

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 - Blackpool	FY3 9HF
RW5HQ	Sceptre Point	Mental health crisis service - Blackburn	BB1 3BL
RW5CA	Burnley General Hospital	Health-based place of safety	BB10 2PQ
RW5X1	Royal Blackburn Hospital	Health-based place of safety	BB2 3HH
RW5X1	Royal Blackburn Hospital	Crisis support unit	BB2 3HH

Summary of findings

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
RW5HQ	Sceptre Point	Single point of access - Fleetwood	FY7 6AH
RW5HQ	Sceptre Point	Single point of access - Preston	PR1 8UY

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

Good 

Are services safe?

Good 

Are services effective?

Good 

Are services caring?

Good 

Are services responsive?

Good 

Are services well-led?

Good 

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 rated mental health crisis services and health-based places of safety as good because:

- The service had enough staff so that people who were in a mental health crisis could be safely managed. Patients had thorough risk assessments that were reviewed and updated at appropriate times. For people in the health-based places of safety, risk assessments were completed jointly with the police. There were good lone working policies and staff were clear on how this was managed at each team. The health-based places of safety provided a safe environment for the risks of people in a crisis to be managed. There was a culture of learning from incidents and staff were clear on what constituted an incident and how they would report it.
- Care records were up to date, personalised and holistic. Patients were involved in completing their care plans. There was good multidisciplinary working especially with the police and ambulance service. Quarterly multi-agency meetings were well attended and staff reported good inter agency working.
- Staff cared for patients in a respectful and dignified way. Our observations of staff interacting with patients were positive. Patients told us that staff were available when they needed them, supported them through their crisis and were kind and caring. Staff supported patients to manage their own crisis through using methods that had worked in the past and creating new ways to manage their symptoms or emotions.
- Referral to assessment time targets were met at all teams, with the exception of the single point of access team at Preston. The teams were proactive in following up patients who did not attend appointments and were clear about the protocols they followed when this occurred. Information about treatments were available in different languages and

formats if patients required them. The trust had recently opened a crisis support unit, which could be used as an alternative to the health-based place of safety for up to 23 hours, to help someone in a crisis that was felt to be short term.

- Staff were positive about the team managers and felt they got the support they needed. Managers felt empowered to do their job and were supported from more senior managers to do this. The staff were committed and passionate about the job they did. The new vision and values were embedded into teams especially through the new appraisal process that staff felt was more personalised.

However;

- Furniture in the mental health crisis rooms in Blackburn was not set out to reduce the risks to staff. Desks were placed in the corner of the room which meant staff were not near the door and could potentially be blocked in if someone became aggressive. There was equipment which could be used as weapons.
- The health-based place of safety in Burnley had a window that did not have privacy screening on it, therefore this meant that if members of the public or patients from other wards walked by they could potentially see the patient in the place of safety.
- The single point of access team in Preston was not meeting targets for assessing new referrals. The target was for urgent referrals to be seen within five working days and at the time of our inspection, staff saw patients within eight days.
- The health-based places of safety had 26 incidents in the 12 months leading up to our inspection where people had been deemed as needing admission but a bed was not found within the 72 hour assessment period of section 136. Patients therefore remained in the health-based place of safety longer than necessary.

Summary of findings

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

Are services safe?

We rated safe as good because:

- The environment of the health-based places of safety we visited provided a safe environment for people detained under section 136 to be managed.
- Staff completed risk assessments to a high standard and these were completed jointly with the police in the health-based places of safety.
- There were good lone working policies for staff completing home visits and all staff we spoke to were aware of these and able to tell us how they were managed within their own team.
- Staffing was sufficient to manage people who were in a crisis and all wards which were attached to a health-based place of safety had increased staffing levels in order to safely staff them.
- Staff had a good understanding of what constituted a safeguarding concern and were able to tell us how they would report this and manage it safely.
- Learning from incidents was evident and staff were clear of the process for reporting incidents.

However;

- The layout of the rooms at the mental health crisis service in Blackburn were not always set up to minimise the risk to staff as much as possible. This included desks being in the back corner of the room and equipment in the rooms that could be used as weapons.
- The health-based place of safety in Burnley had a window that did not have privacy screening on it, therefore this meant that if members of the public or patients from other wards walked by they could potentially see the person in the place of safety.

Good



Are services effective?

We rated effective as good because:

- We reviewed 32 records and found that all contained a comprehensive, holistic assessment which included the views of the patient. They were recovery focused and focused on the strengths and goals of the patient.
- There was good multidisciplinary team working which included work with the police and ambulance services as well as the acute hospital trust for the health-based places of safety. Within crisis teams there was good access to psychology and a full range of roles to support people in a crisis.

Good



Summary of findings

- Staff had a good understanding of the Mental Health Act and the Mental Capacity Act. They were clear of their responsibilities under section 136 of the Act if they were expected to work in a health-based place of safety. Staff ensured that patients were able to make their own decisions about preferred treatment and care where possible and patients' capacity was assessed quickly when needed.

Are services caring?

We rated caring as good because:

- We observed care being given in a respectful and dignified manner.
- Patients and their carers told us that staff were kind and genuinely interested in them. Patients told us that staff were available to talk to when they needed them and always got back to them quickly if they weren't available when they rang.
- Staff involve patients in developing their care plans. If the patient consented, then carers and family were also involved in this.
- Staff encourage feedback from patients and carers and sent them questionnaires to complete following contact with a service.

Good



Are services responsive to people's needs?

We rated responsive as good because:

- There was a clear referral system for all new patients to the service via the single point of access. This reduced any confusion about where people would send referrals to and meant there was one central place for all professionals as well as self referrers to contact.
- The crisis teams oversaw all admissions to acute inpatient beds.
- The trust had recently opened a crisis support unit to reduce bed pressures. This could be used as an alternative to the health-based place of safety for up to 23 hours to help someone in a crisis that was felt to could be managed in the short term with the support of specialised staff.
- Crisis teams and health-based places of safety were available 24 hours a day seven days per week.
- People were contacted quickly following referral and this was usually within four hours for the mental health crisis teams.

Good



However;

Summary of findings

- The single point of access team in Preston was not meeting targets for assessing new referrals. The target was for urgent referrals to be seen within five working days and at the time of our inspection, staff saw patients within eight days.
- The health-based places of safety had 26 incidents in the 12 months leading up to our inspection where people had been deemed as needing admission but a bed was not found within the 72 hour assessment period of section 136.

Are services well-led?

We rated well-led as good because:

- Staff were aware of the trust's vision and values and were able to tell us about how these were developed and their involvement in this.
- Staff spoke positively about their managers and felt supported on a day to day basis.
- Managers felt positive about their role and felt that they had enough authority to carry it out. They felt supported by their managers and were able to approach them for advice if needed.
- Mandatory training, appraisal and supervision figures were good and staff felt that the newly introduced supervision passport was helpful in capturing informal supervision effectively.
- There were good systems to allow the managers to monitor their team performance and act on this if required. Managers felt supported by human resources when carrying out actions around poor performance and sickness absence.
- The morale in all of the teams we visited was high and staff were committed to doing a good job.

Good



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.

During our inspection we visited a sample of the mental health crisis teams and health-based places of safety. These are detailed below:

- crisis support unit at Blackburn
- mental health crisis team at Blackpool
- mental health crisis team at Blackburn
- single point of access team Fleetwood
- single point of access team Preston
- health-based place of safety Ormskirk
- health-based place of safety Lancaster

- health-based place of safety Blackburn
- health-based place of safety Burnley
- health-based place of safety Blackpool.

Mental health crisis services are there to support people who are in a mental health crisis for short periods to either avoid hospital admission or reduce length of stay in an acute hospital bed. This is done by providing home based treatment or support for people who may otherwise have ended up in hospital.

The trust also has six health-based places of safety in total across five sites. We visited the five main ones used at the mental health hospital sites. These are there for people 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

Our inspection team was led by:

Chair: Neil Carr OBE, Chief Executive South Staffordshire and Shropshire Healthcare NHS Foundation Trust

Head of Inspection: Nicholas Smith, Care Quality Commission

Inspection Managers: Sharon Marston and Nicola Kemp, Care Quality Commission

The team that inspected the mental health crisis services and health-based places of safety included a CQC inspector, a CQC assistant inspector, a CQC Mental Health Act reviewer, two specialist advisors - a consultant psychiatrist and a social worker.

Why we carried out this inspection

We inspected this core service as part of our ongoing comprehensive mental health inspection programme. We had previously inspected mental health crisis services and health-based places of safety at Lancashire Care NHS Foundation Trust in July 2015. At this time, we rated the service as good overall. We rated safe as requires improvement. During this inspection, we checked that the trust had acted upon the concerns raised during our previous inspection.

At the previous inspection in July 2015 we told the trust that they must take action in the following area:

- The trust must ensure that the layout and location of the health-based place of safety 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.

We issued the trust with one requirement notice.

Summary of findings

- Regulation 15 HSCA Regulated Activities Regulations 2014 Premises and equipment.

On this inspection, we found that this regulation was now being met.

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?

Before the inspection visit, we reviewed information that we held about the trust's mental health crisis services and health-based places of safety, asked a range of other organisations for information and sought feedback from patients at focus groups.

We carried out announced visits between 13 and 15 September 2016 visiting:

- the single point of access teams at Preston and Fleetwood

- the crisis teams at Blackpool and Blackburn
- the crisis support unit at Royal Blackburn Hospital
- five of the six health-based places of safety that the trust used.

During the inspection visit, the inspection team:

- spoke with 19 patients who were using the service and three carers/relatives
- spoke with the managers for each of the 10 teams
- spoke with 21 other staff members; including doctors, nurses and social workers
- attended and observed two home visits
- looked at 32 treatment records of patients
- carried out a specific check of the medication at the crisis team in Blackpool
- looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the provider's services say

We spoke to 19 patients who had used each of the services we inspected including patients detained under section 136 in the health-based place of safety.

Patients gave positive comments about the staff and the services they had received. Patients found staff to be kind, caring and friendly and they felt they took a genuine interest in their wellbeing.

We spoke to four carers of patients who had used the services. They were complimentary and felt that where possible they were involved in the care of their loved one.

Good practice

The trust has recently opened a crisis support unit to reduce bed pressures. This could be used as an

alternative to the health-based place of safety for up to 23 hours to help someone in a crisis that was felt to could be managed in the short term with the support of specialised staff.

Summary of findings

Areas for improvement

Action the provider **SHOULD** take to improve

- The trust should review the way furniture is laid out in the interview rooms at Daisyfield Mill as well as the amount of furniture that can be used as weapons to reduce the risks to staff using these rooms.
- The trust should improve the privacy and dignity of patients detained under section 136 in the health-based place of safety Burnley.
- The trust should review the waiting list for urgent appointments at the Preston single point of access in order to meet the target contact time of five working days.
- The trust should reduce the number of times patients spend over 72 hours in the health-based place of safety due to shortages of beds on in patient wards.

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
Single point of access team – Preston	Sceptre Point
Single point of access team – Fleetwood	Sceptre Point
Mental health crisis service - Blackpool	Sceptre Point
Mental health crisis service - Blackburn	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.

- Although training figures provided to us by the trust showed that only 44% of staff had completed training in the Mental Health Act, we found that staff had a very good understanding of the Mental Health Act and their responsibilities within it.

Detailed findings

- Staff completed Mental Health Act paperwork and recording of rights in the health-based place of safety as required.
- When people were detained under section 136 of the Mental Health Act there was a quick response from the approved mental health professionals and the section 12 approved doctors to coordinate a Mental Health Act assessment (usually within two hours).
- No patients were subject to a Community Treatment Order. However, the staff we spoke to had a good understanding of what this meant and their role if someone was subject to a Community Treatment Order.
- There was good support from the Mental Health Act law team who staff relied on if they needed advice. They kept track of when tribunals were happening and when staff were required to explain to patients their rights under the Mental Health Act and reminded staff via email to prompt them.

Mental Capacity Act and Deprivation of Liberty Safeguards

- Data provided to us by the trust showed that 70% of staff in mental health crisis teams and health-based places of safety had completed mandatory training in the Mental Capacity Act.
- Staff had a good understanding of the Mental Capacity Act and its guiding principles.
- Staff ensured that where possible patients were able to make their own decisions around treatment and care.
- If staff felt that a patient may lack capacity to make a decision then appropriate steps were taken to assess that person's capacity and were documented accordingly.
- Staff would speak to the mental health law team for any support of questions regarding Mental Capacity Act.

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

Mental health crisis services:

Mental health crisis services Blackburn, Hyndburn and Ribble Valley

Mental health crisis services North Lancashire (Blackpool)

Single point of access services Fleetwood

Single point of access services Preston

Crisis support unit - Burnley

Safe and clean environment

Although the majority of the mental health crisis service work was carried out in the patients' own homes, there were occasions when patients visited the crisis teams building for assessments.

We found all areas we visited to be tidy, clean and well maintained. All interview rooms were fitted with alarms so that staff could summon help if they felt unsafe. If there were concerns about staff safety, two staff would assess the patient in a room where there was an alternative exit if needed. The staff would also let the reception staff know if there were any risks associated with patients coming into the building that they needed to be aware of.

The layout of the rooms at mental health crisis service in Blackburn were not always set up to minimise the risk to staff as much as possible. This included desks being in the back corner of the room and equipment in the rooms that could be used as weapons. However, the furniture in the rooms was not attached to the floor and could be moved around to make the positioning of furniture more suitable. Doors all opened outwards and therefore eliminated the risk of a member of staff being barricaded in the room.

Safe staffing

The staffing levels in each of the mental health crisis services and the single point of access teams were sufficient to meet the needs of the patients. The teams were staffed differently with mental health crisis services having a multidisciplinary approach which included senior nurses, social workers, doctors and support staff. The single

point of access teams were staffed by senior nurses and doctors who triaged and assessed patients to signpost to ongoing care. Each team had a manager in post. There were low levels of staff vacancies across the teams with just seven at the time of our inspection, these were being advertised at the time of our inspection. In the crisis teams the shift patterns were split into long days and night shifts (7am to 9pm and 9pm to 7am); the single point of access teams worked Monday to Friday 9am until 5pm.

We looked at the staff rotas and found the number of staff planned on each shift matched the numbers on duty. There was very low use of bank staff with 168 shifts covered by bank staff and five covered by agency at April 2016. There was no agency use in these teams, which was due to the speciality that they required. Where shifts needed to be covered, the team generally covered these themselves and there was a small pool of bank staff who were experienced in this area. We were told during our inspection that the crisis teams had been busier in recent months due to lack of beds in the inpatient services meaning crisis teams were supporting more people at home whilst awaiting a bed. During our inspection, staff told us they were able to cope with the increase in workload.

Mental health crisis services worked the caseloads in differing ways. Most teams had an average caseload of around five or six patients per member of staff with an average total caseload of 70 per team. In the Blackpool, Fylde and Wyre team they managed the caseload collectively as a team dependent on who was on shift with qualified staff having named nurse responsibilities.

All of the teams we visited had a consultant psychiatrist within their team. This meant that a doctor could be contacted quickly whenever the team required and they could also respond quickly to an emergency. Out of hours cover was provided on an on call system.

Patients had access to staff in a crisis 24 hours a day seven days per week. Out of hours the mental health crisis service was staffed by a qualified nurse covering the crisis line. There were lone working arrangements in place to keep staff safe. The qualified nurse was based at the acute hospital where they would join the accident and emergency liaison team to ensure that there were two members of staff to meet with the patient.

Are services safe?

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

Mandatory training rates were at 83% for the service as a whole, which fell below the trust target of 85%. All teams were above 75% compliance apart from the crisis team at Blackpool who had 72% compliance. However, we were able to see where staff had completed training or were booked on training since the data was provided and this was now above 75%. Mandatory training included moving and handling, basic and immediate life support, fire safety, conflict resolution training, infection control, health and safety and safeguarding children and adults.

Assessing and managing risk to patients and staff

Staff undertook a risk assessment of patients at the initial assessment meeting. During this they would look at factors that increased and decreased risk as well as creating a formulation of risk that sat alongside the risk assessment. This was updated at each visit for the mental health crisis services and also if anything changed in the meantime. Staff within the single point of access teams would also complete a risk assessment with patients and this would help to decide the level of support that service user required and which team would be best suited to manage those risks. We found that all risk assessments we reviewed during the inspection were completed to a high standard. Staff asked the relevant questions and explored the risk of suicide with patients and increased or decreased visits as required during times of higher risk with a clear rationale as to why this was happening. At the mental health crisis services we found that all patients had a crisis care plan which included any previous methods that had helped the individual in a crisis, triggers and coping strategies as well as contact numbers for people that would be able to help them in a crisis. We found that these risks transferred into care plans for patients.

None of the crisis teams had a waiting list and patients were seen quickly from the point of referral. At the single point of access team in Preston the waiting times were currently not in line with the targets for the team. This was a target of five working days for urgent referrals and 14 working days for non-urgent referrals. At the time of our inspection urgent referrals had a current wait of eight days. However, we were able to see that the manager had plans in place to reduce these times and could see evidence of this reducing over recent months. The manager had introduced a phone triage in order to ensure that people who were on the waiting list were monitored and more urgent patients contacted quickly and an appointment offered. The trust had a clinical alert system called a 'blue

light 54' which meant that if a GP marked a referral as urgent clinical staff were not able to downgrade this to routine. This was brought in following a previous incident however, staff reported it had an impact on the number of urgent referrals being received as they would have previously been able to use their clinical judgement to downgrade to non urgent if they felt that was appropriate. In response to this feedback there was ongoing training with GPs in order to educate them around what warranted an urgent referral and what could be deemed routine.

Staff received safeguarding training and at the time of our inspection compliance was at 91%. Staff were aware of the procedure to raise a safeguarding alert. Staff reported they had good links with the local safeguarding team and were happy that they responded quickly to any concerns raised. Staff were able to tell us the name of the safeguarding lead within the trust and how they would contact them if they needed advice or support. There was information in each team on how to report a safeguarding to the local authority as different local authorities covered the trust and managed them in different ways.

There were good protocols in place for lone working within each of the teams we visited. At the crisis teams, staff would record on the noticeboard in the office where they were visiting and what time they expected to return. The teams had their own code word so that they were able to ring and raise the alarm if they required assistance. All teams reported that if there were known risks with a service user they would visit in pairs or arrange an alternative venue for the visit. All staff had a work mobile phone for the team to be able to contact them on and vice versa if there were any problems. The shift leader at the crisis team would ensure they checked when staff were due back in the office, including if there were carrying out assessments in rooms within the building and would chase them up if they were not back within the timeframe agreed. At the single point of access teams visits were rarely carried out in the community unless there was a clinical reason. If for any reason a home visit was required two members of staff would carry out the visit if the service user was unknown and would utilise the same lone working procedures as the crisis teams.

Track record on safety

Between April 2015 to March 2016, there were 12 serious incidents relating to mental health crisis teams. All were categorised as 'unexpected or avoidable death or severe

Are services safe?

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harm of one or more patients, staff or members of the public'. We spoke to staff about serious incidents and they told us that serious incident investigations and reviews took place and were now conducted by a central incident management team. Staff told us they received feedback following serious incidents and this was disseminated via team meetings and individual supervision and actions were agreed from investigations that were to improve the service rather than apportion blame. We saw evidence of this in minutes from team meetings as well as in staff personal files within supervision records. Staff felt supported during these investigations and told us that debriefs occurred for the team and the service user if appropriate.

Reporting incidents and learning from when things go wrong

The trust used an electronic incident reporting system. All staff had access to this including bank staff and were able to tell us in which situations they might report an incident using this system. Staff were able to give us examples of types of incidents they may report. For example, incidents of violence, self harm and staffing issues.

Staff told us that the trust was committed to learning from incidents. The trust had a "huddle" system where staff were able to discuss any issues they wanted to raise in an informal manner and these were fed back in team meetings. Feedback from incidents was given in a number of ways including in one to one supervision, team meetings and group supervision. Debriefs always happened following a serious incident. This was normally headed by the most senior member of staff on duty and this included debriefs for patients. Psychologists were involved in debriefs and would help the team to look at what could be done differently if the same incident occurred as well as what had gone well.

Duty of candour

During our inspection we saw that staff were open and honest with patients regarding their care and treatment. Staff we spoke to were aware of the duty of candour requirements and how they should be open and apologise in writing to patients and families when something went wrong. There was a duty of candour policy and staff followed this if the criteria was met to use it.

Health-based places of safety:

Dunsop Ward, Burnley General Hospital

Darwen ward, Royal Blackburn Hospital

The Harbour, Blackpool

The Orchard, Lancaster

The Scarisbrick Centre, Ormskirk General Hospital

Safe and clean environment

We visited all five of the trusts' health-based places of safety during our inspection. We found them all to be clean, tidy and well maintained. They were on the cleaning schedule which was filled in and up to date. At the previous inspection in July 2015 we told the trust they must take action as the health-based place of safety at the Scarisbrick Centre was not suitable for the purpose for which it was being used and compromised patients' safety, privacy, dignity and confidentiality. At this inspection we found that the health-based place of safety had been moved to a more suitable environment which was integrated onto the adult acute ward in the same building. The layout allowed for clear observation of patients in the suite and there was an integrated toilet and bathroom. We found that although the entrance to the suite was still via a public reception area, there was a clear protocol in place for the staff to ensure the area was clear prior to the patient being brought through this area.

All the health-based places of safety consisted of a room where staff could assess patients. There was an observation panel where staff could observe the patient. There was a separate toilet and wash area. Furniture was appropriate for use in a health-based place of safety, meaning that it could not be easily thrown to damage the suite or harm staff. The health-based place of safety at Burnley had a large observation window that did not have any privacy screening on it. This meant that if someone was to pass by they could potentially see the patient in the suite. There were no blind spots apart from the toilet at Blackburn where there was no observation window on the toilet door, however, staff would carry out a thorough risk assessment prior to patients going into this toilet alone and we were able to see evidence of where this had taken place when reviewing records..

Each health-based place of safety was attached to an adjoining adult acute ward. Emergency medical equipment was not stored in the health-based place of safety but was easily accessible from the adjoining ward quickly in the event of an emergency. Staff wore personal alarms and

Are services safe?

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

there were also panic alarms on the walls of the rooms so that staff could summons help quickly when required. Staff told us that help usually arrived quickly from the wards once these were activated.

Safe staffing

The health-based places of safety were staffed by the adjoining adult acute wards. Each ward had a dedicated person who was nominated each shift to receive any patients detained under section 136 of the Mental Health Act. Shift leaders would ensure that the appropriate person was allocated to carry out the assessments. All wards had staffing levels above their minimum staffing in order to ensure there was a person to meet the police at the place of safety when it was required.

The multi-agency policy in place for the health-based place of safety meant that the police and the staff would complete a joint risk assessment on arrival. Depending on the outcome of this assessment the police would remain with the patient if they were presenting with significant levels of risk or they would leave if ward staff were happy that the patient was deemed low risk and they could safely manage the patient. However, if this changed throughout the course of the detention the staff felt confident that they could call the police back to the place of safety for assistance. We spoke to staff who worked within the place of safety and they were clear that they understood their role in relation to this and were able to respond quickly when a patient arrived.

Staff we spoke to felt that on the whole staffing of the place of safety worked well and we saw no evidence of the places of safety being closed due to staffing. One suite was closed temporarily when a patient had damaged the suite, however it was quickly repaired and reopened. Medical cover was provided by the on call doctor which meant that there was a quick response to people who needed assessment.

Assessing and managing risk to patients and staff

On arrival at the health-based place of safety the detained patient would be received by the allocated nurse for that shift. This then triggered a process whereby the approved mental health professional and the doctor would be contacted by the nurse. A joint risk assessment was carried out by the police and the nurse in order to ascertain the level of risk the detained patient presented with. This would determine if the police needed to stay in the place of safety or if they were able to leave. This was an ongoing

assessment process throughout the detention where the police could be called back if the risks increased at any point. As part of the multi-agency policy for the use of section 136 Mental Health Act the police were required to search the person who had been detained prior to them leaving in order to ensure the person was not carrying anything that could harm themselves or others. The police were able to provide ongoing support to the staff at the place of safety in order to reduce the risk of harm to the detained patient and the staff on duty.

During our inspection we reviewed the assessments of people recently detained in the health-based place of safety. We were able to see how the joint assessments were carried out and documented for each person. We found that when staff had identified a high level of risk the police had remained in the suite to support the staff and when risks were deemed too high the patient was transferred to the police custody suite.

Track record on safety

Health-based places of safety had six incidents of restraint between 1 December 2015 and 3 June 2016. None of these had required rapid tranquilisation and none had been in the prone position.

Reporting incidents and learning from when things go wrong

There were quarterly multi-agency mental health oversight group meetings where representatives from all agencies involved in section 136 and use of the health-based places of safety attend. During these meetings discussions took place about any incidents that had occurred in relation to the health-based places of safety and actions were set to ensure these were reviewed and monitored. On the agenda for these meetings were items such as Police And Criminal Evidence Act breaches, incidents of patients going absent without leave, transportation and restraint. We could see from reviewing these meeting minutes that these issues were taken seriously if there were incidents in this area and they were monitored closely.

Staff who were working within the health-based places of safety were aware of how to report an incident on the electronic recording system. They were aware of what constituted a serious incident and were able to tell us what the protocol was for reporting these. Feedback from serious incidents was fed back via team meetings for the wards that staffed the health-based places of safety.

Are services safe?

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

Duty of candour

During our inspection we saw that staff were open and honest with patients regarding their care and treatment. Staff we spoke to were aware of the duty of candour

requirements and how they should be open and apologise in writing to patients and families when something went wrong. There was a duty of candour policy and staff followed this if the criteria was met to use it.

Are services effective?

Good 

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

Mental health crisis services Blackburn, Hyndburn and Ribble Valley

Mental health crisis services North Lancashire (Blackpool)

Single point of access services Fleetwood

Single point of access services Preston

Crisis support unit - Burnley

Assessment of needs and planning of care

We reviewed 32 care records across all of the teams. The records were kept on an electronic system. Team members completed health and social care needs assessments. These were of good quality, holistic, comprehensive and included interim case management plans. Areas they covered included presenting problems, physical and mental health history, personal history, social circumstances, medication, substance use, communication, mobility, employment and carers views. They included risk assessments using the trust's 5Ps tool (problem, pre-disposing, protective, perpetuating & precipitating factors). There was evidence of updated assessments and reviews taking place at the correct intervals. Following assessment by the single point of access team, staff told us that patients would be referred on to the appropriate services, this included crisis teams, psychological therapies, and drug and alcohol services and we saw evidence of this happening.

We found that care plans were personalised and included the views of the patient. The care plans were recovery focused and included the patient's strengths and things they felt they wanted to achieve. There were crisis plans in place for people under the crisis teams and this included past triggers, protective factors and contact numbers for people they would contact in a crisis. We spoke to patients and they told us that they were involved in their care planning and had a copy of the crisis plan with all relevant contact numbers.

Best practice in treatment and care

During our inspection we saw evidence that the teams followed best practice guidance in relation to the patient

group they cared for. Examples of this included antidepressant treatment, self-harm, suicide prevention and personality disorder from the National Institute for Health and Care excellence.

During the time patients were under the care of the crisis team they were able to offer different ways in which to help the patient through the crisis. This included having clinical psychologists working alongside the teams who could offer formulation plans to support staff and patients in managing the crisis. There was also access to talking therapies and staff carried out relapse prevention work as part of the therapy. There were support time and recovery workers in each team who were able to support the patient with more practical issues they may have such as money problems relating to debt or benefits, housing issues and domestic violence. There was also support for people who wanted to get more involved in their local community by attending groups or the local gym. Pharmacists were based within the crisis teams and they were able to give quick advice around medications and side effects as well as reviewing medication in a timely manner. There were physical health clinics running at some of the teams which meant patients were able to attend to have essential bloods taken for example if someone was on lithium or clozapine. There were plans to expand these further.

Staff were using a range of tools in order to complement their assessments and care plans. These included depression scales and side effects of medication scales amongst others.

Skilled staff to deliver care

Each team had a full range of mental health disciplines working within them. There was good evidence of multidisciplinary working within each team we visited.

The crisis teams consisted of senior staff nurses, support time and recovery workers, psychologists, doctors, pharmacists and administration support.

Any new starters to the trust received a full week corporate induction as well as a local induction within the team they would be working with. This was to ensure that they were up to date with local policies and procedures and were in receipt of all relevant information pertinent to their role prior to starting.

Staff we spoke to told us that their line managers actively support them to undertake specialist training in relation to

Are services effective?

Good 

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.

their role. We were told about staff completing courses outside of the trust and this being funded by the trust as it was a positive addition to the knowledge and skills of the staff team.

Figures provided to us by the trust showed 13% of staff had received an appraisal in the last 12 months. However, the trust had recently introduced a new appraisal system and had reset the appraisal data to 0% from April 2016 therefore the data we received could only tell us who had an appraisal since April 2016. This meant we did not have figures for appraisal rates prior to this date. However, during our inspection we were able to see that staff were being appraised under the new system and that staff felt this was a more individualised person centred approach to the appraisal process than before. Staff told us that they felt supported by their manager and their team and that there was an open door policy should they wish to discuss something with their manager. Staff were aware of their own personal development goals and were happy that these were addressed and supported through the appraisal process. Staff had supervision every six weeks as per the trust policy. Staff reported that they felt supported by their manager and that they could seek extra supervision if they felt they needed it. The trust had introduced a supervision passport which had been recently rolled out across the trust where staff could capture informal supervision they received from other members of the team. Staff reported these were useful to capture regular support they receive from the team which would be otherwise lost.

Managers were clear that there were policies to support any poor performance from the staff team. They reported they received support from human resources in addressing these issues if they became formal and felt that they were able to manage these issues effectively.

Multi-disciplinary and inter-agency team work

All of the teams held regular and effective multidisciplinary meetings on each day of the week. Approved mental health professionals reported good working relationships with the teams as were doctors and inpatient wards. Multi-agency oversight meetings took place quarterly and this was in line with the crisis care concordat. Attendees at these meetings included representatives from crisis teams, local authorities, wards, community teams, ambulance service, acute trust and police liaison officers. The teams had good working relationships with teams both within the trust and outside the trust. This included local GP surgeries,

community mental health teams, inpatient wards and the local authority. There was a good system in place for referral into the service through a single point of access and GPs felt this was a helpful resource as they knew there was one contact to refer patients through which reduced time spent looking for the correct team.

The crisis teams all worked closely together with the single point of access teams in order to ensure a smooth patient journey through the services. This meant that patients were referred to the appropriate team quickly and that they were able to ensure the correct referrals were going to the correct teams. All teams reported that they helped each other out in order to ensure the best outcome for the patient. The doctors within the single point of access teams were available for GPs to call for advice around any patient they suspected or knew to have a mental health issue. This meant that they could give them advice over the telephone around medication or managing that patient and reduce the number of inappropriate referrals to the service.

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

Although data supplied to us by the trust before the inspection showed only 44% of staff had received training in the Mental Health Act. We found that staff had a good understanding of the Mental Health Act and their responsibilities within this. Staff understood and were able to tell us how they would request a Mental Health Act assessment and how this would be coordinated. Staff told us that this would be arranged via the approved mental health professional and was usually done quickly in response to their requests. As doctors were based within the crisis teams they ensured that the first medical recommendation was done quickly by a doctor who knew the patient.

Administrative support and legal advice was available to staff from a Mental Health Act team. Staff knew how to contact this team and valued their support.

At the time of our inspection there were no patients who were subject to a Community Treatment Order receiving treatment within the teams. However, staff were aware of their role in relation to Community Treatment Orders for example attending pre discharge meetings for a patient being discharged from one of the wards on a Community Treatment Order and the circumstances and procedures in which someone may be recalled to hospital on a Community Treatment Order.

Are services effective?

Good 

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.

Good practice in applying the Mental Capacity Act

Data provided to us by the trust prior to our inspection showed that 79% of staff had completed Mental Capacity Act training. We found from speaking to staff and reviewing patients' records that staff had a good understanding of the Mental Capacity Act for their role. For example they understood the need to assess capacity on a decision specific basis. We found that discussions around capacity and consent were recorded in the patients records.

Support and advice around the Act was available via the Mental Health Act team if staff required it.

Patients were given lots of information in leaflet form about the service that the teams offered and advice around medications and other treatment options. This allowed patients to make an informed choice about their care based on all the available options to them.

Health-based places of safety:

Dunsop Ward, 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 preferred way to transport a patient under section 136 Mental Health Act to the place of safety was in an ambulance. One of the reasons for this was so that appropriate physical health checks could be carried out on the patient prior to them arriving at the place of safety. This would include checks for complications with diabetes, head injuries or any suspected overdoses. If the ambulance did not convey the patient then the hospital in receipt of the patient would carry out the physical health checks. This was so that the receiving hospital was aware of any medical complications and could also direct the patient to accident and emergency if needed.

Patient records for people detained under section 136 were kept with the staff in the place of safety. Staff carried out a joint risk assessments with the police when the patient arrived and this was stored with the Mental Health Act team once complete. These were also later scanned onto the electronic notes system so that if the patient was ever seen

again by the trust there was a record of their previous presentation. The paperwork required was stored securely within the place of safety so staff could access this when they needed it quickly.

Best practice in treatment and care

The trust had introduced a street triage service at our last inspection which worked in partnership with the police in order to reduce the number of people detained under section 136. This was still running and provided guidance and advice to help the police in their decisions as to whether a person required detention under the Mental Health Act or not.

When people were brought into the health-based place of safety staff provided them with a leaflet that explained the powers of detention under section 136 Mental Health Act. This allowed patients to have information which they could revisit throughout their detention which detailed the assessment process, their rights, who was looking after them and where they were. There was a copy of the code of practice available for patients if they wanted to see it.

Skilled staff to deliver care

The health-based places of safety were staffed by nurses from the adjoining adult acute wards. They would coordinate the assessment under section 136 informing the relevant people of the person's detention. Staff that we interviewed during the inspection were aware of their responsibilities and had attended the training on use of the health-based provided by the trust. This training included their responsibilities when someone was detained under section 136 Mental Health Act, the length of time they could be detained, who to contact and the role of the police.

As the staff worked on the adult acute wards who staffed the health-based place of safety they were trained in techniques to manage violence and aggression as well as immediate life support. Staff were provided with a list of actions they needed to take when someone was brought into the place of safety that were listed in the order they needed to be done in order to assist staff.

Multi-disciplinary and inter-agency team work

The trust had signed up to the crisis care concordat. As part of their commitment to this they had developed a multi-agency policy in relation to people detained under section 136 of the Mental Health Act. This had been developed in collaboration with other agencies involved in the use of

Are services effective?

Good 

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.

section 136 Mental Health Act. This included the local police constabulary, the north west ambulance service and the local authorities that covered the trust patch amongst others.

There were quarterly multi- agency oversight meetings. Representatives from each of the agencies involved in the multi-agency policy attended this meeting and discussed any issues pertinent to the use of section 136 and the health-based place of safety. Police liaison meetings also took place to discuss any immediate issues that could be resolved prior to the meeting or to follow up on actions from the meeting.

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

Although information provided to us by the trust only 44% of staff had received training in the Mental Health Act at the time of our inspection. We found that staff we spoke to had a good understanding of the Mental Health Act and for those that were working in the health-based places of safety they had a good understanding of section 136 and their responsibilities surrounding this.

Staff explained their rights to people detained under section 136 and the time and date of this was recorded for audit purposes. On the paperwork the trust used to record people who were detained under section 136 there were spaces to record important information that needs to be recorded to comply with the code of practice such as length of detention and transfer between places of safety.

Good practice in applying the Mental Capacity Act

Data that the trust provided to us prior to inspection told us that 79% of people had completed training in the Mental Capacity Act. Staff who worked in the health-based places of safety had a good understanding of the Mental Capacity Act and its guiding principles.

We reviewed records of people detained under section 136 and found that discussions took place as to whether the patient had capacity to consent to informal admission during the Mental Health Act assessments.

Staff we spoke to told us that they were able to contact the Mental Health Act team for any queries relating to the Mental Capacity Act.

Are services caring?

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

Our findings

Mental health crisis services Blackburn, Hyndburn and Ribble Valley

Mental health crisis services North Lancashire (Blackpool)

Single point of access services Fleetwood

Single point of access services Preston

Crisis support unit - Burnley

Kindness, dignity, respect and support

During our inspection we observed staff interacting with patients. This included during assessments and home visits as well as on the phone. We observed staff to be respectful, caring and supportive. We saw examples of staff showing empathy towards patients who were going through a mental health crisis and offering practical and emotional support. Staff knew their patients well and were aware of issues that the patient may have outside of their primary mental health problem that may have an impact on their mental health.

Patient feedback about the staff was positive. Patients told us that staff were helpful, kind and always had time to listen. We gave patients the opportunity to give feedback via comment cards prior to our inspection but none were completed for the mental health crisis teams. At the crisis team at Blackburn we were able to observe an expert by experience the trust had employed to make feedback phone calls to past patients. They would speak to people who had recently used the service to gain useful feedback on how they felt their care and treatment had been managed. The feedback from these was overwhelming positive with 29 out of the 30 being positive. One patient had concerns about seeing different members of staff on each visit and this concern had been used to change practice within the team so that each new referral was allocated a core team of staff to visit them.

We found that staff maintained confidentiality. This included gaining consent from patients prior to speaking with other agencies involved in their care or family members. When visiting patients' homes staff always ensured they were discreet and did not wear uniforms so they would not be identifiable by neighbours.

The involvement of people in the care that they receive

During our inspection we reviewed the records of patients receiving care from the teams. We were able to see that patients and their families, where consent was given, were involved in care planning and were offered a copy of their care plan. This was documented clearly in the notes as it was if someone declined a copy. We saw that care plans were goal orientated and patients were encouraged to take ownership of their crisis and work with staff to note down techniques that they felt would help them in a crisis.

Patients were able to identify who they would like to be involved in their care and this was clearly documented in the records. We saw that advocates were involved where the patients wanted them to be and this was identified at the assessment stage and revisited. We saw posters in the waiting rooms of the teams to explain who the advocacy service was and their role as well as contact details for them. Staff provided patients with leaflets about advocacy at their assessments.

On discharge from the team or if the patients care was transferred to another team they were asked to complete a satisfaction survey to give feedback on the service they received. We also saw comment boxes in waiting rooms at each team where patients could rate their service that day with a sad or happy face with room for comments underneath.

Health-based places of safety:

Dunsop Ward, 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

During our inspection we observed staff caring for patients who were detained in the health-based place of safety. We observed kind and caring interactions where staff tried to reduce the patient's anxiety at a very difficult time. We saw that staff ensured the privacy and dignity of patients was maintained during the time they were in the place of safety. The entrances to the health-based places of safety were all discreet and through a private entrance apart from the places of safety at Burnley and Ormskirk where they went in

Are services caring?

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

through a public entrance. However, we were able to see how staff mitigated this by clearing the area before the patient arrived and ensuring that nobody could see the patient being brought through.

The involvement of people in the care that they receive

There was information displayed in the places of safety to tell patients their rights and how to access advocacy services. There was access to interpreting if this was required and could be booked easily by the staff. Patients were given leaflets explaining their rights under section 136 and it was documented in the notes that this was given and understood.

At the back of the pack of paperwork used for anyone in the health-based place of safety there was a feedback form that patients were asked to fill in. This allowed them to give feedback on the service they received and anything that could be improved upon. The results of these were kept by the Mental Health Act team in order to pick up on any themes from the health-based places of safety across the trust. These were disseminated to managers on a monthly basis in order for them to be able to discuss these with their teams.

Are services responsive to people's needs?

Good 

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

Our findings

Mental health crisis services Blackburn, Hyndburn and Ribble Valley

Mental health crisis services North Lancashire (Blackpool)

Single point of access services Fleetwood

Single point of access services Preston

Crisis support unit - Burnley

Access and discharge

The single point of access teams received and triaged all new referrals to the trust. This meant that all new referrals were sifted quickly and then referred on to the appropriate service. The target times for the single point of access teams were five working days for urgent referrals and 14 working days for non-urgent referrals. At the time of our inspection the single point of access team at Preston were not meeting these targets. They were currently at eight working days for urgent referrals although they were meeting targets for non-urgent referrals. During our inspection we could see the work the team had done in order to reduce these waiting times to back within the targets and that this was reducing month on month. The team had introduced a triage telephone call in order to make initial contact with the patient to assess their level of urgency; once this was done the patient could be offered a face to face appointment based on their level of risk.

The crisis teams were able to take new referrals 24 hours a day seven days per week and all were responded to within the first four hours following referral. There was a crisis line that patients could phone if they needed immediate support. This phone was manned 24 hours a day by a qualified mental health nurse who could give specialist advice over the phone to someone in a crisis, then was able to coordinate visits to that patient quickly if required.

All teams accepted referrals from a number of sources. This included GPs, self-referral, community mental health teams, inpatient wards and referrals from carers and relatives. The crisis teams provided the gatekeeping service for all acute inpatient beds. At the time of our inspection the trust proportion of admissions to acute wards gate kept by the crisis teams was above the England average of 95%. This meant they could assess patients deemed appropriate

for admission to see if they could be managed with intense support from the crisis team and ensure that only people who truly required an inpatient admission were in acute beds.

There were protocols in place for people who did not attend appointments. Staff were clear about the ways in which they would try and re-engage with someone who did not attend including making telephone calls, home visits and police welfare checks if required and the risk was felt to be high.

The teams were able to be flexible in their appointment times as they were fully staffed up until 9pm. This meant they were able to visit outside of office hours for people who may have daytime commitments. All teams we visited told us that an appointment being cancelled would always be the very last resort after other options were explored. When appointments were cancelled there was an alternative appointment the following day and an apology given. People could have home visits or also attend the team base for appointments depending on the level of risk involved.

The crisis teams' main focus was to ensure that people who could avoid hospital admission and remain at home did so. The teams were actively involved in trying to promote early discharge from the adult acute wards where appropriate and attended ward rounds on the wards on a regular basis. The wards would flag people to the team who were suitable for a referral to crisis teams and work with them to ensure a smooth discharge including supporting people who were on home leave. They did this by giving more intense support to people who were almost ready for discharge in their own homes rather than them remaining in hospital. They could offer daily visits if required in order to keep people out of hospital.

When patients no longer required the intensive treatment provided by the crisis teams they would transition those patients back to the community mental health teams to monitor them on an ongoing basis. Staff we spoke to reported good relationships with the community mental health teams with good levels of communication to ensure patients remained with the correct team for their mental health requirements. Planning for discharge from the service began on initial assessment in order to plan the correct pathway for the patient in advance.

Are services responsive to people's needs?

Good 

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

The facilities promote recovery, comfort, dignity and confidentiality

Each of the teams we visited had access to rooms where patients could be seen. For the crisis teams the preference was for patients to be seen at home whereas for the single point of access teams staff mostly saw patients at the team offices. The rooms were all based within the ground floor of the buildings in which we visited and staff areas were separate upstairs. Interview rooms were generally of a good size with comfortable furniture and were adequately soundproofed to maintain confidentiality.

In the waiting rooms of all of the teams there was lots of information displayed about the support and services available in the local area. We saw leaflets for bipolar support groups, advocacy, local women's groups and substance misuse services. There was a vast range of leaflets that people could take away with them to read at home about medication, treatments and psychological therapies.

Meeting the needs of all people who use the service

All of the buildings where patients came for appointments were easily accessible for people with a disability. There were hearing loops in the reception areas, a hearing loop is a special type of sound system for use by people with hearing aids. There were also ramps to access the building. There were special adaptations to the reception desks in the form of a hatch so that people in wheelchairs could see the receptionist

The staff had a good understanding of the local communities and their needs. There were leaflets available in other languages for example in Burnley there was a large South Asian community and leaflets were available in the different languages that the community spoke. There was easy access to interpreters and signers and this was done via an online booking system and staff reported this worked well. We could see in records examples of where interpreters had been used appropriately to ensure patients had a full understanding of their care and treatment.

When carrying out home visits staff were respectful of patients religious and cultural beliefs and ensured this was demonstrated in patient care plans so all staff were aware.

For example asking Muslim patients if they should take off their shoes before entering the house or working visits around days when patients may be attending religious services.

Listening to and learning from concerns and complaints

The service received 41 complaints with four complaints withdrawn, eight not upheld, 15 partially upheld, eight upheld and six were unknown during the last 12 months (1 April 2015 to 31 March 2016). The six complaints that were unknown were still being investigated at the time of our inspection.

Where complaints had been made we were able to see how the trust had responded to these appropriately in line with their policy and the outcome recorded. The service received 94 compliments in the last 12 months that were recorded in the data provided to us by the trust. We also saw lots of thank you cards within the teams displayed from people who used the service recently.

Patients were given information of how to complain at their initial assessment. This detailed how to raise a complaint formally and also the contact details of the team manager if they wanted to raise an issue at local level. Managers were proactive in getting feedback about their team's service. There were exit questionnaires that patients were asked to complete when they were discharged from the service. These were used to improve and review practice and we saw evidence of this in team meeting minutes. For example, one team had received a complaint about different members of the team visiting them on each visit. This was reviewed and a core team system introduced where patients would be allocated a core team of four staff who would always visit them.

Staff were aware of the complaints procedure and were able to explain to us the process if a patient wanted to raise a complaint. Patients told us that they were aware of how to make a complaint and that they would seek assistance from staff to do this. Patients told us that they would feel comfortable in approaching staff if they had a problem and that they felt they would be listened to. At the Blackpool crisis team they had a volunteer ex-service user who would come in once per week to contact recently discharged patients to get their feedback on the service. We observed this process during our inspection and found feedback for the team to be overwhelmingly positive.

Are services responsive to people's needs?

Good 

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

Staff we spoke to during the inspection were clear that they got feedback from any formal complaints made via staff meetings, emails or if necessary one to one supervision. They also told us how they would receive feedback on any informal complaints from the team managers at team meetings in order to alert all staff and reduce the likelihood of that same issue happening again and a formal complaint being made.

Health-based places of safety:

Dunsop Ward, Burnley General Hospital

Darwen ward, Royal Blackburn Hospital

The Harbour, Blackpool

The Orchard, Lancaster

The Scarisbrick Centre, Ormskirk General Hospital

Access and discharge

The health-based places of safety accepted patients of any age who were detained under section 136 of the Mental Health Act. There were no exclusion criteria for people who could be brought into the health-based places of safety. The multi-agency policy developed alongside the police and ambulance services gives staff clear direction on what should happen when the police detain someone under section 136 and staff found this easy to follow.

The trust also had a street triage service who worked alongside the police. This service was introduced before our last inspection in 2015 and was still ongoing at the time of this inspection. The street triage was able to advise the police on whether there were other options available besides section 136 for people in order to reduce the number of admissions to the health-based place of safety. The trust had recently opened a crisis support unit which could be used as an alternative to the health-based place of safety for up to 23 hours to help someone in a crisis that was felt to be short term. Whom it was felt would be able to quickly regulate their emotions with support of specialised staff. There was then a 72-hour assessment unit for people who had used the crisis support unit. These units were both staffed by qualified mental health nurses with experience in crisis support.

The police were expected to contact the "hub" which was a central bed management team as soon as they detained someone under section 136. The hub would then direct the

police to the nearest health-based place of safety that was available for them to use. The police would then need to contact the ambulance service to convey the detained patient to the place of safety.

Once the detained patient arrived at the health-based place of safety a Mental Health Act assessment would be arranged and a decision made as to whether the patient required admission under the Mental Health Act, an informal admission or to be discharged home. If a patient was deemed to be ready for discharge then the staff at the health-based place of safety would ensure the patient got home safely.

In the 12 months leading up to our inspection the health base places of safety were used a total of 720 times. The health-based places of safety at The Harbour were used the most with 309 times and second was the health-based place of safety at Lancaster with 99 times. People in the health-based places of safety were seen quickly within the 72 hours and usually within the four hour target set by the trust. However, due to pressures on beds in the adult acute ward, patients deemed as needing a bed following assessment in the health-based place of safety were on occasions remaining in the health-based place of safety for longer than the 72 hours period as there was no bed available in the trust. There were 26 incidents in the 12 months leading up to our inspection where a patient remained in the health-based place of safety for more than 72 hours. On these occasions patients had always been in agreement for an informal admission and not subject to detention under the Mental Health Act. We were provided with assurances by the trust that these incidents were all reported as a serious incident and investigated accordingly. There were daily bed management teleconferences in order to try and identify people who were ready for discharge from the adult acute wards and therefore open up a bed for people who were remaining in the place of safety. As the trust had a number of identified places of safety, there was always one available if someone was detained in the community by the police. However, this may not have been the nearest to them if this was taken up by someone waiting for a bed. Guidance issued by the mental health law team at the trust made clear the importance of transparency with patients when the Section 136 expired and the need for clear assessment and documentation of capacity to consent to remain whilst a bed was sourced. Lapses of section 136 were monitored through the network mental health law groups and the

Are services responsive to people's needs?

Good 

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

trust mental health law sub-committee. A risk was articulated by adult mental health network and actions to mitigate the impact of lapses of 136 included an agreed procedure for clinical reassessment prior to the lapsing of a section 136. Issues regarding the length of stay in the health-based place of safety due to lack of beds and bed pressures in the adult acute wards were discussed at a meeting attended by the associate medical director, the mental health law manager, social care leads and the police. Ideas for ways to reduce these pressures and reduce length of stay in the places of safety were under review by the trust at the time of our inspection.

The facilities promote recovery, comfort, dignity and confidentiality

The environments at the health-based places of safety were a calm and low stimulus environment for people who were in a crisis. There was a separate entrance at all of the sites for police to be able to discreetly bring the detained patient into the building apart from at the Scarisbrick Centre and the place of safety in Burnley. However, at those sites we were able to see evidence of protocols in place to ensure that privacy and dignity was not affected when the detained patient was brought in through the entrance. This was done by the staff ensuring that all patients and visitors were moved prior to the detained patient being brought through.

All the health-based places of safety provided a comfortable space for detained patients to stay whilst they were being assessed. They had separate toilet and wash facilities as well as a space where patients could relax whilst waiting to be assessed. The rooms were low stimulus which meant there was not much on the walls in terms of art or information. However, this was conducive to the type of environment the staff were trying to create.

In the event of a medical emergency there were designated health-based places of safety at the local acute hospital accident and emergency where patients could be transferred for further assessment.

There was access to facilities to make drinks and provide meals and snacks on the adjoining adult acute mental health wards. Staff in the health-based place of safety had access to a phone or radios to request drinks and food for patients.

Meeting the needs of all people who use the service

The multi-agency policy for the use of the health-based place of safety set out the guidelines for staff on how each patient should be managed. This guided staff on who had responsibility for which tasks and any timescales these should be completed in.

There was a lot of information available for people in the health-based place of safety. There were leaflets on medications, rights, mental health conditions and treatments. There was access to interpreter services and leaflets and other information was able to be translated into different languages on request.

On the rare occasions that someone was brought into the health-based place of safety with a learning disability, the team would seek advice from a specialist consultant in that field. This was the same for older adults and children.

There was a monitoring form attached to the paperwork used in the place of safety which captured information such as age, race, religion and gender. This was then collated by the mental health law team and used to monitor the use of the service.

Listening to and learning from concerns and complaints

In the period 1 April 2015 to 31 March 2016 there was only one complaint made about the health-based places of safety.

There was information available to patients on how to complain should they wish to and staff were aware of the procedures to manage this.

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.

Our findings

Mental health crisis services Blackburn, Hyndburn and Ribble Valley

Mental health crisis services North Lancashire (Blackpool)

Single point of access services Fleetwood

Single point of access services Preston

Crisis support unit - Burnley

Vision and values

The trust values were:

- Teamwork
- Compassion
- Integrity
- Respect
- Excellence
- Accountability

The staff we spoke to during inspection were aware of the trust's vision and values. They were able to tell us how the vision and values fitted into their everyday work and into their annual appraisal programme. The team managers were committed to embedding the values into their teams as well as being able to describe the individual team goals and aspirations.

Staff were aware of the names of the most senior people in the organisation and were able to tell us when these people had last visited their teams.

Good governance

All the teams that we visited were well managed. Staff were having regular supervision with their managers and the trust had just rolled out a new appraisal system in April 2016. This system meant that the appraisal was more focused on the goals and aspirations of that staff member making it more individualised and goal orientated. Staff we spoke to told us they felt the new appraisal system was much more beneficial to their development.

The team managers were clear about the key performance indicators that measured the team's progress. These included monitoring referral to assessment rates, clustering

and training rates. We were able to see in the team meeting minutes and in supervision records how this information was passed on to the team and actions identified to improve them where needed.

Team managers were aware of items their team had on the risk register and how to progress these to the organisation risk register if needed. They were able to add items to the risk register and had oversight of their own local register.

There was good evidence of learning from incidents across all teams. Staff were clear on how incidents were managed and that feedback was given in a clear timeframe.

Managers also utilised feedback from staff and patients to make changes in the service and improve performance.

Leadership, morale and staff engagement

Morale was high in all the teams we visited. People told us they enjoyed their job and found that they got a lot of satisfaction from working with people in a crisis. Staff were complimentary of their immediate line managers and described them as having an open door policy if they had any issues they wanted to discuss.

There was good evidence of communication between the teams and the senior leadership team. Information that was discussed in team meetings that were effective. Managers attended the multi-agency oversight meetings and crisis concordat meetings in order to try and improve patient experience across the crisis services.

Managers told us they felt empowered to lead their teams and were able to make changes that they felt would improve the team performance and patient experience. Managers felt supported by their line managers and were supported by human resources with any disciplinary or sickness and absence cases.

At the time of our inspection there were no bullying and harassment cases ongoing. Staff we spoke to told us that they felt supported by the trust and could raise any concerns without fear of victimisation.

Commitment to quality improvement and innovation

None of the teams we visited were accredited for the home treatment accreditation scheme award.

Health-based places of safety:

Dunsop Ward, Burnley General Hospital

Darwen ward, Royal Blackburn Hospital

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.

The Harbour, Blackpool

The Orchard, Lancaster

The Scarisbrick Centre, Ormskirk General Hospital

Vision and values

One of the trust values was teamwork. There was a multi-agency approach to the health-based places of safety where representatives from all agencies involved were committed to working together to ensure the health-based places of safety were well run and managed. There was a joint policy for section 136 Mental Health Act.

Good governance

Audits were carried out on the use of section 136 and the outcomes of these were discussed at multi-agency meetings to pick up any themes and areas for improvement.

Staff working in the health-based places of safety were from the adjoining adult acute wards. Therefore they had completed mandatory training that was also required in the health-based place of safety for example managing

violence and aggression and immediate life support. There were processes in place so that if staff in the health-based place of safety needed assistance this could be responded to.

Leadership, morale and staff engagement

The health-based places of safety did not have a permanent staff team. The staff working in the health-based places of safety were from the adult acute wards. Despite this staff reported they felt supported by their managers in terms of managing the health-based place of safety and felt they were able to raise issues if they needed to.

Commitment to quality improvement and innovation

The health-based places of safety either met or exceeded the Royal College of Psychiatrists standards for the health-based places of safety environment. There was excellent working relationships with partner agencies such as the police and ambulance service. This meant that there was good attendance at multi-agency meetings and any emerging themes were picked up on actioned via this meeting.