Inspection Report

***We are the regulator:*** *Our job is to check whether hospitals, care homes and care services are meeting essential standards.*

# Trust Headquarters

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Date of Inspections: 20 August 2013
19 August 2013

Date of Publication: October 2013

We inspected the following standards as part of a routine inspection. This is what we found:

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| **Care and welfare of people who use services** | ✓ Met this standard |
| **Cooperating with other providers** | ✓ Met this standard |

## Details about this location

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| Registered Provider | Barnet, Enfield and Haringey Mental Health NHS Trust |
| Overview of the service | Barnet, Enfield and Haringey Mental Health NHS Trust operates community mental health teams of various types in the boroughs of Barnet, Enfield and Haringey. These teams provide care and treatment to people experiencing mental health issues in the community. We inspected one team in each borough, offering different services to people.<br><br>This was an inspection of mental health services provided in police custody suites in Camden by Camlet Lodge Forensic Services. |
| Type of services | Community based services for people with mental health needs<br>Hospital services for people with mental health needs, learning disabilities and problems with substance misuse<br>Community based services for people who misuse substances |
| Regulated activities | Assessment or medical treatment for persons detained under the Mental Health Act 1983<br>Diagnostic and screening procedures<br>Family planning<br>Nursing care<br>Treatment of disease, disorder or injury |

# Contents

*When you read this report, you may find it useful to read the sections towards the back called 'About CQC inspections' and 'How we define our judgements'.*

## Summary of this inspection

### Why we carried out this inspection

This was a routine inspection to check that essential standards of quality and safety referred to on the front page were being met. We sometimes describe this as a scheduled inspection.

This was an unannounced inspection.

### How we carried out this inspection

We looked at the personal care or treatment records of people who use the service, carried out a visit on 19 August 2013 and 20 August 2013, observed how people were being cared for and talked with staff.

### What people told us and what we found

This was an inspection of mental health services provided in police custody suites in the London Borough of Camden by Camlet Lodge Forensic Services. We spoke to police custody staff and doctors who worked alongside the mental health service. We were told that a good service was being provided by the service that met people's needs. We found the service carried out comprehensive assessments and met people's mental health needs. We also found that the service cooperated, liaised and shared information with other providers. This meant that people's needs were more likely to be met.

You can see our judgements on the front page of this report.

### More information about the provider

Please see our website www.cqc.org.uk for more information, including our most recent judgements against the essential standards. You can contact us using the telephone number on the back of the report if you have additional questions.

There is a glossary at the back of this report which has definitions for words and phrases we use in the report.

## Our judgements for each standard inspected

**Care and welfare of people who use services** ✓ Met this standard

**People should get safe and appropriate care that meets their needs and supports their rights**

### Our judgement

The provider was meeting this standard.

Peoples' needs were assessed and treatment was planned and delivered in line with individual need.

### Reasons for our judgement

People experienced care, treatment and support that met their needs. The mental health nurse told us that they were called out by police custody staff when the initial police risk assessment and screening process picked up that someone's mental health required assessment.

We observed an assessment that was carried out jointly by the mental health nurse and the visiting forensic medical examiner (FME [the FME is a doctor who attends custody when a person needs medical assistance]). It was conducted in a way that showed respect for the person who was in some distress. For instance, giving time to listen to their story and treating them with calmness and patience. The mental health element of the assessment included social, mental health and risk. This gave a more holistic view of the person and their needs.

The expectation was that the service attended custody within an hour of referral. This was not recorded or measured, but when we spoke to custody staff we were told this was met most of the time. We also observed the service arrive at custody within an hour of being requested.

We were told by staff that while in the custody suite they discussed other cases with custody staff where a behaviour may suggest a mental health issue that had not been picked up in the initial police assessment. We were given examples where this informal approach had picked up further cases.  Custody staff told us that they felt the service was responsive to the needs of people.

While the FME wrote up basic findings on the police recording system, the mental health nurse's notes were written up on to the trust's electronic recording system which was not shared with custody staff. We were told by the mental health nurse that information would be shared with custody verbally, and on a risk and need to know basis.

**Cooperating with other providers** ✓ Met this standard

**People should get safe and coordinated care when they move between different services**

## Our judgement

The provider was meeting this standard.

People's needs were met when more than one provider was involved in their care because the provider worked in co-operation with others.

## Reasons for our judgement

People's needs were met when more than one provider was involved in their care because the provider worked in co-operation with others. A handover of information took place between the forensic medical examiner (FME) and mental health nurse on duty. This was to ensure that recently assessed cases had been appropriately referred on to community services such as GP and community mental health team.

The mental health nurse from the service told us that, in order to gain a clearer picture about the person's needs, they would regularly contact other service providers in order to gather relevant information. We observed background information being gathered from other services on a person being assessed. Information was received from a psychiatric hospital and a GP. This was so that information shared between services such as diagnosis and current medication could help to meet individual need.

Depending on what course of action was being taken by the police such as charging or releasing, the service shared their assessment with appropriate onward services. This included the court diversion scheme (a mental health service that ensures people receive appropriate treatment in court), GPs and community mental health teams. This meant that people's mental health needs were more likely to be met.

## About CQC inspections

We are the regulator of health and social care in England.

All providers of regulated health and social care services have a legal responsibility to make sure they are meeting essential standards of quality and safety. These are the standards everyone should be able to expect when they receive care.

The essential standards are described in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. We regulate against these standards, which we sometimes describe as "government standards".

We carry out unannounced inspections of all care homes, acute hospitals and domiciliary care services in England at least once a year to judge whether or not the essential standards are being met. We carry out inspections of other services less often. All of our inspections are unannounced unless there is a good reason to let the provider know we are coming.

There are 16 essential standards that relate most directly to the quality and safety of care and these are grouped into five key areas. When we inspect we could check all or part of any of the 16 standards at any time depending on the individual circumstances of the service. Because of this we often check different standards at different times.

When we inspect, we always visit and we do things like observe how people are cared for, and we talk to people who use the service, to their carers and to staff. We also review information we have gathered about the provider, check the service's records and check whether the right systems and processes are in place.

We focus on whether or not the provider is meeting the standards and we are guided by whether people are experiencing the outcomes they should be able to expect when the standards are being met. By outcomes we mean the impact care has on the health, safety and welfare of people who use the service, and the experience they have whilst receiving it.

Our inspectors judge if any action is required by the provider of the service to improve the standard of care being provided. Where providers are non-compliant with the regulations, we take enforcement action against them. If we require a service to take action, or if we take enforcement action, we re-inspect it before its next routine inspection was due. This could mean we re-inspect a service several times in one year. We also might decide to re-inspect a service if new concerns emerge about it before the next routine inspection.

In between inspections we continually monitor information we have about providers. The information comes from the public, the provider, other organisations, and from care workers.

You can tell us about your experience of this provider on our website.

## How we define our judgements

The following pages show our findings and regulatory judgement for each essential standard or part of the standard that we inspected. Our judgements are based on the ongoing review and analysis of the information gathered by CQC about this provider and the evidence collected during this inspection.

We reach one of the following judgements for each essential standard inspected.

| | |
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| ✓ **Met this standard** | This means that the standard was being met in that the provider was compliant with the regulation. If we find that standards were met, we take no regulatory action but we may make comments that may be useful to the provider and to the public about minor improvements that could be made. |
| ✖ **Action needed** | This means that the standard was not being met in that the provider was non-compliant with the regulation.<br>We may have set a compliance action requiring the provider to produce a report setting out how and by when changes will be made to make sure they comply with the standard.<br>We monitor the implementation of action plans in these reports and, if necessary, take further action.<br>We may have identified a breach of a regulation which is more serious, and we will make sure action is taken. We will report on this when it is complete. |
| ✖ **Enforcement action taken** | If the breach of the regulation was more serious, or there have been several or continual breaches, we have a range of actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers include issuing a warning notice; restricting or suspending the services a provider can offer, or the number of people it can care for; issuing fines and formal cautions; in extreme cases, cancelling a provider or managers registration or prosecuting a manager or provider. These enforcement powers are set out in law and mean that we can take swift, targeted action where services are failing people. |

## How we define our judgements (continued)

Where we find non-compliance with a regulation (or part of a regulation), we state which part of the regulation has been breached. Only where there is non compliance with one or more of Regulations 9-24 of the Regulated Activity Regulations, will our report include a judgement about the level of impact on people who use the service (and others, if appropriate to the regulation). This could be a minor, moderate or major impact.

**Minor impact -** people who use the service experienced poor care that had an impact on their health, safety or welfare or there was a risk of this happening. The impact was not significant and the matter could be managed or resolved quickly.

**Moderate impact -** people who use the service experienced poor care that had a significant effect on their health, safety or welfare or there was a risk of this happening. The matter may need to be resolved quickly.

**Major impact -** people who use the service experienced poor care that had a serious current or long term impact on their health, safety and welfare, or there was a risk of this happening. The matter needs to be resolved quickly

We decide the most appropriate action to take to ensure that the necessary changes are made. We always follow up to check whether action has been taken to meet the standards.

## Glossary of terms we use in this report

### Essential standard

The essential standards of quality and safety are described in our *Guidance about compliance: Essential standards of quality and safety*. They consist of a significant number of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. These regulations describe the essential standards of quality and safety that people who use health and adult social care services have a right to expect. A full list of the standards can be found within the *Guidance about compliance*. The 16 essential standards are:

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| Respecting and involving people who use services - Outcome 1 (Regulation 17) |
| Consent to care and treatment - Outcome 2 (Regulation 18) |
| Care and welfare of people who use services - Outcome 4 (Regulation 9) |
| Meeting Nutritional Needs - Outcome 5 (Regulation 14) |
| Cooperating with other providers - Outcome 6 (Regulation 24) |
| Safeguarding people who use services from abuse - Outcome 7 (Regulation 11) |
| Cleanliness and infection control - Outcome 8 (Regulation 12) |
| Management of medicines - Outcome 9 (Regulation 13) |
| Safety and suitability of premises - Outcome 10 (Regulation 15) |
| Safety, availability and suitability of equipment - Outcome 11 (Regulation 16) |
| Requirements relating to workers - Outcome 12 (Regulation 21) |
| Staffing - Outcome 13 (Regulation 22) |
| Supporting Staff - Outcome 14 (Regulation 23) |
| Assessing and monitoring the quality of service provision - Outcome 16 (Regulation 10) |
| Complaints - Outcome 17 (Regulation 19) |
| Records - Outcome 21 (Regulation 20) |

### Regulated activity

These are prescribed activities related to care and treatment that require registration with CQC. These are set out in legislation, and reflect the services provided.

## Glossary of terms we use in this report (continued)

### (Registered) Provider

There are several legal terms relating to the providers of services. These include registered person, service provider and registered manager. The term 'provider' means anyone with a legal responsibility for ensuring that the requirements of the law are carried out. On our website we often refer to providers as a 'service'.

### Regulations

We regulate against the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009.

### Responsive inspection

This is carried out at any time in relation to identified concerns.

### Routine inspection

This is planned and could occur at any time. We sometimes describe this as a scheduled inspection.

### Themed inspection

This is targeted to look at specific standards, sectors or types of care.

## Contact us

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