

# Priory Hospital Burgess Hill

## Quality Report

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This report describes our judgement of the quality of care at this location. It is based on a combination of what we found when we inspected and a review of all information available to CQC including information given to us from patients, the public and other organisations

### Mental Health Act responsibilities and Mental Capacity Act and Deprivation of Liberty Safeguards

We include our assessment of the provider's compliance with the Mental Capacity Act and, where relevant, Mental Health Act in our overall inspection of the service.

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

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

### Overall summary

- Priory Hospital Burgess Hill was well maintained and cleaned to a good standard.
- Staff were aware of their roles and responsibilities and took appropriate measures to safeguard clients from avoidable harm and/or abuse.
- The hospital had identified staffing as a high-risk issue on the hospital risk register and were ensuring wards did not run under their safe staffing numbers by using locum agency staff, while full time positions were recruited to.
- Morale amongst staff was good. Staff felt proud and valued to work at the service. Relationships amongst staff were strong and supportive.
- Physical healthcare was integrated into the care plans and the practice nurse was closely involved across the hospital in supporting the patients.
- There was an induction and annual training programme for all staff that specifically addresses issues of relational security.
- There was a designated safeguarding lead for both children and adults

However:

# Summary of findings

- Staff were not aware they could refer a safeguarding matter straight to the local authority without requiring it to be reviewed by the Priory Hospital Burgess Hill Safeguarding Lead first.
- Senior support workers and nurses did not have the opportunity to meet regularly as a hospital wide clinical reflective group to review case studies and how situations were being managed across different wards within the hospital.

# Summary of findings

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# Priory Hospital Burgess Hill

**Services we looked at:**

Acute wards for adults of working age and psychiatric intensive care units; Forensic inpatient/secure wards;

# Summary of this inspection

## Our inspection team

The team was comprised of three CQC inspectors and two specialist advisors with experience of working in mental health in-patient settings.

## Why we carried out this inspection

We undertook an unannounced focused inspection, following concerns we had received through intelligence monitoring.

These concerns included:

- insufficient training levels of staff in the management of violence and aggression particularly agency staff
- no safeguarding champion on each of the wards
- poor physical healthcare of patients
- lack of therapeutic activities

- lack of assurances that lessons had been learned from incidents.

As this was a focused inspection, we did not pursue all key lines of enquiry.

It was decided to carry out a location based focused inspection inspecting the safe domain and key lines of enquiry in the effective and well led domains.

We visited all six wards at the service. As we focused on the issues of concern, we have not reconsidered the rating of this service.

## How we carried out this inspection

On the 1 September 2018 the service changed its name from The Dene to Priory Hospital Burgess Hill. At the previous comprehensive inspection in October 2016 we rated the service as good overall with effective, caring, responsive and well led all being rated as good. The safe domain was rated as requires improvement. Safe was rated as good following a focused inspection in June 2017. This inspection focused on the safe and caring domains only.

In April 2018 the service had an unannounced focused inspection following information of concern reported to the Care Quality Commission. Areas for improvement were identified but no breaches of regulation were found.

Before the inspection visit we reviewed information that we held about this service including incident reports and initial feedback received from a recent NHS England quality review.

During the inspection visit, the inspection team:

- visited all six of the wards at the hospital site and looked at the quality of the ward environment and observed how staff were caring for patients
- spoke with eight patients who were using the service
- spoke with the managers or acting managers for each of the wards
- spoke with 14 other staff members; including mental health nurses, the practice nurse and support workers
- interviewed the hospital director and the governance manager
- attended and observed four hand-over meetings and three multi-disciplinary meetings.
- looked at a range of policies, procedures and other documents relating to the running of the service.

# Summary of this inspection

## Information about Priory Hospital Burgess Hill

The Priory Hospital Burgess Hill is a modern purpose-built hospital providing acute and psychiatric intensive care units as well as specialised medium and low secure services for people with mental health needs, mild learning disabilities or problems with substance misuse. The hospital currently has six wards which comprise two male wards, one acute, one high dependency unit; one female high dependency unit, one medium secure female ward, one low secure female ward and a specific personality disorders unit for female patients with a diagnosis of emotionally unstable personality disorder.

The hospital has the following core services; Acute wards for adults of working age and psychiatric intensive care units and Forensic inpatient/secure wards.

The hospital was last inspected fully in October 2016. At the October 2016 inspection CQC issued one requirement

notice in relation to ligature risk assessments and mitigation plans. This related to the following regulation under the Health and Social Care Act (Regulated Activities) Regulations 2014:

- Regulation 12 HSCA (RA) Regulations 2014 Safe care and Treatment

A requirement notice is issued by CQC when an inspection identifies that the provider is not meeting essential standards of quality and safety. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

A follow up inspection took place in June 2017 at which the required standards had been met and the requirement notice was met.

In April 2018 CQC carried out an unannounced responsive inspection at the location following information of concern reported to the Care Quality Commission. Areas for improvement were identified but no breaches of regulation were found.

## What people who use the service say

The patients told us they were always enough staff on the wards and this helped them to feel safe. They said that the staff treated them with respect and were available if they wanted to have a 1:1 to discuss their care plans. The patients said they were involved in their care and were able to have a copy of their care plan if they wanted. Patients also felt they were informed about their medicines and could ask questions if they did not understand why they were on medicines.

The patients were happy with the quality and portion sizes of food they received.

The patients said there was enough therapeutic activity on the ward and told us the hospital had recruited new occupational therapy staff to offer more structured activity.

# Summary of this inspection

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

We always ask the following five questions of services.

### **Are services safe?**

We found the following areas of good practice:

- Priory mandatory training was at 91% across all wards at the time of the inspection and this included taught sessions in management of violence and aggression for regular and locum agency staff. Locum staff were not able to work on the site if they did not have their mandatory training in date.
- The service had allocated security leads on every shift who carried out a three times daily environmental audit to ensure a dynamic approach toward environmental risk management.
- The service had a multi-disciplinary handover meeting every day attended by representatives from each of the wards and the senior management team. This meeting reviewed the staffing levels across all the wards and the gender, skill mix and experience of staff, ensuring that any planned activities would take place and all high-risk areas were appropriately covered. This meeting also identified any additional actions that were required, for example if a safeguarding referral been made to the local authority, or if a staff or patient debrief been completed post incident.
- The service had identified staffing as a high-risk issue across the hospital on the risk register and were ensuring wards did not run under their safe staffing numbers by using locum agency staff, while full time positions were recruited to.

However:

- Staff were knowledgeable about the reasons for reporting a safeguarding issue. However the staff were not aware they could refer a safeguarding matter straight to the local authority without requiring it to be reviewed by the Priory Hospital Burgess Hill Safeguarding Lead first.
- Although the seclusion packs were completed consistently, the information was not always recorded in the correct section as defined by the Priory policy. The seclusion paperwork section completed by the patient following the seclusion, was not completed for any of the seclusions recorded.

Senior support workers and nurses felt they did not have the opportunity to meet regularly as a hospital wide clinical reflective group to review case studies and how situations were being managed across different wards within the hospital.

# Summary of this inspection

## Are services effective?

We found the following areas of good practice:

- Physical healthcare was well integrated into the care plans and the practice nurse was closely involved across the hospital in supporting the patients and developing a physical healthcare strategy for the hospital.
- Each ward had a specific activity timetable. The ward timetables covered sessions that were orientated toward the interests of the patient group on each of the wards, they were not generic activities set across the hospital.
- There were systematic shift handovers between nursing teams using a red, amber, green (RAG) system for highlighting elevated risk issues across the wards and shift planning sheets to ensure staff were aware of their responsibilities.

## Are services caring?

At the last comprehensive inspection in October 2016 we rated caring as good. Since that inspection we have received no information that would cause us to re-inspect this key question or change the rating.

## Are services responsive?

At the last comprehensive inspection in October 2016 we rated responsive as good. Since that inspection we have received no information that would cause us to re-inspect this key question or change the rating.

## Are services well-led?

We found the following areas of good practice:

- Staff morale was high and the ward staff were passionate and committed to delivering high quality of care.
- The hospital had a daily morning meeting with the clinical services manager, the hospital director and the governance lead to feedback any concerns or issues from the individual wards. This meeting reviewed incidents, lessons learned and effective use of staffing.



# Detailed findings from this inspection

## Mental Health Act responsibilities

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

## Mental Capacity Act and Deprivation of Liberty Safeguards

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

# Location

Safe	
Effective	
Caring	
Responsive	
Well-led	

## Is the location safe?

### Safe and clean environment

#### Safety of the ward environment

- Each of the six wards had blind spots identified on a specific risk assessment and had planned action recorded to mitigate the risks. The mitigating actions included the use of convex mirrors and additional staffing where required to maintain the safety of patients. A ligature point is anything which could be used to attach a cord, rope or other material for the purpose of hanging or strangulation. The wards had identified all ligature anchor points and had documented these in a structured assessment with an action plan showing how staff would manage those which could not be removed. In addition, each of the wards had a three times daily security walk around by staff which checked all aspects of the ward security, including ligature points, to ensure there was a continuous approach toward ligatures.
- The wards allocated a member of staff to be the security lead on each shift. This role was allocated by the nurse in charge to a suitably experienced member of staff and the security lead completed a checklist. This role was not allocated to members of staff who were unfamiliar with the ward environment. Ward managers reviewed this checklist and the inspection team were able to check completed forms on each ward to ensure this was being routinely completed. This meant was a system in place to manage the environment to help keep patient safe.
- Each ward was single sex and complied with the Department of Health guidance on single sex accommodation. All patient bedrooms had an ensuite shower room.

- All staff carried alarms when they were on the wards and these were managed by the reception area and provided when staff came on duty. There was a checking system in reception for ensuring these alarms were charged and working and reception staff documented this process. On the wards where there were more challenging needs of the patients, audible alarms were also provided to support staff to call for assistance. During the inspection we observed building work being completed on Elizabeth Anderson Ward where a new updated pinpoint alarm was being installed to improve the existing system. This new system was part of a planned update being installed across the whole hospital.
- All the wards inspected were visibly clean and domestic staff had specific cleaning schedules they followed which ensured all areas of the wards were well maintained. Any broken pieces of furniture were highlighted and documented by the daily security checks and were removed from the ward or made safe by the maintenance staff.
- Infection control training was mandatory for all staff and there were gel dispensers available outside each ward and in the reception area for staff and visitors to use when entering and exiting the wards.

#### Safe staffing

- Staffing levels were identified using an agreed staffing ladder implemented across all the wards, this highlighted the core staff required per ward and then how many additional staff were required based on the number of patients who were receiving enhanced observations. All the ward managers and deputy ward managers had a working understanding of the staffing ladder and knew exactly how many staff they should have on duty each shift and how to increase their staffing levels if required in the event of an escalation in risk on the ward.

# Location

- Each ward always ran with a minimum of two registered nurses on duty between 07.30 – 20.00 and each ward had one nurse overnight between 19.30 – 07.00. On top of these numbers the wards all had a ward manager equivalent of a band 7 or in their absence a deputy ward manager equivalent of a band 6 between the hours of 09.00 – 17.00.
- Across the whole hospital the service had vacancies for 38 registered nurses and 48 health care workers. Due to the concerns prompting this inspection this was discussed in detail with the hospital director and with the ward managers to assess the impact of the vacancy rate on clinical care. The service had recruited to a specialist role, a “recruitment co-ordinator” and the service was taking a flexible approach toward recruitment. This means that there was more consideration of flexibility in working hours to meet the needs of the staff to offer more consistent level of care to the patients. The service had highlighted recruitment and retention on the hospital risk register and was taking significant steps to actively recruit to the vacancies. Many of the vacancies had already been recruited to including five full time health care workers (HCW), a permanent medical director, a permanent speciality doctor and a senior occupational therapist.
- While the recruitment process continued, the service had recruited locum nurses into the vacancies. Locum nurses are nurses employed by a nursing agency on longer term contracts ranging from 1-3 months, which are regularly reviewed. These locum staff were considered to be full time staff and were trained either by their agency or by the Priory to the same level as the staff employed on full time contracts. This meant that locum staff were not able to work unless they had provided evidence to the human resources department that they had completed all statutory and mandatory training expected of Priory staff. The training required included practical taught training in managing violence and aggression, so that all locum staff were trained to be able to safely manage aggressive behaviour should it be required. We reviewed the service level agreement information with the locum provider and found that the direction to provide staff that had been trained to the same level as Priory staff clearly formed part of the agreement. We observed new locum qualified staff undertaking paid supernumerary shifts on the wards outside of the shift numbers to ensure that when they started on the wards they were confident with the systems and processes of the unit.
- Locum staff received the same level of induction as full-time staff and were able to access Priory training such as medicine competency, if it was relevant to their role. The locum staff were also set up on the electronic records system and incident reporting systems to ensure there were minimal delays in reporting patient information. Locum nursing staff carried a caseload of patients and regularly completed 1:1 interventions with their patients. When we discussed the use of locum staff with the ward managers they said they were all happy with the quality and consistency of the locums and felt that with the difficult problem of recruitment in that area, the hospital management were doing all they could to provide staff to maintain the safety of the wards.
- We reviewed the previous month’s rotas for all wards. Despite the vacancies, all shifts were covered in advance, using firstly staff from the internal bank / permanent staff doing overtime and then consistent locum nursing staff.
- The service had recently moved away from the Priory central booking system for locum staff as the ward managers had identified there was a problem in the consistency of the staff being provided and there had been no overall understanding of the skills required to work with the clients at the hospital. As a result, cover for staffing gaps was now arranged at a local level so consistent staff could be used on wards they were familiar with, which improved the quality of the patient contact.
- Priory staff mandatory training was 91% across all wards at the time of the inspection. Agency staff were not able to work on site if they did not have their mandatory training in date. If necessary, staff were given protected time to complete mandatory training to ensure they remained compliant. The service had a training officer who managed a robust system to ensure that staff and their managers were notified whenever a training was due to go out of date and when they were booked onto the next available training session. All the ward managers could provide the inspection team with spreadsheets identifying which of their staff were due for upcoming training sessions.

# Location

- The service had a multi-disciplinary handover meeting every day attended by representatives from each of the wards and the senior management team. This meeting reviewed the staffing levels across all the wards. This meeting looked not only at staff numbers, but also reviewed the gender, skill mix and experience of staff ensuring that any planned activities would take place and all high-risk areas were appropriately covered. Staff were moved around the unit following this meeting and managers liaised with each other to make sure all activities were covered.

## Assessing and managing risk to patients and staff

- We reviewed 18 patient risk assessments across six wards. We found they were of a consistently good standard with evidence of both historic risks identified through the HCR-20 (a 20-point historical clinical risk assessment) and up to date risks covered in the current priority risk assessment document.
- Risk assessments were routinely updated on a weekly basis or following a risk incident on the ward. In addition to this we observed each ward had a red, amber, green (RAG) system, which was reviewed by the ward team every shift for each patient. This was updated and reviewed by the clinical team if a risk was elevated. This offered a more dynamic approach to the management of risk.
- Blanket restrictions were in place across the hospital site regarding issues such as access to the kitchens and access to the gardens. When we discussed the purpose of these with the ward staff and checked the care plans we could see that these were normally addressed on an individual basis with the patient in their care plans. The site was non-smoking and patients were supported to access smoking cessation information and nicotine replacement therapy on an individual basis.
- All patients were aware of the policy of restricted items on the wards and the reason as to why some items had to be restricted to protect the patients and staff. We saw the list of restricted items clearly visible in the hospital reception and on the wards, in addition patients told us when they were admitted a member of the nursing team had gone through a “welcome pack” with them and this had helped them to understand what was allowed onto the wards.
- All staff received training in safeguarding children and safeguarding vulnerable adults. Staff were able to give detailed examples of what varied forms of abusive

behaviour would constitute a safeguarding concern. On each ward staff could identify which patients were subject to ongoing safeguarding arrangements. Staff we spoke with all referred to reporting a safeguarding issue to the social worker in the first instance. However, none of the staff were aware they could refer a safeguarding matter straight to the local authority without requiring it to go through the Priory Hospital Burgess Hill safeguarding lead. We reviewed the safeguarding policy and the newly adapted local safeguarding procedure. It did not clearly state that staff could make a safeguarding referral straight to the local authority without going through the “designated Priory Hospital Burgess Hill safeguarding lead” or in their absence a senior member of staff. This meant staff were not aware they could report safeguarding matters straight to the local authority.

- Care plans contained specific examples of how safeguarding issues relating to the patients had been identified in the ‘keeping myself safe’ section of the care plan.
- The wards had designated safeguarding leads.
- Each ward followed safe procedures and ward policies on children visiting their relatives in hospital. Children did not go on to the ward, but the hospital had rooms off the ward for patients to see their children. Staff would supervise these visits where appropriate.
- We reviewed the seclusion documentation for September 2018 in detail with the Director of Clinical Services. We found that none of the seclusion packs contained a completed account from the patient as to their experience of the seclusion. Each ward had a seclusion log which showed how many times patients went into seclusion. These records did not match the seclusion paperwork and the Mental Health Act administrator’s log of seclusions. The seclusion packs contained all the multi-disciplinary reviews of the episode of seclusion as per the Priory policy. However, the entries were not always completed in the same place. This meant that it was sometimes difficult to track the seclusion, although it should be noted all the information was present. We were told the paperwork had recently been updated and the service was in the process of training all medical and nursing staff in the implementation of the new paperwork.

## Track record on safety

# Location

## Reporting incidents and learning from when things go wrong

- There had been one incident that had reached the threshold for a serious incident (SI) in the three months prior to the inspection. The ward manager had completed a 72-hr report and a team incident review within the same week. An external manager had come into carry out a full serious incident review but the service had not received a response at the time of the inspection. An action plan had been devised and shared with NHS England in relation to what immediate action was required to be carried out and timeframes for completion.
- The ward managers met with the Director of Clinical Services on a weekly basis to review all the incidents from the previous week and look at common themes across the hospital. This meeting also looked at what had gone well and what lessons could be learned. The minutes of this meeting were distilled into a “lessons learned bulletin” and shared across all the teams through their daily handovers. Each bulletin was attached to the back of the wards nursing office door. This was to highlight incidents, to identify what had worked and to help share lessons learned across the staff teams.
- The multi-disciplinary team had a senior management handover every day and the governance manager brought a list of all the incidents that had occurred over the previous 24hrs across the whole site. This meeting then identified any additional actions that were required, for example if a safeguarding referral been made to the local authority, or if a staff or patient debrief been completed post incident. This meeting was minuted. We reviewed the minutes for the month prior to the inspection and could see this had been occurring, with incidents being reviewed on a daily basis.
- Staff were aware of the electronic incident reporting system used across all wards. Ward managers were responsible for reviewing and signing off incidents before they went to the Director of Clinical Services who reviewed and kept a tracker which fed into the clinical governance process.
- Staff felt they could discuss patient care within the ward rounds and meetings on the wards. However, senior support workers and nurses felt they did not have the

opportunity to meet regularly as a hospital wide clinical reflective group to review case studies and how situations were being managed across different wards within the hospital.

## Is the location effective? (for example, treatment is effective)

### Assessment of needs and planning of care

- We reviewed 18 sets of patient care records across six wards. Staff completed comprehensive and timely assessments following each patient’s admission. Assessments included a physical health assessment completed by a member of the medical team on admission.
- We reviewed care plans with a specific view on how well physical healthcare was integrated into the care plans and found consistently integrated support from the practice nurse showing that physical health needs were being met. There was evidence of physical health observations, electro cardiogram, routine bloods, specific head injury assessments and the Liverpool University neuroleptic side effect rating scale being carried out regularly and when clinically appropriate across all wards.
- Priory used four electronic care plans; keeping safe, keeping well, keeping healthy and keeping connected. Each care plan related to areas of a patient’s recovery and included aspects of physical health, family and support network involvement, risk management and therapeutic activities. We reviewed patient care plans and found them to be person centred and detailed. Patients had signed their care plans and there was evidence they had been offered a copy. We found care plans were of a consistently good standard, with several showing evidence of positive behavioural support techniques integrated into the care planning process.
- Patient information was stored securely. All staff, including locum agency staff had access the electronic recording system on a secure password protected system.

### Best practice in treatment and care

- Priory Hospital Burgess Hill had a range of staff available to support patients accessing the treatment programme. This included psychiatrists, mental health

# Location

nurses, practice nurse, healthcare assistants, psychologists and social worker. There was a psychology team in place consisting of a locum clinical psychologist, a trainee forensic psychologist and an art psychotherapist. However, the position of lead psychologist was vacant. The position had been shortlisted for and interviews were happening in October 2018 to fill the post. Ward managers felt they had psychology input for formulation work when required and were positive about the input from the trainee forensic psychologist and art psychotherapist.

- The wards had access to occupational therapy (OT) and we interviewed a newly appointed locum OT who had been put in post specifically to complete patient interest checklists and match the wards timetables to each patient's specific interests. Occupational therapy assistants and a senior band 6 OT had been recruited and were due to start mid-October. The lead OT position remained vacant due to the applicant withdrawing. The hospital director had already re-advertised and was actively recruiting.
- NHS England had identified on one ward that there was a hospital wide OT programme and not a timetable of activity specific to that ward. Each ward now had a specific activity timetable for the ward and it was noted when all the timetables were reviewed that these were not hospital wide activities. Each of the ward timetables were different and covered sessions that were orientated toward the interests of the patient group on the wards.
- The physical healthcare was well integrated into the care planning process. The practice nurse had implemented a physical health plan for the hospital which had an 11-point implementation plan to continue to improve outcomes for patients. The plan identified nominated physical healthcare champions on each ward and had specific measurable targets to achieve up to January 2019.

## Multi-disciplinary and inter-agency team work

- Multidisciplinary team meetings/ward rounds took place once a week on each ward. The multidisciplinary team consisted of nursing staff, health care assistants, occupational therapists, consultants and input from psychology. We spoke with patients and reviewed records held regarding multidisciplinary meetings. Staff

documented clearly that patients received information about their medication and treatment plan. Patients we spoke with were all aware of their treatment plan and information about their medicines.

- Staff handovers occurred on every shift and staff were knowledgeable about individual patients. There were good working relationships and handovers between nursing teams. We observed a systematic process followed at handover involving a red, amber, green system for highlighting elevated risk issues across the wards and shift planning sheets to ensure staff were aware of their responsibilities.

## Is the location caring?

At the last comprehensive inspection in October 2016 we rated caring as good. Since that inspection we have received no information that would cause us to re-inspect this key question or change the rating.

## Is the location responsive to people's needs?

(for example, to feedback?)

At the last comprehensive inspection in October 2016 we rated responsive as good. Since that inspection we have received no information that would cause us to re-inspect this key question or change the rating.

## Is the location well-led?

### Good governance

- Priory staff were up-to-date with mandatory training, supervision and appraisal. At the time of the inspection mandatory training for Priory staff was at 91% compliance. Locum staff had to have all mandatory training or they were not able to work. Staffing was sufficient for the ward and any absence was covered by experienced bank and locum staff who were familiar with the wards. This was ensured by an arrangement of local booking, which identified and allocated staff with experience of the individual wards.



# Location

- The ward staff were passionate and committed to delivering high quality of care. Despite a recent serious incident, the staff morale was high and they felt the hospital was evolving in a positive way.
- Staff conducted regular clinical audits and were monitored weekly through key performance indicators in a number of areas including completion of care records. The ward manager conducted monthly audits of care records and any actions were addressed with staff through supervision and presented at monthly clinical and risk governance meetings.
- All wards attended a daily morning meeting with the senior management team to feedback any concerns or issues from the individual wards. We reviewed the previous months minutes from the daily handover and would see incidents, lessons learned and effective use of staffing was discussed daily with input from the Director of Clinical Services, the hospital director and the governance lead.
- Staff spoke highly of the newly appointed Director of Clinical Services and felt that there was a direct connection from the wards to the hospital director, who maintained an open door policy and had regular drop in clinics with the wider staff team.

# Outstanding practice and areas for improvement

## Outstanding practice

- The hospital had started using a system of four key care planning areas: keeping safe, keeping well, keeping healthy and keeping connected. This had improved the consistency of the care planning process since the last inspection.
- The physical healthcare management was effective across all wards and it was clear that the physical healthcare nurse role was making a positive difference.

## Areas for improvement

### Action the provider **SHOULD** take to improve

- The service should ensure the seclusion paperwork is being consistently completed.
- The service should consider reflective practice sessions with the nurses and support workers.
- The service should make the safeguarding process clearer, to identify that any member of staff can make a safeguarding referral directly to the local authority if they felt it was appropriate.