

# Lancashire Care NHS Foundation Trust

## Inspection report

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We plan our next inspections based on everything we know about services, including whether they appear to be getting better or worse. Each report explains the reason for the inspection.






This report describes our judgement of the quality of care provided by this trust. We based it on a combination of what we found when we inspected and other information available to us. It included information given to us from people who use the service, the public and other organisations.

This report is a summary of our inspection findings. You can find more detailed information about the service and what we found during our inspection in the related Evidence appendix.

## Ratings

### Overall rating for this trust

Requires improvement 

Are services safe?	Requires improvement 
Are services effective?	Requires improvement 
Are services caring?	Good 
Are services responsive?	Requires improvement 
Are services well-led?	Requires improvement 

We rated well-led (leadership) from our inspection of trust management, taking into account what we found about leadership in individual services. We rated other key questions by combining the service ratings and using our professional judgement.

# Summary of findings

## Background to the trust

Lancashire Care NHS Foundation Trust was established in April 2002 and authorised as a Foundation Trust in December 2007. The trust employs 7,500 people and has an annual income of over £330 million.

The geography covered by the trust includes both rural and urban areas. There are significant social and health differences in the localities within the trust's catchment area which range from relative affluent areas to some of the most economically deprived areas in the country.

The trust provides a wide range of specialist mental and physical health services to a population of approximately 1.4 million people within Lancashire. The trust has 26 registered locations which provide inpatient and community mental health services, community health services including one community in-patient ward, dental services, eating disorder services and improving access to psychological therapies services.

The trust has 518 inpatient beds across 40 wards, 18 of which are children's mental health beds. The trust also has 301 community mental health clinics per week and 695 community physical health clinics per week.

The trust works with nine clinical commissioning groups in addition to NHS England that commission all specialist services.

We have carried out three previous comprehensive inspections, one responsive focussed inspection and inspection of one adult social care location since April 2015. We carried out our last comprehensive inspection between 8 January to 21 February 2018 when we inspected the following core services;

- acute wards for adults of working age and psychiatric intensive care units
- forensic inpatient / secure wards
- child and adolescent mental health wards
- mental health crisis services and health-based places of safety
- community health inpatient services

We rated the trust as requires improvement for safe, effective, well led and overall. We identified 22 actions the trust must take to improve in three of the core services and trust wide for breaches in the following regulations:

Regulation 9 Person centred care

Regulation 12 Safe care and treatment

Regulation 13 Safeguarding

Regulation 17 Governance

Regulation 18 Staffing

We also identified 23 further actions the trust should consider taking to improve across the five core services.

Since our last inspection, there have been a number of significant changes at board level within the trust. There has been an interim director of nursing and quality in post for over a year. This post has recently been appointed to and the new director of nursing and quality was due to commence in post in September 2019. The trust appointed a new chief executive officer in April 2019. The medical director retired in April 2019 and there has been an interim medical director in post since. The director of strategic development officer has recently retired. There is a new acting director of operations who was seconded into post from another NHS trust a month prior to the inspection and the previous director of operations has recently been appointed to a new director of partnerships and strategy post.

# Summary of findings

## Overall summary

Our rating of this trust stayed the same since our last inspection. We rated it as **Requires improvement** 



## What this trust does

Lancashire Care NHS Foundation Trust is a provider of mental health, community health, primary care, community dental services, adult social care (supported living) and a community health inpatient service.

## Key questions and ratings

We inspect and regulate healthcare service providers in England.

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs, and well-led?

Where we have a legal duty to do so, we rate the quality of services against each key question as outstanding, good, requires improvement or inadequate.

Where necessary, we take action against service providers that break the regulations and help them to improve the quality of their services.

## What we inspected and why

We plan our inspections based on everything we know about services, including whether they appear to be getting better or worse.

We inspected five core services as part of our continual checks on the safety and quality of healthcare services which were:

- acute wards for adults of working age and psychiatric intensive care units
- child and adolescent mental health wards
- community-based mental health services for adults of working age
- mental health crisis services and health-based places of safety
- community dental services.

The core services were either selected due to their previous inspection ratings or our ongoing monitoring identified that an inspection at this time was appropriate to understand the quality of the service provided.

The trust provides the following nine core services which we did not inspect:

- forensic in-patient/secure wards
- wards for older people with mental health problems
- community-based mental health services for older people
- specialist community mental health services for children and young people
- community mental health services for people with a learning disability or autism
- community health services for adults

# Summary of findings

- community health in-patients
- community health (sexual services)
- community health services for children, young people and families

The trust also provides the following services which we did not inspect:

- adult social care (supported living).

All these core services or additional services have previously been inspected and rated as part of our comprehensive inspection programme.

Where services were not complying with regulations during previous inspections and we have not inspected on this occasion, we have reviewed the actions taken by the trust as part of our on-going monitoring of the trust.

Our comprehensive inspections of NHS trusts have shown a strong link between the quality of overall management of a trust and the quality of its services. For that reason, all trust inspections now include inspection of the well-led key question at the trust level. Our findings are in the section headed 'Is this organisation well-led?'

## What we found

### Overall trust

Our rating of the trust stayed the same. We rated it as requires improvement because:

- We rated the trust as requires improvement overall in safe, effective, responsive and well led. Our rating for the trust took into account the previous ratings of the core services not inspected this time. We rated two of the trust's 14 core services as inadequate and two as requires improvement overall.
- We had significant concerns about patient safety, privacy and dignity 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. Trust leaders had failed to address these concerns following our last inspection. Full information about our regulatory response to the concerns we have described will be added to a final version of this report, which we will publish in due course.
- Staff were detaining patients in the health-based places of safety past the expiry time of the section 136. Patients were subject to restrictive interventions without the appropriate legal safeguards in place. This practice had become routine. This had not improved since our last inspection.
- The governance systems in place for the oversight of the health-based places of safety and mental health decision units was not effective. The trust did not have accurate or complete information in relation to patients who remained in the health-based places of safety or the mental health decision units for prolonged periods of time. Staff were not consistently reporting these breaches. This had not improved since our last inspection.
- Due to our concerns, we used our powers to take immediate enforcement action. We issued the trust with a Section 29A warning notice for this core service. This advised the trust that our findings indicated a need for significant improvement in the quality of healthcare. We will revisit these services to check that appropriate action has been taken and that quality of care has improved.
- The trust was not providing consistently safe care within the acute wards for adults of working age and psychiatric intensive care units. There were not sufficient numbers of suitably trained staff. Staff were not managing all risks effectively. Staff were not always following the seclusion policy, infection control practices and best practice in relation to medicines management.

# Summary of findings

- Due to the concerns we found during our inspection of the trust's acute inpatient mental health wards for adults of working age and psychiatric intensive care units, we used our powers to take immediate enforcement action. We issued the trust with a Section 29A warning notice. This advised the trust that our findings indicated a need for significant improvement in the quality of healthcare. We will revisit these services to check that appropriate action has been taken and that quality of care has improved.
- The problems with the health-based places of safety and mental health decision units were symptomatic of an acute care pathway that did not function effectively. This had a direct impact on patient care. In addition to the blockages at point of admission, the home treatment teams did not have effective gatekeeping arrangements and discharges from the acute wards were delayed for other than clinical reasons. High use of out of area beds was another symptom of the problem. Community teams had unacceptable waiting times.
- Within the community based mental health services for adults of working age, risk management plans did not contain detailed information about how to manage specific risks and the legal authority to administer medication to patients on a community treatment order were not kept with the medicine charts.
- Not all staff were receiving supervision or an annual appraisal. This had not improved since our last inspection.
- The trust did not have a strategy or service model for the care of people with a personality disorder. This resulted in some people with a personality disorder being admitted to an acute ward whose admission might have been avoided.

However:

- We rated 10 of the trust's 14 core services as good overall. We rated eleven of the trust's core services as good for caring and the dental services as outstanding for caring. The ratings for the child and adolescent ward in all domains had improved to good. Our rating for the trust took into account the previous ratings of the core services not inspected this time.
- Staff were kind, caring and motivated to provide the best care and treatment they could for patients.
- On the acute and psychiatric intensive care wards, staff completed the physical observations of patients following the administration of rapid tranquillisation. This had improved since our last inspection.
- Staff understood how to protect patients from abuse and they worked well with other agencies to do so. Staff assessed and managed risks to patients and themselves well and followed best practice in anticipating, de-escalating and managing challenging behaviour.
- Staff completed comprehensive, holistic assessments of all patients on admission/referral. Staff developed good care plans and reviewed and updated these when patients' needs changed. They made sure that patients had a full physical health assessment and knew about any physical health problems.
- Staff met the needs of all patients including those with a protected characteristic.
- Staff knew and understood the provider's vision and values and how they applied in their work. Staff morale was improving and staff were optimistic that improvements would be made under the new leadership team.
- Team members worked well together.
- Staff treated concerns and complaints seriously, investigated them and learned lessons from the results were shared.

## Are services safe?

Our rating of safe stayed the same. We rated it as requires improvement because:

# Summary of findings

- We rated one of the trust's 14 core services as inadequate in safe, six as requires improvement and seven as good. In rating the trust, we took into account the previous ratings of the nine core services not inspected this time.
- We had significant concerns about patient safety, privacy and dignity and the functioning of the mental health decision units which the trust had failed to address following our last inspection. The units did not have beds and should only have accommodated patients for up to 23 hours however; they were routinely being used as additional wards with patients including children, staying several days. Staff had failed to incident report these instances. Children admitted to the units did not routinely have access to child and adolescent mental health specialists.
- Staff were not always incident reporting section 136 breaches and breaches over 23 hours in the mental health decision units. There were some environmental issues within some of the health-based places of safety which had not been addressed following our previous inspection. The mental health decision unit in Preston breached same sex accommodation guidance. Staff were not all trained in basic life support and overall completion of mandatory training was below the trust target.
- There were staffing issues within some of the acute wards for adults of working age and psychiatric intensive care units, health-based places of safety, home treatment teams and community based mental health services for adults of working age. There was a lack of medical cover in the mental health decision units which impacted on patient's length of stay.
- Within the acute wards for adults of working age and psychiatric intensive care units, ligature audits were not always comprehensive. Staff were not managing risks in relation to patients smoking on the wards. Staff were not always following the seclusion policy and infection control practices. Staff within the acute wards for adults of working age and psychiatric intensive care units and the health-based place of safety at the Harbour, were not always following best practice in relation to medicines management. Staff were not all trained in basic life support and immediate life support.
- Within the community based mental health services for adults of working age, risk management plans did not contain detailed information about how to manage specific risks. Staff did not have access to patient information that was held on the local authority electronic record system.

However:

- Our rating for safe on the child and adolescent ward went up to good.
- Staff understood how to protect patients from abuse and they worked well with other agencies to do so.
- Staff assessed and managed risks to patients and themselves well and followed best practice in anticipating, de-escalating and managing challenging behaviour. Staff used restrictive interventions as a last resort when attempts at de-escalation had failed.
- On the acute and psychiatric intensive care wards, staff completed the physical observations of patients following the administration of rapid tranquillisation. This had improved since our last inspection.
- Overall, staff recognised incidents and reported them appropriately. When things went wrong, staff apologised and gave patients honest information and suitable support.
- Staff understood the duty of candour.

## Are services effective?

Our rating of effective stayed the same. We rated it as requires improvement because:

- We rated one of the trust's 14 core services as inadequate for effective, four as requires improvement and nine as good. In rating the trust, we took into account the previous ratings of the nine services not inspected this time.

# Summary of findings

- Lengths of stay within the mental health decision units regularly breached the 23 hour timescale whilst patients waited for an in-patient bed. The remit and functioning of the units was not understood within the trust and they were not used effectively to reduce in-patient admissions.
- The trust did not have a personality disorder strategy or model of care for patients with a personality disorder to keep their inpatient admissions to a minimum. Staff within the acute services did not receive training in learning disability, autism or personality disorder even though they were caring for patients with these needs.
- The trust policy for section 136 did not reflect all relevant legislation and the Mental Health Act Code of Practice and the trust's policy for implementing the Mental Capacity Act and obtaining authorisation for Deprivation of Liberty did not give an accurate definition of the meaning of capacity within the Act.
- Staff within the health-based places of safety and mental health decision units did not understand their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice. Patients were detained past the expiry of section 136 and subject to restrictive interventions without appropriate legal safeguards in place. This had not improved since our last inspection.
- Within the adult community mental health teams, the legal authority to administer medication to patients were not kept with the medicine charts. We were not assured that patients on community treatment orders had their rights read in accordance with the Mental Health Act and Code of Practice.
- Not all staff within the crisis service, acute services and community adult mental health teams were receiving supervision in line with the trust's policy and not all staff in the crisis service had received an annual appraisal. Team meetings were not regularly taking place on all wards. This had not improved since our last inspection.

However:

- Staff completed comprehensive, holistic assessments of all patients on admission/referral.
- Staff made sure that patients had a full physical health assessment and knew about any physical health problems. Health promotion was evident throughout the trust.
- All patients had a care plan and staff regularly reviewed and updated these when patients' needs changed.
- Team members worked well together. Staff from different disciplines worked together as a team to benefit patients. Teams had access to the full range of specialists required to meet the needs of patients.
- Staff within the child and adolescent wards and dental services used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives.

## Are services caring?

Our rating of caring stayed the same. We rated it as good because:

- We rated one of the trust's 14 core services as outstanding for caring, eleven as good, one as requires improvement and one as inadequate. In rating the trust, we took into account the previous ratings of the nine core services not inspected this time.
- Within the dental services, patients and those close to them were continually positive about the way staff them and they reported that staff went the 'extra mile'.
- Across all services staff understood and respected the individual needs of each patient and supported them to understand and manage their care, treatment or condition.
- Overall, staff ensured that patients had easy access to advocates when needed.
- Overall, staff informed and involved families and carers appropriately.

# Summary of findings

- Staff were kind, caring and motivated to provide the best care and treatment they could for patients.
- Within the child and adolescent ward, staff and patients had worked together to produce an impressive, large wall display to remind patients of ten key rights when attending care programme approach meetings.

However:

- The mental health decision units did not provide privacy, maintain the dignity or promote the recovery of patients. Some patients had slept on reclining chairs for up to 10 days whilst they waited for a bed. Patients were dissatisfied with their treatment on the units. Food options were limited. There were fridges and freezers located in the lounge where patients slept which were noisy. Staff did not make sure patients could access advocacy services. Patients and carer feedback opportunities were limited.

## Are services responsive?

Our rating of responsive went down. We rated it as requires improvement because:

- We rated one of the trust's 14 core services as inadequate for responsive, two as requires improvement and eleven as good. In rating the trust, we took into account the previous ratings of the nine core services not inspected this time.
- The acute care pathway did not function effectively and services were not able to meet demands. Gatekeeping arrangements within the home treatment teams were not effective and they did not provide a 24 hour service.
- There were significant blockages within the system which directly impacted on patient care throughout services. There were not always beds available for patients in the catchment area. The use of out of area beds was high. Patients stayed on the mental health decision units and in the health-based places of safety for excessive lengths of time due to no bed being available for them to be transferred into. The mental health decision units were not fit for purpose and they persistently failed to meet the basic needs of patients.
- Discharge was delayed for other than clinical reasons on the acute wards, this included waiting for appropriate accommodation for patients to be discharged to.
- Patients referred to community mental health teams had unacceptable waits even those assessed as urgent. The service had long waiting lists. Service users waited too long to be allocated to a care coordinator and for appointments with consultant psychiatrists. In Lancaster and Leyland there were patients waiting for up to 12 months for transfer to community mental health teams from home treatment teams.
- The trust did not have effective local arrangements for young people who were detained under section 136 of the Mental Health Act.
- On Scarisbrick ward, there were four two-bed dormitories, beds were separated by curtains. This meant patients did not have their own space and privacy protected in their bedroom.

However:

- Staff met the needs of all patients including those with a protected characteristic.
- Staff treated concerns and complaints seriously, investigated them and learned lessons from the results were shared.
- Within the child and adolescent ward, staff planned and managed discharge well by liaising with services that would provide aftercare and were assertive in managing the discharge care pathway. As a result, patients did not have excessive lengths of stay and discharge was rarely delayed for other than a clinical reason.

## Are services well-led?

Our rating of well-led went down. We rated it as requires improvement because:



# Summary of findings

- We rated two of the trust's 14 core services as inadequate for well led, one as requires improvement and eleven as good. In rating the trust, we took into account the previous ratings of the nine core services not inspected this time.
- Trust leaders had not addressed the failings within the acute care pathway despite being aware of these issues. Senior managers had not identified and improved the quality of the service. There were significant problems with the performance of the governance framework throughout the pathway.
- We had significant concerns about patient safety, privacy and dignity and the functioning of the mental health decision units which trust leaders had failed to address following our last inspection.
- The governance systems in place for the oversight of the mental health decision units was not effective. It was practice for patients, including children, to remain on these units over the 23 hour limit within the statement of purpose and CQC registration condition. Breaches were not consistently reported by staff. This meant the trust did not have complete data relating to the breaches. This had not improved since our last inspection.
- Trust leaders had failed to ensure that patients were not being detained in the health-based places of safety past the expiry of the section 136. Patients were subject to restrictive interventions without the appropriate legal safeguards in place. This practice had become routine. This had not improved since our last inspection.
- Environmental issues within some of the health-based places of safety had not been addressed following our previous inspection.
- Staffing issues within some of the acute wards for adults of working age and psychiatric intensive care units, health-based places of safety, home treatment teams and community based mental health services for adults of working age had not been effectively addressed.
- Staff were not always providing consistently safe care within the acute wards for adults of working age and psychiatric intensive care units. Staff were not always following the seclusion policy, medicines management policy and infection control practices.
- Staff were not consistently managing risks in relation to patients smoking on the wards.
- Staff were not always receiving appraisals, supervision and training required in line with trust policy.

However:

- Trust leaders and staff we spoke with demonstrated a motivation and commitment to implementing the improvements and changes needed. Staff were optimistic they would be supported in doing so under the new leadership team and by their immediate managers.
- Despite the challenges some staff faced, morale was improving, and staff were committed to providing the best care they could. All staff demonstrated a positive culture of being open and honest.
- Staff knew and understood the provider's vision and values and how they were applied in the work of their team. Staff demonstrated these with patients, carers and team members in the interactions we observed.
- Overall, staff felt respected, supported and valued. They felt able to raise concerns without fear of retribution.
- There were effective systems in place to identify learning from incidents, complaints and safeguarding alerts and make improvements.
- Staff responded to and managed complaints effectively.
- There was a robust audit programme in place to monitor compliance against trust policies and best practice guidance.
- Staff felt that leaders were approachable and visible.

# Summary of findings

- Governance processes operated effectively within the child and adolescent ward and across the dental services where performance and risk were managed well, and quality improvement was embedded.

## Ratings tables

The ratings tables show the ratings overall and for each key question, for each service, hospital and service type, and for the whole trust. They also show the previous ratings for services or parts of them not inspected this time. We took all ratings into account in deciding overall ratings. Our decisions on overall ratings also took into account factors including the relative size of services and we used our professional judgement to reach fair and balanced ratings.

## Outstanding practice

We found examples of outstanding practice in the child and adolescent mental health ward.

For more information, see the outstanding practice section of this report.

## Areas for improvement

We found areas for improvement including 37 breaches of legal requirements that the trust must put right. We found 23 things that the trust should improve to comply with a minor breach that did not justify regulatory action, to prevent breaching a legal requirement, or to improve service quality.

For more information, see the Areas for improvement section of this report.

## Action we have taken

We issued one Notice of Proposal, two warning notices and 15 requirement notices to the trust. Our action related to 37 breaches of legal requirements in three core services and trust wide. That meant the trust had to send us a report saying what action it would take to meet this requirement.

For more information on action we have taken, see the sections on areas for improvement and regulatory action.

## What happens next

We will check that the trust takes the necessary action to improve its services. We will continue to monitor the safety and quality of services through our continuing relationship with the trust and our regular inspections.

## Outstanding practice

### Child and adolescent mental health ward

- Staff and patients had worked together to produce an impressive, large wall display to remind patients of ten key rights when attending care programme approach meetings. These were displayed in the conference room and were designed to ensure that the care programme approach meetings were as accessible and user-friendly as possible.

### Community dental services

- Between June 2018 and June 2019, the service received feedback from 2,379 patients across all service. Across the service, 99% of respondents stated they would recommend or highly recommend the service.

# Summary of findings

## Areas for improvement

Action the trust **MUST** take is necessary to comply with its legal obligations. Action a trust **SHOULD** take is to comply with a minor breach that did not justify regulatory action, to prevent it failing to comply with legal requirements in future, or to improve services.

We told the trust that it must take action to bring services into line with seven regulations in respect of 37 breaches of legal requirements. This action related to three core services and trust wide.

### **Action the trust MUST take to improve:**

#### **Trust-wide**

- The trust must ensure that effective governance systems are in place to assess, monitor and improve the quality and safety of services. (Regulation 17)
- The trust must ensure that the trust policies relating to Mental Health Act and the Mental Capacity Act reflect current legislation. (Regulation 17)
- The trust must ensure that the acute care pathway operates effectively. (Regulation 17)

#### **Community mental health services for adults of working age**

- The trust must improve the quality of risk management plans. Risk management plans must include detailed information relating to the management of service users risks. Risk management plans must match information highlighted within risk assessments and other documents. (Regulation 12)
- The trust must improve service user access to the service. The provider must address issues relating to service users waiting to be assessed, allocated to a care coordinator and for appointments to see a psychiatrist. (Regulation 9)
- The trust must ensure that all service users on Community Treatment Orders are given information on their rights under the Mental Health Act at regular intervals. This includes when service users have declined their rights. (Regulation 9)
- The trust must ensure that the legal authority relating to service users on Community Treatment Orders are kept with medicine cards. (Regulation 9)
- The trust must improve the quality and safety of the service in a timely way. Senior manager must respond appropriately to issues affecting service user care and issues relating to staffing. Improvements to accessing the service, staffing levels and supervision must be prioritised. (Regulation 17)

#### **Mental health crisis services and health-based places of safety**

- The trust must ensure staff attend and are up to date with mandatory training including basic and immediate life support to meet Resuscitation Council (UK) standards. (Regulation 18)
- The trust must ensure patients' privacy and dignity are protected in relation to mental health decision units. (Regulation 10)
- The trust must ensure that staff receive supervision in line with the trust's policy. (Regulation 18)
- The trust must ensure that staff receive annual appraisal in line with the trust's policy. (Regulation 18)
- The trust must ensure that patients are detained with the appropriate legal safeguards in place. (Regulation 9)
- The trust must ensure there is oversight and monitoring of the section136 timescale. (Regulation 17)

# Summary of findings

- The trust must ensure there are effective multi-agency arrangements to agree and monitor the governance of the mental health crisis service and the health-based places of safety. (Regulation 17)
- The trust must ensure there is oversight and monitoring of the 23 hour timescale for admissions to mental health decision units. (Regulation 17)
- The trust must ensure patients are only admitted to mental health decision units for a maximum of 23 hours. (Regulation 10)
- The trust must ensure that admissions of patients under the age of 18 to mental health decision units are reported. (Regulation 10)
- The trust must ensure that incidents are reported as per the mental health decision unit standard operating procedure and the section 136 policy. (Regulation 17)
- The trust must ensure there is oversight and monitoring of medicines management in section 136 suites and mental health decision units. (Regulation 17)
- The trust must ensure that referral pathways between services operate effectively and promptly. (Regulation 17)
- The trust must review the gatekeeping processes in relation to home treatment teams. (Regulation 17)
- The trust must review the management of complaints and actions in relation to mental health decision units. (Regulation 17)
- The trust must ensure that the showering facilities in the Preston 136 suite are fit for purpose. (Regulation 15)
- The trust must ensure that environmental issues at the Ormskirk home treatment team are addressed. (Regulation 15)

## **Acute wards for adults of working age and psychiatric intensive care units**

- The trust must ensure all areas of the wards are clean and do not pose an infection control hazard. Records must be kept to evidence this taking place. (Regulation 12)
- The trust must ensure that medicines are prescribed with the appropriate legal authority. (Regulation 12)
- The trust must ensure there are enough qualified nursing staff to provide the level of care necessary for each ward. (Regulation 18)
- The trust must ensure staff attend and are up to date with mandatory training including basic and immediate life support to meet Resuscitation Council (UK) standards. (Regulation 12)
- The trust must ensure staff follow the seclusion procedure and keep accurate accessible records of seclusion episodes. (Regulation 17)
- The trust must ensure patients' privacy and dignity are protected, including in their bedroom, seclusion and the bathrooms. (Regulation 10)
- The trust must ensure the no smoking policy is implemented within the service and they follow their safety and security procedure for inpatient mental health units including not allowing patients to have lighters on the wards. (Regulation 17)
- The trust must provide staff with training in learning disability, autism and personality disorder to enable staff to meet the needs of these patients. (Regulation 12)
- The trust must assess and care plan for patients with specific needs including epilepsy and moving and handling to ensure staff know how best to meet their needs. (Regulation 9)

# Summary of findings

- The trust must ensure that staff receive supervision in line with the trust's policy. (Regulation 18)
- The trust must ensure that patients are detained with the appropriate legal safeguards in place. (Regulation 11)
- The trust must ensure there is oversight and monitoring of the implementation of the Mental Health Act and Deprivation of Liberty Safeguards and that action is taken following audit findings. (Regulation 17)

## **Action the trust SHOULD take to improve:**

### **Community mental health services for adults of working age**

- The trust should continue to review the provision of the administration support and telephone system to ensure staff respond promptly and effectively when clients contact the service. Recommendations should be implemented without delay.
- The trust should consider the use of a recognised rating scale or other approach to rate severity and to monitor outcomes.
- The trust should ensure staff have access to service user information.

### **Mental health crisis services and health-based places of safety**

- The trust should ensure that staffing levels are kept under review, to ensure that 136 suites are adequately staffed but do not deplete the staffing levels on the inpatient wards.
- The trust should review the establishment staffing levels across home treatment teams.
- The trust should review and improve opportunities for patients and carers to provide feedback on services.
- The trust should ensure staff are fully consulted regarding changes to working conditions.

### **Acute wards for adults of working age and psychiatric intensive care units**

- The trust should ensure that staff have access to the ligature audits for the wards. Ligature audits should identify potential ligature anchor points and advise staff how to mitigate risks.
- The trust should ensure the blind spots are mitigated on Avenham psychiatric intensive care unit and Darwen ward.
- The trust should review the staff inductions to the wards, ensuring relevant topics are on the checklist and staff complete them with new staff when inducting them.
- The trust should ensure staff are aware of where the emergency medicines are, that clinic room storage and temperature readings reflect the trust's policy, that patients' allergies are noted on prescription cards.
- The trust should review the handovers for each ward and ensure consistent information is shared with staff including risk.
- The trust should review the information provided to patients at admission and ensure it is up to date.
- The trust should ensure information is shared with staff, with an opportunity to discuss the information and provide feedback, this may be via team meetings or another method.
- The trust should review the flow of patients within the wards, reviewing the appropriateness of admission of informal patients.
- The trust should ensure the plans to eliminate dormitory sleeping arrangements are implemented.
- The trust should ensure there is signage at Chorley for people to locate the wards.

### **Child and adolescent mental health wards**

# Summary of findings

- The trust should make sure that staff record that parents or carers are informed of each seclusion episode.
- The trust should make sure stock medication does not exceed suggested amounts.
- The trust should make sure that patients' detention papers are checked by a doctor (known as medical scrutiny) to make sure the clinical grounds for detaining patients were made out.
- The trust should make sure patients' religious needs are fully reflected in relevant patients' care plans.
- The trust should make sure patients' care plans provide more detailed information about patients' education status and needs, working in conjunction with staff from the education team.
- The trust should continue to work with local partners to improve the education provision at The Cove to make sure the provision meets the educational needs of patients across the age range and of differing educational abilities.

## Is this organisation well-led?

Our comprehensive inspections of NHS trusts have shown a strong link between the quality of overall management of a trust and the quality of its services. For that reason, we look at the quality of leadership at every level. We also look at how well a trust manages the governance of its services – in other words, how well leaders continually improve the quality of services and safeguard high standards of care by creating an environment for excellence in clinical care to flourish.

Our rating of well-led went down. We rated it as requires improvement because:

- We rated two of the trust's 14 core services as inadequate for well led, one as requires improvement and twelve as good. In rating the trust, we took into account the previous ratings of the nine core services not inspected this time.
- We rated the mental health crisis services and health-based places of safety as inadequate for effective, caring, responsive and well led and requires improvement for safe. We had significant concerns about patient safety, privacy and dignity and the functioning of the mental health decision units which the trust had failed to address following our last inspection.
- The governance systems in place for the oversight of the mental health decision units was not effective. It had become practice for patients, including children, to remain on these units over the 23 hour limit within the statement of purpose and CQC registration condition. Breaches were not consistently reported by staff. This meant the trust did not have complete data relating to the breaches. This had not improved since our last inspection. Full information about our regulatory response to the concerns we have described will be added to a final version of this report, which we will publish in due course.
- We had significant concerns about patients being detained in the health-based places of safety past the expiry of the section 136. Patients were subject to restrictive interventions without the appropriate legal safeguards in place. This practice had become routine. This had not improved since our last inspection. Due to our concerns, we used our powers to take immediate enforcement action. We issued the trust with a Section 29A warning notice for this core service.
- We rated the acute wards for adults of working age and psychiatric intensive care units as inadequate for safe and well led and requires improvement for effective and responsive. The trust was not providing consistently safe care within the acute wards for adults of working age and psychiatric intensive care units. Due to our concerns, we used our powers to take immediate enforcement action. We issued the trust with a Section 29A warning notice for this core service.

# Summary of findings

- Trust leaders had failed to address the failings within the acute care pathway despite being aware of these issues. Senior managers had not identified and improved the quality of the service. There were significant problems with the performance of the governance framework throughout the pathway.
- The trust had introduced a system to monitor compliance rates for staff supervision, but this had not been effective. Effective oversight of supervision compliance was an area for improvement identified in the previous inspection in 2018.
- Trust policies relating to Mental Health Act and the Mental Capacity Act did not reflect all current legislation.

However:

- There had been a significant number of changes at board level within the trust since the appointment of the new chief executive in April 2019. The new chief executive was well sighted on the current challenges which the trust faced, and they had prioritised the development of a senior leadership team to strengthen the executive capacity and support them in making the improvements and changes needed.
- All the board members we spoke with demonstrated a motivation and commitment to supporting the chief executive within their roles to drive the improvements and changes needed.
- The chief executive had successfully engaged with key stakeholders identified in the Lancashire urgent mental health pathway review as being instrumental in developing the pathway. This had resulted in all the stakeholders signing up to the plan and agreeing clear actions to meet the recommendations in the review.
- Staff knew and understood the provider's vision and values and how they were applied in the work of their team. Staff reported they were optimistic that improvements would be made under the new leadership team.
- Despite the challenges some staff faced, morale was improving, and staff were committed to providing the best care they could. All staff demonstrated a positive culture of being open and honest.
- Commissioners told us the culture in the trust had positively changed over the past few months. This reflected what staff at all levels described to us through interviews and focus groups we held within the core services we inspected.
- Staff felt respected, supported and valued. They reported that the provider promoted equality and diversity in its day-to-day work and in providing opportunities for career progression. They felt able to raise concerns without fear of retribution.
- The trust had systems in place to identify learning from incidents, complaints and safeguarding alerts and make improvements.
- The trust had effective systems in place to manage and respond to complaints.
- There was a robust audit programme in place to monitor compliance against trust policies and best practice guidance.
- There was a programme of board visits to services and staff fed back that leaders were approachable.
- The board had recently agreed further investment of £3m for 82 extra qualified staff and additional investment for community teams to recruit 21 extra care coordinators. Where cost improvements were taking place, the trust had effective systems in place to ensure they did not compromise patient care.
- This trust was implementing a £5m programme of investment in new IT systems to support patient care.

## Ratings tables

Key to tables					
Ratings	Not rated	Inadequate	Requires improvement	Good	Outstanding
Rating change since last inspection	Same	Up one rating	Up two ratings	Down one rating	Down two ratings
Symbol *	↔	↑	↑↑	↓	↓↓
Month Year = Date last rating published					

\* Where there is no symbol showing how a rating has changed, it means either that:

- we have not inspected this aspect of the service before or
- we have not inspected it this time or
- changes to how we inspect make comparisons with a previous inspection unreliable.

### Ratings for the whole trust

Safe	Effective	Caring	Responsive	Well-led	Overall
Requires improvement ↔ Aug 2019	Requires improvement ↔ Aug 2019	Good ↔ Aug 2019	Requires improvement ↓ Aug 2019	Requires improvement ↔ Aug 2019	Requires improvement ↔ Aug 2019

The rating for well-led is based on our inspection at trust level, taking into account what we found in individual services. Ratings for other key questions are from combining ratings for services and using our professional judgement.



## Ratings for a combined trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community	Requires improvement 2019	Good 2019	Good 2019	Good 2019	Good 2019	Good 2019
Mental health	Requires improvement ↔ Aug 2019	Requires improvement ↔ Aug 2019	Good ↔ Aug 2019	Requires improvement ↓ Aug 2019	Requires improvement ↔ Aug 2019	Requires improvement ↔ Aug 2019
<b>Overall trust</b>	Requires improvement ↔ Aug 2019	Requires improvement ↔ Aug 2019	Good ↔ Aug 2019	Requires improvement ↓ Aug 2019	Requires improvement ↔ Aug 2019	Requires improvement ↔ Aug 2019

The rating for the well-led key question is based on our inspection at trust level, taking into account what we found in individual services. Ratings for other key questions take into account the ratings for different types of service. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

## Ratings for community health services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community health services for adults	Requires improvement 2017	Requires improvement 2017	Good 2017	Good 2017	Good 2017	Requires improvement 2017
Community health services for children and young people	Requires improvement 2017	Good 2017	Good 2017	Good 2017	Good 2017	Good 2017
Community health inpatient services	Good 2018	Good 2018	Good 2018	Good 2018	Good 2018	Good 2018
Community dental services	Good Aug 2019	Good Aug 2019	Outstanding Aug 2019	Good Aug 2019	Good Aug 2019	Good Aug 2019
Community health sexual health services	Good 2017	Good 2017	Good 2017	Good 2017	Good 2017	Good 2017
<b>Overall*</b>	Requires improvement 2019	Good 2019	Good 2019	Good 2019	Good 2019	Good 2019

\*Overall ratings for community health services are from combining ratings for services. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

## Ratings for mental health services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Acute wards for adults of working age and psychiatric intensive care units	Inadequate ↓ Aug 2019	Requires improvement ↔ Aug 2019	Good ↔ Aug 2019	Requires improvement ↓ Aug 2019	Inadequate ↓ Aug 2019	Inadequate ↓ Aug 2019
Forensic inpatient or secure wards	Good 2018	Good 2018	Good 2018	Good 2018	Good 2018	Good 2018
Child and adolescent mental health wards	Good ↑ Aug 2019	Good ↑ Aug 2019	Good ↑ Aug 2019	Good ↑ Aug 2019	Good ↑ Aug 2019	Good ↑ Aug 2019
Wards for older people with mental health problems	Good 2017	Good 2017	Good 2017	Good 2017	Good 2017	Good 2017
Community-based mental health services for adults of working age	Requires improvement ↓ Aug 2019	Requires improvement ↔ Aug 2019	Good ↔ Aug 2019	Requires improvement ↓ Aug 2019	Requires improvement ↓ Aug 2019	Requires improvement ↓ Aug 2019
Mental health crisis services and health-based places of safety	Requires improvement 2019	Inadequate ↓ 2019	Inadequate ↓↓ 2019	Inadequate ↓ 2019	Inadequate ↓ 2019	Inadequate ↓ 2019
Specialist community mental health services for children and young people	Requires improvement 2017	Good 2017	Good 2017	Good 2017	Good 2017	Good 2017
Community-based mental health services for older people	Good 2017	Good 2017	Good 2017	Good 2017	Good 2017	Good 2017
Community mental health services for people with a learning disability or autism	Good 2017	Requires improvement 2017	Good 2017	Good 2017	Good 2017	Good 2017
<b>Overall</b>	Requires improvement ↔ 2019	Requires improvement ↔ 2019	Good ↔ 2019	Requires improvement ↓ 2019	Requires improvement ↔ 2019	Requires improvement ↔ 2019

Overall ratings for mental health services are from combining ratings for services. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

## Ratings for adult social care services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Garstang Road Preston Learning Disability Supported Living Scheme.	Good 2018	Good 2018	Good 2018	Good 2018	Good 2018	Good 2018
Bickerstaffe House, Ormskirk Hospital	Good 2015	Good 2015	Good 2015	Good 2015	Good 2015	Good 2015

# Community health services

## Background to community health services

The trust provides the following five community health core services:

- community health services for adults
- community health in-patients
- community health (sexual services)
- community health services for children, young people and families
- community dental services.

The core services inspected by short notice announced inspection were:

- community dental services.

## Summary of community health services

**Good** ● → ←

Our overall rating of these services stayed the same. We rated them as good overall because:

We rated community dental services as good overall and outstanding for caring.

# Community dental services

Good 

## Key facts and figures

The Lancashire Care NHS Foundation Trust Dental service offers specialist services, such as children's and special care dentistry and home visits for patients in the local community from 14 different locations throughout the trust. They offer treatment under inhalation sedation and general anaesthesia. Patients requiring specialist services are seen on a referral only basis.

They also provide general dental services and emergency dental services. Emergency patients are triaged by an external organisation.

The service also works with the University of Central Lancashire to provide training and support for undergraduate dental students and dental therapists.

Community and primary dental services are available Monday from 8:30am to 5:00pm and Friday from 8:30am to 4:30pm.

During the inspection we received feedback from 35 patients and spoke with 22 members of staff.

Our inspection between 28 and 30 May 2019 was announced (staff knew we were coming) to ensure that everyone we needed to talk to was available. During the inspection we visited Oak House Dental Centre, Yarnspinner's Primary Health Care Centre, Ringway Dental Centre, Barbara Castle Way Health Centre and St Peters Primary Healthcare Centre.

## Summary of this service

This service has not been inspected before. We rated it as good because:

- Staff had good access to training to support their roles. Managers had oversight on mandatory training levels. Staff had a good awareness of the need to protect patients from abuse and neglect and there were systems in place to support them. Premises and equipment were clean and well maintained. The service followed best practice guidance on the decontamination and sterilisation of used dental instruments. Staff had a good awareness of the incident reporting process. Incidents were investigated and where necessary the patient was fully informed, and an apology given in line with the duty of candour.
- The clinicians provided care and treatment in line with current nationally recognised guidance. There was an effective use of skill mix within the service including dental therapists and dental nurses with extended duties. Staff worked with other healthcare professionals in the best interest of patients. Staff had a good understanding of the importance of obtaining and documenting consent and were fully aware of their responsibilities under the Mental Capacity Act 2005.
- Staff cared for patients with kindness and compassion. During the inspection we received feedback from 35 patients. They told us that staff were friendly, helpful, calm, kind and patient. We witnessed positive interactions between staff and patients throughout the inspection. The service carried out the NHS Friends and Family Test. Between June 2018 and June 2019, the service received 2379 responses. Of these responses 99% of patients would either highly recommend or recommend the service to friends and family. Staff from one location were due to receive an award for obtaining 1435 responses between June 2018 and June 2019.

# Community dental services

- The service took into account patients individual needs. All locations which we visited were fully accessible for wheelchair users and those with limited mobility. They had access to wheelchair tippers. There was access to translation services and arrangements for patients with sight and hearing loss. The service dealt with complaints promptly, positively and efficiently.
- There were clearly defined roles and responsibilities within the service supported by an effective management structure. Governance arrangements were well embedded and there were clear lines of accountability. Morale within the service was good and staff spoke proudly and passionately about the service which they provided. The service actively monitored and managed risk well. The service engaged well with staff, patients, external stakeholders and other healthcare professionals well in order to continually improve the service.

## Is the service safe?

**Good** ●

This service has not been inspected before. We rated safe as good because:

- The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.
- The service used safety monitoring results well. Staff collected safety information and shared it with staff. The service used information to improve the service.
- The service controlled infection risk well. Staff kept themselves, equipment and the premises clean. Decontamination and sterilisation processes followed best practice laid out in nationally recognised guidance.
- The service had suitable premises and equipment and looked after them well.
- Staff kept appropriate records of patients' care and treatment. Records were clear, up-to-date and available to all staff providing care.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.
- The service provided mandatory training in key skills to all staff and made sure everyone completed it.
- The service had enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and abuse and to provide the right care and treatment.
- The service planned for emergencies and staff understood their roles if one should happen.

## Is the service effective?

**Good** ●

This service has not been inspected before. We rated effective as good because:

- The service provided care and treatment based on national guidance and evidence of its effectiveness. This included guidance laid out by the National Institute for Health and Care Excellence, the Faculty of General Dental Practice and the Department of Health's 'Delivering Better Oral Health' toolkit 2013.

# Community dental services

- The service monitored the effectiveness of care and treatment and used the findings to improve them. Audit was used well within the service and feedback was provided to staff to enable continuous improvement.
- The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and monitor the effectiveness of the service.
- Staff of different kinds worked together as a team to benefit patients. Dentists, dental therapists, nurses and other healthcare professionals supported each other to provide good care.
- Staff always had access to up-to-date, accurate and comprehensive information on patients' care and treatment. All staff had access to an electronic records system that they could all update.
- Staff understood their roles and responsibilities under the Mental Capacity Act 2005. They knew how to support patients experiencing mental ill health and those who lacked the capacity to make decisions about their care.

## Is the service caring?

**Outstanding** 

This service has not been inspected before. We rated caring as outstanding because:

- Staff cared for patients with compassion. Feedback from people who use the service and those who are close to them was continually positive about the way staff treat people. Staff were highly motivated and inspired to offer care that is kind and promotes people's dignity. Relationships between people who use the service, those close to them and staff were strong, caring, respectful and supportive.
- Staff involved patients and those close to them in decisions about their care and treatment.
- Staff provided emotional support to patients to minimise their distress. People feel really cared for and that they matter. Patients value their relationships with the staff team and feel that they often go 'the extra mile' for them when providing care and support.

## Is the service responsive?

**Good** 

This service has not been inspected before. We rated responsive as good because:

- The trust planned and provided services in a way that met the needs of local people. Reasonable adjustments had been made to all locations which we visited.
- People could access the service when they needed it. Waiting times for treatment were generally good and these were actively monitored by senior managers.
- The service took account of patients' individual needs.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, which were shared with all staff.

# Community dental services

## Is the service well-led?

**Good** ●

This service has not been inspected before. We rated well-led as good because:

- The service had managers at all levels with the right skills and abilities to run a service providing high-quality sustainable care.
- The service had a vision for what it wanted to achieve and workable plans to turn it into action developed with involvement from staff and patients. The current vision was on-hold until the upcoming tendering had been completed.
- Managers across the service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.
- The service used a systematic approach to continually improving the quality of its services and safeguarding high standards of care by creating an environment in which excellence in clinical care would flourish.
- The service had effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected.
- The service collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards.
- The service engaged well with patients, staff, the public and local organisations to plan and manage appropriate services, and collaborated with partner organisations effectively.
- The service was committed to improving services by learning from when things go well and when they go wrong and promoting training and continuous development.

# Mental health services

## Background to mental health services

The trust provides the following nine mental health core services:

- Acute inpatient mental health wards for adults of working age and psychiatric intensive care unit
- Forensic inpatient/secure wards
- Child and adolescent mental health wards
- Wards for older people with mental health problems
- Community-based mental health services for adults of working age
- Mental health crisis services and health-based places of safety
- Community mental health services for older people
- Specialist community-based mental health services for children and young people
- Community mental health services for people with a learning disability or autism

The core services inspected by unannounced inspection were:

- Acute inpatient mental health wards for adults of working age and psychiatric intensive care unit
- Child and adolescent mental health wards

The core services inspected by short notice announced inspection were:

- Community-based mental health services for adults of working age
- Mental health crisis services and health-based places of safety

## Summary of mental health services

**Requires improvement**   

Our overall rating of these services stayed the same. We rated them as requires improvement because:

- We rated mental health services as requires improvement in safe, effective, responsive and well-led and good in the caring domain. Our rating for responsive went down overall.
- We rated two of the mental health core services as inadequate overall and one as requires improvement.
- One core service had improved from requires improvement to good.



# Acute wards for adults of working age and psychiatric intensive care units

Inadequate ● ↓

## Key facts and figures

Lancashire Care NHS Foundation Trust provides acute inpatient wards and psychiatric intensive care units to the population of Lancashire. The service provides care and treatment to men and women aged eighteen years and over with a mental health illness. Services are provided to patients who are admitted informally and patients who are compulsorily detained under the Mental Health Act. The service is based across 17 wards at five different locations. These are:

The Harbour – a purpose built mental health facility located in Blackpool. The Harbour includes four adult mental health wards and two psychiatric intensive care units. Wards based at the Harbour are:

- Churchill ward, a male acute ward with 18 beds
- Orwell ward, a male acute ward with 18 beds
- Shakespeare ward, a female acute ward with 18 beds
- Stevenson ward, a female acute ward with 18 beds
- Byron ward, a female psychiatric intensive care unit with eight beds
- Keats ward, a male psychiatric intensive care unit with eight beds

Royal Blackburn hospital – includes two assessment wards, two acute wards and one psychiatric intensive care unit. Wards based at Royal Blackburn hospital are:

- Ribble A assessment ward, a male assessment ward with 12 beds
- Hyndburn ward, a female acute ward with 20 beds
- Darwen ward, a male acute ward with 19 beds
- Edisford ward, a female assessment ward with 14 beds
- Calder ward, a male psychiatric intensive care unit with six beds

The Scarisbrick inpatient unit – is located at Ormskirk District General hospital. The unit includes one acute ward and one psychiatric intensive care unit. Wards based at the Scarisbrick inpatient unit are:

- Scarisbrick ward, a mixed sex acute ward, with 20 beds including four two-bed dormitories
- Lathom Suite, a male psychiatric intensive care unit with four beds

Chorley and South Ribble hospital – include two acute wards and one psychiatric intensive care unit. Wards based at Chorley and South Ribble hospital are:

- Duxbury ward, a female acute ward with 15 beds
- Worden ward, a male acute ward with 15 beds
- Avenham ward, a female psychiatric intensive care unit with six beds

The Orchard – is a standalone unit based in Lancaster that is a mixed sex acute ward with 18 beds.

# Acute wards for adults of working age and psychiatric intensive care units

Since we last inspected in 2018, the wards that were at Burnley General hospital have closed and the wards at Chorley have opened. Most staff have moved from Burnley to Chorley.

At the last inspection in 2018 we issued three requirement notices to the trust. One for Regulation 12 Safe Care and Treatment in relation to completing physical health observations of patients following rapid tranquillisation. One for Regulation 17 Good Governance. This was in relation to implementing policy, supervision, appraisal, sharing learning and managers working clinical shifts. The final requirement notice was for Regulation 18 Staffing. In relation to staff receiving appraisals and supervision. We rated the service as Requires improvement overall with Requires improvement in safe, effective and well led and good in caring and responsive.

Prior to the inspection, we spoke with 39 patients during Mental Health Act reviewer visits from 1 June 2018 to 31 May 2019. Themes from reviewer visits included patient involvement in care planning, prescribing medicine with the appropriate legal safeguards, seclusion nursing reviews being conducted by one nurse rather than two, awareness of the mental health advocate.

Before the inspection visit, we reviewed information that we held about these services, asked the trust for information and asked a range of other organisations for information. We inspected the acute wards and PICU from Monday 17 June 2019 to Friday 21 June 2019, we visited all 17 wards. This was an unannounced inspection; the service did not know we were coming.

Our inspection team for this core service comprised two CQC inspectors, one CQC assistant inspector, two nurse specialist advisors, two occupational therapist specialist advisors, a consultant psychiatrist specialist advisor and a CQC pharmacist specialist. Due to the number of wards to inspect, we split into two teams.

During the inspection we:

- toured the wards and clinic rooms
- spoke with three matrons, 13 ward managers and two clinical leads
- spoke with 51 patients
- attended and observed eight patient activities including an occupational therapy session, board games, art activity, pampering group and a gardening group
- received feedback about the service from two community mental health professionals
- spoke with 58 other staff including nurses, health care assistants, doctors, occupational therapists, students, psychologists, pharmacists, a physiotherapist and receptionist
- attended and observed ten ward rounds, two care programme approach meetings, a patient meeting, two morning meetings and a facilitating early discharge meeting
- reviewed 62 care and treatment records of patients
- reviewed 95 prescription cards
- looked at a range of policies, procedures and other documents relating to the running of the service.

## Summary of this service

Our rating of this service went down. We rated it as inadequate because:

# Acute wards for adults of working age and psychiatric intensive care units

We have taken enforcement action against this service which has limited ratings for some key questions to inadequate. We have issued a section 29A warning notice to the trust with improvements that need to be made by 20 December 2019.

- The service did not provide safe care. Four ward environments were not safe and clean and ten ward environments did not protect patients' privacy and dignity. The wards did not have enough nurses. Medicines were not always managed safely.
- Staff did not receive training in how to best meet the needs of people with a personality disorder, learning disability or autism. Staff did not create specific care plans for patients with epilepsy or moving and handling needs.
- Managers did not ensure staff received training, supervision and appraisal.
- A patient had been detained at the Orchard without the safeguards afforded by the Mental Health Act or Mental Capacity Act; 12 detained patients had been given medication that had not been included on the relevant consent to treatment documentation; the trust's Mental Capacity Act and Deprivation of Liberty Safeguards policy did not give an accurate definition of the meaning of capacity within the Act.
- The service did not manage beds well. A bed was not always available locally to a person who would benefit from admission and there was a very high demand for the beds and an ineffective strategy to manage those demands.
- The service was not well led, and the governance processes did not ensure that ward procedures ran smoothly.
- The service had not addressed two regulatory breaches from the inspection in 2018 and had a further regulatory breach that was also a breach in 2016.

However:

- Staff were passionate about their role and were caring and supportive towards patients. Staff understood and implemented safeguarding procedures.
- Staff were now receiving appraisals and conducting observations post rapid tranquillisation of patients, these were regulatory breaches at the inspection in 2018.

## Is the service safe?

**Inadequate** ● ↓

Our rating of safe went down. We rated it as inadequate because:

- The service did not have enough nursing staff, who knew the patients and received basic training to keep patients safe from avoidable harm. There were 34 reported incidents of unsafe staffing levels and 91 incidents of staff not being able to take their breaks from 1 December 2018 to 31 May 2019.
- Staff did not follow infection control practices of ensuring the care plan in relation to a patient with MRSA was being followed and documented. A patient's bedroom and ensuite was soiled and unkempt. Staff had not taken action to resolve this. Calder ward had uneven flooring which was ripped in parts and the seclusion room was stained and smelt of urine.
- There were low training levels of Basic Life Support and Immediate Life Support. Managers did not know if the staff that were working had the appropriate training. This meant staff may not be able to respond in an emergency.

# Acute wards for adults of working age and psychiatric intensive care units

- The storage arrangements for emergency medicines varied across the wards and staff could not easily locate them at the Orchard and Avenham ward. Staff monitored the clinic room temperatures weekly and did not take action at an earlier frequency if there were high readings noted.
- We viewed ligature audits on all wards except the Orchard and Darwen wards. The audits included “various ligature points” which did not tell staff what the risks were and how to mitigate these. Also, when new staff were given their induction, this did not cover the ligature audits for the wards.
- The trust was not implementing the no smoking policy, we observed patients being escorted to the outside space for a cigarette and patients smoking in their bedrooms.
- Staff were not following the seclusion policy, there were occasions of nurses and doctors completing their reviews late and missing documentation.
- There were errors in the prescribing of medicines for 12 patients out of 95 reviewed, where patients had taken medicines without the appropriate legal safeguards. Allergies were not noted on 16 of the prescription cards we reviewed. This meant staff would not know if there was a risk of prescribing a specific medicine to a patient.
- The quality of staff handovers varied across the wards and they did not all include information regarding risk presentation from the previous shift.
- There was no patient call system in the wards.

However:

- Staff assessed and managed risks to patients and themselves well and followed best practice in anticipating, de-escalating and managing challenging behaviour. Staff used restraint and seclusion only after attempts at de-escalation had failed.
- Staff completing the necessary physical observations following the administration of rapid tranquillisation. This was not the case at the last inspection in 2018.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse, and they knew how to apply it.
- Staff had easy access to clinical information and it was easy for them to maintain clinical records.
- The wards had a good track record on safety. The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. When things went wrong, staff apologised and gave patients honest information and suitable support.

## Is the service effective?

**Requires improvement** ● ➔ ➜

Our rating of effective stayed the same. We rated it as requires improvement because:

- Staff did not follow best practice in relation to epilepsy assessment and management.
- The trust did not have a personality disorder strategy or model of care for patients with a personality disorder to keep their inpatient admission to a minimum.
- Staff did not receive training in learning disability, autism or personality disorder even though they were caring for patients with these needs.

# Acute wards for adults of working age and psychiatric intensive care units

- Staff were not receiving clinical and managerial supervision in line with the trust's policy.
- Team meetings were not regularly taking place on all wards.
- At the Orchard, the service did not follow the legal framework for depriving a patient of their liberty and a patient was detained without the appropriate safeguards for three days.
- The Policy for Implementing the Mental Capacity Act and Obtaining Authorisation for Deprivation of Liberty dated June 2017 did not give an accurate definition of the meaning of capacity within the Act.
- There were a high number of informal patients, and a number of patients waiting for a treatment bed. There was a blockage in the system. People in hospital were ready for discharge and people in the community or assessment wards required an admission.

However:

- The ward teams included or had access to the full range of specialists required to meet the needs of patients on the wards.
- Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. The ward teams had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.
- Staff supported patients to make decisions on their care for themselves. They understood the provider's policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly for patients who might have impaired mental capacity.

## Is the service caring?

**Good** ● → ←

Our rating of caring stayed the same. We rated it as good because:

- Staff treated patients with compassion and kindness. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.
- Staff involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided. They ensured that patients had easy access to independent advocates.
- There was a leaflet entitled "information for carers of people admitted to hospital" this included useful information about the hospital, care provided, staff roles and responsibilities and how to access a carers assessment.

However:

- Staff did not have the skills and knowledge to support patients with autism. We saw one patient visibly distressed and the staff not knowing how best to support them.
- The mental health inpatient stay booklet was out of date and did not include the current wards. This meant patients would not have up to date information about their ward.

## Is the service responsive?

**Requires improvement** ● ↓

# Acute wards for adults of working age and psychiatric intensive care units

Our rating of responsive went down. We rated it as requires improvement because:

- The service did not manage beds well. There was not a bed available when needed. Discharge was delayed for other than clinical reasons, this included waiting for appropriate accommodation for patients to be discharged to.
- There was not always beds available for patients in the catchment area. When we visited wards, we saw that patients had been transferred between wards to enable patients to be closer to home.
- The psychiatric intensive care units did not always have a bed available if a patient needed more intensive care. There were patients waiting for beds on the psychiatric intensive care units.
- The assessment wards could not meet their targets of assessment and discharge within three to five days because there were patients on the wards waiting for treatment beds.
- Patients on Ribble A, Hyndburn and Edisford wards did not have easy access to outside space.
- On Scarisbrick ward, there were four two-bed dormitories, beds were separated by curtains. This meant patients did not have their own space and privacy protected in their bedroom.
- Information was not displayed on wards in easy read format, even though the wards were caring for patients with a learning disability and autism.

However:

- The design, layout, and furnishings of the communal areas of the wards supported patients' treatment, privacy and dignity. There were quiet areas for privacy.
- There was a variety of activities available to patients and community participation was embedded at The Orchard.
- The food was of a good quality and patients on acute wards could make hot drinks and snacks at any time.
- The service met the needs of all patients who used the service – including those with a protected characteristic. Staff helped patients with communication, advocacy and cultural and spiritual support.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results.

## Is the service well-led?

**Inadequate** ● ↓

Our rating of well-led went down. We rated it as inadequate because:

- The trust had not addressed regulatory breaches from previous inspection. The no smoking policy was not being followed. Team meetings were not regularly taking place. Staff were not receiving supervision in line with the trust's policy. Staff did not receive training in learning disability or autism.
- Compliance with basic life support and immediate life support training was low and ward managers did not have a system of assurance regarding whether the staff working were trained. The trust had already received a regulatory breach for this during our 2016 inspection.
- Junior staff were not provided with the opportunity to discuss the strategy of the service and provide feedback.
- Our findings from the other key questions demonstrated that governance processes did not operate effectively at ward level and that performance and risk were not managed well.
- Staff did not engage actively in local and national quality improvement activities.

# Acute wards for adults of working age and psychiatric intensive care units

- Staff did not act on findings from audits and did not have oversight of the implementation of the Mental Health Act in relation to capacity to consent to treatment of medicines or the implementation of the Deprivation of Liberty Safeguards.
- Policies and procedure were not followed in relation to medicines management, seclusion and supervision.
- There were unsafe staffing levels, with occasions of qualified nurses working alone and staffing levels not meeting the complement.

However:

- Staff knew and understood the provider's vision and values and how they were applied in the work of their team.
- Staff reported that the provider promoted equality and diversity in its day-to-day work and in providing opportunities for career progression. They felt able to raise concerns without fear of retribution.
- Staffing was on the risk register and incident reported.

## Areas for improvement

We found areas some areas for improvement in this service. See areas for improvement section above.

# Wards for people with a learning disability or autism

Requires improvement  

## Key facts and figures

Lancashire Care NHS Foundation Trust provides community mental health services to adults of a working age across Lancashire. The adult mental health teams were based in:

- Preston
- Chorley and South Ribble
- West Lancashire
- Lancaster and Morecambe
- Fylde and Wyre
- Blackpool
- Blackburn
- Hyndburn
- Pendle
- Rossendale
- Burnley

Community mental health services provided care and treatment primarily for service users with severe and enduring mental health needs that required a multidisciplinary approach. Community mental health services also had specific teams to target vulnerable groups which included, assertive engagement and early intervention. There were specialist triage, assessment and referral teams who dealt with referrals and assessments.

On this inspection we looked at all five key questions. Our inspection was a short notice announced inspection (staff did not know we were coming until the day before the inspection) to enable us to observe routine activity.

We inspected four community mental health teams. We also spoke to staff and sampled records from early intervention teams, specialist triage, assessment and referral teams, a community restart team, community treatment teams and the eating disorder service.

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

- spoke with 20 staff including nurses, doctors, occupational therapists, social workers, support time recovery workers and support workers
- spoke with five managers
- spoke with nine service users
- spoke with five carers
- reviewed 23 care records
- carried out a tour of four community mental health teams including the offices and interview/meeting rooms



# Wards for people with a learning disability or autism

- observed one multidisciplinary referral meeting
- attended and observed two service user clinic appointments
- observed five home visits to service users
- looked at a range of policies, procedures and other documents relating to the running of the service.

A comprehensive inspection of community based mental health service for adults of working age was last carried out by the Care Quality Commission in September 2016. Community based mental health service for adults of working age were rated as good overall. However, effective was rated as requires improvement and the following requirement notice

was issued:

- Regulation 9 Person-centred care. The trust were not always providing person centre care to patients on a community treatment order.

## Summary of this service

Our rating of this service went down. We rated it as requires improvement because:

- The service could not demonstrate that it managed risks to service users effectively. Although staff assessed risk well, the resulting risk management plans did not address all risk identified and were vague and not personalised. Staff did not have access service user information that was held on the local authority electronic records system.
- There were unacceptable waiting times for service users to be assessed, to be allocated to a care coordinator and for appointments to see consultant psychiatrists.
- Staff supervision rates had been low over the last 12 months.
- Systems were still not in place to ensure that the corresponding legal authority to administer medication to patients subject to a community treatment order were kept with the medicine chart and reviewed by nurses administering medication. We were not assured that service users on Community Treatment Order were being read their rights at regular intervals in accordance with the Mental Health Act and code of practice.
- Staff did not have access to information that was held on the local authority electronic record system. Telephone calls from service users often went unanswered.
- Senior managers did not respond promptly to failings within the service. Issues were not identified and addressed causing significant shortfalls to many aspects of service user care.

However:

- Clinical premises where service users were seen were safe and clean.
- Staff developed holistic, recovery-oriented care plans informed by a comprehensive assessment and in collaboration with families and carers. They provided a range of treatments that were informed by best-practice guidance and suitable to the needs of the service user. Staff engaged in clinical audit to evaluate the quality of care they provided.
- The teams included or had access to the full range of specialists required to meet the needs of the service users. Managers ensured that these staff received training and appraisals. Staff worked well together as a multidisciplinary team and with relevant services outside the organisation.

# Wards for people with a learning disability or autism

- Staff understood and discharged their roles and responsibilities under the Mental Capacity Act 2005.
- Staff treated service users with compassion and kindness, respected their privacy and dignity, and understood the individual needs of patients. They actively involved patients and families and carers in care decisions.
- The criteria for referral to the service did not exclude service users who would have benefitted from care.

## Is the service safe?

**Requires improvement** ● ↓

Our rating of safe went down. We rated it as requires improvement because:

- Risk management plans did not contain detailed information about how to manage specific risks. Risks identified within the risk assessments were not included in the risk management plan.
- There were not enough staff to meet the demands of the service. New staff had been recruited but were not yet in post. The service was not yet fully benefitting the recent recruitment and increase in nursing posts.
- Access to service user information was limited for service users who were receiving input from local authority staff.
- Staff did not have access to information that was held on the local authority electronic record system.

However:

- All clinical premises where service users received care were safe, clean, well equipped, well furnished, well maintained and fit for purpose.
- Staff understood how to protect service users from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.
- Staff kept detailed records of service users' care and treatment. Records were clear, up to date and easily available to all staff providing care.
- The teams had a good track record on safety. The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

## Is the service effective?

**Requires improvement** ● → ←

Our rating of effective stayed the same. We rated it as requires improvement because:

- Staff were not receiving supervision, in line with the trust's policy, to support them in their role. Supervision rates had been very low over the last 12 months.
- Systems were still not in place to ensure that the corresponding legal authority to administer medication to Community Treatment Order patients were kept with the medicine chart and reviewed by nurses administering medication.

# Wards for people with a learning disability or autism

- We were not assured that service users on Community Treatment Order were being read their rights at regular intervals in accordance with the Mental Health Act and Code of Practice.
- Staff did not use a recognised rating scale or other approach to rate severity and to monitor outcomes.

However:

- Staff worked with service users and families and carers to develop individual care plans and updated them when needed. Care plans reflected the assessed needs, were personalised, holistic and recovery-oriented.
- Staff provided a range of treatment and care for the service users based on national guidance and best practice. They ensured that service users had good access to psychological interventions.
- The teams included or had access to the full range of specialists required to meet the needs of patients under their care. Managers made sure that staff had a range of skills needed to provide good quality care. They supported staff with appraisals, and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.
- Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. The teams had effective working relationships with other relevant teams within the organisation.
- Staff supported patients to make decisions on their care for themselves. They understood the provider's policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly for patients who might have impaired mental capacity.

## Is the service caring?

**Good** ● → ←

Our rating of caring stayed the same. We rated it as good because:

- Staff treated service users with compassion and kindness. They understood the individual needs of service users and supported service users to understand and manage their care, treatment or condition.
- Staff involved service users in care planning and risk assessment and actively sought their feedback on the quality of care provided. They ensured that service users had easy access to advocates when needed.
- Staff informed and involved families and carers appropriately.

## Is the service responsive?

**Requires improvement** ● ↓

Our rating of responsive went down. We rated it as requires improvement because:

- The service was not accessible to service users when they required it, including those assessed as being urgent. The service had long waiting lists. Service users waited too long to be allocated to a care coordinator and for appointments with consultant psychiatrists. The wait in some areas exceeded six months from referral to treatment. Service users did not receive prompt treatment.
- Not all teams were able to respond promptly and effectively when service users telephoned the service.

# Wards for people with a learning disability or autism

However:

- The referral criteria did not exclude service users who would have benefitted from care. Staff assessed service users who required urgent care promptly. Staff followed up service users who missed appointments.
- The service met the needs of all service users including those with a protected characteristic. Staff helped service users with communication, advocacy and cultural and spiritual support.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff

## Is the service well-led?

**Requires improvement** ● ↓

Our rating of well-led went down. We rated it as requires improvement because:

- There was a failure to respond promptly to failings within the service. Senior managers had not identified and improved the quality of the service. There were significant problems with systems and process to rectify issues such as access to the service, the quality of risk management plans, staff supervision, compliance with the Mental Health Act, access to local authority electronic records and ensuring telephone calls were answered.

However:

- Managers were visible in the service and approachable for service users and staff.
- Staff knew and understood the provider's vision and values and how they were applied in the work of their team.
- Staff felt respected, supported and valued. Morale had been improving since new staff had been recruited. Staff reported that the provider promoted equality and diversity in its day-to-day work and in providing opportunities for career progression. They felt able to raise concerns without fear of retribution.

## Areas for improvement

We found areas some areas for improvement in this service. See areas for improvement section above.

# Child and adolescent mental health wards

Good  

## Key facts and figures

Lancashire Care NHS Foundation Trust provide one child and adolescent mental health ward at The Cove which is located in Heysham. The ward provides care and treatment to children and young people who have severe and/or complex mental health conditions who require hospital care. The ward is an 18-bed acute admission ward for male and female patients aged between 13 and 18 who require hospital admission due to their mental health needs. At the time of our inspection, the ward had been capped at 14 beds and 12 were occupied.

The beds are contracted by NHS England on behalf of Lancashire and South Cumbria commissioners.

The Cove is registered to provide the following regulated activities:

- assessment and treatment for people detained under the Mental Health Act and
- treatment for disease, disorder and injury.

We last inspected Lancashire Care NHS Foundation Trust's child and adolescent mental health wards in January 2018. At that inspection, we rated this core service as requires improvement overall and requires improvement across all five key questions (safe, effective, caring, effective and well-led). We found several regulatory breaches including regulations relating to:

- Regulation 18 - Staffing
- Regulation 9 - Person-centred care
- Regulation 17 - Good governance
- Regulation 13 - Safeguarding service users from abuse and improper treatment

We carried out Mental Health Act monitoring visits to The Cove in November 2018. The trust sent an action statement addressing the shortfalls we found on this visit.

Our inspection team for this core service was two CQC inspectors, one CQC assistant inspector, and two specialist advisors - one nurse manager and one social work manager (both specialising in child and adolescent mental health services).

We inspected this core service as part of our ongoing mental health inspection programme. We looked at all key questions.

Before the inspection visit, we reviewed information that we held about these services, asked the trust for information and asked a range of other organisations for information. We inspected The Cove on 21 and 22 May 2019. This was an unannounced inspection - the service did not know we were coming.

During the inspection visit, we:

- toured the ward environment
- met with seven young people who were patients on the wards
- spoke with the ward manager, and two modern matrons who oversee the ward
- spoke with 15 other staff including consultant psychiatrists, qualified nursing staff, support workers, visiting pharmacist, occupational therapy staff, and a clinical psychologist

# Child and adolescent mental health wards

- spoke with two carers
- observed care and activities provided by staff to patients
- observed four clinical meetings - two care programme approach meetings, a morning handover and a multidisciplinary admission and assessment case meeting
- reviewed prescription charts for all 14 patients
- reviewed seven care records (including Mental Health Act and seclusion records where relevant) and
- looked at a range of meeting minutes, policies, procedures and other documents relating to the running of the service.

## Summary of this service

Our rating of this service improved. We rated it as good because:

- The service provided safe care. The ward environment was safe and clean. The ward had enough nurses and doctors. Staff assessed and managed risk well. They minimised the use of restrictive practices, managed medicines safely and followed good practice with respect to safeguarding.
- Staff developed recovery-oriented care plans informed by a comprehensive assessment. They provided a range of treatments suitable to the needs of the patients and in line with national guidance about best practice.
- The ward teams included or had access to the full range of specialists required to meet the needs of patients on the ward. Managers ensured that these staff received training, supervision and appraisal. The ward staff worked well together as a multidisciplinary team and with those outside the ward who would have a role in providing aftercare.
- Staff understood and discharged their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. They followed good practice with respect to young people's competence and capacity to consent to or refuse treatment.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, and understood the individual needs of patients. Staff actively involved patients and families and carers in care decisions, where possible, including working together to produce an impressive wall display to remind patients of ten key rights when attending care programme approach meetings.
- The service was well led and the governance processes ensured that ward procedures ran smoothly.

However:

- While staff ensured that they were recording most of safeguards relating to seclusion, we found one example where staff had not recorded that parents or carers were informed of one seclusion episode.
- There were a small number of minor issues picked up in our clinic check including some stock medication exceeding suggested amounts and some unnecessary clutter. This was due to the recent change from two wards to one ward and staff were aware and working on these.
- While detention papers had been checked by the receiving nurse and scrutinised by an administrator, on three out of four relevant records, we did not find evidence of medical scrutiny to make sure the clinical grounds for detaining patients were made out.

# Child and adolescent mental health wards

- Staff were discussing patients' religious needs with them but, in one record, these discussions were not fully reflected in the patient's care plans. Care plans could provide more detailed information about patients' education status and needs. The education provision was limited but this was beyond the full control of the trust.

## Is the service safe?

Good  

Our rating of safe improved. We rated it as good because:

- The ward was safe, clean, well equipped, well furnished, well maintained and fit for purpose.
- The service had enough nursing staff, who knew the patients and received training to keep patients safe from avoidable harm.
- Staff assessed and managed risks to patients and themselves well and followed best practice in anticipating, de-escalating and managing challenging behaviour. Staff used restraint and seclusion only after attempts at de-escalation had failed. The ward staff participated in the provider's restrictive interventions reduction programme.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it. The provider had a named nurse and doctor for child safeguarding and the teams had a safeguarding lead.
- Staff had easy access to clinical information and it was easy for them to maintain high quality electronic clinical records.
- The service used systems and processes to safely prescribe, administer, and record medicines. Staff regularly reviewed the effects of medications on each patient's physical health.
- The ward had a good track record on safety. The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team. When things went wrong, staff apologised and gave patients honest information and suitable support.
- Following our inspection, staff took immediate action to make sure there was signage to show the ward had a designated female lounge so young women patients had a safe space to go during the day if they wanted to.

However:

- While staff ensured that they were recording most of safeguards relating to seclusion, we found one example where staff had not recorded that parents or carers were informed of one seclusion episode.
- There were a small number of minor issues picked up in our clinic check including some stock medication exceeding suggested amounts and some unnecessary clutter. This was due to the recent change from two wards to one ward and staff were aware and working on these.

## Is the service effective?

Good  

Our rating of effective improved. We rated it as good because:

# Child and adolescent mental health wards

- Staff assessed the physical and mental health of all patients on admission. They developed individual care plans, which they reviewed regularly through multidisciplinary discussion and updated as needed. Care plans reflected the assessed needs, were personalised and recovery-oriented.
- Staff provided a range of care and treatment interventions suitable for the patient group and consistent with national guidance on best practice. They ensured that patients had good access to physical healthcare and supported patients to live healthier lives.
- Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives.
- The ward team included or had access to the full range of specialists required to meet the needs of patients on the ward. Managers made sure they had staff with a range of skills needed to provide high quality care. They supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.
- Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. The ward team had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.
- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and discharged these well. Managers made sure that staff could explain patients' rights to them.
- Staff supported patients to make decisions on their care for themselves proportionate to their competence. They understood how the Mental Capacity Act 2005 applied to young people aged 16 and 17 and the principles of Gillick competence as they applied to patients under 16. Staff assessed and recorded consent and capacity or competence clearly for patients who might have impaired mental capacity or competence.

However:

- While detention papers had been checked by the receiving nurse and scrutinised by an administrator, on three out of four relevant records, we did not find evidence of medical scrutiny to make sure the clinical grounds for detaining patients were sound.

## Is the service caring?

Good  

Our rating of caring improved. We rated it as good because:

- Staff treated patients with compassion and kindness. They respected patients' privacy and dignity. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.
- Staff involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided. They ensured that patients had easy access to independent advocates.
- Staff and patients had worked together to produce an impressive, large wall display to remind patients of ten key rights when attending care programme approach meetings.
- Staff informed and involved families and carers appropriately.



# Child and adolescent mental health wards

## Is the service responsive?

Good  

Our rating of responsive improved. We rated it as good because:

- The admission and assessment team provided a key role in managing patient admissions well.
- Staff planned and managed discharge well. They liaised well with services that would provide aftercare and were assertive in managing the discharge care pathway. As a result, patients did not have excessive lengths of stay and discharge was rarely delayed for other than a clinical reason.
- The design, layout, and furnishings of the ward supported patients' treatment, privacy and dignity. Each patient had their own bedroom with an en-suite bathroom and could keep their personal belongings safe. There were quiet areas for privacy.
- The food was of a good quality and patients could make drinks and snacks at any time.
- The ward met the needs of all patients who used the service – including those with a protected characteristic. Staff helped patients with communication, advocacy and cultural and spiritual support.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team.

However:

- The education provision at The Cove was limited but this was provided by the local education authority and was beyond the full control of the trust.
- Staff were discussing patients' religious needs with them but, in one record, these discussions were not fully reflected in the patient's care plans.
- Care plans did not always detail information about patients' education status and needs.

## Is the service well-led?

Good  

Our rating of well-led improved. We rated it as good because:

- Leaders had the skills, knowledge and experience to perform their roles, had a good understanding of the services they managed, and were visible in the service and approachable for patients and staff.
- Staff knew and understood the provider's vision and values and how they were applied in the work of their team.
- Staff felt respected, supported and valued. Morale among the staff team had improved significantly and staff from across disciplines reported how much the ward environment and culture had improved.
- Our findings from the other key questions demonstrated that governance processes operated effectively at ward level and that performance and risk were managed well.
- Ward teams had access to the information they needed to provide safe and effective care and used that information to good effect.

# Child and adolescent mental health wards

- Staff engaged actively in local and national quality improvement activities.

## Outstanding practice

We found some outstanding practice for this service. Please see outstanding practice section above.

## Areas for improvement

We found areas some areas for improvement in this service. See areas for improvement section above.

# Mental health crisis services and health-based places of safety

Inadequate ● ↓

## Key facts and figures

The trust provided health-based places of safety for men and women at the following 136 suites:

- 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).

The trust provided short-term support for men and women at three mental health decision units at:

- The Towneley Unit, Royal Blackburn Hospital (6 chairs)
- Mental Health Decision Unit, Arkwright Unit, Royal Preston Hospital (6 chairs)
- Mental Health Decision Unit, Blackpool Victoria Hospital (4 chairs).

The aim of the services was to provide short-term support for up to 23 hours for men and women. This was as an alternative to admission, but up to half of the beds in each unit could be used for patients awaiting a hospital bed.

The trust had eight home treatment teams.

The services we visited were:

- Blackburn and Darwen home treatment team
- Blackpool, Fylde and Wyre home treatment team
- Chorley and South Ribble home treatment team
- West Lancashire home treatment team
- Preston home treatment team
- Lancaster and Morecambe home treatment team

On this inspection we looked at all five key questions. Our inspection was unannounced (staff did not know we were coming) to enable us to observe routine activity.

We inspected all the 136 suites, all three mental health decision units, and a sample of home treatment services.

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

- spoke with 32 staff including nurses, doctors, occupational therapists, social workers, support time recovery workers, administrative staff, student nurses and support workers

# Mental health crisis services and health-based places of safety

- spoke with 12 managers
- spoke with 17 patients
- spoke with two carers
- reviewed 44 care records
- carried out a tour of all eight 136 suites across six sites
- carried out a tour of mental health decision units across three sites
- carried out a tour of the offices and interview/meeting rooms in the six home treatment services we visited (Blackburn, Blackpool, Ormskirk, Leyland, Lancaster and Preston)
- observed one handover / multidisciplinary meeting
- attended three patient review meetings
- looked at a range of policies, procedures and other documents relating to the running of the service.

A comprehensive inspection of mental health crisis services and health-based places of safety was last carried out by the Care Quality Commission in 2018. Mental health crisis services and health-based places of safety were rated as requires improvement.

## Summary of this service

Our rating of this service went down. We rated it as inadequate because:

We have taken enforcement action against this service which has limited ratings for some key questions to inadequate.

- We had significant concerns about patient safety, privacy and dignity in the Trust use of mental health decision units. These units were intended for short stay, under 23 hours, but were now routinely being used as additional wards. The accommodation was not designed for this and patients were sleeping in reclining chairs in shared lounges for up to 10 days. Because these units had not been designed to accommodate patients for long periods, there were issues with food availability, bedding and linen, private space to change clothes and no safe places to store possessions. One decision unit, at Preston, was a mixed sex facility where men and women were sleeping in the same lounge. This is in breach of same sex accommodation guidance where service users in mixed sex accommodation are expected to have individual bedrooms or bed areas which are solely for one gender. Additionally, we had concerns about the use of mental health decision units for patients under 18 years old. In the last 12 months, 13 children were admitted to the decision units at Preston and Blackburn, although three are noted as multiple events so the admissions figure is higher. This practice was of concern because the trust did not recognise under 18-year olds as children. Admissions of children to these units was not incident reported. Children in mental health decision units did not routinely have access to child and adolescent mental health specialists. Staff were not sufficiently guided to consider risks relating to children and their placement alongside adults.
- Full information about our regulatory response to the concerns we have described will be added to a final version of this report, which we will publish in due course.
- We had significant concerns about patients detained without lawful authority once the detention period under section 136 had ended. For patients who had been assessed as needing further detention under the Mental Health Act, they were not able to leave. Staff had been advised to assess capacity and that patients were then detained “in their best interests”, but this is not a lawful deprivation of liberty. The Mental Capacity Act cannot be used to authorise

# Mental health crisis services and health-based places of safety

detention in this way. Some patients had recommendations completed for detention under the Mental Health Act, so appropriate means of detention were already being utilised. The applications were not completed as there had not been a bed identified in a specific hospital. This situation had deteriorated since the last inspection in 2018. This requires significant improvement as patients were being deprived of their liberty without a legal framework in place for this.

- We also had significant concerns that governance systems in place for the oversight of the 136 suites and stays over 23 hours in mental health decision units were not effective. The trust data was incomplete in relation to patients who remained in section 136 suites and admissions over 23 hours to mental health decision units.
- As a result of these concerns, we have issued the trust with a warning notice to make significant improvements.
- In the Preston 136 suite and the home treatment team offices at Ormskirk, there were issues in relation to maintenance of the buildings. The 136 suite at Preston had a shower room which had evidence of mould growing and cracked tiles. This had been identified at a previous inspection but not addressed. In Ormskirk, there was a hole in the ceiling in the waiting area. The reception office floor was cracked. Ventilation in reception and in the interview rooms was poor.
- Across all the teams, there were issues with staffing, despite staff now being recruited specifically to work in 136 suites. Staff were not all trained in basic life support and overall completion of mandatory training was below the trust target. Staff were not receiving regular supervision of their work.
- Gatekeeping arrangements were not effective. Gatekeeping arrangements were not always made with a home treatment team assessment and monitoring of these patients was often over the phone rather than face to face.
- Home treatment teams did not have sufficient flexibility to offer a full 24-hour service. In Lancaster and Leyland there were patients waiting for up to 12 months for transfer to community mental health teams. This impacted on the teams' abilities to work more proactively, for example, in seeing patients on wards to facilitate early discharge or admission avoidance work. Only one home treatment team provided any input into inpatient services in terms of early discharge or diversion.
- Actions in relation to complaints were often recorded as an apology being offered or expectations managed, but there was no evidence of investigation of systemic issues and wider changes.
- Our findings from the other key questions demonstrated that governance processes did not operate effectively at team level and that performance and risk were not managed well. We were not assured that the trust was collecting meaningful data to understand the scale of the issues apparent across this core service. The risks associated with prolonged stays in section 136 suites and decision units were not recognised.

However:

- The home treatment teams included or had access to the full range of specialists required to meet the needs of patients under their care, including clinical psychologists and occupational therapists. Staff working for the home treatment teams provided a range of care and treatment interventions that were informed by best practice guidance and suitable for the patient group.
- Staff in all services were generally described as discreet, respectful, and responsive when caring for patients.

## Is the service safe?

**Requires improvement** ●

Our rating of safe went down. We rated it as requires improvement because:

# Mental health crisis services and health-based places of safety

- There were issues in some units with poor maintenance, for example, the 136 suite at Preston had a shower room which had evidence of mould growing and cracked tiles. This had been identified at a previous inspection but not addressed.
- There were staffing issues at some 136 suites, with staff from neighbouring wards covering the suites at times, although staff were being recruited. At the Harbour, only one substantive qualified nurse remained and shifts were being covered by bank and agency staff.
- There was regular bank staffing required at all home treatment teams and there appeared to be several reasons for this. Some bank usage was to cover vacancies, sickness and absence. In some teams, managers felt their establishment level had been set too low, so they were continually using additional staff to ensure the team could operate effectively. We also saw that several teams were continuing to see patients long after they were ready for discharge, most often due to long waiting lists for community mental health team transfer.
- The decision units in Blackburn and Preston were staffed by a team who also provided staff cover to the 136 suite. At times there were not enough staff on duty to provide this cover safely and staff used incident reports to highlight this.
- Staff at the Harbour 136 service were storing unlabelled medicines and out of date stock.
- Staff were not incident reporting all occasions required by policy, particularly when patients breached timescales in 136 suites and in mental health decision units.
- Lack of medical cover was noted at mental health decision units, contributing to patients staying beyond the timescale.
- Two thirds of staff across this core service were trained in basic life support. Figures provided by the trust indicated that only one nurse had required and received immediate life support training. There have been instances of restrictive interventions, particularly the use of restraint, in 136 suites and decision units and guidance indicates qualified nurses should be trained to immediate life support level if restrictive interventions are used.

However:

- Staff assessed and managed risks to patients and themselves.

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so.

## Is the service effective?

**Inadequate** ● ↓

Our rating of effective went down. We rated it as inadequate because:

- Staff did not understand their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice. There were concerns at this inspection with the trust management of patients detained under section 136 of the Mental Health Act. The trust policy for section 136 did not reflect all relevant legislation and the Mental Health Act Code of Practice.
- Patients were detained past the expiry of section 136 without appropriate legal safeguards in place. Patients were also subject to restrictive interventions, including seclusion, without appropriate legal safeguards.
- The Mental Capacity Act was being relied upon to detain people under best interests, when appropriate assessment under the Mental Health Act had already taken place. Whilst in exceptional circumstances this may be warranted, this was happening routinely in this core service due to a lack of inpatient beds, to the extent that rights leaflets purporting to explain this had been developed and were being given to patients.

# Mental health crisis services and health-based places of safety

- Mental health decision units were not being used for crisis support, but for up to 10 different clinical pathways, which included medicines monitoring, acute crisis, mental health act assessments and patients awaiting admission to inpatient wards. At this inspection, patients within mental health decision units were awaiting admission to inpatient wards.
- Staff in mental health decision units described feeling that other organisations did not understand the remit or function of the units and that pressures in other parts of the system, particularly in relation to inpatient beds, impacted on them.
- Managers did not ensure staff received regular supervision.
- Less than two thirds of staff across this core service had an annual appraisal completed.

However:

- Staff working for the home treatment teams provided a range of care and treatment interventions that were informed by best practice guidance and suitable for the patient group. They ensured that patients had good access to physical healthcare.
- The home treatment teams included or had access to the full range of specialists required to meet the needs of patients under their care, including clinical psychologists and occupational therapists.

## Is the service caring?

**Inadequate** ● ↓↓

Our rating of caring went down. We rated it as inadequate because:

We had taken enforcement action in relation to the care and treatment of patients within mental health decision units which limited our rating to inadequate. This was because:

- Patients were staying for over 23 hours in mental health decision units, which were not designed for this purpose and offered no privacy or dignity, particularly in relation to sleeping arrangements.
- Patients in mental health decision units expressed dissatisfaction with their treatment. They raised concerns about inconsistent treatment and lack of awareness of plans.
- Patients in mental health decision units were dissatisfied with sleeping in chairs, difficulties obtaining bedding and nightwear and a lack of privacy. Patients commented negatively on food, including choice, availability and no snacks or food available away from mealtimes.
- Patients also commented about the noise, including from fridges and freezers located in the lounge where patients slept.
- Staff did not make sure patients could access advocacy services. Patients told us they were not aware of advocacy services they could access.
- Patients feedback opportunities were limited and there was poor completion of the trust friends and family survey.
- Opportunities for families to give feedback on the service were limited. There were no carers surveys in use.

However:

- Staff were generally described as discreet, respectful, and responsive when caring for patients. This was reflected in the interactions we saw between staff and patients.

# Mental health crisis services and health-based places of safety

- We attended three patient reviews within home treatment teams. Patients and carers were actively involved in these and their views and wishes actively sought.
- Staff directed patients to other services and supported them to access those services if they needed help.

## Is the service responsive?

**Inadequate** ● ↓

Our rating of responsive went down. We rated it as inadequate because:

- Patients were frequently remaining in 136 suites after their formal detention had ended. We reviewed figures in services and noted prolonged stays in all of the suites we visited.
- The health-based places of safety were not always available when needed and there was not an effective local arrangement for young people who were detained under Section 136 of the Mental Health Act.
- Across all three mental health decision units, figures suggest at least 50% of admissions have been for patients awaiting admission to inpatient wards. Patients were waiting for prolonged periods of time in units which were not designed for this. At this inspection, all the patients resident in decision units were awaiting admission to inpatient wards.
- We were concerned at the lack of privacy and poor environment of the decision units. These units were intended for short stay, under 23 hours, but were now routinely being used as additional wards. The accommodation was not designed for this.
- We were concerned about service provision for young people aged 16 – 17, particularly in the context of admissions to mental health decision units and also relating to skilled staff provision for section 136.
- Gatekeeping arrangements were not effective. Gatekeeping arrangements were not always made with a home treatment team assessment and monitoring of these patients was often over the phone rather than face to face.
- Home treatment teams did not have sufficient flexibility to offer a full 24-hour service.
- In Lancaster and Leyland there were patients waiting for up to 12 months for transfer to community mental health teams. This impacted on the teams' abilities to work more proactively, for example, in seeing patients on wards to facilitate early discharge or admission avoidance work.
- Only one home treatment team provided any input into inpatient services in terms of early discharge or diversion.
- Actions in relation to complaints were often recorded as an apology being offered or expectations managed, but there was no evidence of investigation of systemic issues and wider changes.

However:

- The home treatment services had clear criteria to describe which patients they would offer services to. None of the teams had waiting lists. The referral criteria for the mental health crisis teams did not exclude patients who would have benefitted from care. Staff assessed and treated patients promptly. Staff followed up patients who missed appointments.
- In section 136 suites section 12-approved doctors and approved mental health professionals attended promptly when required.



# Mental health crisis services and health-based places of safety

## Is the service well-led?

**Inadequate** ● ↓

Our rating of well-led went down. We rated it as inadequate because:

- Our findings from the other key questions demonstrated that governance processes did not operate effectively at team level and that performance and risk were not managed well.
- The risks associated with prolonged stays in section 136 suites and decision units were not recognised.
- We were not assured that the trust was collecting meaningful data to understand the scale of the issues apparent across this core service.
- There were no effective, multi-agency arrangements to agree and monitor the governance of the mental health crisis service and the health-based places of safety. Managers of the service did not work 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.
- In home treatment teams, there were concerns that staff had not been consulted clearly about a move to full 24 hour working.

However:

- The trust was working on a strategy and plans with all relevant stakeholders, following an in-depth review of this care pathway. We saw that some actions were in progress, for example, the recruitment of dedicated staffing for section 136 suites.

## Areas for improvement

We found areas for improvement in this service. See areas for improvement section above.

This section is primarily information for the provider

## Requirement notices

### Action we have told the provider to take

The table below shows the legal requirements that the service provider was not meeting. The provider must send CQC a report that says what action it is going to take to meet these requirements.

For more information on things the provider must improve, see the Areas for improvement section above.

**Please note:** Regulatory action relating to primary medical services and adult social care services we inspected appears in the separate reports on individual services (available on our website [www.cqc.org.uk](http://www.cqc.org.uk))

**This guidance** (see [goo.gl/Y1dLhz](http://goo.gl/Y1dLhz)) describes how providers and managers can meet the regulations. These include the fundamental standards – the standards below which care must never fall.

#### Regulated activity

Assessment or medical treatment for persons detained under the Mental Health Act 1983  
Diagnostic and screening procedures  
Treatment of disease, disorder or injury

#### Regulation

Regulation 9 HSCA (RA) Regulations 2014 Person-centred care

#### Regulated activity

Assessment or medical treatment for persons detained under the Mental Health Act 1983  
Diagnostic and screening procedures  
Treatment of disease, disorder or injury

#### Regulation

Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect

#### Regulated activity

Assessment or medical treatment for persons detained under the Mental Health Act 1983  
Diagnostic and screening procedures  
Treatment of disease, disorder or injury

#### Regulation

Regulation 11 HSCA (RA) Regulations 2014 Need for consent

#### Regulated activity

Assessment or medical treatment for persons detained under the Mental Health Act 1983  
Diagnostic and screening procedures  
Treatment of disease, disorder or injury

#### Regulation

Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

#### Regulated activity

#### Regulation

This section is primarily information for the provider

## Requirement notices

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Diagnostic and screening procedures

Treatment of disease, disorder or injury

Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment

### Regulated activity

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Diagnostic and screening procedures

Treatment of disease, disorder or injury

### Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance

### Regulated activity

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Diagnostic and screening procedures

Treatment of disease, disorder or injury

### Regulation

Regulation 18 HSCA (RA) Regulations 2014 Staffing

This section is primarily information for the provider

## Enforcement actions

We took enforcement action because the quality of healthcare required significant improvement.

### Regulated activity

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Diagnostic and screening procedures

Treatment of disease, disorder or injury

### Regulation

Section 29A HSCA Warning notice: quality of health care

# Our inspection team

Brian Cranna, Head of Hospitals Inspection led this inspection. An executive reviewer supported our inspection of well-led for the trust overall. We were also supported by three specialist advisors two of whom had previous experience as a board level director and one had expertise in safeguarding.

The inspection team included two inspection manager, 10 inspectors, a CQC pharmacist, a Mental Health Act reviewer, four assistant inspectors, 11 specialist advisers, and one inspection planner.

Executive reviewers are senior healthcare managers who support our inspections of the leadership of trusts. Specialist advisers are experts in their field who we do not directly employ.