Camden and Islington NHS Foundation Trust

Liaison psychiatry services

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)
TAF01	St Pancras Hospital	Whittington Psychiatric Liaison Team	N19 5NX
TAF01	St Pancras Hospital	UCLH Psychiatric Liaison Team	NW1 2BU
TAF01	St Pancras Hospital	The Royal Free Psychiatric Liaison Team	NW3 2QG

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.

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.

Summary of findings

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 did not rate this service as this was a focussed inspection.

We found the following issues that the service provider needs to improve:

- Although Camden and Islington hadengaged with the three acute trusts, the Whittington the Royal Free and UCLH, to develop a joint action plan following a serious incident involving the death of a patient, there were some areas where the actions were not fully embedded. Camden and Islington had not effectively assured themselves that necessary actions were being carried out.At the Whittington Hospital ED, the assigned acute staff did not attend to their observation duties consistently. These are responsibilities to observe patients with mental health problems who have been assessed by the liaison team as having a risk of self-harm. At the Royal Free and UCLH, security staff, rather than clinical and adequately trained staff, observed patients whilst mental health nurses were requested.
- Camden and Islington needed to continue their work with the Whittington, to ensure the assessment rooms in the ED offered appropriate levels of privacy and provided an environment where patients could wait in comfort. There were plans to make improvements by December 2017.
- Camden and Islington was not making improvements in response to some feedback from inspections and peer review visits. For example the provision of information about services and legal rights under the Mental Health Act 1983 and Mental Capacity act 2005 and the completion of comprehensive patient records.

However, we also found the following areas of good practice:

- Liaison staff assessed most patients promptly within their target of one hour after they arrived at the ED.
- At all three acute trusts, liaison staff delivered regular training sessions to acute staff working in ED to develop their knowledge of mental health patients.

Summary of findings

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

Are services safe?

We did not rate this service as this was a focussed inspection.

We found the following issues that the provider needs to improve:

- Camden and Islington had not ensured that, in partnership with the acute trusts, appropriate systems were embedded fully to keep mental health patients safe following their initial assessment by the liaison services. At the Whittington Hospital ED, the assigned acute staff did not attend to their observation duties consistently. At the Royal Free and UCLH, security staff, rather than adequately trained clinical staff observed patients whilst mental health nurses were requested.
- Camden and Islington needed to continue work with the Whittington, to ensure the assessment rooms in the ED offered appropriate levels of privacy and provided an environment where patients could wait in comfort. There were plans to make improvements by December 2017.
- All three liaison teams had nursing vacancies and staff said they felt stretched. Ongoing recruitment was taking place and bank staff were used to ensure planned staffing levels were reached.

However, we also found the following areas of good practice:

- Following a recent serious incident, liaison staff developed a new assessment recording sheet with ED staff to share important information consistently.
- Liaison staff assessed most patients promptly within their target of one hour.
- Liaison staff delivered training in mental health conditions to clinical staff working in ED who supported mental health patients.

Are services well-led?

We did not rate this service as this was a focussed inspection.

We found the following issues that the service provider needs to improve:

- Although Camden and Islington had worked closely with its external partners, the Whittington the Royal Free and UCLH to develop a joint action plan following a serious incident involving the death of a patient, they had not effectively ensured all actions were being embedded consistently. The agreed processes in place to provide safe care to mental health patients attending the ED, such as observations, were not being followed as they should be.

Summary of findings

- Camden and Islington was not making improvements in response to some feedback from inspections and peer review visits. For example the provision of information about services and legal rights under the Mental Health Act 1983 and Mental Capacity act 2005 and the completion of comprehensive patient records.

However, we also found the following areas of good practice:

- Staff across the liaison services and the three EDs said that working relationships were strengthening. Staff at all three EDs said liaison staff responded quickly to referrals.
- The liaison team staff said their teams were supportive and communicated information well.

Summary of findings

Information about the service

Camden and Islington NHS Foundation Trust (Camden and Islington trust) provides psychiatric liaison services at three acute hospital trusts. These are The Whittington Health NHS Trust (The Whittington), University College London Hospitals NHS Foundation Trust (UCLH) and The Royal Free Hospital (The Royal Free). The liaison services provide an emergency assessment service for people with mental health conditions who present to the emergency department(ED).

The services operate 24 hours a day, seven days a week at The Whittington and UCLH. At The Royal Free, liaison nurses work seven days a week from 8am to 8pm and a registrar is available outside of these hours. Acute hospital staff refer patients to the mental health liaison services. The mental health liaison services provide assessments and direct patients towards appropriate services for follow-up care and treatment. An operational policy covered all sites and set out the role of the service and the responsibilities in relation to the safety, assessment and treatment of patients.

The mental health liaison services have a target of a one hour response time for a patient referred from ED.

Our inspection team

The team comprised an inspection lead (Natalie Austin Parsons, CQC inspector), three other CQC inspectors and one inspection manager, and a specialist advisor who was a nurse with experience of working in these services.

Why we carried out this inspection

We carried out a focussed inspection of Camden and Islington NHS Foundation Trust's psychiatric liaison service to determine how staff assess and mitigate risks for mental health patients who present at the emergency department of three acute trusts. These acute trusts are:

- The Whittington Health NHS Trust (The Whittington)
- University College London Hospitals NHS Foundation Trust (UCLH)
- The Royal Free London NHS Foundation Trust (The Royal Free)

This was in response to a serious incident that took place at The Whittington Hospital in November 2016 that resulted in a patient death. A patient assessed as needing inpatient care left the emergency department and took their own life. We inspected these services to determine whether actions and learning from this incident were embedded.

How we carried out this inspection

We carried out this inspection to determine whether the service was safe and well-led, in response to the serious incident that took place at the Whittington hospital in November 2016.

Before the inspection, we gathered information about the action taken by the trusts involved in the serious incident in November 2016.

During the inspection visit the inspection team:

- visited three liaison teams based at three acute trust sites and looked at the quality of the environment and observed how staff were caring for patients
- spoke with the service manager who managed all three teams

Summary of findings

- spoke with 29 other staff members employed in the liaison team at the three sites or by the three acute trusts, including doctors, nurses, healthcare assistants, administrators and security staff
- interviewed the clinical leads with responsibility for these services in all four trusts
- attended and observed a hand-over meeting
- looked at 17 treatment records of patients
- looked at a range of policies, procedures and other documents relating to the running of the service

These services had not been inspected previously using our current inspection methodology.

Areas for improvement

Action the provider SHOULD take to improve

- Camden and Islington should ensure they have sufficient assurance that joint learning and actions plans following incidents are consistently applied with their acute partners. This includes ensuring observations of mental health patients are carried out effectively by suitably trained staff.
- Camden and Islington should continue to work with the Whittington to ensure they update the environment of the assessment rooms as planned and complete risk assessments of the furniture.
- Camden and Islington should work with the three acute trusts to develop systems to reduce the number of patients leaving the ED before being assessed, especially at the Whittington.
- Camden and Islington should ensure it provides patients with all relevant information about their care in a suitable format. This includes information about care after discharge and the Mental Health Act 1983 and Mental Capacity Act 2005 where relevant.
- Camden and Islington should ensure it continues to recruit to the liaison teams across all three sites.
- Camden and Islington should ensure staff complete full and detailed care records, including the time and full detail of assessments.

Camden and Islington NHS Foundation Trust

Liaison psychiatry services

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Whittington Psychiatric Liaison Team	St Pancras Hospital
UCLH Psychiatric Liaison Team	St Pancras Hospital
The Royal Free Psychiatric Liaison Team	St Pancras Hospital

Mental Health Act responsibilities

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

Staff worked with approved mental health practitioners employed by the local authority to ensure those patients who required mental health assessment received it.

Staff kept accurate records of assessments in most of the 17 records we reviewed. In one record, staff had not recorded the start time of the detention of the patient, which they should have done.

Staff did not always give patients information about their right under the Mental Health Act 1983 or keep accurate records of this.

Mental Capacity Act and Deprivation of Liberty Safeguards

Staff received training in the Mental Capacity Act and we saw evidence they considered patients' capacity to make decisions. Where they queried a patient's capacity they carried out and recorded capacity assessments appropriately.

Where patients presented to the ED under the influence of a substance, staff recognised this and allowed them time to have capacity before carrying out a mental health and risk assessment.

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

- Psychiatric liaison staff at each acute site had access to rooms where they could conduct assessments. These were located within the emergency department (ED). Each room had a door that opened outwards, an alarm system, panels or windows for observation and were ligature free. The furniture in the rooms was weighted down, but was still movable, so there is a possibility it could be used as a weapon. The room at the Whittington required updating to make the environment more pleasant. This was due for completion in December 2017.
- The rooms at the Whittington were directly off the main ED and had essential viewing panels for staff to see into the room. However, this also meant anyone in the ED could also look into the room, which impacts a patient's privacy and dignity. During our inspection, we saw one member of domestic staff looking into an occupied room on two occasions to check if it was available for cleaning.
- Liaison team offices were based close to the ED and staff had access to computers for recording clinical notes.
- Staff carried personal alarms to summon for help if necessary.

Safe staffing

- The liaison teams consisted of registered mental health nurses and a service manager. Each team had some nursing vacancies: two at The Whittington and UCLH and three at The Royal Free. These roles were filled by bank and agency staff to ensure the right number of staff were working on each shift. At The Royal Free, liaison nursing staff were funded to work from 8am to 8pm. Outside of this time, mental health patients were assessed by a trainee doctor. Acute staff said it would be helpful to have nursing liaison staff available outside of this time, as clinical audits showed there was a demand.
- Staff we spoke with at all three sites, both from the liaison team and the acute trusts, said the demand on the liaison service was high and that the liaison staff were stretched to complete the tasks for which they were responsible. For example, staff could not always re-assess patients at least every four hours as expected and could not respond immediately to a referral if they were already in an assessment with a patient.
- Despite the staff vacancies, liaison staff assessed most patients quickly and were very close to or achieved their targets. At The Royal Free and UCLH, the target was seeing 95% of patients within one hour. The Whittington team had a target of 90% and key performance data showed they achieved this. For those not seen within the hour, across all sites, 96% to 100% of patients were assessed within four hours of coming to the ED. Staff at the acute trusts said it was easy to contact the liaison team and they responded quickly.
- Liaison staff delivered training to acute staff including nurses and students working in the ED. This included training on triage, self-harm and suicide, and general mental health. At the Royal Free, liaison staff delivered 12 areas of training to 120 staff in the 12 months before the inspection. This included topics on the agitated patient, dementia, delirium, depression and difficult cases. At The Whittington, liaison staff delivered two sets of training in March 2017 to 18 acute nurses. This was on self-harm, management of disturbed behaviour, the Mental Health Act 1983, the Mental Capacity Act 2005, delirium, dementia and alcohol problems and reflective discussions. Two ED staff at the Royal Free and four at the Whittington said they would like more training on mental health.

Assessing and managing risk to patients and staff

- Mental health patients were not being observed by sufficiently skilled staff when required.
- At the Whittington Hospital, liaison staff assessed patients and set observation levels. Following a serious incident in November 2016, which involved the death of a patient, the Whittington employed emergency department assistants (EDAs), who were responsible for carrying out the continuous observations of mental health patients the liaison team assessed as needing this. They did this through the observation panels and a CCTV camera and monitor. During our inspection, we

saw that the EDA staff did not attend to this duty consistently. They did not watch the patient observation monitor continuously as required, because other staff in the department requested they complete other tasks at the same time. This was highlighted to the liaison team manager and Whittington staff at the time. Staff we spoke with in this role confirmed they were required to do other tasks during observation responsibilities.

- If a patient required observation at UCLH or The Royal Free, the acute staff requested that UCLH and The Royal Free engaged a bank or agency mental health nurse. In the time it took for this nurse to arrive, security staff or healthcare assistants were assigned to observe patients. These staff had not received training in observing and supporting mental health patients. Service data showed that at each site, between 30 and 45 patients each quarter required constant observation whilst waiting in the ED.
- Incident data showed some patients left the ED before the liaison team arrived and carried out a full risk assessment. This meant that some patients may not receive the assessment and support they need. This happened more often at the Whittington. Between October 2016 and March 2017, staff reported that 7% (60 of 861patients) left the Whittington ED before an assessment, compared to 1% (15 of 1003 patients) at UCLH and 4% (32 of 842 patients) at the Royal Free in the same time frame.
- All staff we spoke with said the delays in finding an available inpatient bed was a problem as it meant patients had to wait in the ED for long periods of time. Staff reported incidents where patients assessed as needing an inpatient bed waited over 12 hours to get one, after their risk assessment. Data from the three to six months before the inspection showed this occurred for 21 patients at the Whittington, 57 at UCLH and 25 at the Royal Free.
- When a patient arrived at ED, ED staff completed a brief risk assessment that they recorded in the patient's ED notes. If the patient needed mental health support, ED staff called the psychiatric liaison team to attend ED. Liaison staff assessed the risks for each patient and recorded this in electronic progress notes, but in two of the 17 notes we looked at, the risk assessment was not completed in sufficient detail. For example, one patient took an overdose before going to the ED, but the necessary level of detail about the overdose was not in the notes to inform their ongoing care. One record did not have a risk assessment completed.
- Records showed that staff asked patients about any weapons they had on them and managed this appropriately.
- In each liaison team, the nurses met daily for handovers in which they shared information about new patients and handed over risks. We observed one handover and saw this was facilitated well. Teams also had weekly safeguarding and risk management meetings.

Discharge

- The liaison teams had developed a care plan document to be completed with and given to patients. This included important information about crisis support including emergency telephone numbers. Staff did not consistently record when they gave this to patients. In four of 17 records, staff did not make clear records of what information they had given the patient on discharge.

Track record on safety

- In the 12 months before the inspection, there were four serious incidents requiring investigation that involved mental health patients supported by the liaison teams. Two of these involved the death of a patient who staff had assessed as requiring inpatient care. The other two involved serious self-harm by patients.

Reporting incidents and learning from when things go wrong

- Staff knew how to report an incident and did this when necessary.
- The Camden and Islington liaison services shared learning. In all three teams, staff knew changes implemented following incidents, including serious incidents. Most (12 of 18) acute staff we spoke with were aware of the recent serious incident at their hospital site and changes made to services as a result.
- Following the serious incidents, Camden and Islington worked together with staff in the acute trusts to develop and implement action plans to mitigate the re-occurrence of incidents. This was successful in some areas, such as the development and use of documents

to share observation levels. In response to a serious incident at UCLH, liaison and UCLH staff were in the process of developing a policy about nursing provision, the role of security personnel and the availability of nurses in the ED facilities when supporting mental health patients.

- However, Camden and Islington had not ensured all necessary changes were embedded. Following the incident in November 2016, when a patient left the Whittington ED and died, The Whittington had introduced the role of emergency department assistants (EDAs) to carry out observations. At this inspection, we found high risk mental health patients were not observed by staff at all times. Camden and Islington trust and The Whittington had not worked together to assure themselves the EDA role was functioning and that staff observed high risk mental health patients.
- 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 clients about their care and treatment. This includes a duty to be honest with clients when something goes wrong. Staff were aware of the need to be open and transparent when things went wrong.

Are services well-led?

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

Our findings

Good governance

- Camden and Islington had engaged with the three acute trusts to introduce change and opportunities for shared learning following incidents. However, not all actions were embedded and carried out as required, and the trust had not sought full assurance on this. For example, ensuring the EDAs at the Whittington were carrying out their observation responsibilities appropriately to keep mental health patients safe.
- Senior staff in the liaison team and acute trust staff had regular meetings. These included joint business and operational meetings. These focussed on developing relationships and communication between teams. The new manager, who started in May 2017, included regular items on the agenda such as serious incidents, shared learning, waiting times and ligature standards. In February and March 2017, officers from the local police attended for a shared learning session.
- Camden and Islington had not ensured that systems for assurance and improvement operated effectively. Camden and Islington trust had not ensured information about services and care pathways was readily available to all patients. During our inspection, we saw that information about the Mental Health Act 1983 was not available in the area for patients and two staff confirmed this was not always given. This was highlighted as a concern at our last inspection in February 2016, and in the most recent review by the Psychiatric Liaison Accreditation Network (PLAN), but had not been addressed. Patients could not access easy read information or information in other formats.
- Camden and Islington had not ensured the teams kept appropriate and accurate records. Staff did not always complete all records completely with sufficient detail. The most recent external peer review in 2016, from the psychiatric liaison accreditation network, run by the Royal College of Psychiatrists, had also highlighted this, and staff had discussed how to improve at a team meeting in February 2017. There were no clear plans in place to address this.

Leadership, morale and staff engagement

- Staff in the liaison teams and acute trusts said they were working to strengthen their relationships and gave examples of work they had done together to improve services. This included the development and introduction of a care plan document to ensure ED and liaison staff could share information about a patient quickly and consistently.
- Liaison staff said they felt supported by their trust, Camden and Islington. Staff from both the liaison team and the acute trusts recognised that the demand on the liaison team was large and they felt understaffed. Staff at all sites said there are times when the number of mental health patients in the ED was overwhelming for both liaison and ED staff.

Commitment to quality improvement and innovation

- At the Royal Free, the team carried out work to identify frequent attenders to the service and were in the process of developing advanced care plans for these patients.
- All three liaison teams were members of PLAN, which is a quality improvement network run by the Royal College of Psychiatrists.