Care Quality Commission

Lancashire Care NHS Foundation Trust

Mental health crisis services and health-based places of safety

Quality Report

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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)
RW5HQ	Sceptre Point	Mental health crisis service	FY3 9HG
RW5HQ	Sceptre Point	Mental health crisis service	BB9 9TG
RW5HQ	Sceptre Point	Mental health crisis service	PR25 1HR
RW5CA	Burnley General Hospital	Health-based place of safety	BB10 2PQ
RW5X1	Royal Blackburn Hospital	Health-based place of safety	BB2 3HH
RW5Z3	The Harbour	Health-based place of safety	FY4 4FE
RW5Z2	The Orchard	Health-based place of safety	LA1 4JJ
RW5FA	Ormskirk General Hospital	Health-based place of safety	L39 2JW

Summary of findings

This report describes our judgement of the quality of care provided within this core service by Lancashire Care NHS Foundation 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 Foundation Trust and these are brought together to inform our overall judgement of Lancashire Care NHS Foundation 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

The physical space of four of the five health-based places of safety (HBPoS) we visited provided safe, clean environments to assess people. However, the layout and location of the HBPoS at the Scarisbrick Centre at Ormskirk General Hospital compromised patient safety and the bathroom door at the Orchard had no observation panel.

The premises at Hope House were not fit for purpose.

Risk assessments completed with the police were not present on 40% of the records we looked at.

The HBPoS were staffed by nurses from the adjacent acute wards when people were brought to the suite. There were concerns about whether the staffing establishment at the Orchard could support management of the HBPoS safely.

At the Orchard, the door to the bathroom lacked an observation panel, which meant people's privacy was compromised. The handle on the entrance door created a ligature point which compromised people's safety. The manager assured us this was due to be corrected. In the meantime, risk was mitigated through observation.

The HBPoS at the Harbour had clear windows which compromised patients' privacy, dignity and confidentiality.

Interview rooms and clinic rooms used by the mental health crisis services (MHCS) were clean, well maintained and safe environments.

Staffing levels and skill mix within the MHCS meant they were able to meet the needs of people accessing the crisis services.

Uptake of mandatory training was in line with trust policy.

Staff carried out risk assessments of patients on initial contact and updated this regularly.

People referred to the MHCS were usually seen within four hours of referral.

MHCS staff worked closely with people on the adult acute wards to provide intensive home treatment and facilitate early discharge.

Safeguarding arrangements were in place and took account of both adult and children's safeguarding. Staff knew how to make a safeguarding alert and showed good understanding of safeguarding issues.

There were good personal safety protocols in place including lone working practices.

There were clear policies and procedures covering all aspects of medicines management. At Hope House, documentation relating to medicines was not being completed consistently.

Staff told us that the impact of the trust implementing a smoke-free policy was putting staff and other patients at risk as people were not following the policy.

There was an incident reporting system in place. Staff understood their responsibilities in relation to reporting incidents. Managers analysed incidents to identify any trends and took appropriate action in response. For a reported incident we looked at, it was not clear whether a root cause had been established.

Across the teams, there was a general understanding of the regulation relating to the duty of candour.

Staff were de-briefed and supported following serious incidents. Debriefing included input from a psychologist. Actions from incidents were discussed in team meetings and at individual supervision to ensure lessons were learnt.

We found examples of excellent practice in disseminating information. At Pendle House, we saw an electronic 'notice board' accessible to all staff that included an SUI 'action tracker' that showed shared learning and good practice.

Staff carried out an initial assessment that focused on people's strengths, self-awareness and support systems, in line with recovery approaches. This usually took place within 24 hours.

At the HBPoS, a comprehensive assessment and physical health check was undertaken when people were brought in by the police under section 136 Mental Health Act 1983 (MHA).

Summary of findings

Care plans were centred on the person's identified needs. They demonstrated knowledge of current, evidence-based practice.

We found evidence that demonstrated the teams implemented best practice guidance within their clinical practice. At Pendle House, we saw an electronic 'notice board' accessible to all staff that flagged up best practice guidelines.

People's physical health needs were considered alongside their mental health needs. One team held a regular clinic for people to attend.

We saw some examples of excellent practice which meant people were able to stay in the community. All the MHCS carried out home-based clozaril titration. People did not have to be admitted to hospital when they were prescribed clozaril as staff carried out monitoring in the person's own home.

People who used services were enabled to participate in the activities of the local community so that they could exercise their right to be a citizen as independently as they were able to.

The MHCS at Hope House had carried out development work analysing how to optimise home treatment. They had looked at reducing or avoiding admissions and out of area treatment.

Staff had an annual appraisal which included setting objectives for personal development and they received regular clinical and managerial supervision. Staff were knowledgeable and committed to providing high quality and responsive care.

The MHCS had access to a range of mental health disciplines required to care for the people using the service. There was effective multi-disciplinary team working.

The MHCS had established positive working relationships with other service providers. They worked with them to plan people's transition between services in a holistic way.

There was a joint agency policy in place for the implementation of section 136 of the Mental Health Act which had been agreed by the local authorities, police forces and ambulance service.

The development of the HBPoS and joint working arrangements with the police reduced the numbers of people being assessed in police cells.

Use of the Mental Health Act 1983 (MHA) and the Code of Practice was good. We found evidence to demonstrate that the MHA was being complied with.

The teams were compliant with the requirements of the Mental Capacity Act 2005 (MCA). Staff took steps to enable patients to make decisions about their care and treatment wherever possible.

Staff were kind, caring and compassionate and supportive of people using the service.

When we spoke with people receiving support they were generally positive about the support they had been receiving and the kind and caring attitudes of the staff team.

We accompanied staff visiting people who used the service and it was clear that they had a good understanding of people's needs.

Care plans were developed with the person using the service. People were offered a copy of their care plan. They were able to decide who should be involved in their care and to what degree.

Carers' assessments were offered to people when appropriate.

Advocacy services were available.

People had access to information in different accessible formats. Interpreting services were also available if necessary.

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

The MHCS worked well with the adult acute mental health wards to prevent inappropriate admissions to inpatient beds. They ensured that people did not stay in hospital longer than necessary and promoted early discharge.

Summary of findings

The MHCS worked within the principles of the recovery model. This meant they focused on helping patients to be in control of their lives and build their resilience so that they could stay in the community and avoid admission to hospital wherever possible.

The MHCS ensured arrangements for discharge from hospital were considered from the time people were admitted, to ensure they stayed in hospital for the shortest possible time.

The HBPoS at Burnley and the Orchard held teleconferences three times a day regarding bed availability.

Assessments had always been completed well within the 72 hours required by the MHA and Code of Practice but not always within the trust's four hour target. We did not identify any additional or arbitrary restrictions when people were placed in the HBPoS.

Staff were committed to provided care which promoted people's privacy and dignity and focused on their holistic needs.

People's diverse needs were integrated in policies and proactively taken into account when devising protocols. This meant that meeting people's diverse needs was embedded in practice.

Complaints were well managed. At Hope House in particular, the MHCS was proactive in their approach to gaining feedback from people who used the service.

Staff knew the trust's vision and values and were able to describe how these were reflected in the team's work.

We saw records of staff appraisals that embedded the trust's vision and values.

Morale was high in the teams we visited. Staff showed a clear commitment to providing the quality care which individuals needed.

There were initiatives in place that supported staff morale and wellbeing. We saw a piece of work analysing the main reasons for staff sickness absences and considering how these could be addressed.

Staff felt well managed locally and mostly had high job satisfaction. They understood the trust whistleblowing policy and reported they felt able to raise concerns without fear of victimisation. Information supplied before the inspection indicated a culture of systemic bullying; however, we found no evidence of this.

Staff were encouraged to discuss issues and ideas for service development within supervision, business meetings and with senior managers.

Staff understood their responsibilities in relation to the duty of candour and their role in the process for any future incidents where patients experienced harm.

There was outstanding commitment to quality improvement, innovation and development.

The staffing establishment in the MHCS had been increased following a scoping exercise that looked at the staffing levels necessary to meet the needs of people who used the service, based on agreed trajectories.

At Hope House, a dedicated member of staff contacted everyone who had been discharged from the service in the previous two weeks to ask their opinions. We found that this information was discussed and used effectively to improve the service.

There were systems in place to monitor the service in order to improve performance. Audits were carried out on the use of section 136 and the use of HBPoS.

Summary of findings

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

Are services safe?

Requires improvement

We rated safe as requires improvement because:

- The physical space of four of the five health-based places of safety (HBPoS) we visited provided safe, clean environments to assess people. However, the layout and location of the HBPoS at the Scarisbrick Centre at Ormskirk General Hospital compromised patient safety.
- The door handle at the Orchard presented a ligature risk.
- The HBPoS at the Orchard and the Harbour compromised patients' privacy, dignity and confidentiality.
- There were concerns about whether the staffing establishment at the Orchard could support management of the HBPoS safely.
- The premises at Hope House were not fit for purpose.
- Risk assessments completed with the police were not present in 40% of the records we looked at.
- At Hope House, documentation relating to medications was not being completed consistently.
- For a reported incident we looked at, it was not clear whether a root cause established.
- Staff told us that the impact of the trust implementing a smoke-free policy was putting staff and other patients at risk as people were not following the policy.

However:

- Staffing levels and skill mix within the mental health crisis services (CMHS) meant they were able to meet people's needs.
- Safeguarding arrangements were in place and took account of both adult and children's safeguarding. Staff knew how to make a safeguarding alert and showed good understanding of safeguarding issues.
- Across the teams, there was understanding of the duty of candour.
- We found examples of excellent practice in disseminating information. At Pendle House, we saw an electronic 'notice board' accessible to all staff that included an SUI 'action tracker' that showed shared learning and good practice.

Are services effective?

Outstanding

We rated effective as outstanding because:

- Staff carried out a comprehensive assessment that focused on people's strengths, self-awareness and support systems, in line with recovery approaches.

Summary of findings

- At Pendle House, we saw an electronic 'notice board' accessible to all staff that flagged up best practice guidelines.
- People's physical health needs were considered alongside their mental health needs.
- All the MHCS carried out home-based clozaril titration.
- People were enabled to participate in the activities of the local community.
- The MHCS at Hope House had carried out development work and looked at reducing or avoiding admissions and out of area treatment.
- Joint working arrangements with the police reduced the numbers of people detained under section 136 being assessed in police cells.
- Use of the Mental Health Act 1983 (MHA) and the Code of Practice was good. We found evidence to demonstrate that the MHA was being complied with.
- The teams were compliant with the requirements of the Mental Capacity Act 2005 (MCA). Staff took steps to enable patients to make decisions about their care and treatment wherever possible.

Are services caring?

We rated caring as good because:

- Staff were kind, caring and compassionate and supportive of people using the service.
- We spoke with people receiving support and they were positive about the kind and caring attitudes of the staff team.
- Care plans were developed with the person using the service. People were able to decide who should be involved in their care and to what degree.
- People had access to information in different accessible formats.

Good

Are services responsive to people's needs?

We rated responsive as good because:

- The referral system enabled anyone to refer into the service, including self-referral from people or their carers.
- The MHCS worked well with the adult acute mental health wards to prevent inappropriate admissions to inpatient beds. They ensured that people did not stay in hospital longer than necessary and promoted early discharge.
- The MHCS helped patients to be in control of their lives and build their resilience so that they could stay in the community.

Good

Summary of findings

- The MHCS ensured arrangements for discharge from hospital were considered from the time people were admitted, to ensure they stayed in hospital for the shortest possible time.
- Staff supported people to consider issues of money and benefits, family issues, life events and vocational and educational opportunities.
- People's diverse needs were integrated in policies and proactively taken into account when devising protocols.

Are services well-led?

We rated well-led as good because:

Good

- Staff knew the trust's vision and values and were able to describe how these were reflected in the team's work.
- Morale was high in the teams we visited. Staff showed a clear commitment to providing the quality care which individuals needed.
- There were initiatives in place that supported staff morale and wellbeing. We saw a piece of work analysing the main reasons for staff sickness absences and considering how these could be addressed.
- Staff were encouraged to discuss issues and ideas for service development within supervision, business meetings and with senior managers.
- Staff understood their responsibilities in relation to the duty of candour.
- There was outstanding commitment to quality improvement, innovation and development.
- The staffing establishment in the MHCS had been increased following a scoping exercise that looked at the staffing levels necessary to meet the needs of people who used the service, based on agreed trajectories.
- At Hope House, a dedicated member of staff contacted everyone who had been discharged from the service in the previous two weeks to ask their opinions. We found that this information was discussed and used effectively to improve the service.
- There were systems in place to monitor the service in order to improve performance.

Summary of findings

Information about the service

Lancashire Care NHS Foundation Trust provides a range of community based mental health services to adults of working age across Lancashire. This includes mental health crisis services (MHCS) and health-based places of safety (HBPoS).

MHCS carry out short-term work to help support people at home when in mental health crisis and to support earlier discharge from hospital. The teams aim to facilitate the early discharge of patients from hospital or prevent patients being admitted to hospital by providing either home- or unit-based support and treatment.

The trust operates eleven HBPoS across the county. An HBPoS is a unit where people detained under section 136 of the Mental Health Act 1983 (MHA) are taken by the police for an assessment of their mental health.

Section 136 authorises the police to remove people found in a public place where they appear to be suffering from mental disorder and in immediate need of care or control, if it is necessary to do so in the interests of that person or for the protection of other people. It enables the police to remove the person to a place of safety, usually health-based, unless there are clear risks, for example, risks of violence that would require the person being taken to a police cell instead. People may be detained for up to 72 hours for the purpose of enabling them to be examined by doctors and assessed by an approved mental health practitioner to consider whether compulsory admission to hospital is necessary. The HBPoS offers a 24 hour, seven days a week service, open 365 days per year.

Lancashire Care NHS Foundation Trust has been inspected on a number of occasions since registration. However, the MHCS and HBPoS had not previously been inspected by the Care Quality Commission.

In September 2014, we carried out a monitoring visit to the Orchard to look at the arrangements the trust had for supporting admission and assessment under the MHA. This highlighted concerns about whether the staffing establishment at the unit could support the management of the HBPoS safely. The protocol in place stated that where a patient was assessed as low risk, the police would leave.

As a stand-alone unit, the ward would not have additional staff to draw on, especially at times when there were patients who required high levels of observation or restraint on the main ward. Concerns were expressed about how the HBPoS could be managed safely.

The trust had submitted an action statement explaining how they would improve adherence to the Mental Health Act 1983 (MHA) and MHA Code of Practice.

We were told by the ward manager that a business plan was being produced for an additional member of staff on each shift to address the matter. This was not finalised and we were not shown the plan.

During 2014, CQC carried out a thematic review of crisis care. The trust performed well in that higher than average numbers of people knew who was in charge of organising their care and who to contact if they experienced crisis outside normal working hours.

The review also showed that the trust had lower than average numbers of 'unnatural deaths of detained patients'. In Lancashire, numbers were much lower than expected in similar trusts. This suggested follow up care was generally good across the trust and that there may be particular areas of good work being developed in Lancashire. However, the number of home treatment episodes in relation to the number of people using secondary mental health services was lower than the national average across the trust, suggesting MHCS were stretched and thus less able to provide a home treatment service. Trust bed occupancy was in line with national averages at 87.5%, suggesting that lack of home treatment did not lead to pressure on specialist mental health beds. However, Blackpool had much higher admissions via A&E for a mental health condition. There were higher than expected numbers of multiple A&E attenders and out-of-hours self-harm presentations at A&E. The Quality and Outcomes Framework indicators for Blackpool and Blackburn with Darwen showed a higher than average percentage of patients on the severe mental illness and depression registers, along with higher exceptions reported by GPs (for example, where patients

do not attend for review or medication cannot be prescribed due to contra-indications or side effects). This suggested that mental health crisis for these groups may be more likely.

When children and young people were accepted for assessment under section 136,staff sought advice from the CAMHS team.

The review found that HBPoS were only being used for the purposes for which they were intended. However, there were delays in providing staffing levels in accordance with the inter-agency policy when police arrived, leading to delays in handover. Additionally, Mental Health Act assessments were taking longer than the target time of four hours. There was no audit against the requirements of the inter-agency policy and the reasons why people were turned away from the HBPoS were not recorded. However, the review identified staffing as one reason for this. It also found that people were not being turned away because the suite was already occupied, suggesting that provision of HBPoS was adequate.

Our inspection team

Our inspection team was led by:

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

Head of Inspection: Jenny Wilkes, Care Quality Commission

Team Leader: Sharon Marston, Care Quality Commission

The team that inspected mental health crisis services and health based places of safety included two CQC inspectors and a variety of specialists: a consultant psychiatrist, two registered mental health nurses, a social worker and a Mental Health Act reviewer.

Why we carried out this inspection

We inspected this core service as part of our on-going comprehensive mental health inspection programme.

How we carried out this inspection

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

· Is it safe?

· Is it effective?

· Is it caring?

· Is it responsive to people's needs?

· Is it well-led?

During this inspection we:

Carried out announced visits to the services on 28, 29 and 30 April 2015.

Visited the mental health crisis services at:

- Hope House, Blackpool (Blackpool, Fylde and Wyre)
- Pendle House, Burnley (Burnley, Pendle and Rossendale)
- Westfields, Leyland (Chorley and West Lancashire)

Visited the health-based places of safety at:

- Ward 20, Burnley General Hospital
- Darwen ward, Royal Blackburn Hospital
- The Harbour, Blackpool
- The Orchard, Lancaster
- The Scarisbrick Centre, Ormskirk General Hospital

During the visit, we met and interviewed 36 members of staff who worked in the services, including managers, nurses, occupational therapists, pharmacists, psychiatrists, psychologists, social workers, support workers and other ancillary staff.

Summary of findings

We met with three patients who were using the services. They shared their views and experiences of the services we visited.

We looked at the care records of 33 people who used the services.

We observed staff interacting with patients.

We accompanied staff on two visits to patients at home and observed how they cared for them.

We looked at a range of records including clinical and management records.

We carried out tours of eight premises and observed two clinical review meetings and two multi-disciplinary team meetings.

What people who use the provider's services say

Only one of the HBPoS was in use during our visit and we were not able to speak with people who had used them.

We spoke with three people who used the MHCS. They were complimentary about the service they had received, saying the teams were 'brilliant' and had 'kept them stable'. People said the staff were respectful and polite. They were clear about their treatment plans.

Good practice

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

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

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

Areas for improvement

Action the provider MUST take to improve

The trust **must** ensure that:

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

Action the provider SHOULD take to improve

The trust **should** ensure that:

- Staffing levels at the Orchard are sufficient to manage the HBPoS safely.
- The HBPoS environments at the Orchard and the Harbour do not compromise patients' safety, privacy, dignity and confidentiality.
- The premises at Hope House are fit for purpose.
- Risk assessments completed with the police are undertaken consistently across the HBPoS.
- Documentation relating to medications is completed consistently.
- Incidents are thoroughly investigated and a root cause established and addressed.
- The impact of the no smoking policy is monitored and reviewed.
- Opportunities for learning and sharing are utilised across the service.
- Mechanisms for collecting feedback from people are consistent across the teams.

Care Quality Commission

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
Mental health crisis service Hope House	Sceptre Point
Mental health crisis service Pendle House	Sceptre Point
Mental health crisis service Westfields	Sceptre Point
Health-based place of safety	Burnley General Hospital
Health-based place of safety	Royal Blackburn Hospital
Health-based place of safety	The Harbour
Health-based place of safety	The Orchard
Health-based place of safety	Ormskirk General Hospital

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.

Use of the Mental Health Act 1983 (MHA) was good in the MHCS and HBPoS. We found evidence to demonstrate that the MHA and the Code of Practice were being complied with.

Detailed findings

Staff understood the statutory requirements of the MHA. Records showed that when people were admitted to the health based place of safety, staff explained their rights to them and repeated them until patients understood their rights. There were effective systems in place to assess and monitor risks to individual people who were detained under the MHA. Records we looked at included information about statutory advocacy services and there was information displayed in waiting areas in the team offices.

Mental Capacity Act and Deprivation of Liberty Safeguards

The training records we looked at showed that all those staff had received training on the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). This was part of the mandatory training provided by the trust.

We found the services were compliant with the requirements of the Mental Capacity Act (MCA).

The staff we spoke with understood that capacity fluctuated and that people may have capacity to consent to some things but not others. They were clear about their responsibilities in undertaking capacity assessments and continuous monitoring to ensure people were able to understand and agree to decisions being made or that they were made in the best interest of the person.

People using the crisis services lived in the community and therefore had a high degree of autonomy and independence to determine aspects of their daily lives. We were told about examples of capacity assessments being made and in the case records we looked at we found supporting evidence that capacity was considered and recorded. We attended review meetings where consent was discussed with the person who used the service.

Requires improvement

Are services safe?

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

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

Summary of findings

Our findings

Mental health crisis services:

Westfields, Leyland (Chorley and West Lancashire)

Pendle House, Burnley (Burnley, Pendle and Rossendale)

Hope House, Blackpool (Blackpool, Fylde and Wyre)

Safe and clean environment

The premises at Hope House were not fit for purpose. Doors opened incorrectly and the alarm system did not work properly. We were told that this was a temporary base for the team but there was no plan in place for its future location.

Interview rooms and clinic rooms used by the mental health crisis services (MHCS) were clean, well maintained and safe environments. Staff were able to raise an alarm if they did not feel safe.

However, most of the crisis teams' work involved visiting people at home to provide an assessment and ongoing care and treatment to support people in mental health crisis.

Where there were concerns about risks to staff, staff visited in pairs or arranged to see patients in safer alternative venues.

Safe staffing

Staffing levels and skill mix within the teams meant the staff on duty were able to meet the needs of people accessing the crisis services.

The out of hours MHCS was managed through a duty system co-ordinated between the teams.

Staff told us there were sufficient numbers of staff to deliver the care and support which people needed. They reported manageable caseloads which helped keep people safe. Staff were able to meet targets, for example, ensuring people were seen or offered an assessment within four hours of referral.

During 2014, the trust had carried out a scoping exercise called 'mind the gap' that looked at crisis services across the trust. As a result, additional staff had been recruited to the teams. Staffing levels were based on a monthly trajectory of the number of patients receiving two visits.

Sickness within the MHCS teams ranged from 4-8%. Where sickness and short term absences needed to be covered, staff were available to provide overtime using a bank system. There was little use of agency staff within the teams due to the specialist nature of the role but agency staff were utilised for long term absences. They were supervised on a daily basis by the manager. Formal clinical supervision was also provided by the trust.

Each team included at least one dedicated consultant. This meant patients had prompt access to a psychiatrist when required. There was adequate medical cover during the day and night. A doctor could attend in an emergency and was available on call on the hospital site out of hours.

Assessing and managing risk to patients and staff

Staff carried out risk assessments of patients on initial contact and updated this regularly.

Staff assessed and managed individual risks on an on-going basis. Risk assessments were comprehensive and recorded within electronic records. Risk formulation was based on the '5 Ps' model, a trust wide initiative which enabled staff to conceptualise risk in a consistent way. The 5 Ps were presenting needs (current), predisposing factors (historical), precipitating factors (triggers), perpetuating factors (that maintain risk) and protective factors (that promote recovery).

The MHCS did not actively promote the use of advance decisions due to the acuity of patients but they referred them on to the community mental health teams via the care co-ordinator.

All the MHCS had approved mental health professionals (AMHPs) within the team. This helped ensure that assessments carried out under the Mental Health Act 1983

(MHA) occurred in a timely manner. AMHPs being embedded within crisis services also enhanced the team's understanding of how staff could manage significant risks using legal powers to bring people into hospital compulsorily if needed. People referred to the MHCS were usually seen within four hours of referral.

MHCS staff worked closely with people on the adult acute wards to provide intensive home treatment and facilitate early discharge. None of the teams had a waiting list for crisis services.

Safeguarding arrangements were in place and took account of both adult and children's safeguarding. Staff had received training in safeguarding. They knew how to make a safeguarding alert and showed good understanding of safeguarding issues. Safeguarding information was displayed in the teams' offices. A safeguarding policy and procedures were available on the trust intranet.

Staff recorded their whereabouts on the team noticeboard including the time they expected to return. Where there was risk they worked in pairs. Teams had a code word so that people could alert and receive assistance in a urgent situations. Each team had a shift co-ordinator who ensured staff were safe and returned to the office or made contact following a home visit. This meant that there were good personal safety protocols in place including lone working practices.

There were clear policies and procedures covering all aspects of medicines management. The level of pharmacy support to the community teams varied across the trust but storage of medication audits were conducted quarterly for all teams storing medication. Arrangements were in place for reporting and investigating medicines incidents. A pharmacist prescriber we spoke with felt well supported in this role. Where available ePACT [electronic prescribing analysis and cost] data was used to monitor prescribing.

At Hope House we found that medicines and blank prescription and administration forms were kept securely at all times. However, the trust pharmacist had identified that although medicines disposal was recorded, nurses were not always completing documentation to record the removal of unwanted medicines from people's homes in order that the transfer of medicines could be fully tracked.

Track record on safety

There had been one reported serious untoward incident (SUI) categorised as severe that involved the death of a patient under the care of the MHCS in the last 12 months.

Recommendations and learning from the reported incident had been disseminated and we saw documentary evidence of the recommended action being tested. However, it was unclear whether a root cause had been established.

Reporting incidents and learning from when things go wrong

There was an incident reporting system in place. This enabled team managers and senior managers to review and grade the severity of incidents. Staff knew how to report an incident. They understood their responsibilities in relation to reporting incidents. Managers analysed incidents to identify any trends and they took appropriate action in response.

Across the teams, there was a general understanding of the regulation relating to the duty of candour.

Staff were de-briefed and supported following serious incidents. Debriefing included input from a psychologist. Actions from incidents were discussed in team meetings and at individual supervision to ensure lessons were learnt.

We found examples of excellent practice in disseminating information. At Pendle House, we saw an electronic 'notice board' accessible to all staff that included an SUI 'action tracker'. The tracker showed what actions had been taken or were due to be taken and shared learning and good practice.

Health-based places of safety:

Ward 20, Burnley General Hospital

Darwen ward, Royal Blackburn Hospital

The Harbour, Blackpool

The Orchard, Lancaster

The Scarisbrick Centre, Ormskirk General Hospital

Safe and clean environment

With the exception of the Scarisbrick Unit at Ormskirk, the HBPoS we visited provided a suitable environment for the

assessment of patients detained under section 136 of the Mental Health Act 1983 (MHA). The physical space of four of the HBPoS provided good environments to assess people and provide safe care.

The location and layout of the HBPoS at the Scarisbrick Centre, Ormskirk General Hospital was not suitable for the purpose for which it was being used. It compromised patient safety, privacy, dignity and confidentiality. The HBPoS had no discrete entrance. The entrance to the suite was via the public reception area, visible from reception and the ward entrance. The only other door leading into the suite was a fire exit. People detained in the HBPoS were brought in through the public area and this compromised their privacy, dignity and confidentiality. This breached Royal College of Psychiatrists' standards thus the suite did not conform to national best practice.

The toilet and washing facilities were not integral to the suite but located across a corridor which was open to the public and ward traffic. They had formerly been used as an accessible toilet. There were grip rails that could be used as ligature points. A ligature point is a place to which patients might tie something to strangle themselves. Although staff could manage the risk through observation, the environment meant people could not be supported safely without compromising their privacy. People were escorted to toilets through the public reception area. This also meant their privacy, dignity and confidentiality were compromised and could put the patient or other people at risk. The toilet and washing facilities did not meet fundamental standards within the good practice guidance of the Royal College of Psychiatrists to assure against the risks of unsafe or unsuitable premises. There was a potential risk of harm to people who use the service and others. Since our inspection, the trust has produced a plan of action to address these issues in part.

At the Orchard, the door to the bathroom lacked an observation panel, which meant people's privacy was compromised. The handle on the entrance door had been positioned upside down. This created a ligature point which compromised people's safety. The manager assured us this was due to be corrected. In the meantime, risk was mitigated through observation.

The HBPoS at the Harbour had clear windows which faced directly onto a courtyard used by patients in the seclusion area. This compromised patients' privacy, dignity and confidentiality. Staff told us they would arrange for this to be rectified immediately.

The units were clean and well maintained and the furniture was in good condition.

Emergency equipment, including automated external defibrillators and oxygen, was in place on the adjacent acute admission wards and checked regularly to ensure it was fit for purpose and could be used effectively in an emergency. Medical devices and emergency medication were also checked regularly. Most staff had undertaken training in life support techniques. There were alarms available in the units to summon additional staff if required from adjacent acute wards. Staff said that when the alarm was used staff responded very quickly. There had been no serious incidents.

Safe staffing

The HBPoS were staffed by nurses from the adjacent acute wards when people were brought to the suite by police. The trust policy stated that there would be a designated nurse. However, on most wards, the shift leader allocated staff to the suite if necessary. At the Harbour, there were dedicated staff on each shift.

In September 2014, we carried out a monitoring visit to the Orchard to look at the arrangements the trust had for supporting admission and assessment under the MHA. This highlighted concerns about whether the staffing establishment at the unit could support management of the HBPoS safely. The current protocol indicated that where a patient was assessed as low risk, the police would leave.

As a stand-alone unit, the ward would not have additional staff to draw on, especially at times when there were patients who required high levels of observation or restraint on the main ward. Concerns were expressed about how the HBPoS could be managed safely.

The trust had submitted an action statement explaining how they would improve adherence to the MHA and MHA Code of Practice.

Requires improvement

Are services safe?

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

We were told by the ward manager that a business plan was being produced for an additional member of staff on each shift to address the matter. This was not finalised and we were not shown the plan.

Staff were clear about their role and function in managing people in the suite and were able to respond in a timely manner when required.

Provided there were two trust staff in attendance and there were no significant risks indicated, the police were able to leave people within the HBPoS for the assessment to be carried out. The multi disciplinary team had agreed a joint protocol for assessing risk. Feedback from AMHPs and from the police indicated that the arrangements for staffing the units generally worked well.

There was appropriate medical cover available from the trust to ensure that a timely response was available to people requiring assessment within the units.

Assessing and managing risk to patients and staff

The designated nurse received the detained patient and there was a process was in place for an approved mental health professional to be contacted regarding making arrangements for a MHA assessment. At the HBPoS, nursing staff and the police completed an agreed joint risk assessment for the patient. When risk assessments had been conducted for patients and the risks were assessed as too high, the police would stay until the risk was reduced to an acceptable level.

Systems were in place to assess and monitor risks to individual patients throughout the detention period to determine whether the police would be required to remain at the HBPoS to provide support.

We found there were local arrangements in place to ensure proper risk assessment before joint decisions were made about the police officers leaving people in the HBPoS. However, risk assessments completed with the police were not present on 40% of the records we looked at. As part of the locally agreed protocol, police undertook a body search on all people before their arrival.

In the records we reviewed we saw appropriate physical and mental health assessments had been undertaken.

Staff were familiar with de-escalation techniques and told us that they used these in the first instance before restraining people. At the Harbour, we observed a good example of good practice in de-escalation and individual risk assessment.

Staff told us that the impact of the trust implementing a smoke-free policy was putting staff and other patients at risk as people were not following the policy. Following on from the mental health safety thermometer, which records incidents of commonly occurring harm, the trust had developed a safety assurance tool in collaboration with the North Lancashire violence reduction team. At the Orchard, we saw the most recent collated data from January 2015. The data showed that five incidents had been reported where patients had been found smoking in areas such as their bedrooms.

Track record on safety

One serious incident had been reported in the last 12 months in relation to the HBPoS.

Reporting incidents and learning from when things go wrong

Regular multi-agency meetings were well established to oversee the operation of section 136 and the use of the HBPoS. The analysis of incident data and areas for improvement were routinely discussed in these monitoring meetings. We saw that all breaches were discussed, for example, breach of the four hour target for assessment.

Staff we spoke with knew how to recognise and report incidents on the trust's electronic incident recording system. The ward managers reviewed all incidents and sent them on to the trust's clinical governance team who maintained oversight. The system ensured senior managers within the trust were alerted to incidents promptly and could monitor the investigation and response to these.

Learning from incidents was also circulated trust-wide via a newsletter.

Staff and people using the service were supported and given time to talk about the impact of serious incidents.

Are services effective?

Outstanding

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

Summary of findings

Our findings

Mental health crisis services:

Westfields, Leyland (Chorley and West Lancashire)

Pendle House, Burnley (Burnley, Pendle and Rossendale)

Hope House, Blackpool (Blackpool, Fylde and Wyre)

Assessment of needs and planning of care

We looked at the care records of 33 people receiving crisis care. Records were stored electronically and access was protected.

Across all the teams, staff completed assessments quickly. They assessed urgent referrals within four hours. All the teams held daily meetings where they discussed people's care and the support they required.

Staff carried out an initial assessment following referral that included a risk assessment and consideration of people's social, cultural, physical and psychological needs and preferences. The assessments focused on people's strengths, self awareness and support systems, in line with recovery approaches. This usually took place within 24 hours.

The person who used the service and staff developed a care plan together. They reviewed the care plans regularly. The care plans were centred on the person's identified needs. They demonstrated knowledge of current, evidence-based practice. They were solution focused and there was evidence of referral to other services such as community services, admission to hospital or discharge to primary care based on the patient's needs. Assessments included an assessment of mental capacity where necessary.

Best practice in treatment and care

We found evidence that demonstrated that the teams implemented best practice guidance within their clinical practice. At Pendle House, we saw an electronic 'notice board' accessible to all staff that flagged up best practice guidelines.

People's physical health needs were considered alongside their mental health needs. This included monitoring symptoms and making referrals to the appropriate health care professionals, for example, a GP or dentist. The teams had dedicated staff who carried out physical health checks, and the team at Hope House ran a regular weekly clinic for people to attend.

We saw some examples of excellent practice which meant people were able to stay in the community. All the MHCS carried out home-based clozaril titration. Clozaril titration is usually carried out in hospital because of the level of monitoring required. People did not have to be admitted to hospital when they were prescribed clozaril because staff carried out monitoring in the person's own home. This practice meant hospital admission was avoided. There were protocols in place for this. The protocol drew attention to cultural issues such as ethnicity in initiating and managing clozaril. This meant that unnecessarily cautious practice could be avoided and people from Black and Asian ethnic backgrounds received appropriate medication. A seven day service was not available for clozaril initiation but patients were provided with an out-of-hours telephone contact and no dose increases were made at the weekends.

The MHCS offered a range of short term interventions. Staff we spoke with described the interventions they used to assist people with managing crises and distress such as anxiety management, psychological interventions, medication and relapse prevention work. The teams provided activities and therapeutic interventions to support people's recovery, such as cognitive behavioural therapy, and made referrals to community based groups.

Staff also assisted people with practical issues such as money, benefits and accessing educational opportunities. This meant that people who used services were enabled to participate in the activities of the local community so that they could exercise their right to be a citizen as independently as they were able to.

The MHCS at Hope House had carried out development work analysing how to optimise home treatment. They had looked at reducing or avoiding admissions and out of area treatment. The team had developed an intervention toolkit based on typical interventions and defined standards for

Are services effective?

Outstanding

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.

gatekeeping. They had also looked at the skill set within the team and commissioned training to fill gaps. In February 2015, the team had won a trust award for this work. This was a good example of excellent practice.

The teams rated severity and outcomes using the Health of the Nation Outcome Scales clustering tool. The information had been collated and scores across the teams showed an average improvement in clinical outcomes of 71%.

Skilled staff to deliver care

The MHCS had access to a range of mental health disciplines required to care for the people using the service. There was effective multi-disciplinary team working within the service, including input from mental health nurses, support workers, social workers, approved mental health professionals, occupational therapists, administrative support and doctors.

Staff had an annual appraisal which included setting objectives for personal development. The appraisal records we saw supported this. Staff received training to support them in their roles. This included specialist training in addition to mandatory training provided by the trust. The training records we saw showed that staff had accessed a range of training so they were able to meet the needs of people who used the service.

Staff received regular clinical and managerial supervision. They said they found supervision valuable. The records we saw showed they discussed complex or challenging clinical issues within these sessions and explored ways to improve the service they provided to people. Staff wellbeing and performance issues were also discussed. Staff were knowledgeable and committed to providing high quality and responsive crisis care.

Multi-disciplinary and inter-agency team work

There was good multi-disciplinary team (MDT) working within the MHCS. The teams worked to an integrated health and social care model. MHCS were made up of nurses, social workers and support time recovery workers, along with psychiatrists, psychologists and occupational therapists.

The MHCS held daily MDT meetings to review the mental health of the people who used the service.

The MHCS had established positive working relationships with other service providers such as the acute admission wards, GPs and community services and groups. The teams worked with the acute wards to plan people's transition between services in a holistic way.

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

Use of the Mental Health Act 1983 (MHA) was good in the MHCS. We found evidence to demonstrate that the MHA and the Code of Practice were being complied with.

Staff understood the statutory requirements of the MHA.

The MHCS had approved mental health professionals (AMHP) integrated within the teams. This meant that when a person required a MHA assessment, an AMHP was available to arrange assessments within reasonable timescales. Where there were delays, these were usually beyond the full control of the trust because they related to the response times of AMHPs and the availability of doctors approved under section 12 MHA to carry out assessments. Of the recorded breaches we saw which related to delays, 70% occurred at night.

Records we looked at included information about statutory advocacy services and there was information displayed in waiting areas in the team offices.

There were effective systems in place to assess and monitor risks to individual people who were detained under the MHA.

Good practice in applying the Mental Capacity Act

The teams were compliant with the requirements of the Mental Capacity Act 2005 (MCA). People using the MHCS lived in the community and had a high degree of autonomy and independence to determine aspects of their daily lives.

Staff took steps to enable patients to make decisions about their care and treatment wherever possible. There was good understanding of mental capacity and consent issues. The teams did not actively promote using advance directives due to acuity but referred people to discuss their future needs with the community mental health teams following discharge from the crisis service. This would be discussed with the care co-ordinator at handover.

Staff understood the process to follow if a decision about or on behalf of a person lacking mental capacity to consent to proposed decisions was needed.

Are services effective?

Outstanding

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.

Health-based places of safety:

Ward 20, Burnley General Hospital

Darwen ward, Royal Blackburn Hospital

The Harbour, Blackpool

The Orchard, Lancaster

The Scarisbrick Centre, Ormskirk General Hospital

Assessment of needs and planning of care

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

The arrangements and availability of staff also meant that the police were able to hand over individuals to health staff within an appropriate timescale.

A comprehensive assessment and physical health check was undertaken when people were brought in by the police under section 136 Mental Health Act 1983 (MHA). Physical health checks were usually carried out by a paramedic who conveyed the person to the HBPoS or by nursing staff on arrival if the person was conveyed by the police. This meant that people had baseline physical assessments before or on admission to the HBPoS. People who were found to be under the influence of drugs or alcohol were transferred to the accident and emergency service.

Records relating to section 136 episodes were available to staff when they needed them. The records we saw consisted of an overview report produced in paper format. This meant that information was readily available so staff could check any decisions made. If the person was admitted, the paperwork was transferred to the ward.

Best practice in treatment and care

People assessed in the HBPoS were given an information pack explaining the powers and responsibilities devolved under section 136. Staff also explained this. Staff repeated explanations until people understood. This ensured that people understood where they were, the assessment process and what their rights were.

Skilled staff to deliver care

Qualified staff from the acute admissions wards co-ordinated admissions to the HBPoS and received the detained patient.

The HBPoS were next to the acute wards or the psychiatric intensive care units so staff from these units could be called to assist where necessary.

Staff had access to a checklist of action to be completed when someone was admitted to the HBPoS. However, there was no space for patients' comments.

Multi-disciplinary and inter-agency team work

There was a joint agency policy in place for the implementation of section 136 of the Mental Health Act which had been agreed by the local authorities, police forces and ambulance service. There was a commitment to multi agency working to improve the arrangements for conveyance and assessment when people were brought in under section 136.

There were good links with the police in the operation of section 136. Good working relationships were evident at a strategic and operational level. All the HBPoS demonstrated good multi-agency working that encompassed monthly meetings, discussion of breaches and multi-agency training.

Staff working at the HBPoS described good working relationships between the agencies. The approved mental health professionals (AMHPs) we spoke with told us the staff working in the HBPoS were effective, made referrals appropriately and communicated information. This helped to ensure assessments were completed in a timely manner and delays minimised.

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

Staff had a good understanding of the duties placed on them when people were brought in by the police under section 136 to ensure they worked within the Mental Health Act (MHA), the Code of Practice and the guiding principles.

Records showed that when people were admitted to the health based place of safety, staff explained their rights to them and repeated them until people understood their rights.

Information on advocacy and Independent Mental Health Advocacy Services (IMHA) services were available to people.

Good practice in applying the Mental Capacity Act

Staff were aware of the Mental Capacity Act 2005 (MCA) and the implications this had for their clinical and professional practice. They had received training on the MCA.

Are services effective?

Outstanding

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.

There was evidence in records that mental capacity issues relating to the assessment process and any decisions following the assessment were being reviewed. The AMHP carried out these assessments to decide if the patient had capacity to consent to admission to hospital informally or whether powers under the Mental Health Act needed to be used.

Are services caring?

Good

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

Summary of findings

Our findings

Mental health crisis services:

Westfields, Leyland (Chorley and West Lancashire)

Pendle House, Burnley (Burnley, Pendle and Rossendale)

Hope House, Blackpool (Blackpool, Fylde and Wyre)

Kindness, dignity, respect and support

In all the teams we observed the staff to be kind, caring and compassionate and supportive of people using the service. All the staff we observed demonstrated this. When we spoke with people receiving support they were generally positive about the support they had been receiving and the kind and caring attitudes of the staff team.

Staff demonstrated a good knowledge and understanding of people using the service. When we accompanied staff visiting people who used the service, it was clear that they had a good understanding of people's needs.

All the staff teams maintained people's confidentiality at all times. When we accompanied staff on home visits the staff members asked if the person was happy for a CQC team member to be present prior to the visit. All staff we spoke with were aware of the need to ensure a person's confidential information was kept securely. Staff access to electronic case notes was protected.

The involvement of people in the care that they receive

People received a welcome letter with information about the service, which included information on complaints, support groups and advocacy information. People were also given information about self-help groups and literature to promote independence and learning. At Westfield, we saw a timetable of alternative interventions planned which encouraged independence. Some of the activities were facilitated by community groups.

Care plans were developed with the person using the service. People were offered a copy of their care plan. When we accompanied staff on home visits, we saw that people had copies. The records we looked at contained personalised, holistic care plans. They documented whether people had received a copy of their care plan and the reason why not if they had not. The support offered was flexible depending on the person's needs. For example, some people received visits several times a day. People's family, friends and advocates were involved in their care if the person wished. People were able to decide who should be involved in their care and to what degree.

Advocacy services were available if people required them. Information available on advocacy varied across the teams, ranging from information in waiting rooms to active discussion and referral from the staff team.

People were able to give feedback on the care they received via surveys. Mechanisms for collecting feedback and response rates were variable across the teams. However, where feedback had been sought, this was generally positive. For example, at Hope House, a dedicated member of staff contacted everyone who had been discharged from the service in the previous two weeks to ask their opinions. All the people who were contacted in the month before our visit had felt they were treated with courtesy and respect at all times. The team acted on the information gathered; for example, to ensure that all people discharged from the service had a discharge care plan in place. We saw discussion of this in the minutes of team meetings.

Carers' assessments were offered to people when appropriate.

Health-based places of safety:

Ward 20, Burnley General Hospital

Darwen ward, Royal Blackburn Hospital

The Harbour, Blackpool

The Orchard, Lancaster

The Scarisbrick Centre, Ormskirk General Hospital

Kindness, dignity, respect and support

The staff at each of the units explained how they would try and support people in a kind and considerate manner.

We observed staff using advanced verbal de-escalation skills, showing compassion and providing comfort and reassurance.

Are services caring?

Good

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

The involvement of people in the care that they receive

Advocacy services were available for people to access from the HBPoS.

Staff explained patients' rights to them routinely whilst they were detained.

People had access to information in different accessible formats. Interpreting services were also available if necessary.

Feedback about people's experiences was not routinely requested during or after being cared for in the health based place of safety.

Are services responsive to people's needs?

Good

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

Summary of findings

Our findings

Mental health crisis services:

Westfields, Leyland (Chorley and West Lancashire)

Pendle House, Burnley (Burnley, Pendle and Rossendale)

Hope House, Blackpool (Blackpool, Fylde and Wyre)

Access and discharge

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

In addition, the mental health crisis services (MHCS) took referrals from inpatient wards, the different functions of the community mental health teams or community based services such as GPs.

The MHCS visited people in their homes or they could attend the team offices, dependent upon their needs and level of risk. Staff also supported people by telephone or an agreed level of contact.

The MHCS were the gatekeepers for inpatient beds. They were operating at 98%. 'Gatekeeping' means that nobody is admitted into care unless the team has agreed that there is no alternative. This is in line with the 'least restrictive' principle of the Mental Health Act 1983 (MHA) Code of Practice. Staff told us there were sometimes problems accessing beds for patients within their own locality when they needed to be admitted to hospital. This meant that people were sometimes admitted to hospital in a different part of the trust, which could be some distance from their home.

The MHCS worked within the principles of the recovery model. This meant they focused on helping patients to be in control of their lives and build their resilience so that they could stay in the community and avoid admission to hospital wherever possible. The home treatment function of the MHCS also enabled the some patients to be discharged from hospital early by offering intensive support during the transition from hospital back to the community. This helped to reduce the risk of them relapsing during their recovery. This meant that the MHCS ensured people did not stay in hospital longer than necessary and promoted patients' early discharge.

The MHCS ensured arrangements for discharge from hospital were considered from the time people were admitted, to ensure they stayed in hospital for the shortest possible time. They had regular daily contact with the acute wards to identify people who may be appropriate for early discharge with support from the team. This included providing support to people during periods of leave from the ward. This proactive planning for discharge at the point of admission demonstrates a recovery oriented service in which care is underpinned by the recovery model. This is in line with National Institute for Health and Clinical Excellence (NICE) guidance and the Mental Health Crisis Care Concordat.

The mental health crisis service (MHCS) at Hope House gathered data on referrals, numbers of contacts and no access visits. The team discussed the data in team meetings and supervision and used it to address performance of both the individual and the team.

The facilities promote recovery, comfort, dignity and confidentiality

Staff were committed to providing care which promoted people's privacy and dignity. Care focused on people's holistic needs and not just on treating their mental distress or illness; for example, the care plans and review meetings we saw showed staff supported people to consider issues of money and benefits, family issues, life events and vocational and educational opportunities.

We observed staff assessing and providing crisis care and saw people were treated with dignity and respect throughout the interventions.

Meeting the needs of all people who use the service

The MHCS had access to interpreting services which assisted them to support people.

The care plans we looked at and the meetings we observed showed that people's individual, cultural and religious beliefs were taken into account and respected. People's

Are services responsive to people's needs?

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

diverse needs were integrated in trust policies and proactively taken into account when devising protocols. This meant that meeting people's diverse needs was embedded in practice.

Listening to and learning from concerns and complaints

We saw that complaints were well managed. At Hope House in particular, the MHCS was proactive in their approach to gaining feedback from people who used the service. People were given written information about making complaints and they knew how to raise concerns. They could do this electronically if they wished.

Complaints within each service were looked into and responded to. The trust employed a dedicated team to investigate complaints where they could not be resolved locally. Where complaints were not upheld, managers would still look at what could be learned or improved.

Complaints and concerns which people had raised were discussed routinely at the monthly team meetings and in supervision, or at the daily multi disciplinary team meeting if necessary. We found evidence that managers had taken appropriate action in response to complaints they had received.

Health-based places of safety:

Ward 20, Burnley General Hospital

Darwen ward, Royal Blackburn Hospital

The Harbour, Blackpool

The Orchard, Lancaster

The Scarisbrick Centre, Ormskirk General Hospital

Access and discharge

People in the HBPoS were seen quickly, well within the 72 hours required by the MHA but not always within the target time of four hours the trust had set. Where there were delays, these were usually beyond the full control of the trust because they related to the response times of AMHPs and the availability of doctors approved under section 12 MHA to carry out assessments. Of the recorded breaches we saw which related to delays, 70% occurred at night.

The HBPoS at Burnley and the Orchard held teleconferences three times a day regarding bed availability.

The facilities promote recovery, comfort, dignity and confidentiality

We saw that assessments had always been completed well within the 72 hours required by the MHA and Code of Practice but not always within the trust's four hour target. We did not identify any additional or arbitrary restrictions when people were placed in the HBPoS.

The environments of four of the HBPoS provided a dignified environment for the assessment of people detained under section 136. There was a separate entrance for parking immediately outside for police to bring people directly into the units which helped maintain the safe and dignified conveyance of people. The units provided clean and comfortable areas to carry out assessments including separate toilet and shower areas, appropriate furniture, comfortable chairs and all had a bed or a sofa available so where there were delays in assessments patients could make themselves comfortable. There were separate staff areas for staff to meet and discuss the assessment.

The trust was aware of the possibility of there being more than one person requiring the facility at any given time. However this occurred on an infrequent basis and we only heard of one example of this happening. We were told that a second person detained under section 136 MHA would be conveyed to another suite within the trust. None of the records we looked at showed that any person had had to be transferred to a different HBPoS.

Meeting the needs of all people who use the service

The joint agency policy explained how the needs of people detained under section 136 would be managed and the appropriateness of the relevant HBPoS. This included circumstances when the police custody suites were more appropriate than the HBPoS within the trust. It also explained when, for example, it may be appropriate for a person to be taken to the accident and emergency department before being admitted to the HBPoS.

When children and young people were accepted for section 136 assessments staff sought advice from the CAMHS team.

Staff confirmed that they had access to translation services and interpreters where required. A range of patient information was available for people placed in the HBPoS.

Are services responsive to people's needs?

Good

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

Records showed that when people were admitted to the HBPoS, staff gave them a leaflet about the powers and responsibilities of section 136 of the MHA as well as a verbal explanation.

Listening to and learning from concerns and complaints

Information about raising concerns and complaints was available to people who were assessed in the HBPoS. During 2014 there had been no complaints received from people detained under Section 136.

Are services well-led?

Good

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

Summary of findings

Our findings

Mental health crisis services:

Westfields, Leyland (Chorley and West Lancashire)

Pendle House, Burnley (Burnley, Pendle and Rossendale)

Hope House, Blackpool (Blackpool, Fylde and Wyre)

Vision and values

Staff members across all services knew the trust's values and were able to describe how these were reflected in the team's work.

Managers in all teams were aware of the team objectives. Staff across the teams told us their priority was preventing admission and facilitating people returning to the community.

Staff knew who the most senior managers in the organisation were and gave examples of when these managers had visited the teams.

Good governance

We found all the teams were well managed. Staff were clear about their roles and they understood the management structure. Staff received mandatory training and were appraised and supervised, incidents were reported and investigated, staff participated in audits, and safeguarding and Mental Health Act (MHA) 1983 procedures were followed.

Staff could submit items to be included on the trust risk register and they explained how they would do this. We saw local risk registers displayed in the teams' offices.

Staff mostly reported they had been supervised and appraised by their line managers and that they were supported by them as well as by their peers. We looked at records which supported this. In supervision, staff were expected to demonstrate how they incorporated the trust's vision and values into their practice. Compliance ranged from 80-100% across the teams. Compliance at the lower end of this range was due to staff absences.

The trust had a good governance structure in place to oversee the operation of the crisis teams. Crisis team managers reported to the trust's clinical governance teams every month.

However, at the time of the inspection there was no formal process for the CMHS to meet with each other. This meant opportunities for learning and sharing may be missed. We found examples of good or excellent practice in individual teams which could have been shared across the service.

Leadership, morale and staff engagement

All the staff we spoke with were complimentary about the support and involvement of their line manager and more senior management. There were initiatives in place that supported staff morale and wellbeing. We saw a piece of work analysing the main reasons for staff sickness absences and considering how these could be addressed.

Staff morale was high in the teams we visited. Many staff told us they were proud of the job they did and said they felt well supported in their roles. Staff members told us that recruitment and retention was good because they felt empowered to raise any issues and promote service development and initiatives. All the staff we spoke with were positive about working in the teams. They showed a clear commitment to providing the quality care which individuals needed. Staff felt well managed locally and mostly had high job satisfaction. They understood the trust whistleblowing policy and reported they felt able to raise concerns without fear of victimisation. Information supplied before the inspection indicated a culture of systemic bullying; however, we found no evidence of this.

There were opportunities for staff to have leadership training and also gain professional qualifications to support them in their roles.

Staff were encouraged to discuss issues and ideas for service development within supervision, business meetings and with senior managers.

Commitment to quality improvement and innovation

There was excellent commitment to quality improvement, innovation and development.

The staffing establishment in the MHCS had been increased following a scoping exercise that looked at the staffing levels necessary to meet the needs of people who used the service, based on agreed trajectories.

Are services well-led?

Good

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.

At Hope House, a dedicated member of staff contacted everyone who had been discharged from the service in the previous two weeks to ask their opinions. We found that this information was discussed and used effectively to improve the service.

Other examples included:

- Home based clozaril titration.
- Proactive planning for discharge at the point of admission.
- Proactive work that supported staff morale and wellbeing.
- Development work that analysed how to optimise home treatment to reduce or avoid admissions and out of area treatment.
- Development of an intervention toolkit based on typical interventions and defined standards for gatekeeping.
- An electronic 'notice board' accessible to all staff that included an SUI 'action tracker' that showed shared learning and good practice and flagged up best practice guidelines.

Health-based places of safety:

Ward 20, Burnley General Hospital

Darwen ward, Royal Blackburn Hospital

The Harbour, Blackpool

The Orchard, Lancaster

The Scarisbrick Centre, Ormskirk General Hospital

Vision and values

There was a joint agency policy in place for the implementation of section 136 of the MHA. This policy and procedure had been jointly agreed by the trust, local police forces and relevant NHS ambulance service. The duties of all agencies were identified and set out to ensure that people receive timely and effective assessment. Staff we spoke with were aware of the trust's vision and values and they understood the joint agency policy.

Good governance

Audits were carried out on the use of section 136 and the use of health based places of safety (HBPoS). These were overseen and discussed by the locality multi agency groups. The group discussed section 136 MHA reports, which included quantitative data on the use of section 136 such as how long people remained in the suite.

Although the information recorded helped audit the use of section 136 and the HBPoS, it was not always complete. For example, although breaches such as delay in assessments were recorded, the reason for delay was not recorded consistently. Where there were problems, these were discussed and resolved at the monthly monitoring meeting.

Leadership, morale and staff engagement

The HBPoS did not have regular staff based there. The units were managed by the ward managers of the adjacent acute admissions wards. Staff told us that they felt well supported by their managers and peers. Staff understood their responsibilities in relation to the duty of candour and their role in the process for any future incidents where patients experienced harm.

Commitment to quality improvement and innovation

There were systems in place to monitor the service in order to improve performance. We saw evidence that the locality multi-agency groups reviewed performance indicators, such as four-hour wait times, the number of times section 136 was used and for how long.

With the exception of the suite at the Scarisbrick unit at Ormskirk, the environments of the HBPoS met or exceeded the Royal College of Psychiatrists standards for the health based places of safety environment.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment How the regulation was not being met The location and layout of the HBPoS at the Scarisbrick Centre, Ormskirk General Hospital was not suitable for the purpose for which it was being used. It compromised patient safety, privacy, dignity and confidentiality. The toilet and washing facility had ligature points and did not meet fundamental standards within the good practice guidance of the RCP to assure against the risks of unsafe or unsuitable premises. There was a potential risk of self-harm and ligature risks to people who use the service. The toilet and washing facilities were not an integral part of the suite but were located across a corridor which was open to the public and ward traffic. People were escorted to toilets through the reception area. This meant their privacy, dignity and confidentiality were compromised and could put the patient or other people at risk. The entrance to the suite was located in the public reception area. The suite was visible from reception and the ward entrance. The suite did not conform to national best practice as it breached Royal College of Psychiatrists' standards and Health Building Note 03-01: Adult acute mental health units. This was a breach of regulation15 (1) (c).