parking available. On street parking was restricted to residents only. Throughout the day we witnessed staff moving their cars to allow other staff to leave.

The Barrow location held a children's eating disorder clinic every Friday. There was no separate waiting room area for children and adults. This meant children where not appropriately safeguarded.

Interview rooms in the service had sound proofing to protect privacy and confidentiality.

Meeting the needs of all people who use the service

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

The service could support and make adjustments for people with disabilities, communication needs or other specific needs. The service had access to interpreter services for people whose first language was not English or they were deaf. All interview rooms were located on ground floor level to support patients with mobility needs.

Staff made sure patients could access information on treatment, local service, their rights and how to complain. There were leaflets available about treatments, external support and complaints. There were also appropriate posters explaining this information.

The service provided information in a variety of accessible formats so the patients could understand more easily. Information was available in other formats upon request.

The service had information leaflets available in languages spoken by the patients and local community. Information was available in other formats upon request.

Managers made sure staff and patients could get hold of interpreters or signers when needed. The service had access to an interpreter service.

Listening to and learning from concerns and complaints

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

Patients, relatives and carers knew how to complain or raise concerns. Information leaflets about how to complain were provided to patients and their carers. Patients and carers were encouraged to access the patient advice and liaison service for support with making a compliant. The patient advice and liaison service which was advertised to patients, families and carers via posters in CMHT settings and on information cards. Patients and carers we spoke to said they knew how to make a complaint.

Staff understood the policy on complaints and knew how to handle them. Staff knew to escalate complaints to managers and to signpost patients and carers to the patient advice and liaison service. Complaints were logged and an investigation process followed. There was an up to date complaints policy for staff to refer to.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint.

Managers investigated complaints and identified themes. There had been 127 complaints in total in the last six months. Of these:

- 52 were not upheld
- 55 partially upheld
- 4 upheld
- 16 ongoing/withdrawn

Managers said themes from informal complaints related to delayed admissions to inpatient units and the impact on patients and families.

Formal complaint themes related to patients being unhappy about being discharged from the service or disputing an assessment outcome.

Staff protected patients who raised concerns or complaints from discrimination and harassment.

Patients received feedback from managers after the investigation into their complaint.

Managers shared feedback from complaints with staff and learning was used to improve the service. Feedback from complaints was shared with staff during team meetings.

Community-based mental health services of adults of working age

The service used compliments to learn, celebrate success and improve the quality of care.

Is the service well-led?

Requires Improvement 

Our rating of well-led stayed the same. We rated it as requires improvement.

Leadership

Leaders had the skills, knowledge and experience to perform their roles. They had a good understanding of the services they managed and were visible in the service and approachable for patients and staff.

Team managers were very skilled and experienced in their roles. Managers were able to demonstrate in depth the challenges the service were facing and where they had been succeeding. Managers had action plans in place to support areas of the service that were experiencing difficulties. Managers were sharing their expertise with other teams that were struggling to improve. Staff spoke very highly of team managers, that they were supportive and professional.

Senior leaders visited the teams regularly and team managers felt they could easily escalate issues and receive the necessary support and advice.

Vision and strategy

Staff knew and understood the provider's vision and values and how they (were) applied to the work of their team.

The trust's vision and values were discussed in team meetings. Staff were regularly reminded about attitudes and behaviour as this was the biggest complaint the trust receive. The vision and values were also revisited during staff appraisal meetings.

Culture

Staff felt respected, supported and valued. They said the trust promoted equality and diversity in daily work and provided opportunities for development and career progression. They could raise any concerns without fear.

Managers and staff reported morale as good and improving. Managers and staff acknowledged that there was some stress due to delayed inpatient admissions but that caseloads were manageable which allowed staff to do more meaningful work with patients.

There were unallocated waiting lists in some teams also causing some additional work and pressure.

Teams were also going through a transitional process and there was lots of changes for staff to contend with.

Staff said they felt they had good managers which limited the impact of stressful situations.

Equality and diversity was embedded into daily practice. Equality and diversity training was mandatory for staff to complete. Equality and diversity issues were considered as part of the assessment and care planning process.

There were some opportunities for career progression such as specialist training for staff to attend to enhance their development.

All staff we spoke to said they trusted their line managers and felt they could raise any concern directly without retribution.

Governance

Our findings from the other key questions demonstrated that governance processes did not always operate effectively at team level and that performance and risk were not managed well or promptly.

At the last inspection in June 2019, we found that there were delays in improving the quality and safety of the service. Senior managers did not respond promptly to issues affecting service user care and issues relating to staffing. We found that improvements to accessing the service, staffing levels and supervision were needed.

At this inspection, we found that improvements remained delayed in areas such as staffing and supervision and further problems had developed as listed below.

However, there were suitable governance processes in place to allow senior managers to understand any issues within the system. Team managers had access to a governance dashboard and a weekly data reports. This allowed managers to easily review data regarding supervision and appraisal rates and staff training figures and other relevant information. This meant that managers and senior managers were sighted on any issues developing.

For most issues, there were appropriate action plans in place to remedy and mitigate risks and concerns. However, progress to implement and change was slow and therefore there were some aspects of the service that were failing and struggling to improve promptly.

This included,

- There was not enough nursing and multidisciplinary staff in some teams and this was impacting on service delivery such as waiting for a care coordinator and waiting for psychological therapy. Although the Trust had made year-on-year investments into CMHT, increasing establishment levels by 31%, and increasing staff in post by 11%, enabling a reduction in unallocated cases in the last 12 months of 28%, improvements were slow to develop in some teams.
- Mandatory training compliance was low in some teams for some modules.
- The quality and content of care plans did not always meet the needs of patients. Physical health care was not always included in care planning.
- Supervision compliance was low.
- There remained a high number of unallocated cases in some teams. These patients were also not always contacted regularly or had suitable care plans in place.
- Information sharing outside of the organisation was not prompt.
- Patients in crisis and requiring admission to hospital were not admitted promptly. This was burdensome to staff to manage.
- Alarms were not consistently used in some team buildings.
- The clinic room temperature in Blackburn was high and not acted upon

- Safety plans need to be completed for all patients consistently.
- Medicines were being re-used for other patients. Unused medicines were being re-labelled and used for other patients without a current protocol in place, The trust took immediate action to cease this practice pending introduction of an in-date protocol, which was completed following the inspection.
- Appraisal rates were low in some teams.
- Interview rooms in Kendal and Chorley were not suitable.
- Children shared the waiting room with adults in the Barrow team.

Most of the above issues were known by senior managers due to being picked up within the trust systems and processes. Despite mitigation and action plans being in place, these issues persisted.

Some managers were hopeful that once the transition process was completed, that many of the above issues would lessen.

Management of risk, issues and performance

Teams did not always have access to the information they needed to provide safe and effective care and did not use that information to good effect.

There were processes in place to ensure that the quality of care was measured and that risks were identified and control measures put in place. There were sufficient and regular audits of care records which highlighted issues.

There were 24 key performance indicators that captured data and information relating to the running of the service. This information demonstrated to managers and senior managers areas of risk that required action.

There was a bed hub to specifically manage and prioritise patients who were waiting for a bed. This system meant that those most in need and at risk would receive a bed first. However, this system gave priority to patients who were in accident and emergency or section 136 suites and patients in the community waited longer.

There was a risk register in place which highlighted pertinent issues such as staffing, high caseloads, unallocated waiting lists and gaps in psychology provision. However, the risk register did not mention the risk of staff caring for patients in the community who had been assessed as requiring hospital admission.

Although there was the necessary information available about teams required to manage and mitigate risks, there were still risks that remained. However, teams appeared to be on an improving trajectory. Teams that were further ahead of the transformation process, were in better positions than other teams.

Information management

Staff collected analysed data about outcomes and performance and engaged actively in local and national quality improvement activities.

Information was collated and analysed to assess the performance of each team. For teams that were under performing, business continuity plans were devised to support that team to improve. Teams that had improved shared their experience and learning with struggling teams.

Engagement

Community-based mental health services of adults of working age

Managers engaged actively in local health and social care providers to ensure that an integrated health and care system was commissioned and provided to meet the needs of the local population. Managers from the service participated actively in the work of the local transforming care partnership.

Feedback from the integrated care board (ICB) noted a significant change the trust leadership and culture. The integrated care board felt the trust had developed into a transparent and honest organisation which had developed positive relationships with the ICB team and key stakeholders including local authorities, police, voluntary sector, ambulance and acute colleagues. The ICB felt they were promptly informed of any emerging risk and that relationships were good.

The ICB was aware of the shortfall in inpatient bed numbers but felt that following the opening of the new wards based at the Whalley site that this would then only leave a seven bed deficit.

However, staff working for local authorities in safeguarding and AMHP roles felt that their concerns were not listened to and that risks to patients was too high.

Learning, continuous improvement and innovation

The service was in the process of transforming into a multiagency hub model. The aim was for services to be more integrated and easily accessible for patients.

Teams we visited in Chorley and Blackburn with Darwen explained how 12 months ago they had significant problems with recruitment and retention of staff and had built up a waiting list of patients wanting to access the service. They felt that improvements were made to the throughput of patients and this helped to ease pressure on the service and also improved staff wellbeing. Both teams now have stable staff teams and no waiting lists.

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

Requires Improvement ➔➔

Is the service safe?

Requires Improvement ➔➔

Our rating of safe stayed the same. We rated it as requires improvement.

Safe and clean care environments

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

Safety of the ward layout

Staff completed and regularly updated thorough risk assessments of all ward areas, and removed or reduced any risks they identified. We reviewed the ligature risk audits on all the wards visited and found that they were detailed, up to date, routinely reviewed and contained appropriate mitigation measures.

Staff could not observe patients in all parts of the wards. In areas where there were blind spots, parabolic mirrors had been installed to allow full visibility.

The ward complied with same sex accommodation guidance and on most of the wards there was no mixed sex accommodation. However, on the Dova Unit, Orchard Unit and at the Scarisbrick Centre there were mixed gender wards. We saw that male and female patients occupied two different corridors on the wards. All bedrooms had ensuite bathrooms and there were separate male and female quiet lounges.

Staff knew about any potential ligature anchor points and mitigated the risks to keep patients safe. They did this by using individual risk assessments, patient observations and staff supervision.

Staff and visitors had easy access to attack alarms and patients had easy access to nurse call systems on the wall in communal areas. There were no alarms in patient bedrooms so patients could not immediately alert staff if they had an emergency. Staff told us that they mitigated against this though individual risk assessments and by stationing staff on the bedroom corridors.

Maintenance, cleanliness and infection control

Most ward areas were clean, well maintained, well-furnished and fit for purpose. However, some wards on the Harbour Unit (Orwell, Shakespeare, Keats) were visibly unclean. The unit was undergoing a period of refurbishment, but the cleaning regime was not effective. Ward managers explained that they had escalated this and had identified concerns with the cleaning company used by the Trust.

Staff did not always ensure that the cleaning records were up to date. We saw on Orwell, Shakespeare and Keats ward at the Harbour Unit that records were incomplete and the premises were not clean. Following the inspection, the trust implemented a range of actions to improve upon the cleanliness of the wards.

Staff followed infection control policy, including handwashing. There were hand wash signs and handwashing stations in communal areas on the wards.

Seclusion room (if present)

Seclusion rooms allowed clear observation and two-way communication. They had a toilet, hand washing facilities and a clock. There was a means to vary the temperature in line with the Mental Health Act Code of Practice. The seclusion room on Calder ward at the Pendleview Unit had been de commissioned due to a blocked toilet and damage to the flooring. This had been escalated to estates for repair. Staff could also use the extra care area to nurse patients who needed to be away from the communal ward areas.

Clinic room and equipment

Clinic rooms were fully equipped, with accessible resuscitation equipment and emergency drugs that staff checked regularly. The emergency trolley was checked daily with a full check and re-tag on the first day of each month and a weekly manager check. We found that all records were in place and complete. We conducted a random check of expiry dates for several medicines and found that they were all in date. Medicines were stored securely and there was a process in place for disposal of waste medicines.

Staff checked, maintained, and cleaned equipment. The scales, height and equipment for physical observations were calibrated and tested regularly.

Safe staffing

The service had enough nursing and medical staff, who knew the patients and received basic training to keep people safe from avoidable harm.

Nursing staff

The service had enough nursing and support staff to keep patients safe. However, wards at the Harbour unit relied on redeploying staff from neighbouring wards and this meant that on occasion, wards were left short. Staff and patients confirmed that this sometimes resulted in leave being cancelled and rearranged. Between 01 August 2022 and 31 July 2023 there were two incidents of cancelled leave on Stevenson ward at the Harbour Unit and two incidents of cancelled leave on Orwell ward at the Harbour Unit.

The service had reducing vacancy rates. There were 92 vacancies for registered nurses and the trust had recruited to 65 posts at the time of the inspection. There were 19 vacancies for health care assistants and the trust had recruited to 14 posts at the time of the inspection.

The service had used an average of 79 bank and agency qualified nurses in June 2023 and 89 bank and agency nurses in July 2023.

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

Managers limited their use of bank and agency staff and requested staff familiar with the service and the patients. They block booked bank and agency staff where possible to achieve this.

Managers made sure all bank and agency staff had a full induction and understood the service before starting their shift. During the inspection we saw a comprehensive induction booklet which contained detailed information about the ward, ward processes and risk management.

The service which had the highest turnover rates was Dova Unit (8%) and Keats ward at the Harbour Unit and the lowest turnover rates at 0% on Kentmere ward, Darwen ward, Calder ward, Stevenson ward and the Lathom suite.

Managers supported staff who needed time off for ill health. Staff that we spoke with said that they had been well supported by managers during extended sick leave and that this continued on their return to work.

Average levels of sickness were at 11% in July 2023. The highest sickness level was 23% on Keats ward at the Harbour Unit and the lowest sickness level was 5% on the Lathom Suite at the Scarisbrick Centre.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants for each shift. Senior managers had twice weekly staffing meetings, identified qualified nurse ward shortages. Matrons phoned the wards each morning to check staffing levels and shifts were reviewed daily.

The ward managers could adjust staffing levels according to the needs of the patients. There was a system whereby managers could request additional staff either in advance or on the day as required.

Patients had regular one to one sessions with their named nurse. One patient told us that their one-to-one sessions were sometimes cancelled due to a lack of staff. However, patients rarely had their escorted leave or activities cancelled, even when the service was short staffed. Escorted leave had been cancelled four times over the last 12 months on the Harbour Unit.

The service had enough staff on each shift to carry out any physical health interventions safely. Physical health checks were completed twice a day on all wards.

Staff shared key information to keep patients safe when handing over their care to others. Staff had handovers twice per day and daily huddles. Any changes or emerging risks concerning patients were discussed at these meetings. We attended a staff handover and saw that patients, their care and treatment and emerging risks were discussed.

Medical staff

The service had enough daytime and nighttime medical cover and a doctor available to go to the ward quickly in an emergency.

Managers could call locums when they needed additional medical cover.

Managers made sure all locum staff had a full induction and understood the service before starting their shift. The service tried to use regular staff who knew the wards and patients.

Mandatory training

Staff had completed and kept up to date with most of their mandatory training. The positive and safe training which included de-escalation skills and restraint training was below compliance at 59%. Safeguarding level 3 training was also below compliance at 63%.

The mandatory training programme was comprehensive and met the needs of patients and staff. In addition to the mandatory training there was locally mandated training which staff were required to complete. This included topics which enabled staff within this core service to provide appropriate care to the patients on the acute and PICU (Psychiatric Intensive Care Unit) wards. Examples of additional training included early intervention in psychosis and a variety of cognitive behavioural therapy courses.

Managers monitored mandatory training alerted staff when they needed to update their training.

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

Assessing and managing risk to patients and staff

Staff assessed and managed risks to patients and themselves well and followed best practice in anticipating, de-escalating and managing challenging behaviour. Staff used restraint and seclusion only after attempts at de-escalation had failed. The ward staff participated in the provider's restrictive interventions reduction programme.

Assessment of patient risk

Staff completed risk assessments for each patient on admission, using a recognised tool, and reviewed this regularly, including after any incident. We reviewed 47 risk assessments during the inspection. We saw that the risk assessments were up to date and that changes were made when incidents happened.

Staff used a recognised risk assessment tool. At this service an enhanced risk assessment tool was used on the electronic recording system, and this included a formulation and management plan.

Management of patient risk

Staff knew about any risks to each patient and acted to prevent or reduce risks. Staff used enhanced patient observations as one means of preventing or minimising risks. Any changes in risk were discussed at handover each day.

Staff identified and responded to any changes in risks to, or posed by, patients. We saw that staff routinely updated risk assessments every 7 days and after every incident.

Staff followed procedures to minimise risks where they could not easily observe patients. There were parabolic mirrors in the areas of the wards where there were blind spots. Staff also used enhanced patient observations and ligature risk assessments to keep patients safe.

Staff followed trust policies and procedures when they needed to search patients or their bedrooms to keep them safe from harm. Staff only searched patients as a last resort and only if they had identified a concern.

Use of restrictive interventions

Levels of restrictive interventions were reducing. Wards were part of the reducing restrictive practice quality initiative collaborative and held a reducing restrictive practice meeting monthly. We saw evidence of a reduction in restrictions over the previous three months prior to inspection.

Staff participated in the provider's restrictive interventions reduction programme, which met best practice standards. The trust used the positive and safe skills model to reduce or prevent the use of restrictive intervention. Staff that we spoke with told us that compliance had been affected by Covid 19 and that there was a board level agreed plan to support the staff who were physically unable to complete the training and that this would improve compliance further in the coming months.

Staff made every attempt to avoid using restraint by using de-escalation techniques and restrained patients only when these failed and when necessary to keep the patient or others safe. Staff used verbal de-escalation, use of exercise and use of the sensory room as methods of managing escalating situations on the wards.

Staff understood the Mental Capacity Act definition of restraint and worked within it.

Staff followed NICE guidance when using rapid tranquilisation. There were 55 rapid tranquilisation incidents reported in the four weeks prior to the inspection. Of those incidents, 36 (65.5%) were fully compliant with monitoring mental and behavioural state every hour for two hours. There were 35 (63.6%) incidents that were fully compliant with monitoring of physical health

Staff used seclusion as a last resort when all other interventions had failed. When a patient was placed in seclusion, staff kept clear records and followed best practice guidelines. We conducted a review of seclusion records during the inspection and found that records were kept correctly in line with best practice guidelines.

Safeguarding

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

Staff received training on how to recognise and report abuse, appropriate for their role. This was part of the mandatory training programme. The Harbour had a Safeguarding week of action to raise awareness and promote the training and was developing this into a safeguarding road show which will attend all networks going forward.

The Trust target for compliance in safeguarding training was 80%. Staff kept up to date with their safeguarding level 2 training The service had achieved 92% compliance. However safeguarding level 3 training was below compliance at 63%.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. A staff member gave an example of a female patient who was at risk from her husband and had escalated this to keep the patient safe.

Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them. Staff liaised with internal safeguarding leads and with the external local authority safeguarding board.

Staff followed clear procedures to keep children visiting the ward safe. Visits took place in rooms off the wards.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. There were safeguarding leads on each ward whom staff could go to for advice and guidance.

Managers took part in serious case reviews and made changes based on the outcomes.

Staff access to essential information

Staff had easy access to clinical information, and it was easy for them to maintain high quality clinical records – whether paper-based or electronic.

Patient notes were comprehensive, and all staff could access them easily using their secure log in. Although the service used a combination of electronic and paper records, staff made sure they were up-to-date and complete.

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

Records were stored securely. Most of the records were electronic and were accessed using a secure log on, paper records were kept in a locked filing cabinet in the ward offices.

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

Medicines management

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

Staff followed systems and processes to prescribe and administer medicines safely. The service used an electronic system for the prescribing and administration of medicines, and the monitoring of people's physical health, for example blood tests and blood pressure checks.

We reviewed the records for one person who was prescribed medicines for their physical health condition. It showed clear directions and information to support staff to safely administer medicines to them. Where needed the appropriate Mental Health Act authorities for prescribing were in place. However, there were delays in putting this paperwork in place for 2 people, this had been identified and addressed by the trust. Should people need their medicines covertly, hidden in food or drink, there was information to support staff to do this safely. Staff considered and assessed patients' capacity and held a best interests meeting where patients were found to lack capacity.

On two wards we found that when people were prescribed a medicine with a minimum time interval between doses, for example paracetamol, they were given repeated doses of medicine too closely together. This placed the people at unnecessary risk of side effects. This was escalated to the trust during the inspection for investigation.

We reviewed the records for people prescribed valproate who were of childbearing age, we found one person's records did not show that the requirements of the pregnancy prevention programme (MHRA drug safety update April 2018) had been met. Valproate is associated with affecting the development of babies in the womb)

Staff reviewed each patient's medicines weekly during ward round and provided advice to patients and carers about their medicines. We saw people's medicines were reviewed regularly. Pharmacy staff were available to speak with people and provide advice around their medicines. However, pharmacy capacity for this was more limited at some hospitals than others, ongoing recruitment was in place. Nursing staff told us people were given leaflets about their medicines and they had access to them in different formats and languages.

Staff completed medicines records accurately and kept them up to date. We found that all medicines were recorded as administered or an appropriate code was recorded in the patient record.

Staff stored and managed all medicines and prescribing documents safely and securely. Emergency medicines were checked regularly to ensure they were available when needed. The pharmacy team attended the wards to ensure there was sufficient supplies of medicines. We randomly checked several medicines and found they were all within their expiry date. Electronic fridge temperature monitoring had been rolled out across the trust, but staff were not always aware of the process to monitor the temperatures remotely. This meant staff were not always clear about who was responsible for acting on temperature alerts. Fridge temperature audits were carried out monthly.

Pharmacy staff reviewed and reconciled people's medicines when they were admitted to the ward to ensure they were prescribed the correct medicines. We found patients allergies were recorded on their prescription records which reduced the risk of them being prescribed a medicine they had previously reacted to. Trust policy states that a Venous Thromboembolism (VTE) risk assessment must take place within 24 hours of direct admission to the hospital. We found that this had not taken place in full for all people that were admitted.

Staff learned from safety alerts and incidents to improve practice. The medicines safety officer reviewed all medicines incidents and produced a quarterly report to promote sharing of learning. Awareness of low medicines incident reporting had been shared through these reports and addressed by the trust. It was important that all medicines incidents were reported so that staff could learn from mistakes and improve medicines management.

The service ensured people's behaviour was not controlled by excessive and inappropriate use of medicines. Medication and side effects were reviewed regularly and prescribed and administered within national guidelines. Staff monitored patients who were on high dose antipsychotic medication

Staff reviewed the effects of each patient's medicines on their physical health according to NICE guidance. We found when people should have had additional monitoring following the administration of medicines for the management of severe agitation and aggression (Rapid Tranquilisation) this was not always recorded. The service had introduced a booklet to promote consistency in recording, but this was not always in place. On some wards we were told that booklets were not available. Similarly, we found that trust policy for recording physical health monitoring was not always followed when medicines were first prescribed (Clozaril), making this more difficult to find for review.

Track record on safety

The service had a good track record on safety.

Reporting incidents and learning from when things go wrong

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

Staff knew what incidents to report and how to report them. All incidents were reported on an electronic recording system and escalated to managers for investigation and sign off. Staff were able to give examples of the types of incidents that they reported.

The staff reported serious incidents clearly and in line with trust policy. Incidents were investigated and learning from incidents was passed to staff via email, team meetings and supervision.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong. Staff gave verbal and written apologies to patients and families if this was required.

Managers debriefed and supported staff after any serious incident. Debriefs took place as soon as possible after the incident and staff were offered reflective practice sessions and support from psychology if they required it.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations.

Staff received feedback from investigation of incidents, both internal and external to the service.

Staff met to discuss the feedback and look at improvements to patient care.

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

There was evidence that changes had been made because of feedback. We were aware of a serious incident which had occurred at the Harbour Unit in October 2022. The Trust conducted an investigation and there was identified learning and actions taken as a result of this. As a safety improvement the Trust had begun a programme of work to change all the bedroom door tops to anti-ligature to minimise patient risk. The observation policy was reviewed following this incident and additional training was developed for staff.

Managers shared learning with their staff about never events that happened elsewhere.

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Is the service effective?

Requires Improvement 

Our rating of effective stayed the same. We rated it as requires improvement.

Assessment of needs and planning of care

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

Staff completed a comprehensive mental health assessment of each patient either on admission or within 24 hours of their admission.

Patients had their physical health assessed soon after admission and reviewed daily during their time on the ward. We saw evidence in patient records of physical health assessments being completed and daily ongoing monitoring. Managers and staff had good oversight of this as any physical health issues flagged up on the electronic recording system.

Staff developed a comprehensive care plan for each patient that met their mental and physical health needs. We reviewed 47 care plans and saw that where appropriate; they included physical health issues such as diabetes management, asthma and weight management.

Staff had regularly reviewed and updated care plans when patients' needs changed and care plans were personalised, holistic and recovery orientated.

Best practice in treatment and care

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

Staff provided a range of care and treatment suitable for the patients in the service. This included access to psychological therapy, occupational therapy, section 17 leave, and appropriate medications.

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

Staff delivered care in line with best practice and national guidance. They followed guidance from the National Institute for Care Excellence (NICE).

Staff identified patients' physical health needs and recorded them in their care plans. We saw evidence of the management of weight loss, diabetes and asthma in patient care plans.

Staff made sure patients had access to physical health care, including specialists as required. A patient on the Harbour Unit told us that staff had assisted them to access a specialist doctor for the treatment of asthma and inhalers had been prescribed.

Staff met patients' dietary needs and assessed those needing specialist care for nutrition and hydration. Staff completed food and fluid charts for specific patients who had been assessed to need their dietary and fluid intake monitoring. Staff made referrals to the dietician for specialist advice and guidance.

Staff helped patients live healthier lives by supporting them to take part in programmes or giving advice. There were walking groups, healthy eating groups and access to the gym. Patients were encouraged to choose the healthier meal options and to keep hydrated. Patients were also screened during the initial assessment process for reducing risky behaviour which included illicit substances and alcohol. Patients had access to smoking cessation groups and smoking cessation tools if they required it.

Staff used recognised rating scales to assess and record the severity of patients' conditions and care and treatment outcomes. At this service staff used Health of the Nation Outcome Scales (HoNOS)

Staff used technology to support patients. This included electronic patient records, iPads and the use of closed circuit television for the review of incidents.

Staff took part in clinical audits, benchmarking and quality improvement initiatives. The audits undertaken included care plans, risk assessments, safeguarding adults and children, Malnutrition Universal Screening Tool (MUST) and falls risk assessments.

Managers used the results from audits to make improvements. This included management review and sign off for all enhanced observation records.

Skilled staff to deliver care

The ward team(s) included or had access to the full range of specialists required to meet the needs of patients on the ward(s). Managers made sure they had staff with the range of skills needed to provide high quality care. They supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.

The service had (access to) a full range of specialists to meet the needs of the patients on the ward. There were occupational therapists, doctors, nurses, pharmacists, and dieticians available.

Managers ensured staff had the right skills, qualifications and experience to meet the needs of the patients in their care, including bank and agency staff. Managers considered the acuity of the wards and the skill mix of staff daily at the morning meeting to ensure that staff could meet the needs of the patients.

Managers gave each new member of staff a full induction to the service before they started work. New staff received a corporate induction and were given a detailed induction booklet. Staff then had the ward based local induction and were given time to shadow more experienced staff. A range of mandatory training was provided along with useful reading materials.

Managers had not supported all staff through regular, constructive appraisals of their work. On some wards, appraisal rates were low at 34% on Ribble ward, 44% on Keats ward, 44% on Hyndburn ward and 51% on Churchill ward.

Managers supported permanent medical staff to develop through yearly, constructive appraisals of their work.

Managers had not supported all staff through regular, constructive clinical supervision of their work. On some wards supervision rates at the time of inspection were low at 32% on Stevenson ward, 39% on the Orchard Unit, 52% on Scarisbrick inpatient ward and 55% on Calder ward.

Managers supported medical staff through regular, constructive clinical supervision of their work. Medical staff received internal and external supervision and peer support with individual cases.

Managers made sure staff attended regular team meetings or gave information from those that could not attend. Staff received an email of the team meeting minutes to keep them up to date with all of the issues discussed.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Staff were given study days and flexible shift patterns to support this.

Managers made sure staff received any specialist training for their role. Staff attended additional local training in line with the requirements of the acute and PICU wards. This included mandatory training in learning disability and autism. Staff could undertake additional training such as a range of cognitive behavioural psychology courses, early intervention in psychosis, non-medical prescribing, and the leadership in care training program for managers.

Managers recognised poor performance, could identify the reasons, and dealt with these. We saw evidence of performance management and support in staff personnel files and supervision records. Managers sought support from HR to manage this appropriately.

Multi-disciplinary and interagency team work

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

Staff held weekly multidisciplinary meetings to discuss patients and improve their care. These were attended by a range of ward staff and the patient. Care coordinators from the community mental health teams were invited and involved in discharge planning.

Staff made sure they shared clear information about patients and any changes in their care, including during handover meetings and at the daily huddle meeting.

Ward teams had effective working relationships with other teams in the organisation. The acute and PICU wards worked closely with Crisis and the community mental health teams along with the bed hub which managed patients waiting to be admitted into hospital.

Ward teams had effective working relationships with external teams and organisations. Staff that we spoke with told us that they worked closely with external safeguarding teams, housing providers and the benefits agency.

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

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and discharged these well. Managers made sure that staff could explain patients' rights to them.

Staff received and kept up to date with training on the Mental Health Act and the Mental Health Act Code of Practice and could describe the Code of Practice guiding principles. The compliance figure for Mental health act training was 85%.

Staff had access to support and advice on implementing the Mental Health Act and its Code of Practice. They spoke to qualified staff, managers or staff in the Mental Health Act Office.

Staff knew who their Mental Health Act administrators were and when to ask them for support. Staff routinely contacted the mental health act office for advice and support with queries.

The service had clear, accessible, relevant and up-to-date policies and procedures that reflected all relevant legislation and the Mental Health Act Code of Practice. There was a copy of the Mental Health Act Code of Practice in each nursing office.

Patients had easy access to information about independent mental health advocacy and patients who lacked capacity were automatically referred to the service. We saw advocacy posters on the notice boards and patients told us that an advocate visited the ward weekly.

Staff explained to each patient their rights under the Mental Health Act in a way that they could understand, repeated as necessary and recorded it clearly in the patient's notes each time.

Staff made sure patients could take section 17 leave (permission to leave the hospital) when this was agreed with the Responsible Clinician and/or with the Ministry of Justice. Staff prioritised section 17 leave and planned it in advance to ensure that patients went out as prescribed.

Staff requested an opinion from a Second Opinion Appointed Doctor (SOAD) when they needed to. We saw evidence of this in the patient records.

Staff stored copies of patients' detention papers and associated records correctly on the electronic recording system and staff could access them when needed.

Informal patients knew that they could leave the ward freely and the service displayed posters to tell them this. We saw posters on the walls and ward staff understood the rights of informal patients.

Care plans included information about after-care services available for those patients who qualified for it under section 117 of the Mental Health Act.

Managers and staff made sure the service applied the Mental Health Act correctly by completing audits and discussing the findings. Mental Health Act staff completed the audits and escalated their findings to managers and ward staff.

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

Good practice in applying the Mental Capacity Act

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

Staff received training in the Mental Capacity Act and had an understanding of at least the five principles. The Mental Capacity Act was a module within all three levels of the safeguarding training, and included the following modules : safeguarding children, safeguarding adults, Mental Capacity Act. This meant that to be compliant in safeguarding, staff would have completed all of the modules shown above. Staff kept up to date with their safeguarding level 2 training. The service had achieved 92% compliance. However safeguarding level 3 training was below compliance at 63%. This meant that there may have been elements of the Mental Capacity Act which staff had not received complete training in.

There were no deprivations of liberty safeguards applications made in the last 12 months and managers knew which wards made the highest and monitored staff so they did them correctly.

There was a clear policy on Mental Capacity Act and deprivation of liberty safeguards, which staff could describe and knew how to access.

Staff knew where to get accurate advice on the Mental Capacity Act and deprivation of liberty safeguards. They routinely contacted the Mental Health Act office for guidance.

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

Staff assessed and recorded capacity to consent clearly each time a patient needed to make an important decision. We saw evidence of this on the electronic recording system where patient records were held.

When staff assessed patients as not having capacity, they made decisions in the best interest of patients and considered the patient's wishes, feelings, culture and history. We saw evidence of Mental Capacity Act assessments and best interest meetings in patient records. Staff also liaised with relatives and carers where appropriate.

Staff made applications for a Deprivation of Liberty Safeguards order only when necessary and monitored the progress of these applications.

The service monitored how well it followed the Mental Capacity Act and acted when they needed to make changes to improve.

Is the service caring?

Good 

Our rating of caring stayed the same. We rated it as good.

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

Kindness, privacy, dignity, respect, compassion and support

Staff treated patients with compassion and kindness. They respected patients' privacy and dignity. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.

Staff were discreet, respectful, and responsive when caring for patients. Patients that we spoke with said that staff always knocked before entering their room and were genuinely interested in their wellbeing.

Staff gave patients help, emotional support and advice when they needed it. This included support with communicating with families, accessing benefits and supporting patients who were distressed.

Staff supported patients to understand and manage their own care treatment or condition. Patients were given written information about their treatment plan and medication and side effects.

Staff directed patients to other services and supported them to access those services if they needed help. Examples of this included access to benefits, domestic violence agencies and sexual health clinics.

Patients said staff treated them well and behaved kindly. We observed that staff on all wards interacted well with patients and were warm and patient in their conversations with them.

Staff understood and respected the individual needs of each patient. It was clear that staff worked to develop relationships with patients. They were aware of patients' personal circumstances and worked with patients to support them.

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

Staff followed policy to keep patient information confidential. Staff always sought consent to treatment and all patient records were stored electronically or kept locked away in a locked office.

Involvement in care

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

Involvement of patients

Staff introduced patients to the ward and the services as part of their admission. Staff gave new patients a welcome pack, introduced them to their named nurse and explained the ward routines during the day and at night.

Staff involved patients and gave them access to their care planning and risk assessments. Staff spent time with patients discussing risk assessments and care plans and patients were offered a copy of their care plan if they wanted.

Staff made sure patients understood their care and treatment (and found ways to communicate with patients who had communication difficulties). This included providing easy read leaflets and leaflets in different languages.

Staff involved patients in decisions about the service, when appropriate. There were monthly community meetings held on the wards where patients could raise issues and make suggestions.

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

Patients could give feedback on the service and their treatment and staff supported them to do this. Patients and families were encouraged to complete friends and family feedback forms. Patients could also raise issues with their named nurse and could attend multidisciplinary team meetings to discuss their treatment and care.

Staff supported patients to make advanced decisions on their care. Staff also sought advice from relatives and carers to support this process.

Staff made sure patients could access advocacy services. We saw advocacy posters and leaflets on the wards and staff and patients told us that the advocates regularly attended the wards to speak with patients

Involvement of families and carers

Staff informed and involved families and carers appropriately.

Staff supported, informed and involved families or carers. Families and carers were invited to patient meetings where patients had agreed this. Staff updated families if an incident had occurred or if there had been a change to their treatment plan. Some of the carers that we spoke with said that communication from staff was poor and they struggled to get information about their loved one.

Staff helped families to give feedback on the service. Carers drop-in sessions were held weekly, the service routinely held carers days and there were carers champions amongst the staff team.

Staff gave carers information on how to find the carer's assessment. There was information on the carers notice boards on the wards about how to access a carers assessment and there were carers assessment booklets on the wards.

Is the service responsive?

Good ↑

Our rating of responsive improved. We rated it as good.

Access and discharge

Staff managed beds well. A bed was usually available when a patient needed one. Patients were not moved between wards except for their benefit. Patients sometimes did have to stay in hospital when they were well enough to leave.

Bed management

Managers made sure bed occupancy did not go above 85%. While there had been an increase in Trust bed capacity towards the NHS Benchmark average level, the Trust has not yet reached this national average level of beds. Trust bed occupancy has therefore remained high.

However, the increase in Trust bed capacity has meant that there are fewer people waiting at any time for admission to a bed and the Trust were able to demonstrate that people were not staying longer in their beds (average LOS increasing because of the prevention of short admissions).

The increase in community alternatives to admission has meant fewer short 'crisis' admissions have been needed. While there are fewer admissions, this does mean that the average Length of Stay for those people admitted has increased.

System partners and the Trust recognise that the issue of very long stays is a system issue, requiring capacity in long-term placements or specialist support to address."

Managers regularly reviewed length of stay for patients to ensure they did not stay longer than they needed to.

The number of open bed stays had been relatively stable since July 2022.

The service had 113 patients in acute out of area placements. Of those, 97 patients were in appropriate independent sector acute ward placements and 16 patients were in inappropriate independent sector acute ward placements. There were 21 patients in PICU out of area placements. Of those, 15 patients were in appropriate independent sector PICU placements and six patients were in inappropriate independents sector PICU placements. Barriers to discharge included a lack of suitable accommodation to move patients on to.

Managers and staff worked to make sure they did not discharge patients before they were ready.

When patients went on leave there was always a bed available when they returned.

Patients were moved between wards only when there were clear clinical reasons, or it was in the best interest of the patient.

Staff did not move or discharge patients at night or very early in the morning. Most discharges were planned for the mornings to allow time for travel or to resolve any unexpected issues.

The psychiatric intensive care unit did not always have a bed available if a patient needed more intensive care and this could be away from the patient's family and friends. The longest wait for a male PICU was 60 days. There were no females waiting for a PICU bed.

The longest wait for a female acute bed was 16 days. This patient was being recalled to hospital under a Community Treatment Order. The longest wait time for a male acute bed was 27 days.

Discharge and transfers of care

Managers monitored the number of patients whose discharge was delayed, knew which wards had the most delays, and took action to reduce them by meeting with community teams and discharge coordinators to identify appropriate placements to move patients to. The service had moved away from recording delayed discharges to recording clinically ready for discharge as a more accurate indicator of when patients were no longer on the most appropriate ward for their care needs. The percentage of delayed discharges for adult mental health patients had remained stable in 2023.

Some patients had to stay in hospital when they were well enough to leave. Over the last 12 months since capture of clinically ready for discharge began, 276 patients on the adult acute and PICU wards had been recorded as clinically ready for discharge. The top four reasons for delay in discharging after a patient had become clinically ready for discharge were: arranging professionals' meetings (22% of all delays); waiting for a placement to be identified (12%); patient was homeless and needed accommodation (11%) and awaiting assessment by a rehabilitation ward (7%)

Staff carefully planned patients' discharge and worked with care managers and coordinators to make sure this went well. Care managers were invited to patients' meetings to engage in the discharge planning process.

Staff supported patients when they were referred or transferred between services. They liaised with new providers, visited new services with patients and made appropriate arrangements for transfer.

The service followed national standards for transfer. This included ensuring that new providers received prompt details of risk management, care plans, medication and crisis plans for patients.

Facilities that promote comfort, dignity and privacy

The design, layout, and furnishings of the ward supported patients' treatment, privacy and dignity. Each patient had their own bedroom with an en-suite bathroom and could keep their personal belongings safe. There were quiet areas for privacy. The food was of good quality and patients could make hot drinks and snacks at any time.

Each patient had their own bedroom, which they could personalise. We saw examples of bedrooms with posters and photographs on the wall, personal bedding and other personal items.

Patients had a secure place to store personal possessions. They had lockable bedroom doors and each patient had a lockable safe in their bedroom.

Staff used a full range of rooms and equipment to support treatment and care. There was a clinic room, meeting rooms and activity rooms on each ward which could be utilised by staff with patients.

The service had quiet areas and a room where patients could meet with visitors in private. There were quiet lounges on each ward and where appropriate these were gender specific. There were patient visitor rooms either on the ward or just off the ward for patients to meet with families and carers.

Patients could make phone calls in private. Most patients had a mobile phone which was individually risk assessed or they could use the ward mobile phone if they needed to.

The wards had an outside space that patients could access easily. There were outside courtyard spaces on most wards except Hyndburn ward at the Pendleview unit which was shared with a neighbouring ward. Staff made arrangements for patients to go in the garden at alternate times to the other ward. This had been identified as a concern and work was being undertaken to try to resolve this.

Patients could make their own hot drinks and snacks and were not dependent on staff. Hot and cold drinks were available in the communal area and patients could access snacks whenever they wanted.

The service offered a variety of good quality food. Patients were able to choose their meals from a range of options which included healthier food items such as salads and fruit.

Patients' engagement with the wider community

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

Staff made sure patients had access to opportunities for education and work, and supported patients to access this. The trust had a recovery college based in Preston which some patients could access if they had sufficient leave.

Staff helped patients to stay in contact with families and carers. They encouraged communication and facilitated visits to patients by loved ones.

Staff encouraged patients to develop and maintain relationships both in the service and the wider community.

Meeting the needs of all people who use the service

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

The service could support and make adjustments for disabled people and those with communication needs or other specific needs. All bedrooms were ensuite and there were accessible bathrooms on each ward. Staff bought specialist equipment for patients with specific needs. There was a sensory room on Orwell ward at the Harbour unit which patients could use to relax in.

Staff made sure patients could access information on treatment, local services, their rights and how to complain. We saw that there was information on ward notice boards about patients' rights and how to make a complaint. Patients were given written information on different treatments and staff spent time explaining treatment and side effects to patients. On the Orchard Unit staff had devised a game to assist patients to understand the different treatments.

The service had information leaflets which could be made available in languages spoken by the patients and local community.

Managers made sure staff and patients could get help from interpreters or signers when needed. Staff had easy access to an interpreter service and they routinely used this to support patients who required it.

The service provided a variety of food to meet the dietary and cultural needs of individual patients. This included low fat, vegan, gluten free, halal and kosher diets. Staff assisted patients with their menu choices and weekly menus were displayed on the wall in the dining rooms. One patient was unable to get a culturally appropriate meal on the day of admission as staff said that they were unable to obtain it that day. Staff offered other alternatives to the patient.

Patients had access to spiritual, religious and cultural support. There were prayer rooms on the different units and the hospital chaplain and other spiritual leaders visited the wards to see patients. Patients who had leave were also supported to access the church or religious centre of their choice.

Listening to and learning from concerns and complaints

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

Patients, relatives and carers knew how to complain or raise concerns.

The service clearly displayed information about how to raise a concern in patient areas. We saw leaflets and posters on all of the wards on how to make a complaint.

Staff understood the policy on complaints and clearly knew how to support patients to make a complaint and how to escalate the complaint to managers for investigation and resolution. The service had received 148 complaints between 1 July 2022 and 31 July 2023. Of those complaints, 44 were not upheld, 64 were partially upheld and 28 were upheld. Six complaints were withdrawn and six were still under investigation.

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

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. Patients received verbal and written feedback in line with the trust complaints policy.

Managers investigated complaints and identified themes.

Staff protected patients who raised concerns or complaints from discrimination and harassment.

Patients received feedback from managers after the investigation into their complaint.

Managers shared feedback from complaints with staff and learning was used to improve the service. The learning was shared at team meetings and supervision.

The service used compliments to learn, celebrate success and improve the quality of care. We saw thank you cards displayed on the wards and read positive feedback in the friends and family cards.

Is the service well-led?

Requires Improvement 

Our rating of well-led stayed the same. We rated it as requires improvement.

Leadership

Leaders had the skills, knowledge and experience to perform their roles. They had a good understanding of the services they managed and were visible in the service and approachable for patients and staff.

Leaders had the skills knowledge and experience to deliver high quality personalised care. Leadership development was embedded into the service and there was a culture of staff development across all levels of service.

Leaders had an in-depth knowledge of the priorities, risks and challenges in their service and used this to develop and improve service delivery and staffing.

Vision and strategy

Staff knew and understood the provider's vision and values and how they (were) applied to the work of their team.

The provider had the following vision and values: kind, respectful, always learning and teamwork. The values were supported by six strategic priorities.

Staff that we spoke with knew the vision and values and used them in their everyday work. Supervision and appraisal were aligned with the vision and values however supervision and appraisal rates were low and not provided in line with trust policy.

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

Culture

Staff felt respected, supported and valued. They said the trust promoted equality and diversity in daily work and provided opportunities for development and career progression. They could raise any concerns without fear.

Staff spoke highly of colleagues and managers at all levels. Staff were able to give feedback on the service via the suggestions box and at team meetings.

Managers supported staff development and we heard examples of staff undertaking courses in health and social care or going to university to study nursing.

Teams were collaborative and cohesive and shared a vision and determination to deliver a good quality service. There were effective systems and processes in place to ensure that equality and inclusion underpinned the service.

Governance

Our findings from the other key questions demonstrated that most governance processes operated effectively at team level and that performance and risk were managed well.

Staff had access to electronic dashboards to enable them to have oversight of the wards. However, elements of mandatory training, appraisals and supervision were below compliance levels.

Management of risk, issues and performance

Teams had access to the information they needed to provide safe and effective care and used that information to good effect.

The organisation had systems and processes in place to manage current and future performance. There was an effective and comprehensive process to identify, understand, monitor and address current issues and future risks. The organisation reviewed its processes and ensured that staff at all levels had access to the information that they needed.

Where challenges arose, leaders dealt with them quickly and effectively and risk management was effective.

Information management

Staff collected analysed data about outcomes and performance and engaged actively in local and national quality improvement activities.

Staff collected data on compliance with reading patients their section 132 rights, environmental checks, infection prevention and control and door top alarm checks. The modern matrons' quality checks included record keeping, supervision compliance and ward resuscitation checks. Areas of good practice for May 2023 included door top alarms, sexual safety, infection prevention and control and service users' feedback on feeling safe on the wards. The acute and PICU wards participated in AIMS accreditation which is an accreditation system developed for psychiatric intensive care units in acute settings.

Engagement

Managers engaged actively other local health and social care providers to ensure that an integrated health and care system was commissioned and provided to meet the needs of the local population. Managers from the service participated actively in the work of the local transforming care partnership.

There was constructive engagement with staff and people who use services, including all

equality groups. Constructive challenge from people who use services, the public and stakeholders was welcomed and seen as a vital way of holding services to account. Services were developed with the full participation of those who use them, staff and external partners as equal partners. Staff were encouraged to talk new plans through and given the time to present them to managers.

Learning, continuous improvement and innovation

There was a focus on learning and improvement across the service. Staff were supported and given flexible working, study days and protected time to pursue courses and personal development. The service had been recognised by the Carers Trust Triangle of Care programme for their commitment to improving the way that they work with families and carers. Wards had also received accreditation for inpatient mental health services (AIMS) by the Royal College of Psychiatrists. This was in recognition of high standards of organisation and care.