Camden and Islington NHS Foundation Trust

Mental health crisis services and health-based places of safety

Quality Report

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Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
TAF		Health-Based Place of Safety	N19 5NX

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

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

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

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

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

Summary of findings

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Summary of findings

Overall summary

- The trust had recently opened a new purpose-built centralised health-based place of safety (HBPoS) at the Highgate Mental Health Centre in Camden. This replaced the previous provision it was using in local acute hospital emergency departments. This was an improvement as the busy and noisy environments of emergency departments were not best suited to support people detained under Section 136 of the Mental Health Act 1983. The purpose-built facility ensured that there was a safe, calm, clean and secure environment for people presenting to the service detained under Section 136 of the Mental Health Act 1983.
- In line with guidelines set out in the London HBPoS specification, the centralised HBPoS was staffed 24 hours a day, seven days a week. There was an identified nurse in charge of the facility at all times who coordinated the admission and assessment of people detained under a Section 136.
- Staff carried out appropriate risk assessments of every patient on admission. Medical or nursing staff carried out an initial screening of the individual as soon as possible to exclude medical causes or complicating factors and had a clear triage protocol in place. Staff understood and discharged their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005.
- Staff worked closely with colleagues from other agencies such as the police, allied mental health professionals and the local acute emergency department to ensure a smooth operation of the Section 136.
- Staff treated patients with compassion and kindness and understood the individual needs of patients.

However:

- The new purpose-built centralised health-based place of safety had only been open a week before our inspection. Therefore, systems and procedures were in their infancy, and the trust needed time to embed them to ensure that the unit ran smoothly.
- Although staff worked hard to ensure that Section 136 patients were not held for longer than 24 hours, in line with the Mental Health Act Code of Practice. Out of 22 admissions to the HBPoS, two admissions had breached the 24-hour length of stay.
- We noted some environmental issues during our inspection. However, the trust was aware of these and had plans in place to address them in a timely manner. These included identifications of blind spots in the secure communal area, computer stations posing as possible ligature risks, and a lack of a two-way communication system for the assessment suites.

Summary of findings

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

Are services safe?

- The trust had recently opened a purpose-built centralised health-based place of safety. Although some initial issues identified during its opening still needed to be addressed, it was safe and fit for purpose. It provided a discreet, quiet and secure environment for patients. It was visibly clean, had good furnishings and was well maintained. It met the requirements of the Mental Health Act Code of Practice.
- The services had enough staff, who received basic training to keep patients safe from avoidable harm. In line with guidelines set out in the London HBPoS specification, the centralised HBPoS was staffed 24 hours a day, seven days a week by a team that included dedicated nursing staff, a unit manager, a specialist registrar and consultant psychiatrists. There was an identified nurse in charge of the facility at all times.
- Staff had received and were up to date with appropriate mandatory training.
- Staff assessed and managed risks to patients and themselves. They responded promptly to sudden deterioration in a patient's health. They carried out appropriate risk assessments of every patient on admission. They were brief, but focussed and practical. Staff followed good personal safety protocols. Staff had easy access to alarms. They wore personal alarms to summon assistance in an emergency.
- 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 recognised incidents and reported them appropriately. Staff knew how to report an incident using the trust electronic system and did this when necessary. Staff reported incidents of 24-hour length of stay breaches.

However:

- We noted some environmental issues during our inspection. However, the trust was aware of these and had plans in place to address them.
- There were two blind spots in the secure communal area. The trust had ordered two convex mirrors to reduce the risk of these blind spots and ensured that one staff member was always present in the area.

Summary of findings

- There were desktop computers outside each assessment suite in the secure communal area, which posed as a ligature / weapon risk. These were being replaced by laptops and tablets, which were ready, pending installation of Wi-Fi. One staff member was always present in the secure communal area to mitigate risk.
- The trust had built assessment suites in line with the Health Act Code of Practice seclusion room specification requirements. However, the rooms did not provide a two-way communication system, which meant it might have been difficult to calmly and discreetly communicate with a distressed patient. There were plans to install intercom systems in the assessment rooms by March 2020.

Are services effective?

- Staff assessed the mental health needs of all patients. The HBPoS had a clear process for how to manage a person on a Section 136 upon their arrival. Staff used a specific HBPoS electronic proforma to document key parts of the Section 136 pathway.
- Staff ensured that patients had good access to physical healthcare. Records showed staff assessed a patients' physical health quickly after arriving at the HBPoS to determine any physical health concerns.
- 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 and with relevant services outside the organisation. Staff worked closely with colleagues from other agencies including the police. Before the health-based place of safety opened, managers held monthly multiagency meetings with the police and allied mental health professionals to discuss the operation of the Section 136 pathway. There were plans to continue these meetings to discuss the functioning of the service and how improvements could be made.
- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice. Staff gave people appropriate information about their Section 132 rights. Staff had received an appropriate induction in the Section 136 policy so they understood their role and responsibilities. Managers audited its practices with regard to Section 136 and planned to review it in six months' time. Staff

Summary of findings

worked hard to ensure that Section 136 patients were not held for longer than 24 hours, in line with the Mental Health Act Code of Practice. Of 22 admissions, two breachedthe 24-hour length of stay.

Are services caring?

- 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. We observed kind and respectful interactions between staff and patients.
- There was an information leaflet that was given to all patients when they arrived at the HBPoS to orientate themselves to the service.

Are services responsive to people's needs?

- The health-based places of safety was available when needed. People subject to Section 136 of the Mental Health Act 1983 had access to the centralised HBPoS 24 hours a day, seven days a week. Patients had their own assessment suites, which were located directly off the secure communal space. Assessment suites had en-suite bathrooms and TVs.
- Medical or nursing staff carried out an initial screening of the individual as soon as possible to exclude medical causes or complicating factors and had a clear triage protocol in place.
- Section 12-approved doctors and approved mental health professionals attended when required. Staff worked hard to ensure that an assessment by the doctor and AMHP began as soon as possible, ideally with three hours, which was in line with best practice. There had been one occasion where a patient’s admission breached the 24-hour length of stay target due to the out of hours AMHP lacking capacity to complete the assessment. The trust told us they had secured additional funding to book extra sessional AMHPs out of hours to meet the needs of people presenting to the HBPoS out of hours.
- The services met the needs of all patients who use the service – including those with a protected characteristic. Staff helped patients with communication, advocacy and cultural support.
- The unit had only been open a week before our inspection, and there had been no formal or informal complaints raised.

Summary of findings

Are services well-led?

- The trust had improved its provision for people using its health-based place of safety. Since our last inspection it had opened the purpose-built centralised health-based place of safety to meet guidelines set out in the London HBPoS specification. This was staffed by dedicated staff.
- The purpose-built centralised health-based place of safety had been open a week before our inspection. Therefore, systems and procedures were in their infancy, and the trust needed time to embed them to ensure that the unit ran smoothly. A HBPoS dashboard was due to go live shortly after our inspection, which would help managers keep on track of the unit's performance indicators.
- Staff collected data to monitor the service, including information about time taken to begin and complete an assessment, outcome of the assessment and the total time the person spent in the health-based place of safety.
- Leaders had a good understanding of the HBPoS and had good working relationships with organisations involved in the operation of Section 136, including the police, local acute emergency departments and AMHPs.
- Staff felt respected, supported and valued. Staff felt positive and proud about working for the trust and their team. Staff felt able to raise concerns without fear of retribution.

Summary of findings

Information about the service

The health-based place of safety is where patients experiencing a significant deterioration in their mental health are taken, usually by the police, for an assessment by a team of mental health professionals. The health-based place of safety is based at the Highgate Mental Health Centre in Camden and is commissioned for adults only.

Our inspection team

The team that inspected the health-based place of safety consisted of a CQC inspector and a CQC mental health act reviewer.

Why we carried out this inspection

This was a focussed inspection of the trust's new centralised health-based place of safety at Highgate Mental Health Centre. It opened on 20 January 2020, a week before our inspection.

How we carried out this inspection

We inspected the trust's mental health crisis services in October 2019, which included the trust's three crisis resolution and home treatment teams, Rivers Crisis House in South Camden, and the crisis call centre. This was part of a wider trust inspection. However, we did not inspect the trust's health-based place of safety at the time of inspection. This was because the trust was in the process of building a new health-based place of safety for adults at Highgate Mental Health Centre to replace the current provision it was using in local acute hospital emergency departments.

Before the inspection, we reviewed information that we held about the trust.

During the inspection visit, the inspection team:

- Spoke with the service manager of the health-based place of safety
- Spoke with the divisional director for the health-based place of safety
- Spoke with four staff members, including the specialist registrar and registered nurses
- Looked at the quality of the environment
- Reviewed four patient care and treatment records
- Spoke with one patient

Our inspection of the health-based place of safety took place on 28 January 2020. This was a short-term announced inspection, which meant staff knew we were coming one week before the inspection. This was in line with CQC guidance.

Good practice

The HBPoS had recruited a peer volunteer who would provide peer support to patients or go to the shop for them if required. The peer volunteer was due to start the week after our inspection.

Summary of findings

Areas for improvement

Action the provider SHOULD take to improve

- The trust should continue to monitor and work towards making sure patients do not stay in the health-based place of safety for longer than 24 hours.
- The trust should ensure the health-based place of safety systems, policies and procedures are embedded to ensure smooth operation of the Section 136 pathway.

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
Health-Based Place of Safety	Highgate Mental Health Centre

Mental Health Act responsibilities

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

Staff understood the trust policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly for patients who might have impaired mental capacity.

Seventy-five percent of staff had received training in the Mental Capacity Act (MCA).

Staff were aware of their responsibilities under the MCA. Patients would not stay under the care of the HBPoS for long periods of time, but staff considered patient capacity in assessments and fluctuating capacity due to being under the influence of drugs and/or alcohol, or at risk to self or others.

Staff documented consent for any treatment given, as Section 136 does not give power to treat without consent (although emergency medicines may be prescribed under common law).

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

All clinical premises where patients received care were safe, clean, well equipped, well furnished, well maintained and fit for purpose.

At the last inspection in December 2017, the trust provided health-based places of safety (HBPoS) at three local acute emergency departments. The busy, noisy environments of emergency departments were not best suited to support people detained under Section 136 of the Mental Health Act 1983. Since this inspection, the trust had opened a purpose-built centralised HBPoS at the Highgate Mental Health Centre in Camden. This meant there had been an improvement in ensuring that there was a safe and secure environment was for persons presenting to the service detained under Section 136 of the Mental Health Act 1983.

The HBPoS had its own dedicated unit that was discreet, quiet and secure. There were five assessment suites. At the time of the insepction, only three assessment suites were commissioned for use. The suites were designed to assist the assessment process, enable a distressed person to be safely managed, and had good observation facilities in place.

There were two blind spots in the secure communal area. We highlighted this to managers on the day of inspection, who told us that convex mirrors had been ordered to reduce the risk of blind spots. These were due to be delivered by the end of February 2020. A member of staff was always present in the secure communal area to mitigate risk.

Staff had carried out a ligature risk assessment to manage and reduce the risk of ligature points. A ligature anchor point is an environmental feature or structure, to which patients may fix a ligature with the intention of harming himself or herself. The provider had taken steps to reduce the number of ligature points, by installing anti-ligature fixtures and fittings. However, there were desktop computers outside each assessment suite, which presented a number of wires, screens and keyboards that could easily be used to harm. We highlighted this to managers on the day of inspection, who told us they had plans to remove the computers and replace with laptops. The laptops and tablets were in stock, pending Wi-Fi installation. In the interim period, a staff member was always present in the secure communal areas to mitigate the risk.

The HBPoS had developed assessment suites in line with the Health Act Code of Practice seclusion room specification requirements. The assessment suites allowed clear observation, and included toilet facilities, a clock and temperature control. However, the assessment suites did not have a two-way communication system, which is a standard in the Mental Health Act Code of Practice. The service manager told us there were plans to install intercoms in the assessment suites, with work due to be completed by 13 March 2020.

Staff had easy access to alarms. They wore personal alarms to summon assistance in an emergency. There were display panels on the walls to indicate where the alarm had been triggered. In the event of an emergency, and the personal alarm was triggered, staff from the inpatient wards in the Highgate Mental Health Centre would respond.

The HBPoS used furniture that would not cause injury. For example, tables and chairs were heavy duty so they could not be lifted, and the televisions in the assessment suites were in a protective case displayed on the wall.

The HBPoS was clean, had good furnishings and were well-maintained. The unit had dedicated cleaning staff, who maintained cleanliness in the service daily, seven days a week.

Staff adhered to infection control principles, including handwashing.

The clinic room was fully equipped with accessible emergency equipment and emergency drugs. The clinic room formed part of the team mananger's office, and was not used by patients. Staff conducted physical examinations on patients in the assessment suites.

Safe staffing

The services had enough staff, who received training to keep people safe from avoidable harm.

Are services safe?

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

In line with guidelines set out in the London HBPoS specification, the centralised HBPoS was staffed 24 hours a day, seven days a week by a team that included dedicated nursing staff, a unit manager, a specialist registrar and consultant psychiatrists. This was an improvement since the last inspection in December 2017, where the HBPoS sites located at local acute emergency departments and did not have a dedicated staff team for persons detained under Section 136.

Nursing staff

The service had enough nursing and support staff to keep patients safe.

Staffing levels were sufficient to enable handover of a detained person from the police as soon as possible after arrival. Each shift had a minimum of two registered nurses(band 6 and/or 5) and one assistant practitioner (band 4). Nursing staff worked day shifts from 7.30am to 8pm and night shifts from 7.30pm to 8.45am. The service manager said they were able to increase staffing levels if required and would contact the on-site duty team.

A qualified nurse or an assistant practitioner was present in the secure communal area of the unit at all times.

The unit had one vacancy for the team manager post, and the service manager had provided interim support. However, at the time of the inspection, the post had been recruited into and a new team manager was due to start the week after our inspection.

At all times, the unit had a clearly identified registered nurse in charge of the facility. This role was the central point of contact for the unit, optimising patient flow through the unit, and troubleshooting where necessary.

Medical staff

There was good medical cover day and night. Medical input included a speciality doctor working Monday to Friday 9am-5pm, and staff could access timely medical support out of hours. The unit had not been able to recruit a full-time consultant psychiatrist. Therefore, in the interim, three consultant psychiatrists that worked on the on-site inpatient wards provided four-hour daily sessional support to the unit. As of March 2020, a full-time consultant psychiatrist was due to start on a locum basis.

Mandatory training

Staff had received and were up to date with appropriate mandatory training. For example, all staff had completed safeguarding and mental capacity act training.

Assessing and managing risk to patients and staff

Staff assessed and managed risks to patients and themselves. They responded promptly to sudden deterioration in a patient's health. Staff followed good personal safety protocols.

Assessment of patient risk

Staff completed risk assessments for each patient on arrival. We looked at four care records that demonstrated that staff carried out appropriate risk assessments of every patient on admission. They were brief, but focussed and practical. Police provided staff with a telephone handover to assess risk, and if they were accepted to the HBPoS, staff completed a second risk assessment to assess if it was safe to accept them.

The HBPoS had a designated entrance for police and individuals detained under a Section 136, which led to a triage airlock. HBPoS staff were able to search the individual using a metal detector wand, and complete the handover with the police and and complete the triage process. If the person was deemed appropriate for admission to the HBPoS, only then would the individual enter the secured unit.

Staff followed good observation policies and procedures to ensure patient safety.

Management of patient risk

Staff completed restraint training and could safely manage disturbed behaviour without police support.

Staff followed an out-of-hours place of safety protocol, which included medical cover out of hours. There was an on call duty doctor to assist with triage assessments, physical health concerns, emergency psychiatric medicine prescribing and seclusion reviews.

The unit had only been open a week before our inspection and in that time there had been no incidents of rapid tranquilisation being administered to patients.

The HBPoS used a private secure ambulance company contracted with the trust to facilitate transport of people between places of safety.

Safeguarding

Are services safe?

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

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 were trained in safeguarding and knew how to make a referral if needed. A safeguarding referral is a request from a member of the public or a professional to the local authority or the police to intervene to support or protect a child or vulnerable adult from abuse. Commonly recognised forms of abuse include: physical, emotional, financial, sexual, neglect and institutional.

Staff knew how to identify adults and children at risk of, or suffering, significant harm. Staff spoke about a recent safeguarding alert where there were concerns regarding domestic abuse. The trust's domestic abuse practitioner had provided support to staff in the management of this safeguarding. There was also evidence of staff working in partnership with other agencies.

Staff access to essential information

All information needed to deliver patient care was available to all relevant staff when they needed it and was in an accessible form. Staff used a specific S136/135 electronic form that included information on contact with the police, accident and emergency (A&E), approved mental health practitioners and Section 12 appointed doctors.

Medicines management

The service used systems and processes to safely prescribe, administer, record and store medicines.

The HBPoS kept a small stock of medicines in a locked cupboard in the clinic room. These medicines were accessible to medical, nursing and pharmacy staff. This included commonly used antipsychotics, medicines for rapid tranquilisation, common anxiolytics that could be used on a PRN basis.

A trust pharmacist provided input in the HBPoS, who oversaw and supported staff with the effective use and management of medicines.

Staff stored medicines appropriately and used medicines in line with current national guidance. Staff monitored the medicines fridge temperature to ensure they were within the appropriate range so that medicines stored in the fridge would remain effective.

Track record on safety

The unit had only been open a week before our inspection and in that time there had been no serious incidents.

Reporting incidents and learning from when things go wrong

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.

Staff knew how to report an incident using the trust electronic system and did this when necessary. For example, we saw examples where staff reported a breach of detaining someone under Section 136 for longer than 24 hours.

Staff knew their responsibilities under the duty of candour. Duty of Candour is a legal requirement, which means providers must be open and transparent with persons about their care and treatment.

Are services effective?

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

Our findings

Assessment of needs and planning of care

The HBPoS had a clear process for how to manage a person on a Section 136 upon their arrival. The electronic system had a dedicated HBPoS proforma for staff to document key responsibilities such as the location the person was detained, the time the police left and what time the medical doctor and allied mental health professional (AMHP) completed an assessment.

Staff assessed the mental health needs of all patients. The four records we reviewed demonstrated that staff carried out detailed assessments and the necessary information was recorded. Qualified doctors and AMHPs conducted Mental Health Act (MHA) assessments on patients to ensure that arrangements for their ongoing care and treatment were appropriate. However, staff did not always record when the police called for advice before detaining people. The service manager told us that this was because the police did not always call the trust to discuss a potential detention.

Records showed staff assessed patients' physical health quickly after arriving at the HBPoS to determine any physical health concerns. This included blood pressure, heart rate and respiratory rate. If there were physical health concerns, such as overdose, head injury or loss of consciousness, they would be diverted to the local acute emergency department.

Best practice in treatment and care

Staff ensured that patients' physical health needs were met through a physical health assessment upon admission. Staff were trained in national early warning score (NEWS), which is a tool to monitor a patient's vital signs to alert them of a clinical decline in physical health. There was a protocol in place for who to contact in the event of a medical emergency.

Staff assessed and met patients' needs for food and drink. The unit had a kitchen, which could only be accessed by staff. Patients could request a range of hot/cold drinks, and hot/cold meals 24 hours a day, seven days a week.

Smoking was not allowed on trust premises. However, the HBPoS stocked nicotine replacement therapy to offer to patients who required it during their stay.

Staff participated in clinical audits, which helped to assure the quality of the service provided to patients. Staff completed audits on the MHA and ligature risks.

The HBPoS audited its practice in respect of Section 136. The unit collected data to monitor the service, which included information about age, gender, ethnicity, time the police remained and total time the person spent in the place of safety.

The unit recorded instances where an individual was brought to the HBPoS, but was not accepted, and the reason for this. For example, it may have been due to the patient's physical health or the capacity of the HBPoS.

Skilled staff to deliver care

The team included or had access to the full range of specialists required to meet the needs of patients at the HBPoS. For example, medical doctors, qualified nurses, assistant practitioners and pharmacists.

Managers provided new staff with an appropriate induction specific to working in a HBPoS. Staff had a two-week induction before the opening of the service, which they said was helpful. This included training on Section 136 MHA legislation, and training from the AMPH and psychiatric liaison teams.

The unit had only been open a week before our inspection, therefore supervision data was not provided. Staff were expected to have supervision every four to six weeks, in line with trust policy.

Ninety percent of staff had received an appraisal, which had been obtained from when they worked in previous teams at the trust.

Managers ensured that staff received the necessary specialist training for their roles. For example, the trust had received funding as part of the North Central London sustainability transformation partnership to improve quality of care for mental health patients in crisis who attend the HBPoS and the local acute emergency department by providing more integrated physical and mental healthcare at both sites. This had not yet taken place, but would mean that qualified HBPoS nurses would complete a bespoke programme of physical health training in the local acute emergency department

Managers ensured that staff had access to regular team meetings.

Are services effective?

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

The HBPoS had recruited a peer volunteer who would provide peer support to patients or go to the shop for them if required. The peer volunteer was due to start the week after our inspection.

Multidisciplinary and interagency team work

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 HBPoS had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.

Staff held regular multidisciplinary meetings. We reviewed the minutes for the first weekly team meeting, which included discussion on topics such as searching individuals and the triage process.

Staff attended handovers three times a day to ensure essential information was passed over to staff during shift changes. Staff did not follow a structured template or document the verbal handover, which meant there was a risk that key issues may have been missed.

HBPoS staff demonstrated good multiagency working in the operation of Section 136. Records showed staff liaised well with other agencies involved in the patient care pathway. This included the police, ambulance service, emergency departments, local authority, housing authority and third sector charities.

The HBPOS manager described good working links with the local acute emergency department, and attended monthly operational meetings with them where the Section 136 pathway was discussed.

In the lead up to the opening of the HBPoS, managers met regularly with the police and AMHPs to discuss the Section 136 pathway. Since the HBPoS opened, plans were in place to set up a multi-agency group involved in the operation of Section 136, which would include the police and AMHPs. Managers told us that the ambulance provider were under a lot of pressure and may find it a challenge to attend regular face-to-face meetings. However, the trust had an identified mental health lead for the ambulance service and planned to liaise with them to ensure regular feedback.

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

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice.

All staff had received training in the Mental Health Act (MHA). Staff were trained in and had a good understanding of the MHA, the Code of Practice and the guiding principles.

Staff worked collaboratively with external agencies, such as the police to ensure s135/136 patients detained for an assessment were not held for longer than 24 hours, in line with MHA. There had been two 24-hour breaches out of the 22 patients who had been admitted to the HBPoS since it had opened. One breach due to lack of AMHP availability out of hours, and one breach due to a patient firstly being admitted to another HBPoS in a different borough. Staff justified keeping a patient at the HBPoS beyond the legal breach under common law. This meant that staff acted in the patient's best interest in an emergency.

If staff required more time to assess a patient, for example due to alcohol intoxication, a medical doctor completed a form to legally extend the assessment time for a further 12 hours.

Staff explained to patients their rights under the MHA, and recorded that they had done this. Staff also provided patients with a leaflet with their rights under Section 136 of the MHA.

Good practice in applying the Mental Capacity Act

Staff understood the trust policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly for patients who might have impaired mental capacity.

Seventy-five percent of staff had received training in the Mental Capacity Act (MCA).

Staff were aware of their responsibilities under the MCA. Patients would not stay under the care of the HBPoS for long periods of time, but staff considered patient capacity in assessments and fluctuating capacity due to being under the influence of drugs and/or alcohol, or at risk to self or others.

Staff documented consent for any treatment given, as Section 136 does not give power to treat without consent (although emergency medicines may be prescribed under common law).

Are services caring?

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

Our findings

K**indness, privacy, dignity, respect, compassion and support**

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.

We observed kind and respectful interactions between staff and patients. We spoke with one patient who was generally positive about their stay at the HBPoS. They said the doctor was very helpful and clearly explained what was happening.

Staff were responsible for collecting background information about a patient from other professionals, to inform care. This was carried out and recorded in patient notes.

Staff directed patients to other services when appropriate, for example homelessness and substance misuse services.

Involvement in care

Where possible, staff involved patients in discussions about their care, treatment and risk management. This was recorded in patient notes.

There was an information leaflet that was given to all patients when they arrived at the HBPoS. This included information on their rights under Section 136 of the Mental Health Act (1983), the multidisciplinary team, meals and how to make a complaint.

The trust had planned to enable patients to feedback on the HBPoS, via a friends and family test. However, at the time of inspection, they did not have a tablet device available for patients to fill the survey out on, so no patients had filled in the survey.

Involvement of families and carers

Where practicable, staff encouraged visits and involvement in the assessment process by family members, carers and/or friends to the person admitted to the HBPoS.

Are services responsive to people's needs?

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

Our findings

Access and discharge

People subject to Section 135/136 of the Mental Health Act 1983 had access to the centralised HBPoS 24 hours a day, seven days a week. Specifically those persons detained under Section 136 by the Metropolitan Police or British Transport Police in the locality of Camden and Islington regardless of their address, found anywhere other than a private dwelling.

The trust HBPoS was commissioned to provide services to adults only. If police officers approached the HBPoS with a young person under 18, staff would direct officers to the most appropriate emergency department. At the time of the inspection, there were three adult patients in the three commissioned assessment suites.

The HBPoS did not exclude people if they had consumed alcohol or drugs (unless there was a medical risk in with case an emergency department was appropriate), had a history of violence or had committed a criminal offence.

During the triage process, if a person was pregnant or over the age of 65 years of age, they were diverted to the local acute emergency department for medical attention.

The HBPoS would attempt to admit patients to an appropriate assessment suite on the unit. If this was not possible, they would try other local places of safety.

The HBPoS received admissions from Camden and Islington, and from other London boroughs and from outside of London. Out of the 22 admissions since the HBPoS opened, 14 were people from out of area. This represented a high use of HBPoS for non-residents of the boroughs served by the trust.

Staff worked hard to ensure that an assessment by the doctor and AMHP began as soon as possible, ideally with three hours, which was in line with best practice recommendations by the Royal College of Psychiatrists. Due to a full-time doctor based at the HBPoS, patients received an initial medical assessment in a timely manner.

The HBPoS could obtain allied mental health professional (AMHP) assessments Monday to Friday, 9am to 5pm. Out of hours (evenings and weekends), the AMHP service was provided by the emergency duty team in both Camden and Islington Local Authorities. As Highgate Mental Health Centre was based in the London Borough of Camden, most requests were made to the AMHP in Camden. Out of hours there was one AMHP covering all social care requests, including mental health assessment requests, for Camden Local Authority. This meant that a lot of requests out of hours were not being fulfilled due to lack of capacity. We saw an example, where an individual had been detained on a Section 136 for longer than 24 hours due to the emergency AMHP being able to complete an assessment for detention as they had been dealing with another social care priority.

Staff recorded breaches of the 24-hour length of stay as an incident. Since the HBPoS opened, data recorded by the trust showed that, of the 22 admissions to the HBPoS, two breached the 24-hour length of stay. One patient's length of stay on a Section 136 was 28 hours, which was due to being initially accepted at a HBPoS in a neighbouring borough. A second patient's length of stay was 31 hours, which was due to the out of hours AMHP lacking capacity to complete an assessment. The service manager was concerned about the capacity for out of hours AMHPs to complete timely assessments. Senior managers discussed AMHP response times at monthly A&E delivery board meetings, and monitored AMHP response times through monthly reports. There had also been some additional funds secured to book sessional AMHPs out of hours

HBPoS staff liaised with the trust's bed management team if the decision was made to admit a patient under the Mental Health Act. The bed management team were available 24 hours a day, seven days per week.

The HBPoS recorded the discharge destination for people on a Section 136. This included formal admission to an inpatient ward, discharges to community mental health teams, crisis teams and GP services.

For all persons discharged from the HBPoS, staff ensured they had means of accessing safe accommodation, means to access funds, and the person's GP and their local community mental health team (if known) was notified of the admission within 24 hours via a written discharge summary.

Facilities that promote comfort, dignity and privacy

The design, layout, and furnishings of the HBPoS rooms supported patients' treatment, privacy and dignity.

Are services responsive to people's needs?

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

At the last inspection in December 2017, the three HBPoS environments located at the local acute emergency departments did not always promote privacy, dignity and recovery for persons detained under Section 136 as these were busy environments. During this inspection, improvements had been made. The trust had a purpose built new centralised HBPoS. Patients were seen within an appropriate environment, which was secure, calm and discreet. Patients could come out of their room and use the secure communal area.

Patients had their own assessment suites, which were located directly off the secure communal space. Assessment suites had en-suite bathrooms. Some of the assessment suite windows backed onto the hospital grounds and were not tinted to ensure privacy. This meant that there was risk that staff/patients/visitors walking past could see into the rooms . Staff told us that the blinds would be closed when assessment suites were in use to ensure privacy of the patient in the room.

Patients had somewhere secure to store their possessions on the unit. Patients had access to their mobile phones if staff risk assessed this as safe and appropriate.

Staff provided drinks, snacks and hot meals to patients 24 hours a day, seven days a week.

Meeting the needs of all people who use the service

The service met the needs of all patients – including those with a protected characteristic. Staff helped patients with communication, advocacy and cultural and spiritual support.

The unit was designed so that disabled patients could access the premises. One of the assessment suites was larger than the others and had a bathroom that was adapted for disabled patients.

Staff gave patients a leaflet upon admission with information about the service and what to expect.

Staff could use interpreters for patients, if needed. Staff assessed a patient's social and religious needs and took this into account.

Listening to and learning from concerns and complaints

Staff were aware of how to handle complaints, and informed patients of how to complain.

The unit had only been open a week before our inspection, and there had been no formal or informal complaints raised.

Are services well-led?

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

Our findings

Leadership

Leaders, which included the service manager and the acute divisional director had a good understanding of the HBPoS. They could explain how the team was working to provide good quality care.

Leaders were visible on the unit and approachable for patients and staff. Staff said the service manager was regularly on the unit.

Vision and strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The main vision was the establishment of the centralised health-based place of safety, which was in line with guidelines set out in the London HBPoS specification. The service was aligned to local plans and the wider health economy. Managers made sure staff understood the vision and values and knew how to apply them.

Staff understood the trust's vision and values and how they applied in the operation of the HBPoS.

Leaders included other organisations such as the police and the acute trust in discussions about the strategy for the HBPoS. Staff felts that they were able to feedback on issues on the day to day operating of the service. For example, staff had fed back that there was too much wiring around the computers in the secure communal area. Managers had listened to this and were planning to remove them.

Culture

Staff felt respected, supported and valued. They felt the service promoted equality and diversity, and provided opportunities for career development. They could raise concerns without fear.

In the short time that the HBPoS had been open, staff described the morale as good. Some staff had never worked on a HBPoS before (only inpatient wards), and found learning to work in a new service a challenge, but felt supported to do their role.

Staff felt positive and proud about working for the trust and their team. Staff felt able to raise concerns without fear of retribution.

Staff knew how to use the whistleblowing process and that there was a Freedom to Speak Up Guardian. However, not all staff knew who the Freedom to Speak Up Guardian was. The Freedom to Speak Up Guardian enables people to speak up safely in the workplace.

Governance

Leaders ensured there were structures, processes and systems of accountability for the performance of the service. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

As the HBPoS had only been open a week before our inspection, systems were still getting started and in the process of being embedded. There was a clear operational police in place that ensured an effective delivery of the service. Staff worked hard to ensure compliance with Section 136 Mental Health Act 1983 and trust targets. Staff assessed and discharged/transferred most patients within the 24-hour required length of stay. The HBPoS environment was purpose built, and appropriately met patients' needs. Staff were new in their role and getting familiar with the policies and procedures for working in a HBPoS, but had been appropriately trained and felt supported to do their role. Staff demonstrated good working relationships with police, ambulance services and acute emergency departments.

Staff were recording key information about the patient's Section 136 pathway, and managers were using this to review performance. Managers had planned to complete a review in six months time to identify trends and where improvements were needs. They monitored patients' age, gender, and ethnicity, and they checked the mode of transport that had been used to transfer them, the time taken to start and complete assessments, the outcome of assessment, and the total time the patient spent in the place of safety. In particular, they looked at 24-hour length of stay breaches to see how they could prevent further breaches.

Management of risk, issues and performance

Leaders managed performance using systems to identify, understand, monitor, and reduce or eliminate risks. The service manager could escalate and discuss risks with senior managers. Senior managers were managing risks through a project risk log, which included the risk of breaching the 24-hour maximum length of stay.

Are services well-led?

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

Information management

The service collected reliable information and analysed it to understand performance and to enable staff to make decisions and improvements. The information systems were integrated and secure.

The service used systems to collect data from the unit that was not over-burdensome for frontline staff.

The trust had developed a HBPoS electronic dashboard and was due to go live the day after our inspection. It contained information on the unit's key performance indicators.

IT infrastructures and telephones worked well to support care. Staff had access to the equipment and systems needed to do their work. The trust had developed its own Section 136 electronic proforma, that ensured essential information was captured on the system during the operation of a Section 136.

Information governance systems were in place, including ensuring the confidentiality of patient records.

Engagement

The service engaged well with local organisations to plan and manage appropriate services. It collaborated with partner organisations to help improve services for patients. The service was still embedding systems to effectively gather feedback from people who used the HBPoS.

Staff had access to up-to-date information about the work of the trust. For example, via internal trust bulletins, which were emailed to staff.

Some staff did not feel that they were consulted in the development of the HBPoS, and that their feedback would have been helpful given that they had worked on inpatient wards and were familiar with secure environments.

The trust had planned to enable patients to feedback on the HBPoS, via a friends and family test. However, at the time of inspection, they did not have a tablet device available for patients to fill the survey out on, so no patients had filled in the survey.

Directorate leaders engaged with external stakeholders, such as commissioners.

Learning, continuous improvement and innovation

All staff were committed to continually improving services and had a good understanding of quality improvement methods. Leaders encouraged innovation and participation in research.

The trust encouraged staff to use quality improvement methods to improve practice. One of the consultant psychiatrists was looking at legal highs / novel substances and appropriate testing and the time taken for patients to sober up before conducting a mental health act assessment.