Inadequate

Camden and Islington NHS Foundation Trust

Mental health crisis services and health-based places of safety

Quality Report

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Date of inspection visit: 22 – 26 February 2016
Date of publication: 21/06/2016

Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
TAF01	St Pancras Hospital	Health based place of safety and Liaison Service at: Whittington Hospital University of London College Hospital and Royal Free Hospital	NW1 0PE
TAF01	St Pancras Hospital	The Rivers crisis house Drayton Park crisis house North Camden crisis house	NW1 0PE
TAF01	St Pancras Hospital	North Camden recovery centre	NW1 0PE
TAF01	St Pancras Hospital	North Camden CRHT team South Camden CRHT team	NW1 0PE
TAF72	Highgate Mental Health Centre	Crisis Call Centre Islington CRHT team	N19 5NX

Summary of findings

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

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

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

Summary of findings

Ratings

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

Overall rating for the service	Inadequate
Are services safe?	**Inadequate**
Are services effective?	**Requires improvement**
Are services caring?	**Requires improvement**
Are services responsive?	**Requires improvement**
Are services well-led?	**Inadequate**

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

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

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

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

Summary of findings

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Summary of findings

Overall summary

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

- Staff working in and emergency departments had repeatedly raised concerns regarding the provision of this service, but no action had been taken to address the concerns. Facilities at two of the three health based places of safety did not promote dignity, recovery, comfort or confidentiality for people using this service. There were significant safety issues at all of the health based places of safety and they did not meet the Royal College of Psychiatrist's guidance.
- The health based places of safety were not clean or well maintained.
- Emergency equipment checks were not available in all areas for us to look at what staff checked and how often. We found essential emergency equipment was not present or had perished. Staff told us they checked the defibrillator was present, but did not check that it was functional.
- Staff did not copy crisis plans on to the electronic system. There was no clear record to show whether the person using the service had been involved in developing the plan or whether they had a copy of the plan.
- Staff did not show a clear understanding of the Mental Capacity Act and consent to treatment was not clearly documented in people's records.
- Frontline staff told us they did not receive feedback from incidents.
- Governance arrangements were not in place locally to support the quality, performance and risk management of the services.
- Staff reported feeling under pressure because services were short staffed.

However:

- There was rapid access to a psychiatrist.
- Teams included staff from different disciplines with varied skill bases.
- Interventions included support for housing, employment and benefits. Patients had access to a range of psychological therapies.
- Some patients told us they felt understood and listened to by staff and never had to repeat information to them.
- Patients knew how to complain.
- We saw evidence of staff proactively trying to engage people who were avoiding contact with the service.
- Senior staff used balance score cards to monitor service performance and outcomes.
- Staff felt able to raise concerns without fear of victimisation.
- Staff told us they worked well together within their teams.

Summary of findings

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

Are services safe?

Inadequate

We rated safe as inadequate because:

- During the inspection we identified environmental risks in two of the three health based places of safety used for adults. These included potential ligature points and limited ability to observe people who were detained under section 136 of the Mental Health Act. None of these met the Royal College of Psychiatrist's guidance.
- Emergency equipment audit checks were not completed in all areas to look at what staff checked and how often. We found essential emergency equipment was not present or had perished. Staff told us they checked the defibrillator was present, but did not check that it was functional.
- Staff had differing views about what a crisis plan was or should be. The use of crisis plans across the service was inconsistent.
- Risk assessments did not always reflect the person's circumstances. Some staff did not date their entries on the risk assessments when updating them.
- Staff were unable to manage and reassess their caseload regularly because of the volume of new assessments coming through and poor staffing levels. Caseloads were high.

However:

- There was rapid access to a psychiatrist when required.
- Staff had a good knowledge of safeguarding, including what to report and who to report concerns to.
- Each person using the service had a risk assessment in place.

Are services effective?

Requires improvement

We rated effective as requires improvement because:

- Staff did not show a clear understanding of the Mental Capacity Act, the need to gain consent to treatment or where this should be documented in care records.
- Care plans were not person centred and were not clearly recorded in electronic care notes.
- People using the service were monitored on closed circuit television (CCTV) in most centres, but there was no signage to inform people of this.

However:

- Interventions included support for housing, employment and benefits. Patients had access to a range of psychological therapies.

Summary of findings

- Multi-disciplinary teams and inter-agency working were effective in supporting patients.

Are services caring?

Requires improvement

We rated caring as requires improvement because:

- Care records did not show whether a person had been offered a copy of their care plan.
- Staff were not observed to act in a caring way towards people who were using the service in some areas we visited. We observed staff avoiding patient contact in one service we visited.
- People using the service did not always feel able to raise concerns or did not feel they would be taken seriously if they did so.

However:

- Information about access to advocacy was available for patients.
  Patients in some areas told us they felt understood and listened to by staff and never had to repeat information to them.

Are services responsive to people's needs?

Requires improvement

We rated responsive as requires improvement because:

- Facilities at two of the three health based places of safety did not promote dignity, recovery, comfort or confidentiality for people using this service.
- People using the health based places of safety experienced delays in being transferred to an acute inpatient bed.
- Frontline staff told us they did not receive feedback from incidents.
- Staff had mixed views about the effectiveness of the crisis call line.

However:

- Urgent referrals were seen quickly by skilled professionals.
- Patients knew how to complain.
- Staff proactively tried to engage people who were avoiding contact with the service.

Are services well-led?

Inadequate

We rated well-led as inadequate because:

- Governance arrangements were not in place locally to support the quality, performance and risk management of the services.

Summary of findings

- Staff working in health based places of safety and emergency departments had repeatedly raised concerns regarding the provision of the service, but did not feel the trust was taking these seriously.
- Staff reported feeling under pressure because services were short staffed.

However:

- Senior staff used balance score cards to monitor service performance and outcomes.
- Staff felt able to raise concerns without fear of victimisation, and senior staff confirmed that this was done regularly.
- Staff told us they worked well together within their teams.

Summary of findings

Information about the service

The mental health crisis services and health-based places of safety are part of the mental health service delivered by Camden and Islington NHS Foundation Trust.

The crisis resolution and home treatment teams (CRHT) provided initial assessment and home treatment for adults who presented with a mental health need that required a specialist mental health service. Their primary function was to undertake a comprehensive assessment of needs, whilst providing a range of short term treatment/therapies aimed at a quicker recovery for people who did not need long term care and treatment and as an alternative to hospital admission. The teams supported people who were discharged from hospital and the crisis houses. The teams were based at The Rivers Crisis House in South Camden, Daleham Gardens in North Camden and Highgate Mental Health Centre in Islington.

Crisis houses were located in the Rivers Crisis House in South Camden, the North Camden Crisis House and the Drayton Park Crisis House in Islington. These houses offered an alternative to hospital admission for people who were in need of treatment for their mental health problem. Admission to the crisis houses was on a short term basis and patients had to be able to give consent to accept treatment.

A health based place of safety is a place where someone who may be suffering from a mental health problem can be taken in order to be assessed by a team of mental health professionals. The health based place of safety for adults were at the Royal Free hospital, the University College London hospital (UCLH) and the Whittington hospital.

The liaison service in the Royal Free hospital offered assessment for people presenting to the acute hospital with a mental illness. They aimed to assess people presenting to the accident and emergency department within one hour and responded to referrals from the hospital wards within 24 hours.

The Camden and Islington NHS Foundation Trust was last inspected in May 2014 by the CQC, but no rating was given at this time as the inspection was carried out under a pilot scheme. During the inspection it was identified that the trust should work towards recruiting more nurses, improve their medicines management policies and introduce more psychological therapies for people using the service. In relation to crisis resolution and home treatment teams, health based places of safety, crisis houses and liaison teams, it was found that the trust must improve their arrangements for obtaining consent from people using the service and improve staff knowledge of steps to take when a person lacks capacity. It was found that the trust should improve the transport and management of medication, prioritise the involvement of carers and develop systems to analyse feedback on services so this can be used to improve services.

Our inspection team

Our inspection team was led by:

Chair: Professor Heather Tierney-Moore, Chief Executive, Lancashire Care NHS Foundation Trust

Head of Inspection: Julie Meikle, head of hospital inspection, mental health hospitals, CQC

Inspection Manager: Margaret Henderson, inspection manager mental health hospitals CQC

The team that inspected mental health crisis services and health-based places of safety consisted of six people: two inspectors, one mental health nurse, one social worker, one Mental Health Act reviewer and one psychiatrist.

Summary of findings

Why we carried out this inspection

We inspected this core service as part of our ongoing comprehensive mental health inspection programme

How we carried out this inspection

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

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

Before the inspection visit, we reviewed information that we held about these services and asked a range of other organisations for information.

During the inspection visit, the inspection team:

- Visited the North Camden, South Camden and Islington crisis resolution and home treatment teams.
- Visited health based places of safety at the Royal Free hospital, the Whittington hospital and University College London hospital (UCLH).
- Visited mental health liaison teams based at the Royal Free hospital, the Whittington hospital and UCLH.
- Observed staff working in the crisis line call centre at the Highgate Mental Health Centre.
- Visited crisis houses in North Camden, South Camden and Islington.
- Spoke with 44 staff members; including doctors, nurses, support workers, social workers, pharmacists and managers.
- Interviewed the divisional director with responsibility for the crisis service and liaison service.
- Spoke with eight people who used the service or who had recently been discharged from the service.
- Telephoned one carer.
- Attended and observed four handovers in different locations and one business meeting.
- Looked at 52 treatment records of people using the service.
- Carried out a specific check of the medication management across the sites and looked at 50 medication charts.
- Looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the provider's services say

People gave mixed opinions about the support provided to them during their treatment. The majority of people using the service told us that staff treated them with respect, listened to them and were compassionate. However, some people using the service said they did not feel listened to during a crisis and staff did not give them adequate support when they needed it.

People using the service said they were involved in their care and treatment, but only a few of the people we spoke to had a copy of their care plan.

Some patients told us they had to repeat information because they saw different members of staff due to the nature of the service. However, people using Drayton Park said they felt different, staff always knew them well and they never had to repeat their history.

People told us that appointments ran on time and they were kept informed if there were any unavoidable changes.

Summary of findings

People knew how to raise concerns and make a complaint. They felt they would be able to raise a concern should they have one and some believed that staff would listen to them. However, other said they did not feel staff would take their concerns seriously.

Areas for improvement

Action the provider MUST take to improve

- The trust must address the identified safety concerns in the health-based places of safety.

Action the provider SHOULD take to improve

- The trust should ensure that policies, procedure and practice on the use of S136 adhere to the MHA Code of Practice.
- The trust should ensure learning from serious incidents is shared across the three access, assessment and brief intervention teams.
- The trust should ensure consistency between teams in the documentation of risk assessments.
- The trust should ensure that staff record the level of involvement of a person using the service in their care planning.
- The trust should ensure consistency in where staff record a person's ability to consent to treatment and whether or not this consent was obtained.
- The trust should ensure signs are clearly displayed to inform people who are using the service that closed circuit television (CCTV) is in operation.
- The trust should ensure robust governance structures are in place to monitor the quality, performance and risk management of services.

Camden and Islington NHS Foundation Trust

Mental health crisis services and health-based places of safety

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Whittington Hospital health based place of safety and Liaison Service Royal Free Hospital health based place of safety and Liaison Service University of London College Hospital health based place of safety and Liaison Service	TAF01
The Rivers crisis house North Camden crisis house Drayton Park crisis house	TAF01
North Camden recovery centre	TAF01
North Camden CRHT team South Camden CRHT team	TAF01
Crisis Call Centre Islington CRHT team	TAF72

Detailed findings

Mental Health Act responsibilities

We do not rate responsibilities under the Mental Health Act 1983. We use our findings as a determiner in reaching an overall judgement about the Provider.

A total of 76.2% staff had received training in the Mental Health Act in North and South Camden crisis resolution and home treatment teams. A total of 26.9% of staff at Islington crisis resolution and home treatment team had completed the same training.

Staff had access to Approved Mental Health Practitioners (AMHP) if a person using the service required an assessment under the Mental Health Act. They felt confident in recognising the signs of a relapse in a person's mental illness and of the action they should take in this event.

Relevant documentation was completed correctly for those people detained under section 136 in the health-based place of safety

People detained under section 136 of the Mental Health Act were given oral and written information about their rights and the process of assessment. Patients and AMHPs told us that detained people were informed of their rights, but there was no written evidence to confirm this.

People detained under section 136 were usually transported to the health based places of safety by ambulance rather than police, which reflected best practice.

Staff in the crisis houses sometimes cared for people on leave from hospital on section 17 leave. The staff knew the implications of this, how paperwork should be stored and the action to take if a person on this leave did not return within the allocated time frame.

Mental Capacity Act and Deprivation of Liberty Safeguards

A total of 76% staff in the crisis resolution and home treatment team in North and South Camden, and 26% of staff in the team in Islington, had received training in applying the Mental Capacity Act (MCA). Staff we spoke with were not always aware of the MCA and the implications this may have on practice, but all stated they would seek advice from a senior staff member if they were unsure of the correct action to take.

Capacity assessments were not being completed appropriately or routinely in the 50 care records we looked at. There was no consistency between services in where consent or capacity was documented. 16 of the 50 care records we reviewed showed that informed consent had been sought and capacity had been considered.

Inadequate

Are services safe?

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

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

Our findings

Safe and clean environment

- The health based place of safety in the Royal Free did not comply with Royal College of Psychiatrists guidelines. There was one door in and out, the toilet was separate to the facility and contained several ligature points from the taps and adaptations made to accommodate a person with disabilities. Furniture was not weighted and a ceiling tile had been punched out and had a wire hanging down. We raised this with staff during the inspection who reported this to the maintenance department to be fixed.
- The health based place of safety in the Whittington hospital had poor visibility for observing people using the service. Furniture was not weighted and was of fabric material. The facility did not meet Royal College of Psychiatrists guidelines as there was one door to enter and exit the facility. The toilet for people using the service was separate to the facility and featured ligature risks. People using the service had to be accompanied by security guards or health based places of safety staff to walk through the accident and emergency department to access the toilet.
- The health based place of safety in the University of London College hospital (UCLH) had closed circuit television (CCTV) in operation, which was monitored by security within the hospital. Security guards from the hospital supported staff to manage people using the service whose behaviour was unsettled.
- The health based places of safety in the Royal Free hospital and the Whittington hospital were not clean, despite staff telling us at the Whittington hospital that the environment was cleaned daily. Staff were unable to confirm if the room was cleaned after every patient if more than one patient accessed the room in a day.
- Staff from all areas had access to alarms in interview rooms; staff could use pin point alarms or alarms set on the wall of rooms. Staff said there was a quick response when an alarm was used.
- Clinic rooms were available, with the necessary equipment to carry out physical examinations.
- Emergency equipment audit checks were not available in all areas to show what staff checked and how often. We found essential emergency equipment was not present or had perished. Staff told us they checked the defibrillator was present, but did not check that it was functional. This meant that patients were at risk of not receiving lifesaving treatment quickly in the event of a medical emergency.
- The Recovery Centre in North Camden was the only location we visited which used clean stickers to indicate that medical equipment had been cleaned.
- Most locations were clean, but staff at sites we visited in South Camden said they had problems with cleaners not turning up regularly. Despite this, areas still appeared to be clean.
- Environmental risk assessments were carried out in all crisis houses and crisis resolution and home treatment teams. These were available to view and we saw evidence that these assessments were reviewed regularly.
- The toilet available for visitors seeing the crisis resolution and home treatment team at South Camden had ligature points. Staff were aware of the potential risks and so monitored patients who were using the facility.
- Closed circuit television was used in the University College of London hospital health based place of safety and in all three crisis houses we visited to monitor people using the service. However, there were no clear signs displayed to inform patients of this.

Safe staffing

- Staffing levels were established by considering service need. The provider did not use a recognised tool to reach the agreed numbers, but instead determined staffing requirements by considering service need and patient safety.

Inadequate

Are services safe?

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

- The North and South Camden crisis resolution and home treatment team had 5.2 whole time equivalent qualified nurse vacancies.All other services had one qualified staff or less vacancy.
- Average caseload per month per team was 82 for North Camden crisis resolution and home treatment team and 84 for Islington crisis resolution and home treatment team. Data for average caseload in South Camden was not available.
- Managers were able to allocate additional staff if more staff were required for some shifts. Managers found bank staff willing to work on a regular basis and used them to provide continuity of care.
- Bank staff and overtime for existing staff in the teams were mainly used to cover any vacant shifts. Bank staff had an induction and relevant training to carry out the role safely.
- Rapid access to a psychiatrist was available when required in all locations. Outside of core time on call arrangements were in place.
- Training figures showed that 69% of staff in North and South Camden crisis resolution and home treatment team and 75% in Islington crisis resolution and home treatment had attended mandatory training. This was below the trust target of 80%.
- Staff at the health based place of safety told us staffing was adequate to carry out their roles. However, the Royal Free hospital and UCLH staffing was supplemented with a “Winter Allowance” (money released by the government to help alleviate pressure on services related to increased demand on services during winter). This funding was due to stop at the end of March 2016 and staff were concerned they would not be able to deliver the service within the target times without this allowance.
- Staff in crisis resolution and home treatment teams were unable to manage and reassess their caseloads regularly because of the pressures of new assessments and poor staffing levels. This led to delayed discharges.

Assessing and managing risk to patients and staff

- The 50 treatment records we reviewed showed that staff had completed a risk assessment at the initial assessment and then reviewed and updated this when required. Risk assessments were not sufficiently detailed. Several risk assessments carried out across all locations were not dated. Parts of the assessment which did not apply to the person using the service were left blank but no note to say not applicable. Care plans to address any potential risk were not in place for every person who had an identified risk.
- Staff in the crisis resolution and home treatment teams told us people using the service had a crisis plan which was documented on a leaflet following an assessment. However, staff did not record this had taken place on the electronic system by recording it in the notes or by scanning the leaflet on to the system.
- Risk levels for people who used the service were discussed at handover meetings in order to detect any increases and take prompt action. Staff demonstrated a good understanding of the needs and assessed risks of patients.
- Lone working policies and procedures were in place for staff to follow to ensure safety. Staff identified a shift coordinator at the start of each shift who was responsible for monitoring the whereabouts of staff.
- Staff had received training in breakaway techniques and de-escalation to ensure their safety in the event of a person using the service becoming violent or aggressive. Staff said they felt safe with this level of training.
- An average of 72% of staff had received training in adult safeguarding. An average of 37% of staff in crisis resolution and home treatment teams and health based places of safety were trained in children’s safeguarding. We spoke with 44 staff and they knew how to recognise and report a safeguarding concern. The trust had a safeguarding lead in place who staff could contact for further advice.
- Pharmacists regularly visited each location to review medicine management practice. Medication charts were in order in the majority of cases. However, we found discrepancies in prescribing at North Camden crisis resolution and home treatment where the specific type or form of medication, which can have an effect on the way it is released in to the body, was not specified. The same team did not routinely record allergies.

Inadequate

Are services safe?

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

Track record on safety

- Between November 2014 and November 2015 eight serious untoward incidents were reported relating to the crisis resolution and home treatment teams, health based places of safety, crisis houses and liaison teams.
- Two of these eight incidents were unexpected deaths of people using the services. We did not see any evidence regarding lessons learnt from the incidents. Staff told us they were not aware of any changes being made to practice as a result of these incidents happening.
- Other serious incidents included people being treated by the liaison team absconding whilst under their care or people carrying out self harm whilst on observations. There was no evidence for lessons learnt as a result of these incidents or how the service could change to reduce the risk of these recurring. When asked, staff were not aware of any learning from incidents.

Reporting incidents and learning from when things go wrong

- Staff knew how to report incidents and could describe what should be reported. The trust used an electronic system to record all incidents.
- Staff said they reported incidents as soon as they could following an incident or concern being raised.
- Staff were de-briefed and supported after a serious incident. Psychologists facilitated this process.
- Senior staff told us that feedback and learning from incidents took place during business meetings, which took place fortnightly or monthly. However, frontline staff told us they did not receive feedback from incidents and did not get a direct response when they submitted an incident form. We saw minutes from business meetings which showed feedback from incidents was a standing item on the agenda at Drayton Park.

Are services effective?

Requires improvement

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

Our findings

Assessment of needs and planning of care

- All locations we visited completed an assessment of a patient within 24 hours of a referral being made,although there was one exception due to extenuating circumstances.
- Staff in liaison services responded to referrals from the accident and emergency department within an hour and to referrals from the wards within 24 hours. Key performance indicators showed they achieved 98% compliance with this target.
- Care records in crisis houses showed up to date care plans, which included personalised views and were recovery orientated.
- Care records for people using the crisis resolution and home treatment teams did not contain holistic, personalised and up to date care plans. Staff told us they gave crisis plans on a leaflet to patients. Patients agreed they received a plan of care.
- We reviewed 50 care records across the locations we visited and did not find evidence to show that staff routinely offered copies of care plans to patients.
- The trust used a system to document all care records electronically. Crisis houses we visited had care plans recorded on paper, which were scanned in to the system.
- The crisis resolution and home treatment teams we visited were piloting using the system on an ipad to allow for prompt recording of interventions and person centred care plans to be developed alongside the patient.

Best practice in treatment and care

- We looked at 52 prescription records across all sites. We found that prescription cards at North Camden crisis resolution and home treatment were not following best practice. Staff did not routinely record allergies of people using the service and did not record the specific type of a prescribed medication. One prescription had not been signed for by the prescriber, however, this had been raised by the pharmacist before staff could administer it.
- In other areas staff followed NICE guidance when prescribing medication and pharmacists conducted regular audits to ensure this was happening.
- Systems were in place for medication reconciliation in crisis houses and crisis resolution and home treatment teams to ensure that the trust's record of medication taken by a person using the service was up to date with general practitioner records.
- At our last inspection In May 2014, improvements were needed in recording and transportation of medicines in the Islington crisis resolution and home treatment team based at Highgate Mental Health Centre. We inspected medicines management in the Islington crisis resolution and home treatment team at this inspection and saw that improvements had been made. A team medication lead had been appointed.
- The crisis resolution and home treatment team medicines policy and medicines chart had been revised, to include codes specific to people receiving their medicines in the community, for example a code was added for "patient not at home" and a separate section to record medicines that were not supplied by the trust, for example medicine for physical health supplied by people's GPs.
- There was now a regular weekly audit of medicines charts. The trust pharmacist carried out 3-monthly medicines training sessions for staff, and the Clinical Team Manager was in the process of carrying out medicines competency checks for crisis resolution and home treatment team staff.
- Medicines were available as pre-packs, pre-printed with instructions for use, and were stored securely. Lockable bags were now available, to transport medicines securely when staff visited people in the community to administer or deliver medicines. The team was supervising the administration of medicines for 10 out of the 79 people. The other people were managing their own medicines. We reviewed these 10 medicines charts, and they were completed in full.
- We saw that if staff were unable to make contact with someone and medicines were missed, the risk to the person was highlighted promptly at the daily crisis resolution and home treatment team handover meeting, which was an improvement in the management of risk compared to our last inspection.

Are services effective?

Requires improvement

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

- All crisis resolution and home treatment and crisis house teams had access to a variety of staff who were able to offer a range of therapies to people using the service.
- Interventions included support for housing, employment and benefits. These issues were considered as part of the assessment and care plans.
- Staff assessed physical health needs as part of the initial assessment when a person was admitted to the crisis house. In crisis resolution and home treatment teams physical health was not routinely assessed but all three crisis resolution and home treatment teams we visited had plans in place for a physical health care clinic to be held weekly. All crisis resolution and home treatment teams had plans for this to start by mid-March.

Skilled staff to deliver care

- The access, assessment and brief intervention teams consisted of staff from a range of professional backgrounds, including nursing, medical, occupational therapy and psychology.
- In January 2016 there were 5.2 whole time equivalent band 6 nurse vacancies and one band 4 across the crisis resolution and home treatment teams. The vacancy rates in the crisis houses and liaison services were lower.
- Staff were experienced and qualified. Specific training was available for staff, however, managers said they could not always facilitate this because service demand could make it difficult to release staff to attend.
- New staff had a period of induction before being included in the staff numbers on a shift. This included attending a corporate induction and a period of shadowing experienced staff.
- Staff were regularly supervised. Staff told us they had managerial supervision, which may sometimes be late. They also had access to clinical supervision on a one to one basis and a group basis. Group supervisions were facilitated by a psychologist.
- There were regular team meetings and staff told us they found these useful to raise concerns or request feedback from incidents. However, staff told us that if they were not on shift for these they did not receive the information. Managers told us minutes of meetings were forwarded to all staff following meetings. At Drayton Park we saw minutes of meeting pinned to the staff notice board in a private area so staff could read them.

Multi-disciplinary and inter-agency team work

- Different professionals worked together to assess and plan people's care and treatment. Staff told us there was effective team working within the service.
- We observed four handover meetings and found they were effective in sharing information about people and reviewing risks and progress in delivering their plan of care.
- Staff told us they had good working relationships with GPs and social services.
- We saw effective inter-agency working in assessing and supporting those people detained under section 136 at the health based places of safety. Staff reported good working relationships with accident and emergency staff, police and security guards at the hospital they worked in.
- Liaison staff used two recording systems. Specific patient information was not always found in the Camden and Islington note system as this was left in the accident and emergency records. Staff did not take a copy to keep in the trust's own note system.
- There was evidence of missing information in notes relating to Mental Health Act (MHA) paperwork. The allied mental health professional (AMHP) report was uploaded but not the MHA assessment paperwork. Staff told us this was due to paperwork travelling with the patient in accident and emergency.
- We found evidence that three people who used the health based place of safety in the Royal Free hospital had to wait over 14 hrs to access an appropriate bed. Staff across all sites said that AMHPs did not always attend assessments within a timely manner. Nurses and doctors told us that AMHPs did not attend assessments until a bed had been identified. This caused a delay in assessment for the person using the service.
- The health based places of safety in all sites was based in an acute hospital site. Staff worked well together, but

Are services effective?

Requires improvement

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

there was no clear ownership or protocol in place to identify who should take ownership of complaints addressed to the acute hospitals relating to the health based places of safety.

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

- Information provided by the trust showed that 76% of staff in the crisis resolution and home treatment team in South Camden, 76% of staff in the team in North Camden and 27% of staff in the team in Islington had received training on the MHA. Staff we spoke with were knowledgeable about the MHA; those who were not as confident knew how to escalate concerns about this to ensure a person using the service was safe.
- Consent to treatment was not clearly documented by any of the teams we visited. Staff told us they assumed a person using the service consented to treatment by letting them in to their home for visits, but there was no evidence of this consideration being made in care records.
- At the time of the inspection no teams were caring for a person who was subject to a community treatment order.
- We saw posters in various locations with details of an independent mental health advocacy service, which people using the service could contact for advice.
- Relevant legal documentation was completed appropriately for those people detained under section 136 in the health-based place of safety, but the paperwork did not always remain with the trust and instead travelled with the patient before staff could scan this on to their own system.
- People detained under section 136 were usually transported to the health based places of safety by ambulance rather than the police. There were occasions when people using the service were transported by police, but this did not happen frequently.
- The health based places of safety was not monitored in terms of timescales for assessments to be completed. This meant that no actions were taken to improve long waits in health based places of safety.

Good practice in applying the Mental Capacity Act

- The trust informed us 76% of staff in the South Camden crisis resolution and home treatment team, 76% of staff in the North Camden crisis resolution and home treatment team and 27% of staff in the Islington crisis resolution and home treatment team had received training in applying the Mental Capacity Act (MCA).
- The trust had an MCA lead in place that staff could approach for further advice if needed.
- Staff did not show a clear understanding of the MCA when speaking with us, some confused this with the MHA, stating they would implement an MHA assessment if they felt a person using the service did not have the capacity to consent to treatment.
- We did not see evidence in care records that capacity was assessed during initial contact with the teams or on subsequent contact with the team.

Requires improvement

Are services caring?

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

Our findings

Kindness, dignity, respect and support

- Staff spoke with patients respectfully and with kindness which we observed when we attended the crisis call centre.
- We saw that staff at the North Camden Crisis House sat in the office with the door closed throughout the morning. Patients told us they did not feel staff at this service treated them with respect and they did not feel able to approach staff.
- Patients at the service at Drayton Park told us that staff treated them with kindness, respect and dignity. They said they felt staff genuinely cared about them and got to know them.
- Patients at all the services said they felt safe.
- Patients who used the Islington crisis resolution and home treatment service said they felt cared for by the staff.

The involvement of people in the care that they receive

- In the crisis houses staff used paper forms to develop care plans so these could be done in collaboration with patients.
- There was no evidence of patients being involved in planning their care in crisis resolution and home treatment teams. Staff told us patients held copies of their crisis plan, which was written on a leaflet at their initial assessment. Patients did not agree with this and we did not see evidence in care records of this crisis plan being formulated.
- Carers told us they felt satisfied with the level of involvement they had in their loved ones care.
- People using the service had access to advocacy services to seek independent advice.
- All services used the friends and family test as an opportunity for people using the service to provide feedback. This was carried out on discharge from the service, but teams told us they only had one ipad so this could not be done with every person who used the service.
- Staff showed us the leaflet they used to document the crisis plan on during initial assessment, this featured details of how to make complaints, give compliments and feedback on the service they received.

Are services responsive to people's needs?

Requires improvement

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

Our findings

Access and discharge

- Target times for assessment were set for liaison, health based places of safety, crisis resolution and home treatment teams and crisis houses. Crisis houses, liaison services and crisis resolution and home treatment teams provided evidence to show they met their targets; unless it was patient choice that an assessment took place outside of the 24 hour target from referral.
- Staff working in the health based places of safety said they experienced a delay in finding beds resulting in long stays at the health based places of safety.
- The crisis house had exclusion criteria in place, which was under review. Staff in these areas reported experiencing pressure to accept people in to the service, who may not be appropriate, because of the pressure on acute ward beds. There were no clear criteria in place in crisis resolution and home treatment teams for which people would be offered a service.
- Crisis houses accepted referrals from a range of professionals as well as self referrals.
- Urgent referrals were seen quickly by skilled professionals in all the teams we visited. Non-urgent referrals were seen within 24 hours unless the person using the service had asked for an assessment to take place several days after the referral, so it was convenient to them.
- The trust had set targets for the times from referral to assessment for those people in the accident and emergency departments of the local acute hospitals. Targets were being met.
- The trust had established a crisis call centre, where calls for all three crisis resolution and home treatment teams were directed. This was staffed by members of the three crisis resolution and home treatment teams. This allowed data to be gathered on how promptly calls were answered. Staff in the centre had access to staff diaries in all areas so assessments and home visits could be booked in there and then. Staff in crisis resolution and home treatment gave mixed reviews about the call centre. They said the office environment was more productive since the calls had been directed there, but they felt more pressured owing to staff being at the call centre and not the office.
- The crisis resolution and home treatment teams took a proactive approach to engaging with people who found it difficult or were reluctant to engage with mental health services. This included re-engaging with people who did not attend their appointments.
- People were given a degree of choice in the times of appointments on the first contact by the service following a referral.
- People using the service said they were not always updated on changes to their care, particularly in health based places of safety. One person who used the service told us that staff were able to explain the reasons for this and they understood the need for rapid changes in their care following this explanation.

The facilities promote recovery, comfort, dignity and confidentiality

- Crisis resolution and home treatment teams had one room in their premises to see patients.
- The location of the health based places of safety facilities at the Royal Free and Whittington hospital did not ensure recovery, comfort, dignity and confidentiality for patients who were using them.
- Information on how to complain was displayed by the acute hospital at each health based place of safety. This meant people using the service directed their complaints to the acute hospital and not the mental health trust. There was no clear plan in place about how these should be handled and which trust should take ownership.
- There was no information available for informal patients in the health based places of safety and their rights as an informal patient.
- There was limited information available for patients around the premises. However, crisis resolution and home treatment staff said the majority of their visits were home visits and they were able to take information out to the person using the service.

Are services responsive to people's needs?

Requires improvement

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

Meeting the needs of all people who use the service

- All locations we visited were accessible for people with a disability.
- Information available was written in English. Staff said they could request the brochures in different languages if there was a need to do so.
- All teams had access to an interpreting service, which was contracted with the trust. Interpreters had to be booked 24 hours in advance, but sometimes could be booked with shorter notice dependent on their availability.
- Staff working in health based places of safety wore identification which displayed the name of the acute hospital in which they worked. This could be confusing to people receiving care from the mental health trust, about who they are receiving care from.

Listening to and learning from concerns and complaints

- Between February 2015 and January 2016, the service received 22 complaints, 12 of which were either fully or partially upheld. No complaints were referred to the ombudsman.
- People using services said they would speak directly with staff in the service they were using if they wished to complain. When asked about other means of complaining, such as the patient and liaison service (PALS), people using the service were not clear about what this was and stated they had not been given information on this service.
- Staff knew how to address complaints raised by people using the service and felt confident in handling them.
- Frontline staff said they did not receive feedback from complaints or investigations. We saw that this was a standing item on the business meeting agenda across all services, but this has only recently been implemented. Managers told us they emailed minutes of all of these meetings to staff.

Are services well-led?

Inadequate

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

Our findings

Vision and values

- Staff said they were aware of the trust's values. However, these were not clearly displayed around all areas we visited.
- Staff were aware of senior managers in the trust, but they said they rarely visited the premises.
- Staff had regular contact with their immediate managers. They reported that immediate managers supported them to carry out their roles. All staff said they felt able to raise concerns with their manager.

Good governance

- Governance arrangements were not in place locally to support the quality, performance and risk management of the services. Managers of the service had raised concerns about the health based places of safety but the senior managers had not pursued the issues in order to address them. The issue was not on the trust risk register nor mentioned in the estates strategy.
- Trust wide systems did not support wider learning. The average number of staff who had completed mandatory training was 72%.
- Managers had recently made feedback from incidents and lessons learnt a standing item on the agenda at all business meetings, which happened fortnightly or monthly across the sites we visited. Frontline staff did not feel informed of feedback from incidents, despite managers saying minutes from these meetings were emailed to all staff members.
- The trust had balance score cards in place to rate performance and monitor outcomes.
- Managers told us that they had enough autonomy to manage the service. They also said that where they had concerns they could raise them.
- Team managers were unsure about whether or not they had the authority to submit items to the trust risk register.

Leadership, morale and staff engagement

- Staff were very positive about team working and the mutual support they gave one another. They felt supported by their immediate managers who they said would get involved in daily clinical practice if needed.
- The highest sickness rate amongst staff was for those working within the liaison team at the Whittington hospital at 13%, the lowest was for the liaison team working at UCLH at 1.6%.
- Staff generally had good morale, but they were feeling stressed due to there being several vacancies and working extra hours to cover the shortfall.
- There were no bullying or harassment cases ongoing at the time of the inspection.
- All staff felt able to raise concerns without fear of victimisation from their immediate manager. However, staff said they did not feel listened to by senior members of the trust. Staff working in health based places of safety and emergency departments had repeatedly raised concerns regarding the provision of this service, but did not feel trust members were taking these seriously.
- Opportunities for leadership development were available for qualified staff, but managers were not always able to release staff from practice to engage in this training due to being short staffed.

Commitment to quality improvement and innovation

- Crisis resolution and home treatment teams were engaging in the Home Treatment Accreditation Scheme (HTAS).

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **The trust did not protect patients from the risks associated with unsafe or unsuitable premises by means of suitable design and layout.** **There were significant safety issues at all of the health based places of safety and they did not meet the Royal College of Psychiatrist's guidance.Risks included potential ligature points and limited ability to observe people who were detained under S136 of the MHA.** **This was in breach of regulation 12 (1)(2)(a)(b)(d)**