Requires improvement

Barnet, Enfield and Haringey Mental Health NHS 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)
RRP23	Edgware Community Hospital	Barnet Crisis Resolution Home Treatment Team	HA8 0AD
RRP16	Chase Farm Hospital	Enfield Crisis Resolution Home Treatment Team Enfield Health-Based Place of Safety	EN2 8JL EN2 9JL
RRP46	St Ann's Hospital	Haringey Crisis Resolution Home Treatment Team Haringey Health-Based Place of Safety	N15 3TH N15 3TH

Summary of findings

This report describes our judgement of the quality of care provided within this core service by Barnet, Enfield and Haringey Mental Health NHS 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 Barnet, Enfield and Haringey Mental Health NHS Trust and these are brought together to inform our overall judgement of Barnet, Enfield and Haringey Mental Health NHS Trust.

Summary of findings

Ratings

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

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

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

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

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

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

Summary of findings

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Summary of findings

Overall summary

We rated mental health crisis services and health based places of safety as **requires improvement** because:

Care was not always delivered safely for patients and staff. The lone-working policy was not robust across the teams. The documentation of risk assessments and risk management plans on patient electronic records lacked sufficient detail across the three sites.

The service was not always a responsive as needed. Team caseloads were high across all the home treatment teams, which impacted on staff not having enough time to support patients on home visits. The high caseloads across the teams meant that staff often had to inform patients that their appointments were delayed or needed to be re-scheduled. Some patients said that they had to hold on the phone a long time waiting to speak to a member of staff in the home treatment team. Within the health based places of safety, some patients were having to wait a long time for an assessment or for an inpatient bed.

Whilst staff and managers knew that improvements were needed, issues were not always escalated through the risk registers and leadership was not provided to make the necessary improvements.

Staff did not always feel confident in using the Mental Capacity Act. Access to psychologists and occupational therapists were limited at Barnet and Haringey, which meant that teams were unable to provide a full range of interventions to patients.

There were also several positive aspects to the service. Staff treated patients with kindness, dignity and respect. Staff engaged with patients with compassion and professionalism on home visits. Staff supported patients with other aspects of their care, including help with housing and employment opportunities. Staff had used feedback from patients to develop community packs for carers with information leaflets and contact telephone numbers of the crisis teams.

Staff demonstrated good practice around safe storage and transport of medication into the community. Staff had good knowledge on reporting incidents. Following a serious incident in the health based palce of safety in May 2014 the trust had made appropriate changes to improve the service. Staff were able to attend to urgent referrals at patients' homes 24 hours-a-day, 7 days per week.Patients received information on accessing local services tailored towards a range of ethnic groups and religious communities, which reflected the diverse population they served.

Staff received two days of specialist training on crisis resolution home treatment care in conjunction with Middlesex University, and the feedback from staff was positive.The trust provided staff with opportunities for leadership development, including masters degree programmes for team managers.

Summary of findings

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

Are services safe?

Requires improvement

We rated safe as **requires improvement** because:

- The lone-working policy was not robust across the teams.
- The documentation of risk assessments and risk management plans on patient electronic records lacked sufficient detail across the three sites.
- Team caseloads were high across all teams.
- In Enfield and Haringey, less than 50% of staff were up-to-date with mandatory training in adult basic life support.

However, clinic rooms were clean, well equipped and well maintained. Staff demonstrated good practice around safe storage and transport of medication into the community. Staff had good knowledge on reporting incidents, lessons learned were shared at team meetings. The trust had reviewed and improved its management of the places of safety.

Are services effective?

Good

We rated effective as **good** because:

- Staff working in the home treatment teams and places of safety had received specific training to support them to perform their work to a high standard.
- Staff assessed patients physical health.
- The teams worked well with other internal and external teams to support the patients to access different services.

However, the documentation of care records in the home treatment teams was limited in scope. Care plans were not holistic or personalised to the people who used the services. Staff in the home treatment teams did not feel confident in the use of the Mental Capacity Act. An assessment of capacity to consent to specific decisions was not evident in care records. Access to psychologists and occupational therapists was limited at Barnet and Haringey. The daily meeting in the Barnet home treatment team needed to be more effective.

Are services caring?

Good

We rated caring as **good** because:

- Staff treated patients with kindness, dignity and respect. Staff engaged with patients with compassion and professionalism on home visits.
- Patients spoke positively about staff, and felt supported and empowered by staff to get better in their own ways.

Summary of findings

- In Haringey, the team had used former patients during the interviews for recruitment of senior staff.

However, care records did not routinely demonstrate that patients were being actively involved in the decisions about their care.

Are services responsive to people's needs?

Requires improvement

We rated responsive as **requires improvement** because:

- The teams had large numbers of patients who needed to be discharged to other teams.
- Some patients told us about their experiences waiting for long periods of time trying to connect to staff via the 24 hour crisis lines.
- Staff did not routinely communicate with people throughout the day to inform them about likely times of arrival to their homes.
- Patients in the places of safety had to wait extended periods of time to be assessed.

However, staff were able to attend to urgent referrals at patients' homes 24 hours-a-day, 7 days a week. Staff had clear protocols in place when they experienced difficulties contacting patients. Patients received information on accessing local services tailored towards a range of ethnic groups and religious communities, which reflected the diverse population they served.

Are services well-led?

Requires improvement

We rated well-led as **requires improvement** because:-

- The teams did not review and update their risk registers regularly.
- Key performance indictors did not provide the teams with clear information to monitor and review the performance of all aspects of the team.
- Whilst staff and managers knew that improvements were needed, staff with the appropriate leadership skills were not in place to make the necessary improvements.

However, staff spoke positively about their work and felt well supported. The trust provided staff with opportunities for leadership development, including masters degree programmes for team managers. Teams were participating in the CORE study, a National Institute of Health Research funded programme, in conjunction with University College London (UCL), that aimed to improve the standard of support offered to people using crisis resolution home treatment teams across England.

Summary of findings

Information about the service

Barnet Enfield and Haringey Mental Health Trust provide crisis mental health services across the three boroughs of Barnet, Enfield and Haringey.

The home treatment teams, which are based in each of the three boroughs, operate between the hours of 8am and 10pm every day, with a single combined team providing support at night.

The home treatment teams offer assessment and treatment to any person over the age of 16 in an acute mental health crisis. The aim of the home treatment teams is to provide assessment and where appropriate intensive support for a limited period within the person's own home. Where the clinical risks indicate that a hospital admission is needed the team will arrange this.The teams accept referrals from community mental health teams, local GPs, inpatient wards as well as from psychiatric liaison services based in local acute trusts. Most referrals come through the trust's telephone hub, where they are reviewed by clinical staff before being passed to the teams.

The teams also facilitate early discharge from the trust's inpatients beds and provided support for community-based recovery houses located in each of the boroughs.

The trust had two health-based places of safety located at Chase Farm hospital in Enfield and St Ann's hospital in Haringey. These provided facilities for the support and assessment of people under section 136 of the Mental Health Act who were thought to be in immediate need of care or control in a safe environment.

The home treatment teams had been inspected previously in May 2013 and March 2014. There were no outstanding areas of non-compliance at the time of the inspection.

Our inspection team

The team that inspected the mental health crisis services and health based places of safety consisted of two inspectors, a mental health nurse, a Mental Health Act reviewer, a psychiatrist, a social worker, and a pharmacist.

Why we carried out this inspection

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

How we carried out this inspection

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

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

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

During the inspection visit, the inspection team:

- Visited the three home treatment teams across Barnet, Enfield and Haringey.

Summary of findings

- Visited the two health-based places of safety located at Chase Farm and St Ann's hospitals.
- Interviewed the three team managers with responsibility for the home treatment teams.
- Interviewed the two managers with responsibility for the health based places of safety.
- Interviewed the assistant clinical director for inpatient services in Haringey, the interim service manager for inpatient services in Enfield and the assistant director for inpatients in Enfield.
- Spoke with 37 other staff members: including doctors (consultant psychiatrists, staff grade and GP trainees); nurses, including senior nurse practitioners; psychologists; pharmacists; social workers; associate mental health workers; community support workers; administrative staff; and a dual diagnosis worker.
- Attended and observed three hand-over meetings.
- Attended other meetings with the complex care team and the community teams.
- Shadowed 11 staff members across 19 home visit appointments with people who used the service.
- Spoke with 26 people who were accessing the home treatment teams, and two carers of the people who were using the services.
- Looked at 24 care records of patients receiving support from home treatment teams.
- Looked at 13 records of patients who had been in the places of safety.
- Looked at 68 prescription charts of patients.
- Looked at 22 supervision records of staff.
- Carried out specific checks of the medication management at Barnet and Haringey home treatment teams.
- Looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the provider's services say

Feedback we received from people using the service was generally positive. People told us that that staff listened to them, and were caring and respectful. The people we spoke to felt supported and empowered by staff during home visits into the community. People were informed when staff had to cancel or re-schedule appointments. People told us that they knew who to contact in emergency crisis situations, and felt comfortable raising any issues or complaints with the trust. People who used the services also told us that staff helped them with other aspects of their care, such as housing and employment opportunities.

However, some people felt frustrated about their experiences waiting for long periods of time trying to connect to staff through the 24 hour crisis lines. Some carers felt that staff had not listened to them when they raised a concern about their relative.

Good practice

The trust worked with a local university to develop a two day training course in CRHT teams.

At Barnet, staff took part in monthly educational meetings where staff champions were nominated on a range of topics to lead teaching sessions with colleagues.

Teams were participating in the CORE study, a National Institute of Health Research funded programme, in conjunction with University College London (UCL), that aimed to improve the standard of support offered to people using crisis resolution home treatment teams across England.

Summary of findings

Areas for improvement

Action the provider MUST take to improve

- The trust must ensure that lone-working policies are robust, and that they minimise risk to staff while carrying out home visits in the community.
- The trust must ensure that the documentation of risk assessments in patient care records is improved so that appropriate risk plans are recorded.
- The trust must ensure that patients accessing the home treatment teams receive a more responsive service. This includes patients phonecalls being answered in a timely manner, patients having a clearer knowledge of when their appointment will take place and being told if this is delayed.
- The turst must ensure that managers with the appropriate leadership skills are in place to make the improvments that are needed in the home treatment teams.

Action the provider SHOULD take to improve

- The trust should review team staffing and caseloads to ensure the teams can meet the needs of patients.
- The trust should ensure staff teams continue to make progress towards meeting the trust target for mandatory training, especially in the Haringey home treatment team.
- The trust should ensure that staff receive training on, and understand the use of, the Mental Capacity Act and patient consent.
- The trust should ensure that patients are involved in their care planning, and that care records document personalised and holistic patient needs.
- The trust should continue to audit medication charts to ensure these are completed correctly for all patients.
- The trust should ensure that learning from incidents is shared across the home treatment teams and other parts of the trust.
- The trust should ensure that staff from the home treatment teams monitor patient's physical health needs where needed after the initial assessment.
- The trust should review the multi-disciplinary team skill mix across the teams, particularly around access to psychologists and occupational therapists, to ensure that the range of interventions offered to patients meets the needs of the people who use the service.
- The trust should review the effectiveness and length of some of the team handover meetings to ensure key information around patient risks are disseminated appropriately across all staff.
- The trust should ensure that governance systems clearly collate information from incidents, complaints and audits which are accessible to staff across the teams.
- The trust should work with other agencies to ensure that where possible patients are taken to a place of safety by ambulance or other health transport.
- The trust should ensure it works with partner organisations to ensure that where possible patients are seen by an AMHP within three hours in the places of safety and that the length of time patients are waiting in the suite are reduced.

The trust should ensure children admitted to the places of safety are always reviewed by appropriately qualified staff.

Barnet, Enfield and Haringey Mental Health NHS 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
Barnet Crisis Resolution Home Treatment Team	Edgware Community Hospital
Enfield Crisis Resolution Home Treatment Team Enfield Health-Based Place of Safety	Chase Farm Hospital
Haringey Crisis Resolution Home Treatment Team Haringey Health-Based Place of Safety	St Ann's Hospital

Mental Health Act responsibilities

- Staff had not received training on the MHA as part of their mandatory training. However, individual teams were able to request tailored MHA training sessions via the trust's Mental Health Law Department. All staff working in the places of safety had received Mental Health Act (MHA) training as part of their induction.
- The team visited wards and completed an assessment to identify what support the patient may require. At the time of inspection, three patients across the home treatment teams were given section 17 under the MHA. Staff informed people about their rights when on section 17 leave.
- Staff had not completed all paperwork fully in the places of safety. At St Ann's we reviewed the section 136 monitoring forms for nine patients and the electronic patient notes for seven of these patients. At Chase Farm we reviewed the electronic patient notes for four patients. We found that the section 136 monitoring sheets were not completed fully, or correctly, for three

individuals we reviewed at St Ann's. In the individual's progress notes on the electronic we found that the time of detention under section 136 was not consistently recorded.

- The new MHA code of practice was available in the Chase Farm place of safety. The protocol for the use of the places of safety had been updated to reflect the new code of practice.
- Staff did not always record that they had informed patients of their rights. In nine of the 11 notes we reviewed individuals had been informed of their rights as required by section 132 of the MHA. We were unable to locate evidence of this in two files (one at St Ann's and one at Chase Farm).
- Staff did not always clearly explain to patients they had a right to leave. We reviewed the section 136 monitoring documentation at St Ann's for one person who was found not to have a mental disorder. We found that this individual did not leave the section 136 suite for more than three hours after this had been confirmed. It was not possible to confirm from the monitoring data that the patient had been promptly informed he was no longer detained and could leave the suite. Whilst we found evidence in the file that this did take place, a nurse told us that, although the person had no mental disorder, he had to be seen by the approved mental health professional before he could leave the place of safety.

Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff had not received training on the MCA as part of their mandatory training. However, individual teams were able to request tailored MCA & Deprivation of Liberty Safeguards (DoLS) training sessions via the trust's mental health law department. We saw copies of the trust's guidance on MCA/DoLS that was available to staff via the intranet.
- Staff knowledge of the MCA was varied, and non-medical staff told us that only doctors carried out capacity assessments. We observed staff discuss some patients' capacity during handover meetings.
- Capacity to consent to treatment was not being routinely recorded in the 24 care records we reviewed across the three home treatment teams. This was the case both during initial assessments and as ongoing practice.
- At Barnet, the social worker was a champion on capacity and led educational sessions for the home treatment team on capacity.

Requires improvement

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

- Staff visited most patients in their homes for assessments and ongoing care and treatment. All teams had access to rooms for meetings with patients if required. For example, at Barnet patients occasionally used the lounge room and the doctor's room for review meetings. These were fitted with fully functioning alarm buttons mounted on the walls.
- The rooms and facilities in the home treatment teams were clean. Infection control audits were being undertaken, and signs reminding staff about hand washing were routinely displayed.
- All three home treatment teams had access to a clinic room that was clean and well equipped, with the necessary equipment to carry out physical examinations. The team at Barnet also had access to inpatient wards that were occasionally used for physical examinations. At Barnet and Enfield, cleaning records and fridge temperature records were available and updated regularly. However, the fridge in the clinic room at Haringey was broken at the time of inspection. Staff informed us that a new fridge had been ordered.

Safe staffing

- Between August 2014 and July 2015, there were 27 substantive members of staff in Haringey (11.3% vacancy rate & 9% sickness rate). In Enfield, there was 28 members of staff (12.3% vacancy rate & 4% sickness rate) and in Barnet, there was 35 members of staff (7.2% vacancy rate & 2% sickness rate). All teams included registered nurses, health care assistants, associate mental health workers, psychiatrists, psychologists, and social workers. Enfield had an occupational therapist. At the time of inspection, there were vacancies across all teams. The team at Barnet had four vacancies for nursing staff; Enfield had five vacancies, which consisted of four for nursing staff and one for a deputy manager; and Haringey had four vacancies for nursing staff. Staff told us that that the recent recruitment drive had helped with staffing levels.
- The teams had two shift patterns over a 24 hour period across each site. The early shift was between 08:00 and 16:00, and the late shift between 14:00 and 22:00. The established levels of minimum staffing set by the trust was 11 staff across the early and late shift combined. However, this was under review. Team managers ensured there was six staff for the early shift and six staff for late shift. Each shift usually had three qualified nurses.
- At night one team covered the three boroughs, based at Chase Farm hospital. This consisted of five members of staff from across the three boroughs.
- Team managers used bank and agency staff as and when required, for example, to cover staffing gaps due to sickness, annual leave or vacancies, and when team caseloads increased. Teams mostly accessed regular bank staff who were familiar with the service, and had received an appropriate induction. Between August 2014 and July 2015, the total shifts covered by bank or agency staff were 218 for Barnet, 230 for Enfield and 134 for Haringey. The total number of shifts that had not been filled were 5 for Haringey and 81 for Barnet. When possible managers block booked agency staff for extended periods of time to provide continuity.
- There was no maximum caseload identified by the trust for the home treatment teams. At the time of inspection, team caseload for Barnet was 65 patients, 59 patients for Enfield, and 63 patients for Haringey. The team caseload went above 80 for Barnet during November 2015 and above 90 for Haringey earlier in the year of 2015. In response to this managers had identified staff to focus on discharging patients and proactively reduce the caseload. Between April and November 2015, the team at Enfield completed a total of 766 patient assessments, 941 for Haringey and 956 for Barnet.
- Staff discussed team caseloads during handover at the start of every early and late shift. Staff told us they found the caseload volume to be high in relation to the number of staff in each team. This meant that staff felt pressured to meet targets, and felt this impacted on their ability to support patients during home visits within limited timescales.
- The Enfield team had recently introduced a named key worker system to try and provide more continuity for patients. This meant that patients were allocated to

specific staff who, where possible, would visit them. At Barnet and Haringey, patient cases were allocated to staff during a given shift, and allocations of appointments were made twice daily.

- People who used the service had access to a psychiatrist when required. At Enfield, a consultant psychiatrist and an associate specialist doctor worked weekdays, and two specialist registrars alternated during weekdays. However, at Haringey the team did not have a permanent consultant psychiatrist or a specialist doctor, and shifts were covered by locum doctors. All three home treatment teams had access to an on-call duty doctor during weekends and night shifts.
- Mandatory training completion rates varied across the teams. Not all staff were up-to-date in all relevant courses. The average mandatory training completion rates across all courses was 65% for Haringey, 73% for Enfield and 84% for Barnet. For some courses staff were not up-to-date. At Enfield less than 50% of staff were up-to-date with mandatory training in moving & handling and adult basic life support. At Haringey, less than 50% of staff were up-to-date with breakaway, care programme approach and basic life support.

Assessing and managing risk to patients and staff

- All three teams had two dedicated qualified staff to complete initial assessments on each shift.
- We reviewed 24 care records across the three home treatment teams. Staff completed initial risk assessments. However, the documentation of risk management plans lacked sufficient detail across the teams. For example, records lacked information around individual triggers, immediacy of risks, protective factors, formulation and crisis planning. At Enfield, two care records did not contain up-to-date risk assessments.
- The three teams used a traffic light rating system that related to a patient's level of risk. All patients rated as red were discussed and reviewed by the multi-disciplinary team (MDT) in the morning handover meeting across the three teams. Patients that were amber or green were reviewed at least twice weekly by the MDT. Staff regularly discussed whether there was a change in the risk rating of patients, and communicated what level of input a person required. However at Barnet, not all staff received information on the most up-to-date risks of patients because staff had to leave part way during the 2.5 hour-long morning handover meeting, in order to meet pre-arranged home visit appointments. This meant these staff were not able to contribute to the overall handover discussion due to time constraints.
- Patient risk rating colours were documented on white boards in the MDT handover rooms across the three sites. Staff discussed patient risk in the daily handovers, although this discussion was not consistently recorded in the care records. In Barnet, the white boards appeared difficult to read, they did not show details of patient risks or the risks to staff. This meant that new staff working at the site would have difficulties in gaging the necessary patient information from the white boards during handover meetings.
- Staff responded to safeguarding concerns appropriately. Staff discussed patient safeguarding concerns during handover meetings. Staff gave examples of raising safeguarding alerts to the nominated safeguarding lead and to the local authorities, particularly around child protection. This was documented and staff received individual feedback on the progress of alerts. Over 78% of staff across each team were up-to-date with safeguarding adults level 1 & 2 training, and over 82% for safeguarding children level 1 & 2. Guidance on safeguarding children and adults that was available to staff from the intranet.

- The lone-working policy was not robust across all three sites, and meant that staff safety was being put at risk. The shift leader allocated visits at the morning multi-disciplinary meeting and recorded the team members name on the whiteboard next to the patient's name. The staff would then undertake the visits. Staff could be out for up to four hours without making contact with the central team. The Haringey team did not have a signing in or out board to record when they left the office.
- Staff had trust mobile phones, which they could use to contact the shift lead. However the shift lead was often out on home visit assessments at the same time. This meant that there was insufficient means in place to monitor the ongoing safety of staff during home visits. Staff told us about their experiences of being in positions where they felt there safety could have been compromised. Team managers told us that the shift lead would call staff if there was a significant delay in returning back to the office. Staff conducted visits in pairs if they felt a patient was high risk.

Requires improvement

Are services safe?

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

- Staff stored medication safely in a locked cupboard, and this was accessible by qualified staff only. Staff transported medication to people in the community using a locked bag, and medication records were signed and checked routinely. Staff followed the trust policy on medicines management that was issued in September 2014. Pharmacists audited medicines management fortnightly across the three sites. Staff had signed and dated most of the 58 medication records we reviewed. However, eight medication records across Barnet and Enfield were either not dated or had a missing prescriber name. At Haringey, 11 people were self-administering their medicines. Care records did not always record why people had been assessed as being able to self-administer their medicines.

Track record on safety

- Between July 2014 and June 2015, there was one serious incident at Enfield, five serious incidents at Barnet and two serious incidents in Haringey.
- One incident at Haringey was an outpatient suicide and the other was a self-harm incident. In response to these the team had identified a need to improve the information and history received about carers and a need to improve communication with psychiatric liaison services at A&E. In response a new carer's risk assessment had been introduced and staff now attended A&E to complete assessments when they received a referral.
- Two of the serious incidents at Barnet were outpatient suicides. One of these followed a referral from a GP. In response, the trust had organised educational sessions for GPs on referrals. The trust's hub had also started to provide feedback to local GPs on referrals. Staff also developed a protocol for sharing key information with psychiatric liaison services following the outcome of assessments.

Reporting incidents and learning from when things go wrong

- All staff knew what to report and how to report incidents. Copies of the trust's guidance on serious incidents was available to staff on the intranet.
- Staff identified learning from incidents. For example, the Barnet team had introduced new information leaflets with 24 hour crisis telephone numbers and website details for every new patient. However, information on learning from incidents was not being shared in a systematic way across the three home treatment teams, to ensure learning from one team was shared across the teams.
- Staff received feedback and were debriefed following incidents during team meetings. Staff discussed any outstanding concerns during supervision. Senior staff, including psychologists facilitated debriefs following serious incidents. Staff told us they found this useful.
- Staff were open and transparent and explain to patients if and when something went wrong. For example, at Barnet, after a patient had died whilst under the care of the team, staff had met with their relatives.

Health-based places of safety

Safe and clean environment

- In both the places of safety the environment was good. Both places of safety had their own dedicated entrances. The trust had conducted environmental audits to identify and manage risks. The trust had renovated all three rooms to be ligature free. Following an incident last year, the trust had changed the taps used in the bathroom area to make them ligature free.
- Staff observed people using closed circuit television (CCTV) cameras. There were no cameras in the toilet areas of the rooms. Staff observed patients via a viewing panel, which could be opened and closed by staff, whilst they were using the toilet areas.
- Both places of safety had ligature cutters available in the suite office. Resuscitation bags were available in the suites and staff checked these on a regular basis.
- Both the places of safety were located adjacent to acute wards and had access to equipment to complete physical observations. The suite at St Ann's had access to a clinical room where physical observations could be completed if required.
- The places of safety were clean and well maintained. Each room was cleaned in-between being used. We observed this taking place at the St Ann's place of safety. The trust audited the cleanliness of the suites and adherence to infection control policies. In the last audit the St Ann's suite had scored 98% compliance.
- Both health based places of safety were equipped with an alarm system. Staff we spoke with were aware of how the alarm systems worked and reported that these were effective.

Requires improvement

Are services safe?

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

Safe staffing

- Following an incident last year, the trust had reviewed how it staffed the places of safety.

The places of safety were now staffed by staff who were booked to be supranumery on the acute wards at the hospitals where the places of safety are located. Whenever a patient used the places of safety there must be at least two members of staff working in the suite.

- At Chase Farm from 7am until 7:30pm two extra staff were booked on inpatient acute wards to staff suites when people are brought in for assessment. Staff from the wards cover the place of safety from 7:30 until 10pm. At night the trust's crisis resolution and home treatment (CRHT) provided staff for the suite. The place of safety also had a coordinator on a 24/7 rota who supported staff. They were supernumerary on weekdays from 9am until 5pm. At night this role was carried out by the CRHT night manager.
- At St Ann's from 7am until 8pm two staff were allocated by Haringey assessment unit to cover the suites when people are brought in for assessment. From 8pm until 7am one member of staff from Haringey ward and a Band 7 site manager staffed the place of safety.In order that this did not have an impact on the staffing of the Haringey assessment unit, the trust was recruiting 10 more qualified nurses for this ward. At the time of the inspection five nurses had been recruited.
- The trust did not use bank or agency staff in the places of safety.
- All staff working in the suite had to complete an induction for the place of safety before working in the place of safety. This included the protocols for the unit and how to complete records.

Assessing and managing risk to patients and staff

- Staff working in the health based places of safety had received training in preventing and managing violence and aggression and felt confident in using de-escalation techniques.
- Staff had recorded five incidents of physical restraint being used in the six months prior to the inspection. We reviewed the records for three of these. Staff had completed appropriate records and incident forms following restraints. Where appropriate, physical observations had been taken.
- Rapid tranquilisation was used rarely when people are being assessed in the places of safety. When rapid tranquilisation was administered to people who used the service, records showed that staff followed trust protocols and ensured that there was regular observations and monitoring of the patient's health and wellbeing.
- Staff undertook a risk assessment of the detained person prior to the patient's attendance at the place of safety. On arrival at the place of safety, the patient was searched by the police, in line the Police and Criminal Evidence Act.
- Staff conducted continual observation of people whilst they were detained. Staff documented this in the records.
- Staff completed an initial risk assessment when a patient arrived in the place of safety.
- Assessments were completed by the approved mental health professional (AMHP) and approved doctors.
- Staff completed safeguarding referrals when required.

Track record on safety

- In the last year there had been no serious incidents in the trust's places of safety. In May 2014 a patient had died in the St Ann's place of safety after they had fixed a ligature on a tap in the toilet area.
- Following this incident the trust had completed a serious incident report. This had identified the need for the taps to be changed in the toilet area, for the staffing to be reviewed to ensure there were always two members of staff in the suite whilst it was being used and that these staff were permanent trust employees where possible, a change in the medical on call arrangements and a need for an induction for staff working in the place of safety. All of these actions had been completed by the time of the inspection. The places of safety were now staffed by permanent trust staff working supernumery in the acute wards, who had received training and induction to working in the place of safety.

Reporting incidents and learning from when things go wrong

- Staff knew how to report incidents and completed the trust's electronic incidents reporting system

Requires improvement

Are services safe?

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

appropriately. All six staff we spoke with knew how to complete incident forms. Staff at St Ann's had completed nine incident report forms from August to October 2015. Where learning was required this had taken place. For example, staff now had a metal detector to help them when searching people arriving at the unit following an incident when a patient had arrived with a knife. In another incident, where communication needed to be improved, staff had followed up with the local ambulance trust at a liaison meeting.

- There were opportunities to discuss and debrief following incidents in the health based places of safety.

Are services effective?

Good

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

- Qualified staff completed initial assessments and crisis plans when patients were referred to the team. The initial assessment included the risk to self, medication, the mental state of the person and the presenting problem.
- We reviewed 24 care records across the three home treatment teams. Of these, 6 care records were not personalised to reflect the patients' needs, and 11 care records showed some degree of personalisation. Three patients being supported by the Enfield team did not have a care plans in place even though one of the patients had been supported by the team for over two months. Care records were not fully holistic or recovery orientated across the three sites. For example, 18 out of 24 care records lacked information around social and occupational concerns, including housing, employment and financial issues. Care records were stored securely and recorded on the trust's electronic notes system.

Best practice in treatment and care

- Staff prescribed in accordance with best practice and national institute for health and care excellence (NICE) guidelines The 58 medication charts we reviewed all showed prescribing within the British national formulary guidelines.
- Staff used stickers on medication charts where lithium or clozapine was prescribed, which detailed the results of patients' most recent blood tests as part of a risk management strategy. Staff used rating scales to monitor the side effects of antipsychotic medication. A trust wide titration protocol had been developed in line with NICE guidance for the use of antipsychotic medication such as clozapine in the community. Staff received information on NICE guidance best practice at monthly clinical governance meetings, for example, information on conditions such as schizophrenia.
- All three teams had access to a psychologist, although the time they had was limited. At Barnet a psychologist worked in the team one day a week, whilst at Haringey 2.5 days per week. This meant that teams were not able to provide a full range of psychological interventions to support patients.
- Staff supported patients to access assistance for housing and employment. For example, staff at Barnet referred patients to the outreach Barnet service for housing and benefit support. The teams could also refer to the trust's the discharge intervention team, for help with housing, and the enablement team, for ongoing support with recovery. Staff discussed social and occupational needs of patients during handover meetings.
- Staff assessed each patients physical healthcare during an initial assessment by recording blood pressure, pulse rates and body mass index. Staff also monitored the physical healthcare of patients that were titrated on clozapine. However, 18 care records across the three sites did not document whether full physical health issues were routinely re-assessed and monitored as ongoing practice. Staff told us that the local GPs monitored the ongoing physical healthcare of patients.

Skilled staff to deliver care

- Staff were experienced and qualified. All staff received the trust's corporate induction. Staff also completed two weeks supernumerary induction within the home treatment teams. This involved shadowing experienced staff on home visits, and completing a checklist of clinical tasks under supervision, including training on risk assessments and risk management. Staff were assessed as competent before they were able to supervise the administration of medicines, and received regular ongoing training on medicines management from pharmacists across the teams.
- All teams included registered nurses, health care assistants, associate mental health workers, psychiatrists, psychologists, and social workers. A pharmacist visited all the teams regularly.Only the Enfield team had an occupational therapist. The team at Haringey had access to a dual diagnosis worker.
- Supervision of all staff working in the teams had improved in regularity and now took place every 4-6 weeks. For example, between June and November 2015, 92% of staff at Barnet had received supervision.
- Most staff had received a formal appraisal. Between 2014 and 2015, the percentage of non-medical staff that received appraisals was 75% for Haringey, 85% for Enfield, and 90% for Barnet. Some of the staff who had not received appraisal were either on long term absence or new to the teams.
- Staff had access to specialist training in crisis resolution home treatment care at Middlesex University. Staff told

Are services effective?

Good

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.

us that the training was very useful and helped them in their work. Individual staff had also been supported in their development. For example, a nurse in the Haringey team was receiving training to become nurse prescriber.

- Appropriate measures were in place to manage poor staff performance promptly and effectively. Where required, team managers offered additional supervision, and created action plans with support from the trust's human resources department.
- Staff attended monthly MDT clinical governance meetings and fortnightly team meetings. At Barnet, staff also had monthly MDT educational meetings, which focussed on a different topic every month. Individual staff became team champions in particular areas, such as in smoking cessation.

Multi-disciplinary and inter-agency team work

- All teams had MDT handover meetings twice daily where caseloads were discussed. The quality of these varied between the teams when we observed them. At Enfield, we saw efficient MDT working with care being discussed and planned, with input from a variety of different mental health disciplines. However at Barnet, handover meetings were primarily consultant-led with limited input into the discussion of patient care from different professions.
- Staff from each team completed verbal handovers with the night team, as well as completing an email to pass on information.
- The teams were trying to improve how they communicated with other teams in the trust. For example, the Haringey team had established regular liaison meetings with the complex care team. Staff discussed patients who may be able to transfer between the teams at this meeting. The team would like to develop further liaison meetings with other community teams.
- Staff called into bed management conference calls twice daily and discussed referrals between teams. Staff from the home treatment teams also regularly attended ward rounds of patients who were approaching discharge from a mental health ward, to assess whether they would be suitable for support from crisis services and try and facilitate early discharge for patients.
- The teams engaged with other local services on a regular basis. For example, the Haringey team attended quarterly liaison meetings with other services in Haringey, including the local authority and police. The trust had also contributed to joint action plan with other agencies as part of the crisis care concordat.
- The trust's contact hub had started to give feedback to GPs on referrals and whether the referral was appropriate.

Adherence to the MHA and the MHA Code of Practice

- Staff had not received training on the MHA as part of their mandatory training. However, individual teams were able to request tailored MHA training sessions via the trust's Mental Health Law Department.
- The team visited wards and completed an assessment to identify what support the patient may require. At the time of inspection, three patients across the home treatment teams were under section 17 of the MHA. Staff informed people about their rights when on section 17 leave.
- Staff had access to guidance on the MHA via the trust intranet. The team at Barnet had access to a copy of the MHA code of practice 2015 in the handover room.
- Patients supported by the home treatment teams did not have a record of using independent mental health act advocates.

Good practice in applying the MCA

- Staff had not received training on the MCA as part of their mandatory training. However, individual teams were able to request tailored MCA & Deprivation of Liberty Safeguards (DoLS) training sessions via the trust's Mental Health Law Department. We saw copies of the trust's guidance on MCA/DoLS that was available to staff on the intranet. Educational sessions on the application of the MCA and assessment of capacity were being provided by a social worker who worked for the Barnet team and was acting as a champion of the implementation of the principles of the MCA.
- Nursing staff knowledge of the MCA was not embedded, and non-medical staff told us that only doctors carried out capacity assessments. We observed staff discuss some patients' capacity during handover meetings. However, this was not routinely recorded in patients' care records.

Health-based places of safety

Assessment of needs and planning of care

Are services effective?

Good

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 physical health of patients was reviewed prior to accepting a patient at the place of safety. If there were any concerns about the patient's health they were required to attend an A&E department for a full examination. This included where individuals appeared to be highly intoxicated. In these circumstance individuals were not accepted at the hospital place of safety until they had been medically checked by A&E.

Best practice in treatment and care

- Patients admitted to the place of safety were seen by the duty doctor who reviewed both the patient's physical and mental health. The trust had a target for the doctor to see the patient within an hour of their arrival. In order to facilitate this, the duty doctor, was contacted. The duty doctor was usually not section 12 approved. We noted in the section 136 monitoring sheets we reviewed at St Ann's that only three people were initially assessed by a section 12 approved doctor. This meant they could not decide if the patient should be detained and the patient would then have to wait for an appropriate professional.

Skilled staff to deliver care

- Permanent nursing staff worked in the place of safety. Prior to working in the place of safety they received an induction and training. This included training in the safety operational protocol, immediate life support and the prevention and management of violence and aggression.
- Staff received management and supervision on the wards on which they worked.

Multi-disciplinary and inter-agency team work

- The trust had worked with local clinical commissioning groups in the production of a joint crisis concordat action plan. This was available on the trust intranet. The trust held monthly interagency liaison meetings with the police and the local authority AMHP service in Haringey. At this meeting issues affecting the service were discussed. The service had an interagency joint working protocol, although this was overdue for a review which was due by October 2015.
- Staff referred and signposted patients to relevant support agencies or services to provide follow up care if a person had been discharged from the place of safety.
- The staff would alert the bed management team immediately when a patient arrived in the place of safety in case they needed a bed.

Good practice in applying the Mental Health Act and code of practice

- Staff had not completed all the section136 paperwork fully. At St Ann's we reviewed the section 136 monitoring forms for nine patients and the electronic patient notes for seven of these patients. At Chase Farm we reviewed the electronic patient notes for four patients. We found that the section 136 monitoring sheets were not completed fully, or correctly, for three individuals at St Ann's. In the individual's progress notes on the electronic record we found that the time of detention under section 136 was not consistently recorded.
- All staff working in the places of safety had received Mental Health Act (MHA) training as part of their induction.
- The new code of practice was available in the Chase Farm place of safety. The protocol for the use of the places of safety had been updated to reflect the new code of practice.
- Staff did not always recorded that they had informed patients of their rights. In nine of the 11 notes individuals had been informed of their rights as required under section 132 of the MHA. For two patients there was no record of this.

Good practice in applying the Mental Capacity Act

- Staff assessed the capacity of patients during the assessment process.
- Staff had an awareness of the guiding principles of the MCA.

Good

Are services caring?

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

Our findings

Kindness, dignity, respect and support

- Staff treated patients with kindness, dignity and respect. All 11 members of staff we shadowed across 19 home visits engaged with patients with compassion and professionalism.
- We spoke to 26 people who were accessing the home treatment team services. Patients spoke positively about staff, and felt supported and empowered by staff to get better in their own ways.
- Staff demonstrated good understanding of the individual needs of patients. Staff recorded the cultural and ethnic backgrounds of patients and we observed staff discussing these around people's care planning during handover meetings. Staff supported patients with other aspects of their care, including help with housing and employment opportunities.
- Staff maintained the confidentiality of people who used the services. For example, when visiting people in their homes staff would seek to see them in private, and kept their ID badges out of sight until they entered patient homes.

The involvement of people in the care they receive

- Staff sought the views of patients when conducting their initial assessments. However, the 24 care records we reviewed did not all record the views of that patients were being actively involved in the decisions about their care. Staff also did not always document whether patients had received a copy of their plans. For example, staff had only documented that they had offered the patient a copy of their care plan in one out of five records of patients receiving ongoing care in the Haringey team.
- We observed staff involving patients' family members and carers during home visits where it was deemed appropriate. Staff liaised with family members to help oversee people's adherence to their medicines. However, one relative we spoke with felt that staff had not listened to them when they raised a concern about their relative.
- The trust had an advocacy service which was provided by Voiceability, and information leaflets about the service were available. The Enfield carers centre worked with the teams to offer carers effective advocacy and regular drop-in sessions.
- Some patients had been involved in decisions about the team. For example, the Haringey team had used former patients during the interviews for recruitment of senior staff.
- Staff had started to collect feedback from patients. Staff kept records of the surveys on the electrical portal system. This led to the development of community packs for carers with information leaflets and contact telephone numbers of the crisis teams.

Health-based places of safety

Kindness, dignity, respect and support

- Staff treated patients with kindness and respect. Staff we spoke with at both places of safety described how they would support patients in a considerate manner. They explained they would try and talk in a calm way with patients and offer them drinks.
- On the day of our inspection we saw three patients being supported in the places of safety. Staff we observed interacting with patients did so in a kind and considerate manner.

The involvement of people in the care they receive

- As part of their assessment, staff sought patients' views.
- The trust had an advocacy service that patients could access.
- Staff sought to support carers of patients. Where possible they contacted carers and relatives. At the Chase Farm place of safety we saw staff efforts to support the carer of a person who was detained at the time of our visit. The carer had also been involved in helping to communicate with the detained person.

Requires improvement

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

- The trust provided home treatment crisis support 24 hours a day, seven days a week. Between 8am and 10pm this was provided by the borough based teams, whilst at night one joint team covered the three boroughs.
- Patients could access information and advice through phoning the team. During the day, administrative and clinical staff in the trust's 'hub' answered calls to the team. At night phone calls to the hub were responded to by the night team. Patients on team caseloads could also call the teams directly. Patients told us they sometimes had long periods of trying to connect to staff through the 24 hour crisis lines.
- Staff in the hub screened and triaged referrals to decide which team was the most appropriate to respond to a referral. When staff decided that a person should be assessed by the home treatment team the referral was passed to the respective borough team.
- The teams accepted referrals from community mental health teams, local GPs, inpatient wards as well as from psychiatric liaison services based in local acute trusts. Many referrals were received via the 'hub', although at the time of the inspection, it was not acting as a single point of access as the teams also received some direct referrals. The hub had been set up in January 2015.Not all staff we spoke with were clear about the function of the hub.
- Two qualified nursing staff were allocated by each team to complete initial referrals. The trust had agreed a target with local commissioners to respond to all patient referrals from GPs within four hours. The teams were meeting this target. For example, the Haringey team had responded to 95% of referrals within four hours. All new non-GP referrals that were accepted by the teams had a target to be assessed by staff within a 24 hour period. Staff we spoke with told us that the pressure of responding to the four hour target, given their resources, was hard.
- The teams supported patients in recovery house houses located in each of the boroughs, which were managed by another provider. The recovery houses supported patients in a home environment who needed short term support whilst living in the community. They could also support patients being discharged from inpatient wards. At the time of inspection, most patients living in the recovery house were awaiting housing.
- At the time of inspection team caseloads for Barnet were 65 patients, 59 patients for Enfield, and 63 patients for Haringey. Of these patients a number were rated as presenting a green risk, 18 patients in Barnet, 16 in Enfield and 18 in Haringey. Staff told us this meant that these patients could be ready to be supported by other teams or discharged. The teams often had delays in discharging patients due to delays in other teams taking referrals.
- Staff were able to request an inpatient bed if they felt a patient presented with significant risk and they could not provide alternative support to meet their needs safely. If a bed was not available, managers could escalate a concern and ask for a bed in the independent sector. Staff told us that they would stay with patients whilst waiting for a bed if they deemed it was necessary. Team managers were able to request increased staff to support the team when required. Staff members from each team dialled into daily telephone bed management meetings.
- The teams operated with an open access referral system and provided services which did not include diagnosis as an exclusion criterion. This represented good practice and adhered to national guidelines. People were accepted by the home treatment teams based on appropriate clinical need, their risk level, and their geographical location.
- Protocols were in place to engage with patients who could not be contacted. Staff initially called patients multiple times at different points in the day. Staff also attempted a minimum of three face-to-face home visits, including cold-calling, which meant that staff turned up unplanned at a patient's home and posted a letter at the home address. Staff could also ask the police to complete a welfare check.
- The teams had taken active steps to engage with people who find it difficult or are reluctant to engage with mental health services. For example, the Haringey team had developed links with local services, including in the Turkish and Gypsy / traveller communities.
- Where possible, staff tried to offer patients flexibility in the times of appointments. The teams provided a service from 8 am until 10pm. This meant staff could visit people at a range of times. However, the teams did

Requires improvement

Are services responsive to people's needs?

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

not always communicate with people to tell them when they were likely to attend and or were non-specific in times. For example, telling patients they would attend in the morning. This meant that patients were not clear about when staff would be visiting them.

The facilities promote recovery, comfort, dignity and confidentiality

- Teams had access to a clinic room that was clean and well equipped, with the necessary equipment to carry out physical examinations across the three sites.
- Staff visited most patients at their homes on in the community. The teams could use outpatient rooms if required. In Barnet, patients occasionally used the lounge room and the doctor's room for review meetings.

Meeting the needs of all people who use the service

- Patients received information on accessing local services tailored towards a range of ethnic groups and religious communities, which reflected the diverse population they served. Patients could request the trust's complaints, concerns and compliments pamphlet as well as other information in a variety of different languages and formats, including audio, large print easy-read and braille.
- Staff across the three teams demonstrated sensitivity and understanding of the cultural and religious needs of the patients. Staff discussed and considered the cultural and ethnic backgrounds of patients in MDT handover meetings.
- Access to interpreter service was good and readily accessible. There were no reported difficulties of meeting the communication and language needs of service users from diverse ethnic and cultural backgrounds.
- Information about local counselling services and non-statutory organisations such as MIND, Samaritans and Carers UK were routinely provided to patients.This promoted access to services to support recovery and wellbeing of patients.
- Patients received information on the service.They received a welcome pack with a leaflet that contained a crisis plan, with contact telephone numbers to use in the event of an emergency.

Listening to and learning from concerns and complaints

- Between 2014 and 2015, the Barnet team received 10 complaints, the Enfield team five and the Haringey team nine. Of these, one complaint from Barnet and three complaints from Haringey were upheld. One complaint from Enfield was referred to the ombudsmen and this was upheld.
- Access and support for making complaints was provided by the patient experience advisors who worked as part of the wider patient engagement team within the trust.
- Staff knew how to respond to complaints, and shared learning from complaints during team meetings. At Barnet, staff described the investigation protocols that took place after a formal complaint, and told us about the action planning, lessons learned and feedback that they received. However, information on learning from complaints was not being shared in a systematic way across the three home treatment teams.

Health-based places of safety

Access and discharge

- In the six months prior to the inspection the trust's places of safety had been used 261 times. Fifty percent of patients had been discharged to the community, 23% of patients had been admitted to the trust under the Mental Health Act, 21% had been admitted as informal patients and 5% had been transferred to a different trust.
- The service had a place of safety operational protocol.This said that the exclusion criteria for the places of safety were that the person had significant acute medical concerns, presented unmanageable risks. If a patient was intoxicated they would not accept them if they required acute medical support. If one place of safety was in use staff would call the other place of safety in the trust to see if the patient could be taken there. If this was also full they would call other local trusts.
- Some patients had to wait for extended time periods in the places of safety. In September and October 2016, 100 patients used the trust's health based places of safety, 70 in the Chase Farm suite and 30 in the St Ann's suite. The average time spent by patients in the suites was just over seven hours.
- 21 patients spent longer than 12 hours in the Chase Farm suite, with four spending more than 24 hours. No patient was in the suite for more than 72 hours, with a

Requires improvement

Are services responsive to people's needs?

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

patient who spent 46 hours in the suite spending the longest amount of time in the suite. Five patients spent longer than 12 hours in the St Ann's suite. No patients were in the suite for more than 24 hours.

- A doctor reviewed most patients promptly, although some had to wait a long time to see a doctor. In September and October 2015 the average time between a patient arriving on the suites and being seen by a doctor was one hour. Doctors reviewed 88 patients at the suites within four hours, with 49 of these patients being reviewed within one hour.Three patients had to wait for more than 12 hours to be seen by a doctor.
- Data produced for the London mental health partnership board in April 2015, covering the period June 2014 – February 2015, showed that for 28% of patients it was more than three hours before a doctor arrived to assess them. This was the second highest for London trusts.
- Patients did not always get reviewed by an Approved Mental Health Professional (AMHP) promptly. Ninety three patients were seen by an AMHP during September and October 2016. Patients had to wait on average just under five hours to be seen by an AMHP. Thirteen patients had to wait for more than 10 hours to be seen by an AMHP. Paragraph 16.47 of the MHA Code of Practice states that an "assessment by the doctor and AMHP should begin as soon as possible after the arrival of the individual at the place of safety. In cases where there are no clinical grounds to delay assessment, it is good practice for the doctor and AMHP to attend within three hours". Staff at St Ann's told us that there were often delays in accessing AMHPs in Haringey, especially out of hours. At Chase Farm the AMHP service would not agree to a referral before the patient had been reviewed by a doctor. This meant delays in patient's being reviewed by an AMHP occurred regularly.

The facilities promote recovery, comfort, dignity and confidentiality

- Both suites were separated from the rest of the hospital in which they were located and afforded privacy for conducting assessments.
- The rooms had mattresses on the floor, but did not have any chairs. If a patient's risk assessment allowed they could sit on chairs outside the room in the suite.
- Patients at St Ann's could, if their risk assessment allowed, have access to the suite entrance/ waiting area. The doors from this area to the outside drive contained large clear glass panes.This did not afford maximum privacy for individuals.
- The rooms at both health based places of safety offered environments which maintained the dignity and confidentiality of patients. All rooms were private and both suites were accessed through their own doors. However, patients at Chase Farm could, if their risk assessment allowed, have access to a court yard for fresh air. We noted that this area was not secure and could be overlooked by patients from another part of the service. Although, this allowed them access to outdoor space, it also meant their privacy may be compromised.
- All three rooms had visible clocks, an intercom to facilitate staff-patient communication and an external thermostat and temperature controls.
- Both places of safety had access to facilities for staff to make drinks for patients.
- Staff informed us that in Haringey it was normal practice for the police to transport patients to the St Ann's place of safety and that this was undertaken in a caged vehicle. At Chase Farm we were told that patients were transported by either police vehicles or by the ambulance service. The interagency policy stated that individuals should normally be transported in ambulance vehicles. The trust should work with other agencies to ensure that where possible patients are taken to a place of by ambulance or other health transport.

Meeting the needs of all people who use the service

- Both places of safety had disabled access.
- Staff could access an interpreter services at both places of safety. We saw this recorded in records and for a patient on the day of our visit.
- Staff downloaded information on patients' rights in different languages from the internet as required.
- The trust protocol recorded that children would usually go to the local A&E. However, staff at the Chase Farm place of safety told us that the local Barnet A&E department would not accept individuals in need of a place of safety. We saw in one file that a young person aged 16 years was taken by the police to Barnet A&E but was not accepted and was subsequently taken to the Chase Farm place of safety. The inter-agency joint

Requires improvement

Are services responsive to people's needs?

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

working protocol stated that "every effort" must be made to have a person under 18 years of age assessed by a CAMHS (child and adolescent mental health service) consultant psychiatrist. We were informed by staff at Chase Farm that CAMHS consultants were only available for telephone consultation. Paragraph 16.49 of the MHA code of practice states that "where the person detained is under the age of 18 `…they should be taken to an appropriate place of safety … where either a child and adolescent mental health services (CAMHS) consultant or an AMHP with knowledge and experience of caring for this age group should undertake the assessment."

- Patient's identified as having a learning disability did not automatically receive support from a specialist.

Listening to and learning from concerns and complaints

- In the last year the Chase Farm place of safety had received one complaint. The St Ann's place of safety had received no complaints.
- Staff were aware of how to handle complaints.

Are services well-led?

Requires improvement

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

Our findings

Vision and values

- Staff knowledge of the trust's values were varied across the teams. The staff we spoke to did not provide any consistent understanding across the three sites of the trust's core vision and values.
- Staff spoke positively about their managers and felt well supported by them. Staff knew the names of senior managers of the trust board and how to access senior staff if required. Staff attended monthly clinical governance meetings where they met with more senior management within the trust.
- Staff felt that the change to a borough-based structure had improved the service and communication.

Good governance

- Teams had key performance indicators (KPIs) on a variety of areas including GP referrals, supervision records, care planning, and care records. Staff recorded the percentage of whether particular actions had been completed or were missing on the electronic records system. However, teams were not monitoring the make-up of the caseloads on an ongoing basis.
- The teams had a risk register and managers were able to submit any key issues, which were then reviewed by senior management. However, the risk registers for the Enfield and Haringey teams had not been updated recently.
- The trust had recently introduced borough quality improvement meetings that provided an overview of information relating to the performance of services. The home treatment teams did not yet have access to a heat map indicator to obtain key performance indicators for the service, which was available routinely in other services within the trust.
- Staff had started to collect feedback from patients, although staff told us they wanted to improve this. Staff kept records of the surveys on the electrical portal system. This had led to the development of community packs for carers with information leaflets and contact telephone numbers of the crisis teams.
- The trust had made some changes as a result of feedback received. For example, in Enfield, feedback received from staff and patients from the recovery house was discussed at quarterly deep dive meetings. Patients reported that they did not receive their morning medication on time, and a plan of action had been implemented from October 2015 to rectify this.
- Team managers felt supported by senior management and colleagues, and had sufficient authority across the teams.

Leadership, morale and staff engagement

- Overall staff morale was generally good. Staff did not report any concerns around bullying or harassment. However, staff felt stretched due to the pressures around meeting the demands of high team caseloads. Team managers felt listened to by senior management when they raised concerns around high team caseloads.
- Despite the positive morale and support from senior managers there were still a number of areas where improvements were needed to ensure patients received safe, effective and responsive services from the home treatment teams. Staff needed the appropriate leadership skills to make these changes and improve the services.
- We found differing sickness rates across the teams, ranging from 2%-9%. Staff did not find sickness rates as a particular issue within their teams.
- Staff felt confident in raising any issues and concerns, including whistleblowing without fear of victimisation. We saw copies of the trust's guidance on whistleblowing that was available to staff on the intranet.
- The trust provided staff with opportunities for leadership development. For example, a nurse in the Haringey team was receiving training to become nurse prescriber and one team manager was undertaking a masters in leadership & management.
- Staff had the opportunity to give feedback on services during team meetings and clinical governance meetings.

Commitment to quality improvement and innovation

- The team at Haringey had made an application for accreditation via the Royal College of Psychiatrists' Home Treatment Accreditation Scheme (HTAS).
- Teams were participating in the CORE study, a National Institute of Health Research funded programme, in

Are services well-led?

Requires improvement

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.

conjunction with University College London (UCL), that aimed to improve the standard of support offered to people using crisis resolution home treatment teams across England.

Health-based places of safety

Vision and values

- Staff were aware of the values of the trust.
- The teams held regular liaison meetings with other provider to improve the service.

Good governance

- Incidents and performance information was reviewed through the borough-based inpatient clinical governance meeting.

Leadership, morale and staff engagement

- The management of the place of safety had changed and these now fell within the inpatient management structure. Staff felt this had been an improvement and had provided clear management and supervision of staff within the places of safety.
- All six staff we spoke with felt well supported in their role in the places of safety.

Commitment to quality improvement and innovation

- The Chase Farm team was working on a business proposal to get dedicated staff to run the place of safety.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **Regulation 18 HSCA (RA) Regulations 2014** **Staffing** Sufficient numbers of competent and skilled staff must be deployed to meet the requirements of the service. Staff must receive appropriate support as is necessary to enable them to carry out the duties they are employed to perform. The lone-working policy was not robust across the teams, and meant that staff safety was being put at risk. The trust had not ensured that managers were providing the leadership skills needed to improve the home treatment teams and ensure patient and staff safety and a responsive service. This was in breach of regulation 18 (2)(a)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **Regulation 12 HSCA (RA) Regulations 2014** **Safe care and treatment** The trust had not ensured that care and treatment was provided in a safe way for patients.

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care **Regulation 9 HSCA (RA) Regulations 2014 Person-centred care:** The trust had not ensured the care and treatment of patients was appropriate and met their needs and reflected their preferences. Patients being supported by the home treatment teams found it hard at times speak to staff on the phone, were not given clear appointment times and were not informed when staff were delayed. This was in breach of regulation 9(1)(2)(3)
	The trust had not ensured that the documentation of risk assessments on patient care records contain sufficient detail to reflect risks accurately. This was in breach of regulation 12 (1)(2)