Inadequate

Lancashire & South Cumbria 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)
RW5KM	The Harbour	Health-based places of safety	FY4 4FE

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

Summary of findings

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

Contents

Summary of findings

Overall summary

This was a focused inspection which looked at the trust's response to the warning notice issued following our inspection in June 2019. We found that the service had improved and met the requirements of the warning notice. However, because this was a focused inspection we did not re-rate the individual key questions or the overall service. The existing ratings from our inspection in June 2019 remain in place. The requirements of the warning notice had been met because:

- At the last inspection we had significant concerns about patient safety and the functioning of the mental health decision units within the mental health crisis services. The unit designs were not fit for purpose, they were not being used in the way intended and they persistently failed to meet the basic needs of patients. All the mental health decision units had now been closed.
- At the last inspection we had significant concerns that systems were not in place to ensure that patients were not detained without legal authority in 136 suites. At this inspection we found that all breaches of s136 had now been reported as incidents. The reason for each breach was now documented, along with the eventual outcome and any lessons learned. Staff understood and discharged their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice.
- The provider had introduced a number of improvement measures to support the urgent care pathway and address the issues raised at the last inspection. This included increased staffing for community teams and closer working relationships with partner agencies. This meant that the requirements of the warning notice had now been met.

Summary of findings

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

Are services safe?

- Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service.

Are services effective?

- The provider had taken action to ensure staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice.

Are services well-led?

- The provider had introduced a number of improvement measures to support the urgent care pathway and address the issues raised at the last inspection.
- There were effective, multi-agency arrangements to agree and monitor the governance of the health-based places of safety. Managers of the service worked actively with partner agencies (including the police, ambulance service, primary care and local acute medical services) to ensure that people in the area received help when they experienced a mental health crisis, regardless of the setting.

Summary of findings

Information about the service

The trust provided health-based places of safety for men and women detained under section 136 Mental Health Act 1983 at the following sites:

- Chorley District General Hospital (one suite)
- Ormskirk Hospital (one suite)
- Royal Blackburn Hospital (one suite)
- The Rigby Suite, at Royal Preston Hospital (two suites)
- The Harbour, in Blackpool (two suites)
- The Orchard, in Lancaster (one suite)

All suites were for people over 18 years, except the Rigby Suite which was for young people aged 19 years and under (but also took adults over 18).

In 2019, the Care Quality Commission carried out a comprehensive inspection of mental health crisis services and health based places of safety. Mental health crisis services and health based places of safety were rated inadequate. We issued a s29A warning notice on 11 July 2019. The notice required the trust to make improvements in relation to the breaches of s136 and to ensure the governance arrangements that enabled oversight of the health based places of safety were effective.

All three of the mental health decision units had been closed.

Our inspection team

The inspection team consisted of two CQC inspectors.

Why we carried out this inspection

We carried out this focussed inspection to check whether improvements required by the s29A warning notice issued on 11 July 2019 had been made.

How we carried out this inspection

Our inspection was unannounced (staff did not know we were coming) to enable us to observe routine activity.

We inspected the health based place of safety at the Harbour in Blackpool.

Before this inspection, we reviewed information that we held about the service. During the inspection we:

- spoke with one nurse and one matron
- reviewed two care records
- reviewed the register of admissions in the health based place of safety at the Harbour
- looked at a range of policies, procedures and other documents relating to the running of the service
- spoke with one police officer.

Summary of findings

Areas for improvement

Action the provider SHOULD take to improve

The trust should ensure it fully implements its action plan in relation to seclusion in s136 suites.

Lancashire & South Cumbria NHS Foundation Trust

Mental health crisis services and health-based places of safety

Detailed findings

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Health based places of safety	The Harbour

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

Reporting incidents and learning from when things go wrong

At the last inspection, we found that staff were not reporting breaches of section 136 in line with the trust's policy, which stated that staff must complete an incident form if a patient remained in the section136 suite past the section expiry.

At this inspection, we reviewed incident data from 11 October 2019 to 13 December 2019.

All breaches of section 136 had been reported. The reason for each breach was documented, along with the eventual outcome and any lessons learned.

Are services effective?

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

Our findings

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

At the last inspection, we found four incidences of seclusion that had occurred after formal detention under s136 had ended. At this inspection, from 11 October 2019 to 13 December 2019, there were three incidences of seclusion being used after formal detention under s136 had expired. All three had begun during detention under s136 and had continued afterwards due to clinical presentation while waiting for a bed or transport.

The trust had taken action to address the concerns relating to seclusion in the s136 suites. Following the last inspection, the trust completed an annual clinical audit of the seclusion procedure across all areas, including the health-based places of safety, covering six standards. This audit included all patients who were secluded whilst detained under s136 or following s136 lapse between April and October 2019. It showed that compliance with the seclusion procedure at this time was 69%. Of the standards audited, three were fully compliant, one was partially compliant and two were non-compliant. The trust had produced an action plan that highlighted the areas requiring improvement.

Are services well-led?

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

Our findings

Good governance

At the last inspection, we found that the governance systems to enable oversight of the 136 suites were not effective. Trust data in relation to patients who remained in section 136 suites for longer than 24 hours was incomplete. This meant the trust was not assured that the health-based places of safety were being used in accordance with the Mental Health Act Code of Practice.

The trust had since introduced a number of improvement measures to support the urgent care pathway and address the issues raised at the last inspection.

Locally, staff in the health-based place of safety at the Harbour had developed a checklist of s136 detentions, to be completed hourly by staff in the suite. The checklist set out what actions should be taken and when. This was discussed for rolling out across all sites.

All s136 detentions were recorded on a single spreadsheet and validated every week. All breaches were reviewed and there was a weekly conference call between the trust, the police and the local authority adult mental health practitioner. The review considered the timeline for each detention, what had happened, the outcome and any lessons learned. It also identified whether the breach had been reported as an incident. If it had not been reported by the time of the weekly review, there was an action to ensure the incident was reported. The review findings were then reported to a weekly meeting to scrutinise performance and improvements, which was led by the chief executive officer. The clinical review of breaches supported understanding of why they occurred and the actions needed for improvement.

The provider had expanded the capacity of the mental health advice line for the police and ambulance services. This had led to an increase in police calls to the advice line. The trust provided data that showed a correlation between the reduced total number of s136 detentions and increased use of the advice line by the police. We spoke to a police officer who confirmed that there had been a steady increase in police use of the advice line since October 2019.

Crisis care had been enhanced. This provided increased support and more appropriate care for patients in crisis. Investment into key components of the urgent care pathway meant the provider had moved away from 9am - 5pm crisis and home treatment provision to 24-hour provision. By the end of December 2019, there was 24-hour crisis care across all localities. The staffing establishment had been increased by 51%. Although recruitment was still in progress, actual staffing numbers had increased by 14%. There was reduced reliance on admissions for managing acute mental health presentations, with both bed requests and actual admissions reducing over this time period. The teams' responsiveness was to be kept under regular review to ensure that they could continue to meet the demands for input.

The community mental health teams had also been enhanced. This was to ensure each mental health practitioner had the capacity to support patients aligned to their case load and provide the care co-ordination necessary to prevent relapse, support recovery and develop strategies to enable patients to live in their own home.

This was also intended to enable the provider to adopt a 'home first' approach to care delivery for patients returning from out of area placements without the need to be transferred into a trust bed. Additional funds were identified for investment and the staffing establishment had been increased by 17%. Recruitment was ongoing and by the end of December 2019, actual staff numbers had increased by 4%.

There was provider oversight of s136 via the newly re-established multi-agency group and 'frequent attenders' group. Meetings were chaired by the provider's staff.

The trust had developed 'frequent attenders' teams across the localities, to support patients who frequently accessed crisis support, either via s136 suites or via A&E. This involved a multi-disciplinary team proactively reviewing those patients' care plans to ensure there were meaningful crisis contingency plans. Care plans were to include links to appropriate support, such as third sector support, and that the plans were developed with the patient and shared with other providers such as the ambulance service. One team was fully established and had been meeting regularly since September 2019. In the remaining localities, work was still under way to establish the teams. In the meantime, discussions around 'frequent attenders' were addressed as part of the locality multi-agency groups, which had been

Are services well-led?

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re-established. We reviewed minutes of these meetings. There was comprehensive discussion of 'frequent attenders', and other s136 and crisis activity such as admissions, staff training and wellbeing.

In 2019, the provider began actively in-reaching into a Crisis café in Preston. The Richmond Fellowship were commissioned to deliver the service by Greater Preston CCG. The café, called the Haven, opened in January 2020. It operated seven days a week, from 11am – 11pm Monday to Friday and from 12pm – 11pm on weekends and bank holidays. It was available to people over the age of 16 who live in Preston, Chorley and South Ribble. The crisis café provided a free service where people could drop in to access immediate informal support, signposting them to appropriate services from a clinical and social support perspective. A team of professionals and volunteers offered interactive one-to-one and group support. People could refer themselves to the Haven, either by contacting the team by telephone in advance, or by visiting during opening times.

The provider had secured additional resources for a new a crisis house in Blackpool, due to open in July 2020. The new crisis house would provide short-term (up to seven days) intensive 24-hour, specialist mental health support to patients assessed by the crisis intervention and home treatment teams as needing additional support to avoid admission to hospital. Along with the other two crisis houses situated in Chorley and Burnley, this meant the provider would have a spread of crisis house provision across its geographical footprint. All three were delivered in partnership with the third sector.

During 2019, the trust underwent a system review carried out by a neighbouring trust. Following the review, the provider was working to re-design and enhance the community mental health pathways. Work had commenced in one Integrated Care Partnership, with the expectation that this would be rolled out across the rest of the mental health pathways during spring 2020.

Several patients were receiving care within the provider's acute admission wards who would benefit from access to rehabilitation facilities. The shortfall in dedicated rehabilitation provision impacted on both patients and the mental health system, through the utilisation of acute admission beds by patients with different clinical requirements.

The provider was planning to open 11 complex care beds in spring 2020 at the Avondale Unit at Royal Preston Hospital. This would meet the needs of some patients in the short term. There was also continuing work on planning additional 'moving on' facilities at Wesham Hospital site. This was subject to an option appraisal and full business case.

The trust provided data that showed the number of breaches of the 24-hour period in 136 suites had reduced between June and December 2019.

We reviewed data from 11 October – 13 December 2019. During that period there were 166 admissions to the health-based places of safety and 30 breaches of the s136 timescale, amounting to 18%.