Lancashire Care NHS Foundation Trust

Mental health crisis services and health-based places of safety

Quality Report

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

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Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RW5AA	Royal Blackburn Hospital	Health-based place of safety	BB2 3HH
RW5KM	The Harbour	Health-based place of safety	FY4 4XQ

This report describes our judgement of the quality of care provided within this core service by Lancashire Care NHS Trust. Where relevant we provide detail of each location or area of service visited.

Our judgement is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from people who use services, the public and other organisations.

Where applicable, we have reported on each core service provided by Lancashire Care NHS Trust and these are brought together to inform our overall judgement of Lancashire Care NHS Trust.

Summary of findings

Ratings

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

Overall rating for the service

Are services safe?	
Are services effective?	
Are services caring?	
Are services responsive?	
Are services well-led?	

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

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

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

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

Summary of findings

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Summary of findings

Overall summary

We did not rate services at this inspection. During the inspection we found:

- Patients admitted to health-based places of safety (136 suites) were unlawfully detained beyond the legal timeframe for their detention. Mental capacity assessments and best interest decisions were not always formally recorded. Patients were not always given their rights under the Mental Health Act in line with the code of practice guidance.

Summary of findings

Are services safe?
We did not inspect this domain during this inspection.

Are services effective?
We did not rate this domain as part of this inspection. During the inspection we found:

- Patients admitted to health based places of safety (136 suites) were unlawfully held beyond the legal timeframe for detention.
- Patients in health based places of safety were not routinely given their rights under the Mental Health Act.
- Staff did not record formal mental capacity assessments or best interest decisions for each patient.

Are services caring?
We did not inspect this domain during this inspection.

Are services responsive to people's needs?
We did not inspect this domain during this inspection.

Are services well-led?
We did not inspect this domain during this inspection.

Summary of findings

Information about the service

Lancashire Care NHS Foundation Trust provides a range of mental health crisis services and health-based places of safety across the footprint of Lancashire; this includes Blackpool, North, East, Central and West Lancashire and Pendle, Hyndburn and Ribble Valley.

The trust has eleven health-based places of safety in total. We visited two locations to review the quality of care provided. The two locations we visited were:

• Health-based place of safety at Blackburn

• Health-based place of safety at Blackpool

Health-based places of safety are for patients who are detained under section 136 of the Mental Health Act by the police in the community to be assessed by specialist mental health staff and a decision made about their need for future care.

Our inspection team

The team that carried out this inspection consisted of one lead CQC inspector, one CQC inspector and two Mental Health Act Reviewers.

Why we carried out this inspection

We carried out this inspection in response to concerns that were raised regarding some patients being held within the health-based places of safety (136 suites) within Lancashire Care NHS Foundation Trust beyond the expiration of their section 136 detention and therefore without legal authority.

How we carried out this inspection

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

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

In this focused inspection we concentrated on the application of the Mental Health Act and Mental Capacity Act within the effective domain.

Before the inspection visit, we reviewed information that we held about these services. During the inspection visit, the inspection team

- Reviewed 11 care records for patients who had been admitted to health-based places of safety

Summary of findings

Areas for improvement

Action the provider MUST take to improve

- The trust must ensure that patients admitted to health based places of safety (136 suites) are not unlawfully detained beyond the legal timeframe for the detention.

Action the provider SHOULD take to improve

- The trust should ensure that patients admitted to health based places of safety are informed of their rights under the Mental Health Act
- The trust should ensure that mental capacity assessments and best interest decisions are formally recorded.

Lancashire Care NHS Foundation Trust

Mental health crisis services and health-based places of safety

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Health-based place of safety	Royal Blackburn Hospital
Health-based place of safety	The Harbour

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.

We found that patients admitted to health-based places of safety were being unlawfully held beyond the legal timeframe for detention. We found that patients within health-based places of safety were not routinely given their rights under the Mental Health Act.

Mental Capacity Act and Deprivation of Liberty Safeguards

We found that mental capacity assessments and best interest decisions were not always formally recorded in patient notes.

Are services safe?

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

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

Our findings

We did not inspect this domain during this inspection.

Are services effective?

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

Our findings

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

As part of this inspection we reviewed 11 records of patients who had been detained beyond 72 hours in the health-based places of safety. Each patient had been assessed and appropriate medical recommendations had been made to detain the patient under section 2 or 3 of the Mental Health Act before their section 136 expired. In each of the cases a bed on an adult acute mental health ward had been requested prior to the expiration of the section 136. However: approved mental health practitioners were unable to complete and execute the section due to an inability to locate an available inpatient bed.

This meant that staff had no legal authority to detain patients within the health based places of safety beyond the 72 hour time period of the section 136 lapsing. The shortest time period a patient remained in a health based place of safety following the expiration of their section 136 was for 45 minutes. The longest breach was for six days.

We reviewed the care records of the 11 patients. We found that in six there was no evidence that the patients had had their rights under the Mental Health Act explained to them. This meant that there was no evidence to demonstrate that the patients had been made aware that they were no longer detained under the Mental Health Act and had the right to leave if they chose to do so.

Good practice in applying the Mental Capacity Act

We looked at 11 records. In each record the daily clinical notes made reference to the patient lacking capacity and being cared for in their best interests. However: there were no associated mental capacity assessments to document the decisions and evidence of how they had been made in line with the principles set out within the Mental Capacity Act 2005.

This meant there was no evidence to demonstrate that patients' capacity was being assessed on a decision specific basis and that best interest decisions recognised the importance of the patients' wishes, feelings, culture or history. This was because the safeguards associated with the application of the Mental Capacity Act had not been followed by staff.

Are services caring?

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

Our findings

We did not inspect this domain during this inspection

Are services responsive to people's needs?

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

Our findings

We did not inspect this domain during this inspection

Are services well-led?

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

Our findings

We did not inspect this domain during this inspection

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment **How the regulation was not being met:** Patients were being unlawfully detained in the health-based places of safety beyond the expiration of their section 136 detention. **This was in breach of Regulation 13 (5)**