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)
RRP46	St Ann's Hospital	Haringey Crisis Resolution Home Treatment Team	N15 3TH
RRP02	Chase Farm Hospital	Enfield Crisis Resolution Home Treatment Team Trust wide Health-based place of safety	EN2 8JL EN2 9JL
RRP01	Edgware Community Hospital	Barnet Crisis Resolution Home Treatment Team	HA8 0AD

Summary of findings

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

- Staff in the home treatment teams did not always complete and update a full multidisciplinary risk assessment for all patients. They did not always update records during planning meetings. The teams did not ensure that staff knew patient risks prior to supporting them.
- Managers in the Haringey and Enfield teams did not ensure that all staff received regular supervision that was recorded and monitored.
- Patients could not always contact the trust easily. Calls to the trust hub did not always get answered.
- The trust did not have effective systems or processes to effectively assess, monitor and improve the quality and safety of the services provided. Although the trust had made many improvements since the last inspection, staff in the Enfield team did always receive regular supervision, communicate clearly with patients and assess patient risks. The trust needed to embed the sharing of learning between teams.

However:

- Since the last inspection, the trust had made improvements. The trust had opened a new health-based place of safety, implemented a new lone working policy and reduced caseloads across the home treatment teams.
- Patients received care from staff from a range of professional backgrounds. Staff received specialist training.
- The home treatment teams supported patients 24 hours a day, seven days a week. Staff responded to referrals quickly and assessed most patients promptly. They approved almost all admissions to inpatient wards. The teams had access to crisis houses in which they could support patients in the community. They worked proactively with community teams to discharge patients.
- The trust had redesigned patient pathways in Barnet. This had improved continuity of care for patients, as consultants could support patients throughout the care pathway.

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:

- Staff in the home treatment teams did not always complete and update a full multidisciplinary risk assessment for all patients. They did not always update records during planning meetings. Staff, especially in the Enfield team, did not demonstrate they had effective systems, processes and practices in place to manage risk at all levels. Staff in this team supported patients without a full knowledge of the risks to the patients or themselves.
- The trust needed to embed the sharing of learning between teams. The teams did not share learning from incidents across the home treatment teams and other parts of the trust. Not all staff knew the key risks to the service.
- The home treatment teams did not track ongoing safeguarding concerns that involved their patients.
- The trust had not ensured that the Enfield team clinic room was clean and tidy.
- Managers in the Enfield home treatment team had not ensured that all staff completed their mandatory training. The team had high rates of staff sickness.

However:

- The trust had opened a new health-based place of safety, which had dedicated staff who were fully compliant in their mandatory training. Although staff had not identified all potential ligature points, they had processes in place to ensure they could observe patients in the rooms.
- The trust had implemented a more reliable lone-working policy in the home treatment teams.
- The trust had reduced caseloads across the three home treatment teams, which meant that staff were more able to meet the needs of patients.
- The trust had improved its monitoring and auditing of medication errors and had put measures in place to ensure the safe management of medicines.
- Staff across the teams were clear about their roles and responsibilities for reporting incidents and were encouraged to do so.

Are services effective?

Requires improvement

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

Summary of findings

- Managers in the Enfield and Haringey teams did not ensure that all staff received regular supervision.
- Staff in the Haringey and Enfield teams did not monitor patients' physical health needs where needed after the initial assessment.
- Staff did not always assess the mentalcapacity of patients to make decisions.
- Staff did not always involve patients fully in developing personalised and holistic care plans. Staff in the Haringey and Enfield home treatment teams did not record that patients had a copy of their care plan.

However:

- The trust had developed specialist training for staff. Staff in the Barnet home treatment team had a robust schedule of specialist training, which helped them to meet the needs of patients. Haringey home treatment team's staff were trained in Open Dialogue to support patients and their families.
- Staff worked with other teams to support patients. The Haringey home treatment team had weekly meetings with specialists in housing, benefits and other services to support staff to meet patients' needs.
- Staff were involved in clinical audits, which helped the service have oversight into the performance of the teams.
- Staff in the health-based place of safety had received specialist training. They assessed patients in line with guidance and the Mental Health Act.

Are services caring?

Good

We rated caring as **good** because:

- We observed staff treating patients with kindness and support in the home treatment teams and the health based place of safety. Although we received mixed feedback from patients, many patients told us they found staff caring and respectful. In addition surveys said that patients and carers were very positive about the care provided.
- Staff in the home treatment teams sought to involve patients in decisions about their treatment. Most patients felt involved in decisions about their care.

However:

Summary of findings

- Some patients and carers felt that staff were not caring. Care records showed that some staff sometimes demonstrated a lack of empathy for patients and their needs. Staff from the Enfield home treatment team said that some staff did not demonstrate empathy and understanding with patients.
- Staff did not always record that they shared care plans with patients.

Are services responsive to people's needs?

Requires improvement

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

- Whilst the home treatment teams tried to offer patients a two hour window for appointments, they frequently did not arrive during this time. In addition patients and carers were not always informed when the appointment was delayed. Appointments described as happening in the morning could take place between 10am to 2pm which could cause confusion. Patients and carers described how this could make them feel anxious.
- Patients could not always contact the trust through the hub. Staff had not answered 10% of calls.

However:

- The home treatment teams supported patients 24 hours a day, seven days a week. Staff responded to referrals quickly and assessed most patients promptly. They approved almost all admissions to inpatient wards. The teams had access to crisis houses in which they could support patients in the community.
- Staff in the home treatment teams worked proactively with community teams to discharge patients. In Barnet, the trust had recently redesigned the pathway. This helped teams to link closer to other longer-term community teams.
- The trust had a new health-based place of safety. When appropriate, patients had access to seated areas and a kitchen.
- 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.
- Staff provided information to patients on how to complain and responded to complaints.

Are services well-led?

Requires improvement

We rated well-led as re**quires improvement** because:

Summary of findings

- The trust did not have effective systems or processes to effectively assess, monitor and improve the quality and safety of the services provided. At our last inspection in December 2015, the service was rated as requires improvement overall. At this inspection, we saw that many improvements had been made. However, the trust still needed to embed some improvements.For example, the trust needed to ensure staff in the Enfield team assessed and understood the risks patients presented to themselves and others.
- The trust did not ensure that staff in the health based place of safety were able to access a governance dashboard with their performance against key performance indicators. The team needed to collate and share with stakeholders data gathered by staff, for example, how patients are transported to the service and how long they wait to be seen by an AMHP, to monitor and drive improvement.

However:

- Staff knew the trust values and how they applied to their work.
- The trust had redesigned patient pathways in Barnet. This had improved continuity of care for patients, as consultants could support patients throughout the care pathway.
- Staff had begun to use the trust's quality improvement methodology to improve services. Staff in the Barnet team had recently started completing physical health observations for all the patients in the service.

Summary of findings

Information about the service

Barnet, Enfield and Haringey Mental Health Trust provide mental health crisis 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 including people over the age of 65 where appropriate. The aim of the home treatment teams is to provide assessment and, where appropriate, intensive support for a limited period within the patient's own home. Where the clinical risks indicate that a hospital admission is needed, the teams 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 inpatient beds and provide support for community-based recovery houses located in each of the boroughs.

The trust had one health-based place of safety located at Chase Farm hospital in Enfield. Since the previous inspection the service at St Ann's hospital in Haringey had transferred to Chase Farm. This provides 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 were inspected previously in May 2013, March 2014 and December 2015. At our last inspection in December 2015, the service was rated as requires improvement overall, with requires improvement for safe, responsive and well-led. The service was rated as good for effective and caring.

Our inspection team

The team that inspected this core service comprised a CQC inspector, a CQC inspection manager, a CQC Mental Health Act reviewer, three specialist advisers which were two qualified nurses and a social worker, and an expert by experience. A CQC expert by experience has experience of using or caring for people using a similar service.

Why we carried out this inspection

We inspected this core service as part of our ongoing comprehensive mental health inspection programme. When we last inspected the mental health crisis services and health-based places of safety in December 2015, we rated them as **requires improvement** overall. We rated the core service as **requires improvement** for safe, responsive and well-led, and **good** for effective and caring.

Following the December 2015 inspection, we asked the trust to make the following improvements to mental health crisis services and health-based places of safety:

- 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

Summary of findings

service. This includes patients' phone calls 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 trust must ensure that managers with the appropriate leadership skills are in place to make the improvements that are needed in the home treatment teams.

Following the December 2015 inspection, we made the following recommendations to the trust to improve mental health crisis services and health-based places of safety:

- 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 patients' physical health needs where needed after the initial assessment.
- The trust should review the multidisciplinary 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 approved mental health professional 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.

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, asked a range of other organisations for information and sought feedback from patients at three focus groups.

During the inspection visit, the inspection team:

- visited three home treatment teams at the three hospital sites, the team that manage the telephone contact (the hub) and the health based place of safety and looked at the quality of the environment and clinic rooms

Summary of findings

- spoke with 23 patients and carers who were using the service
- spoke with the managers or acting managers for each of the home treatment teams, the night service, the hub and the health based place of safety
- spoke with 31 other staff members; including doctors, nurses and social workers
- interviewed the divisional director with responsibility for these services
- attended and observed two planning meetings and two handover meetings
- collected feedback from 20 patients and carers from focus groups and enquiries
- looked at 33 care records of patients
- carried out a specific check of the medication management at the three sites
- 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

We received mixed feedback from patients and carers of patients. Of the 17 patients and six carers we spoke to, 12 patients and carers told us that the staff were caring and respectful.

Some patients and carers felt the service needed to improve. They raised concerns with regards to staff shortages, lack of consistency in the quality of staff, some staff visiting for only ten minutes, and staff not turning up or cancelling appointments with no notice. Two patients said that they were discharged too quickly from the crisis service and therefore relapsed quickly into crisis again; they felt they did not have an effective discharge plan.

Three patients and carers felt staff answering the phones at the hub were not suitable for the role and came across as uncaring. They also mentioned difficulties in getting through on the phone.

Good practice

Staff in the Haringey home treatment team had a mindfulness session before the start of their shift.

The Haringey home treatment team staff were being trained to use the Open Dialogue approach, which uses family therapy and social network building.

Areas for improvement

Action the provider MUST take to improve

- The trust must ensure that all staff receive regular supervision.
- The trust must ensure that the documentation of risk assessments on patient care records contain sufficient and up to date detail to reflect risks accurately.
- The trust must ensure that, prior to undertaking visits, staff know patient risks.
- The trust must ensure that staff communicate with patients when they are running late for an appointment.
- The trust must ensure that patients can contact the service through the hub.
- The trust must ensure that it effectively assesses services. In Enfield, the trust did not have effective audit systems in place to identify areas for improvement. It did not support the team manager to provide effective leadership.

Action the provider SHOULD take to improve

- The trust should ensure that staff in the Enfield home treatment team demonstrate empathy towards patients or carers that complain.
- The trust should ensure that staff in the Enfield and Haringey home treatment teams are clear in their communications with patients regarding appointment times.
- The trust should ensure that the clinic room in the Enfield home treatment team is kept clean and tidy.

Summary of findings

- The trust should ensure that staff involve patients in their care plans and that they are holistic and recovery focussed.
- The trust should ensure that staff understand the Mental Capacity Act and are confident to use it.
- The trust should ensure staff monitor and document patients' physical health needs.
- The trust should ensure that staff monitor and track safeguarding alerts that had been raised by staff or where patients have safeguarding alerts raised in regards to them.
- The trust should ensure there are systems in place such as team or business meetings, for all staff working in the health-based place of safety to cascade information and learning.
- The trust should ensure that staff in the health based place of safety are able to access a governance dashboard with their performance against key performance indicators.
- The trust should ensure that data gathered by staff, for example, how patients are transported to the service and how long they wait to be seen by an AMHP is collated and shared with other stakeholders to monitor and drive improvement.
- The trust should ensure that all staff complete mandatory training.

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 Health-based place of safety	Chase Farm Hospital
Haringey Crisis Resolution Home Treatment Team	St. Ann's Hospital

Mental Health Act responsibilities

- Staff in the home treatment teams did not usually treat patients who were detained under the Mental Health Act. Staff worked with patients on a community treatment order under the Mental Health Act and could contact the Mental Health Act office to support them with this.
- Staff compliance with the MHA at the health based place of safety had improved since our last inspection. Staff completed section 136 paperwork fully and had recorded in six of the eight patients whose records we reviewed that they had explained to patients their rights. Staff told us that they gave all patients a leaflet with their rights on admission and talked this through with them.

Detailed findings

Mental Capacity Act and Deprivation of Liberty Safeguards

- At our last inspection in December 2015, nursing staff knowledge of the MCA was not embedded, and non-medical staff told us that only doctors carried out capacity assessments. At this inspection, staff in Haringey and Enfield HTTs said the doctor completed mental capacity assessment for patients.
- In Barnet, half of the staff had completed MCA training in the previous month. Staff told us that the team was trying to improve its use of mental capacity assessments and record capacity to consent in all assessments of patients. We looked at eight care records in Barnet HTT, and three of them included a record that the patient had given their informed consent to their treatment.

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

Mental health crisis service

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.
- The Haringey and Enfield home treatment teams (HTTs) had no issues regarding maintenance of the offices. In the Barnet HTT, four staff complained about the building and said that they had raised requests to address leaks and environmental hazards including faulty fire alarm panels. Staff had registered this concern on the team risk register.
- Each team had a clinic room where the staff prepared medication to take out on visits. Patients did not visit the clinic rooms. The clinic rooms for the Haringey and Barnet HTTs were clean and orderly. The clinic room in the Enfield HTT site was disorganised. The room had out of date information displayed on the wall, and in the medication fridge there was medication for a discharged patient. The sink did not have soap or paper towels. Staff had registered this concern on the team risk register. This item had been on the risk register since January 2015 and was closed on January 2017 with no actions identified.

Safe staffing

- Since the last inspection a skill mix review had been undertaken and agreed with commissioners.
- The provider had sufficient staff available to deliver a safe service in terms of completing the visits that needed to take place. But, particularly in Enfield, the impact of vacancies and sickness affected the quality of the service provided to patients in terms of the time they could spend with them or the time of day that they visited.
- The trust had an ongoing programme of recruitment. In the Haringey HTT, there were 14 qualified nurses and 14 healthcare assistants (HCAs). The team had three vacancies for qualified nurses. The team had recently recruited qualified nurses to fill two of these vacancies. In the Enfield HTT, there were 13 qualified nurses and nine HCAs. The team had no vacancies for qualified nurses and one vacancy for an HCA. In the Barnet HTT, there were 13 qualified nurses and 10 HCAs.The team had two vacancies for qualified nurses and one vacancy for an HCA.
- Teams had caseloads of between 35 and 65 patients across the three sites. The caseload for each team included all the residents in each of the three crisis houses. During the previous six months, Enfield had the highest caseloads of between 60 and 65 patients. In this team, five of the ten staff we spoke to said that due to staff leaving, staff sickness and having to train new staff, the caseload for remaining staff was higher and it was difficult to deliver the quality of care that they wanted.
- The service used bank and agency staff to cover vacancies, but did not cover all shifts. Between March and August 2017, there were 73 shifts in Haringey, 99 shifts in Enfield and 18 shifts in Barnet that managers had not been able to cover with bank or agency staff.
- The trust provided a service 24 hours a day. Out of hours, the trust had six members of staff based at the Enfield team's offices at Chase Farm hospital. Each team provided two staff members every night. On a number of occasions, the Haringey team had not provided two members of staff at night. Four of these staff members responded to calls from patients and professionals, went into the community to do assessments for patients in crisis, and worked with other professionals such as the police and accident and emergency departments in the area. Two of these staff members staffed the health-based place of safety.
- There was a high level of staff sickness in the Enfield HTT team. In June 2017, the team had a sickness rate of 11%. We saw from supervision records from the past year that out of 21 substantive staff, seven had taken or were taking sick leave of over a month. Five of the ten staff we spoke to told us that this had impacted on their work and felt that the management was not addressing the issue. Staff had put this concern on the team risk register in September 2017, but there were no actions associated with this risk.

Requires improvement

Are services safe?

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

- The hub had 12 HCA staff members, some of whom were agency. The team manager and deputy team manager of the hub were both on long term sick leave. In the interim the staff were managed by the bed manager who also covered the Enfield acute wards.
- There was access to adequate levels of medical staff in the HTTs, in the telephone call centre (the hub) and during the night shift. Each team had a psychiatrist. Out-of-hours, staff could contact the duty doctor.

Mandatory training

- At our last inspection in December 2015, not all staff had completed mandatory training. The average completion rate across the teams was 74%. At this inspection, this had not improved. The average completion rate across the teams was 73%. The completion of mandatory training varied between teams and the completion of some mandatory training courses was low.
- At this inspection, in Barnet HTT, staff average mandatory training was 89%. The Enfield HTT staff had completed 69% of mandatory training. There were lower levels of completion for some courses. For example, 59% of staff had completed breakaway training and 64% of staff had completed care pathway assessment training.

Assessing and managing risk to patients and staff

Assessment of patient risk

- Staff did not always complete an initial risk assessment and update it. At our last inspection in December 2015, the documented risk management plans lacked sufficient detail and did not always clearly state how risks would be managed. Since then the trust had provided training for staff and audited the risk assessments. At this inspection, the Barnet HTT completed and updated risks assessments, but the Haringey and Enfield HTT did not ensure they completed and updated assessments for all patients.
- In Barnet, we looked at eight patient care records. For seven of these patients, staff had completed risk assessments and updated them within the previous week.
- In Haringey, we found that patients' risk assessments were often a brief statement about historical risk, rather than a reflection of the patients' current risk. Risk assessments did not always include a plan of how the risk would be managed. For example, staff had identified one patient as being at risk of self-harm but did not formulate a management plan to support that patient with this risk.
- Staff in the Enfield HTT had completed risk assessments on admission to the team in four out of eight records we reviewed but none of these had been updated. One patient did not have a risk assessment completed yet and the other three patients had risk assessments completed by other teams, which had not been updated.

Management of patient risk

- Each team had a white board on which they recorded essential information about patients. Staff reviewed this at daily meetings and recorded the level of risk for each patient on a scale of red, amber or green.
- The HTTs planning meeting covered safeguardings, incidents, patients' risk assessments, care planning, and medication reviews. In planning meetings, staff discussed patients who were assessed as the high risk of harm to themselves or others. These patients were assessed as in the 'red' zone and required daily or twice daily visits by staff. After this, staff discussed 'amber' patients, who were assessed as lower risk and these patients were visited up to three times a week by staff. At the time of the inspection, there were no patients assessed as 'green' in any of the teams. Staff made notes on patients' progress notes when the team discussed them. In all of the teams, the white board was updated with changes to patients' risk during the planning meeting.
- Staff met daily to discuss patient risk. At our last inspection in December 2015, staff discussed patient risk in the planning meetings. They did not record these discussions consistently in the care records. At this inspection, we found that this was still the case. In Haringey, we attended the morning planning meeting and then looked at the care records for the patients staff had discussed. We found that the notes were not clear and did not reflect the change in patient risk adequately.
- At our last inspection in December 2015, not all staff in Barnet received information on the most up-to-date risks of patients because staff had to leave part way during the morning handover in order to meet home

visit appointments. At this inspection, we saw that the Barnet morning planning meeting was well structured and lasted an hour. This meant that all staff could attend the planning meeting and have time to go to their appointments with patients.

- The Enfield HTT did not adequately assess and manage risks to staff. During the inspection, a female staff member attended an appointment with a patient without another staff member. This patient had a forensic history of violence towards women and was very unwell at the time. Prior to the appointment, the team had not completed a face-to-face assessment or risk assessments for the patient. At the morning planning meeting, the team did not discuss the potential risks of the patient in sufficient detail. The lack of information and discussion of risk could have put the staff member at risk.
- At our last inspection in December 2015, the teams did not follow a robust lone-working policy. Following the inspection, the trust implemented a new lone working protocol. At this inspection, we found staff followed lone working procedures. Staff had GPS tracking alarm badges and let colleagues know when they attended appointments.

Safeguarding

- Most staff had completed training in safeguarding. In Barnet, 85% of staff had completed safeguarding adults level one and two and 88% of staff had completed safeguarding children level one and two. In Enfield, 83% had completed safeguarding adults level one and two and safeguarding children level one and two. To increase staff knowledge in safeguarding, the trust had recently increased the number of staff that it required to complete safeguarding children level three training, and staff were in the process of receiving this training.
- Staff knew how to raise a safeguarding alert, and we saw the pathway for the safeguarding process displayed on each site. However, staff did not always record safeguardings on the internal incident recording system. This meant that some concerns may not get followed up. Team managers did not know how many safeguarding alerts had been made by their staff in the last year.
- The team managers did not track the progress of the safeguardings that had come to the attention of the staff or had been raised by them. Information from the trust showed that the Haringey team had raised no safeguarding alerts the previous year, the Enfield team had raised five, and the Barnet team had raised three.

Staff access to essential information

- Staff stored and accessed patient information on an electronic care record system.
- Staff used the white boards in each office to record essential information regarding the patient and their risk. At our last inspection in December 2015, in Barnet, the white boards appeared difficult to read. At this inspection, all the white boards were legible and staff updated them daily with the key risks.

Medicines management

- The teams managed medicines safely. At our last inspection in December 2015, staff did not complete all medication records fully. At this inspection, the trust had improved its monitoring and auditing of medication errors and had put measures in place to ensure the safe management of medicines. Staff recorded medication errors as an incident on the trust's online incident reporting system. The number of medication errors had decreased over the previous six months. We looked at 12 medication charts and saw that staff had completed them appropriately and that they had been checked regularly by a pharmacist.
- All patients had a medication chart. Staff took these medication charts with them when they went to visit patients. The teams stored these in the clinic room, and staff signed a log when they took them on visits.
- A pharmacist visited each HTT weekly. They checked the medication charts and gave advice and support to staff.
- A qualified nurse supported patients prescribed clozapine, or a medication requiring an intramuscular injection.
- Staff transported medicines and patient charts securely in a lockable laptop bag.
- The trust had implemented quality improvement projects to improve medicines management. All staff were involved and were able to suggest improvements. One of these improvements was to assign an early morning staff member to do visits to patients that need regular medication.

Requires improvement

Are services safe?

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

Track record on safety

- Between 1 July 2016 and 30 June 2017, the teams reported 15 serious incidents: four in Enfield, four in Haringey and six in Barnet. The majority of incidents (13) related to apparent, actual, suspected self-inflicted harm, with one additional incident relating to apparent, actual, suspected homicide. One incident was also pending review at the time of reporting.

Reporting incidents and learning from when things go wrong

- Most staff knew which incidents to report and how to report incidents on the trust's electronic reporting system.
- The trust investigated incidents and identified learning from them. We looked at five serious incident reports involving the HTTs. Staff had identified a number of lessons. These included the importance of updating risk assessments, the need to obtain consent to share information, and the need to improve communication and joint working between the team and acute wards and other community teams.
- Team leaders shared learning from incidents in their own team at team meetings. We looked at the minutes for the last three months for team meetings. We noted that they had some discussion about learning from incidents, such as making sure that the fridge temperatures were checked every day and making sure that staff completed initial risk assessments before working with patients.
- The trust still needed to embed the sharing of learning between teams. At our last inspection in December 2015, learning from incidents was not being shared in a systematic way across the three teams. At this inspection, most staff could not tell us what incidents had happened at other teams and what the learning had been from those incidents. Each site had a folder available for staff that documented serious incidents and the learning from them. However, staff in Haringey and Enfield HTT did not give examples of the learning that the trust had taken from these serious incidents. Staff in the Barnet HTT gave examples of learning from serious incidents. For example, they had developed a protocol to use when deciding not to accept a patient with no prior history with mental health services in the borough.
- Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when something went wrong.

Health-based places of safety

Safe and clean environment

Safety of the ward layout

- The service had been reconfigured since the last inspection. A new health-based place of safety had been developed, with two en-suite rooms and a communal area. The suite also contained a kitchen area, clinic room and nursing station. Patient bedroom areas were spacious, well-lit and included an observation window. Doors in patient bedrooms opened outwards to promote the health and safety of patients and staff. Each bedroom included a mattress so the patient could take rest.
- The old place of safety on site was still available for use in exceptional circumstances, and this was attached to the new suite. Staff followed a protocol to manage environmental risks when they used this space. The trust planned to upgrade the old place of safety and fully integrate it to the new unit in November 2017.
- The place of safety was a self-contained unit on the ground floor within the hospital, separate from other wards. It had a separate entrance to allow patients to be escorted into the unit away from people using other services. This supported the privacy and dignity of patients using the place of safety.
- Staff could observe patients in the place of safety using closed circuit television, which covered the whole suite with the exception of en-suite bathrooms.
- Staff had completed a ligature risk assessment. This included photographs of potential ligature points and the measures in place to manage and mitigate these. Staff could refer to a copy kept in the office. The assessment did not include potential ligature risks from window frames in the new bedrooms and en-suite bathrooms although this risk was mitigated through observation.
- The suite was not fitted with a call alarm system for patients. This was mitigated by the use of increased observations where needed and an extensive CCTV system, which covered all areas apart from bathrooms.

Maintenance, cleanliness and infection control

Requires improvement

Are services safe?

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

- Staff completed regular environmental checks. The whole suite was visibly clean and well maintained. The suite was appropriately furnished with furniture and fittings that were comfortable and easy to clean. Furniture and fittings had been chosen so they could not be used to cause injury
- Staff cleaned the rooms between patients using the rooms.

Clinic room and equipment

- The place of safety suite included a clinic room, which was fully equipped and included resuscitation equipment and emergency medicines. These were checked regularly by staff. The clinic room was clean and well ordered. Records demonstrated that equipment was regularly cleaned and maintained. The clinic room included an examination couch and equipment for physical health tests and checks.

Safe staffing

Nursing staff

- The place of safety had its own dedicated staff team covering the suite from 7am to 7pm. This comprised of three senior qualified nurses and four qualified nurses. Permanent staff were in place. During the night shift, the unit was staffed by two qualified nurses from the home treatment teams. When any patient was admitted the baseline staffing was one senior qualified nurse and two qualified nurses. This meant that staff were immediately available to receive patients being admitted to the suite. On each shift, the senior nurse was designated as lead. They had access to a manager either on site or on call at all times.
- Healthcare assistants were not used by the place of safety. Staffing numbers could be increased by the use of bank staff as needed. Bank staff used had received an induction and additional training relating to the health based place of safety to ensure they had appropriate knowledge, skills and experience to meet patient needs. The service did not use agency staff for the place of safety. Staff we spoke with told us the service was safely staffed.
- Dedicated staff could be redeployed on local acute wards if they were not required on the place of safety. As it was busy, staff spent most of their time on the place of safety. Monthly occupancy rates between Jan 2017 and June 2017 showed a lowest occupancy of 50 admissions and a high of 64 admissions.

Medical staff

- The place of safety had appropriate medical cover. A consultant psychiatrist was attached to the unit 9am to 5pm each weekday on a rota. A specialist registrar was available at all times. An on call doctor was available to deal with physical health issues. In addition, a consultant psychiatrist specialising in children and young people was on call at all times to assist with any referrals to the unit for young people under the age of 18.

Mandatory training

- Staff had received and were up to date with appropriate mandatory training. All mandatory training courses had staff take up rates in excess of 75%. Mandatory training compliance was regularly monitored, with refresher training booked in advance.
- Staff were trained in the use of physical interventions and safe restraint, administration of rapid tranquilisation and observational skills. Staff also received simulation training in emergency life support and the use of resuscitation equipment.

Assessing and managing risk to patients and staff

Assessment of patient risk

- We looked at the care and treatment records of eight patients who had recently been admitted to the health based place of safety. These demonstrated that staff assessed and documented patients' risks when they were admitted to the place of safety. Staff used a standardised, trust wide risk assessment tool.

Management of patient risk

- Patients care and treatment records demonstrated that appropriate measures were put in place to manage identified risks, including the use of one to one observations. Records also demonstrated that staff were able to identify changes in patient risk and respond appropriately.

Use of restrictive interventions

Requires improvement

Are services safe?

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

- When staff restrained patients or administered rapid tranquilisation medication, they monitored and documented patient's physical health observations afterwards.
- The staff used restraint and rapid tranquilisations rarely. They had recorded one episode of restraint in the previous two months and no episodes of rapid tranquilisation.
- Staff aimed to provide the least restrictive care possible for patients. Patients could access their bedrooms and communal areas freely if staff assessed this as safe. Staff only restricted patients to their bedrooms when individual risks indicated this was appropriate.
- When patients were restricted to their bedrooms, staff recognised this as seclusion and followed the safeguards outlined under the MHA and code. When patients were secluded, this was appropriately authorised and reviewed. Staff provided one to one nursing and recorded regular observations.

Safeguarding

- Staff were trained in safeguarding, knew how to make a safeguarding alert, and did that when appropriate. Where safeguarding concerns had been identified, these were appropriately recorded and followed through including, where needed, safeguarding alerts to the local authority. We spoke to two staff; they had a good understanding of safeguarding procedures.

Staff access to essential information

- Staff maintained patient care and treatment records on the trusts electronic records system. They could also access information on this system for patients known to other services within the trust. Staff were able to access trust policies and procedures.

Medicines Management

- A small number of stock medicines were stored in the clinic room. Staff followed good practice in the storage, reconciliation, recording and disposal of these medicines.

Track record on safety

- There had been one serious incident at the place of safety during the previous year.

Reporting incidents and learning from when things go wrong

- Staff knew which incidents to report and how to report incidents on the trust's electronic reporting system. They reported all incidents that should be reported.
- Staff demonstrated a sound understanding of their incident reporting responsibilities. Staff reported each incident on the trust's electronic system, and these were reviewed by the manager. Themes identified over the last three months included delays in accessing beds and incidents of violence and aggression. The manager escalated incident themes within the trust. We saw that where a young person under the age of 18 was brought to the unit this was raised as an incident, as was the use of rapid tranquilisation and approved mental health professionals not attending within 4 hours.
- Staff were debriefed after serious incidents and received feedback on learning from incidents.

Are services effective?

Requires improvement

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

Our findings

Assessment of needs and planning of care

Mental health crisis services

- All three teams were split into staff that carried out initial assessments with patients and those who carried out the subsequent home visits. Staff in the assessment teams completed initial assessments of patients.
- At our last inspection in December 2015, we found staff did not always develop personalised plans for all patients.At this inspection, we found that staff did not always develop plans that took into account all of the patients' identified risks. Staff did, however, discuss the holistic needs of patients, such as access to housing, in the planning meeting and put in place plans to support patients with these needs.

Best practice in treatment and care

- At our last inspection in December 2015, we found that all three teams had limited access to a psychologist. For example, in Barnet, a psychologist was available for one day a week. At this inspection, we found that all teams could refer a patient to a psychologist if needed. Due to the short intervention of the crisis team, patients did not usually start a course of psychology within the service.
- The service had not improved the monitoring or documenting of patients' physical health in Haringey and Enfield HTTs. At our last inspection in December 2015, we found that 18 care records across the three sites did not document whether full physical health issues were routinely re-assessed and monitored as ongoing practice. At this inspection, we did not find physical health care plans or reviews for any of the patients in the Haringey and Enfield HTTs.
- Staff in the Barnet HTT had recently started completing physical health observations for all the patients in the service. This was part of a quality improvement initiative where staff completed observations for all patients in the service at least once a week. This information was included on the white board and in the patients' care records.
- Staff were involved in clinical audits, which helped the service have oversight into the performance of the teams.

Skilled staff to deliver care

- The teams included a full range of specialties to meet the needs of patients. All three teams had consultant psychiatrists, junior doctors, social workers, nurses, family therapists and pharmacists.
- The teams had access to specialist training. The Barnet HTT staff had a schedule of specialist training which included sessions about diabetes, perinatal mental health, and how to complete the modified early warning system charts. This helped staff to meet the needs of patients. The Haringey HTT staff were receiving training on the Open Dialogue approach. This involved working with the whole family or patient network rather than just the individual.
- Not all staff received regular supervision. In Barnet HTT, all staff received supervision every month for the past year, except if they were on leave. In the Enfield HTT, staff received supervision up to four times in the previous year. We did not see data for how regularly staff in the Haringey HTT received supervision.
- At the time of the inspection, all Barnet HTT staff had an appraisal for the year. The data for the other two teams was not clear.

Multi-disciplinary and inter-agency team work

- At our last inspection in December 2015, we found that planning meetings were primarily consultant-led with limited input from other professionals. At this inspection, we found that these meetings varied between teams. In the Haringey HTT, the consultant led the discussion about patients, formulated the risk level for each patient and directed the course of the crisis team intervention. This meant that there was the risk to the service delivery if the consultant was absent, as other team members were not enabled to take that role on themselves. In Barnet, the team manager had enabled senior nurses to direct the service delivery and had ensured that staff took training to support them in their roles.
- Staff had a handover between the morning shift and the afternoon in order to discuss any changes to patients' risks that were observed during the day. Staff updated the white board with any changes to patients' risks.

Are services effective?

Requires improvement

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

- Each team had meetings with their associated acute wards and community mental health teams. This ensured a smooth pathway for most patients going into or recovering from crisis.
- The Haringey HTT staff had weekly meetings with specialists in housing, benefits and other services to support staff to meet patients' needs. They also held weekly meetings with the recovery house team, the drug and alcohol team, the complex care team that supported patients with personality disorders, the early intervention service for patients with psychosis and housing and benefits advisors. These weekly meetings helped the service to deliver a better service to patients.

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

- There were no detained patients in the service. Information from the trust showed that the HTTs worked with 83 patients who were on a CTO during the previous year. A community treatment order (CTO) is where a patient is on a Mental Health Act section, but is in the community subject to conditions placed in that order. Staff had access to the Mental Health Act office for support.

Good practice in applying the Mental Capacity Act

- At our last inspection in December 2015, nursing staff knowledge of the MCA was not embedded, and non-medical staff told us that only doctors carried out capacity assessments. At this inspection, staff in Haringey and Enfield HTTs said the doctor completed mental capacity assessment for patients.
- In Barnet, half of the staff had completed MCA training in the previous month. Staff told us that the team was trying to improve its use of mental capacity assessments and record capacity to consent in all assessments of patients. We looked at eight care records in Barnet HTT, and three of them included a record that the patient had given their informed consent to their treatment.

Assessment of needs and planning of care

- We looked at the care and treatment records of eight patients. All were assessed by a doctor within one hour of arrival. This assessment included appropriate consideration of patients' physical health.
- At our previous inspection in December 2015, approved mental health professionals (AMHP) did not always review patients promptly. At this inspection, the unit made referrals to the AMHP service promptly, but the response from the service was slow. AMHPs had assessed none of the eight patients whose records we reviewed within the trust target of three hours. Two of these patients waited more than 24 hours to see an AMHP.Staff had raised the delays at the monthly meeting with the local authority that managed the AMHP service.
- Staff completed good quality assessments. They showed appropriate consideration of alcohol and drug misuse as a potential factor in presentation.

Best practice in treatment and care

- Staff gathered data and carried out some audits relating to the running of the suite. Data was gathered in relation to occupancy levels, mode of transport to the unit, length of time for a doctor to assess the patient and length of time for an AMHP to attend.

Skilled staff to deliver care

- The trust made specialist training available to dedicated staff, bank staff and night staff. The team planned to deliver additional training around domestic violence and the new crime bill.
- Staff said that they had completed mandatory training and specialist trainingThe service inducted staff onto the suite before they started work on the unit. Staff received training in the documentation used on the unit such as the alcohol and drug screening checklist.
- The service did not use agency staff. When they used bank staff, it made sure that the staff had the same competencies and induction as substantive staff.
- Staff received regular clinical supervision. From January to May 2017, 100% of staff received supervision.

Multi-disciplinary and inter-agency team work

- The manager for the service held regular monthly inter-agency meetings to review the use of the unit and deal with any issues. The AMHP lead, police, local authority, trust mental health lead and trust risk manager attended these meetings. In addition, the manager and staff at the unit met regularly with AMHPs from the three boroughs to look at the running of the unit and look at any local operational or governance issues.

Are services effective?

Requires improvement

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

- Staff worked closely with the home treatment teams who took on the care of some patients after they were discharged from the place of safety. They communicated and met with them regularly.
- The place of safety was located on an acute hospital site, so patients could be readily transferred to address physical health issues identified upon arrival at the place of safety if required.
- Staff encouraged police to contact them before transporting patients to the place of safety. This meant staff could give advice, plan the admission and find an alternative place of safety if the suite was full.However, sometimes the police arrived at the place of safety with a patient without warning. If the place of safety was full, staff located another place of safety for the patient before they were transported on.

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

- At our last inspection in December 2015, staff had not completed all the section 136 paperwork fully, and staff did not always record that they had informed patients of their rights. At this inspection, we saw this had improved. Section 136 paperwork was fully completed and six of the eight patients whose records we reviewed noted that staff had explained patients their rights. Staff told us that they gave all patients a leaflet with their rights on admission and talked this through with them.
- The suite aimed to detain patients for the shortest time possible, and no incidents of patients being detained for more than 72 hours had been reported. However, delays in AMHPs attending the unit meant that some patients were detained for longer.
- Patients and their carers were given regular updates as to their status and when they would be discharged or admitted for treatment. Patients were able to access advocacy services by telephone whilst in the suite.

Good practice in applying the Mental Capacity Act

- There was appropriate application of the Mental Capacity Act. Staff understood that blood testing and other tests relating to physical health conditions required patient consent and a capacity assessment if the patient appeared to lack capacity. They recorded in patients' records when they considered a patient's capacity to consent.

Good

Are services caring?

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

Our findings

Mental health crisis services

Kindness, dignity, respect, compassion and support

- Patients' views of staff varied. Of the 17 patients and six carers we spoke to, 12 patients and carers told us that the staff were caring and respectful. Other patients provided less positive feedback. Some patients said that some staff, including staff answering the telephone at the hub, could be abrupt and uncaring. Two patients from the Haringey HTT said that they had felt abandoned after being discharged from the service and were not given the tools needed to support ongoing care and recovery.
- Staff provided questionnaires for patients and carers to complete after visits. In the last six month, 84% or respondents in Haringey, 94% in Barnet and 99% in Enfield felt they were treated with dignity and respect.
- During the 14 home visits we did with staff, we observed positive and caring interactions between staff and patients.
- Some staff used language that could be disrespectful. Two members of staff in the Enfield team said that if patients were well enough to go into the community to attend work or other commitments, then they were ready to be discharged from the service. These staff members told us that if the patients were truly in crisis, then they should be at home all the time and not mind when the visits took place. This demonstrated a lack of empathy with the needs of patients.
- Two staff members in the Enfield team said that some staff in their team did not demonstrate empathy and understanding with patients and that management did not address these concerns. Care records showed that some staff in the Enfield HTT demonstrated a lack of empathy for patients and their needs. For example, in progress notes concerning visits that were delayed by between six hours and two days, staff did not show empathy for the patients and did not state whether they had apologised to the patients.

Involvement in care

Involvement of patients and carers

- At our last inspection in December 2015, the care records did not all record the views of patients or show that patients were being actively involved in the decisions about their care. At this inspection, staff discussed care with patients but did not always record patients' views in records.
- Staff sought to involve patients in decisions about their care. Patients and carer surveys showed that most patients who responded felt they had enough information about their care and were involved in decisions about their care. In Barnet, 94% of the 82 patients and carers who responded in the last six months thought they received enough information about their treatment and 92% felt involved in their care. In Enfield, 97% of the 116 patients and carers thought they received enough information about their treatment and 93% felt involved in their care. In Haringey, 88% of the 62 patients and carers thought they received enough information about their treatment and 76% felt involved in their care.
- At our last inspection in December 2015, staff did not always document whether patients had received a copy of their plans. At this inspection, staff did not always share care plans with patients. Staff in the Haringey and Enfield HTTs did not record whether they gave patients a copy of their care plans. Staff in the Barnet HTT told us they left a copy of the care plan with patients.
- Staff supported patients to access advocacy services.

Health-based places of safety

Kindness, dignity, respect, compassion and support

- During the inspection, we observed staff supporting patients with kindness and respect.
- Staff sought to understand patients' needs. When patients were known to mental health services, staff attempted to contact professionals who knew the patient well to get their advice and involve them in the care of patients.
- The service aimed to provide female staff to nurse female patients wherever possible.

Involvement in care

Involvement of patients

Good

Are services caring?

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

- Staff were reassuring, comforting and proactive in asking after the patient's welfare and the welfare of dependants. Staff involved patients in discussions about their care and treatment and management of risk.
- The trust aimed to develop a patient experience survey so they could gather feedback on patient's experience of being detained in the unit and identify areas for improvement.

Involvement of families and carers

- Staff sought to support carers of patients. Where possible, they contacted carers and relatives and kept them informed. We looked at eight care records and they showed that patients and their next of kin were kept up to date with what was happening during the admission.

Are services responsive to people's needs?

Requires improvement

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

Our findings

Mental health crisis services

Access and waiting times

- The teams conducted assessments of patients 24 hours a day, seven days a week.
- The service accepted referrals from patients directly, from GPs and from other professionals, including staff at accident and emergency departments. The trust set a target that all referrals from GPs were assessed by the staff within four hours. For all other referrals, the target was for staff to assess patients within 24 hours. The service generally met these targets, with an average of 95% of referrals being seen within target times.
- The service assessed most patients who may need an inpatient bed in an acute ward in the trust. As of July 2017, the service assessed 97.5% of patients who went onto the acute wards in the trust. The service assessed whether patients could safely be supported in the community by team. Each HTT had access to a crisis house managed by another third sector provider. Staff referred patients who temporarily needed accommodation with extra support to these crisis houses.
- The trust had worked with commissioners and the local authorities to review all adult care pathways over the previous year for Haringey, Enfield and Barnet mental health service users. The Barnet service redesign was the most developed, having been implemented in April 2017. This provided closer alignment between primary and secondary care mental health services. This was achieved through the creation of a link worker attached to each GP practice. In practice, this meant that patients were attached to one of five GP catchment areas in Barnet, and when they were supported by the Barnet home treatment team (HTT), the consultant for that GP catchment area saw the patient. A consultant for each catchment area attended the planning meeting one day a week, to review the risks for patients under their care. In Barnet, this has resulted in lower caseloads for the HTT, a smoother patient journey, and improved staff morale. The trust planned to redesign its pathways in Haringey and Enfield but, at the time of the inspection, it had not implemented these changes fully.
- The first point of contact for patients and professionals regarding referrals was the hub. Staff in the hub took telephone referrals. They did not accept email referrals and there was no facility to leave messages for a call back. This was so no referrals were overlooked. Staff in the hub knew the criteria for a referral to the crisis service and applied it through asking patients and professionals prepared questions regarding patient eligibility for the crisis service, and nature of the concerns. There were two clinicians available in the hub to go through the clinical need for a referral to the crisis service.
- At our last inspection in December 2015, patients told us they sometimes had long periods of trying to connect to staff through the 24 hour crisis lines. At this inspection, we found that this was still the case for some people. Three people in the focus groups that we held prior to and during the inspection, told us that it could be difficult to get through to someone at the hub. Four patients and carers we spoke to told us that it was difficult to get through to someone at the hub and that they had to spend a long time on the phone waiting for an answer.
- Information from the hub showed that the team had started logging the number of abandoned calls where callers had stopped waiting for an answer. In the previous month, this was 10% of calls. On the day of the inspection, we noted that the hub received 251 calls. Staff in the hub received 5218 calls in July 2017, 4940 calls in August 2017, and 4534 calls in September 2017. As this is the crisis phone line, this meant that there could be significant impact for a number of people who are unable to get to speak to staff at the crisis service.
- At our last inspection in December 2015, not all staff we spoke to were aware of the function of the hub. At this inspection, all staff could explain what the hub was and how it related to the delivery of the crisis service.
- The service was able to facilitate twice-daily home visits, seven days a week when needed.
- Patients had a key worker with the crisis team. Staff managed caseloads as a team, so patients did not always see their key worker regularly. If a patient was rated as 'red' in the risk assessment, this meant that staff had to see these patients every day, and sometimes twice a day, to make sure they were safe. As staff did not work seven days a week, this made it

Are services responsive to people's needs?

Requires improvement

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

impracticable for patients to see their key worker. Staff explained this to patients, and it was written down in the patient information booklet that staff gave patients when they first started the service.

- Carers for patients who used the Enfield HTT told our inspectors that staff repeatedly told them that there is a lack of resources, which meant that staff stayed not more than ten minutes per visit, which they felt was not enough to support patients through a crisis.
- The Barnet HTT had developed a protocol for informing patients when the staff might by late to visits. This included staff phoning patients beforehand to tell them when the visit would start, or if they were delayed.
- Staff understood the protocol regarding patients who were not at home for assessments and visits as arranged. This protocol included attempting to contact the patients by telephone, contacting their carers and relatives, and phoning emergency services in order to do a welfare check on patients.
- At our last inspection in December 2015, staff did not always communicate with people to tell them when they were likely to attend or gave patients non-specific times. At this inspection, the teams varied in how they communicated with patients.
- Staff in the Haringey and Enfield HTTs told us that they tried to give patients a two hour slot within which they would come to visit them. They did not monitor how frequently they kept to this two hour slot. In the Barnet HTT, staff arranged a time with patients, not a two hour time slot, and phoned the patient 15 minutes before they arrived. Feedback from focus groups and enquiries to the Care Quality Commission showed that patients still had multiple visits cancelled without warning, or had long delays in being seen by staff. Four carers for patients who used the Barnet HTT said that they had multiple appointments cancelled. Two carers said that the service was causing the patient to become more agitated and upset due to the delay of the visits.
- There was a confusing use of terminology in place in regards to the timing of visits in the Enfield and Haringey HTTs. Staff said that a 'morning visit' meant a visit that happened between 10am and 2pm. We saw two examples of where carers thought that a 'morning visit' was one that happened before noon and became distressed because the visit did not happen during the time frame they expected.

Discharge and transfers of care

- The number of delayed discharges had lowered at the service. At our last inspection in December 2015, teams often had delays in discharging patients due to delays in other teams taking referrals. At this inspection, staff said that discharging patients from the service was not an issue as there were strong communication channels with the acute and community mental health teams.
- Discharge planning started at assessment and staff discussed what the next steps would be with patients during the initial assessment.
- Staff supported patients' discharge process through meetings with a care coordinator in the community mental health team five days before the end of crisis service. If the care coordinator did not accept a meeting to plan the discharge, the team leader raised their concerns with the team leader at the community mental health team, to make sure that any delay in discharge was kept to a minimum. The team leaders met with the team leaders for the community mental health teams each week. There was good communication and working between the HTTs and the community mental health teams.

Patients' engagements with the wider community

- Staff supported patients in the community. They supported patients to access other support in the community and to maintain relationships with family members.

Meeting the needs of all people who use the service

- Staff assessed patients at the hospital site if patients were homeless or if they did not want to be seen at home.
- Team managers and staff told us that they very rarely worked with patients under the age of 18 and could not remember the last young person that had been referred to the service. Information from the trust showed that the HTTs had 21 referrals for patients under the age of 18 during the previous year.

Are services responsive to people's needs?

Requires improvement

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

- Staff assessed or visited patients at their GP surgeries if this was more appropriate for patients.
- Staff gave information to patients and carers about the service. There were leaflets available describing the service. Staff also carried a number of other information leaflets with them when they went out on visits, so that they could signpost patients to other services in the trust and in the community.
- Staff could access interpreters for visits in the community.

Listening to and learning from concerns and complaints

- The teams provided information on how to make a complaint.
- The trust investigated and responded to complaints. The HTT received 22 complaints in the last year. The trust had fully upheld none of the complaints. It had partially upheld 11 of the complaints. Some carers for patients who used the Enfield HTT told inspectors that they felt staff ignored their complaints and that staff did not respond to their specific concerns.
- One of the complaints had been escalated to the Parliamentary and Health Services Ombudsmen.
- Each team had thank you cards from patients and carers. These were displayed in the team office. Staff did not monitor the number of verbal and written compliments.
- Staff received feedback from complaints in their teams. Managers shared feedback at team meetings.
- At our last inspection in December 2015, the teams did not share information on learning from complaints in a systematic way with each other. At this inspection, the teams still did not ensure they shared information between them, so staff did not always learn lessons from complaints in other teams.

Health-based places of safety

Access and discharge

- The health based place of safety was available 24 hours a day, seven days a week. Staff encouraged emergency services to contact them before bringing a patient to the suite. This reduced the risk of patients being transported to the suite when it could not accommodate them. The suite participated in a London wide scheme which meant that it could quickly locate a place of safety with capacity to admit a patient. Staff used this service to reduce the risk of patients being driven between places of safety looking for a vacant suite.
- The suite included a waiting area for emergency service staff to wait and to handover to staff.
- The service had clear criteria for who it would accept. At our last inspection in December 2015, the service would not accept patients who were intoxicated and required acute medical support. At this inspection, staff were trained to assess the impact of alcohol or substance misuse on the patients' mental health presentation, and it did not turn away patients who were intoxicated. If patients needed medical clearance because of the level of their intoxication, staff would support them to attend the accident and emergency department before coming to the place of safety.
- Staff were able to describe the referral and discharge pathways from the place of safety. Contact details for approved mental health professionals (AMHPs) were readily available.
- At our last inspection in December 2015, some patients had to wait for extended time periods in the places of safety. The average time spent by patients was just over seven hours. At this inspection, we found that some patients waited longer than necessary because of the delays in getting an AMHP to assess them. Staff told us that AMHPs were reluctant to attend the place of safety to assess the patient until an inpatient bed had been identified. The service monitored how long patients had to wait before being assessed by an AMHP and followed this up during interagency meetings.

Discharge and transfers of care

- Staff put discharge plans for patients in place prior to leaving the place of safety. Staff documented appropriate information in the discharge plans to make sure that follow up care could be arranged. Staff ensured that discharge plans and, if required, other documentation was shared with relevant parties without delay.

The facilities promote recovery, comfort, dignity and confidentiality

- The facilities had improved since the last inspection. At our last inspection in December 2015, the suite did not have any chairs. At this inspection, the unit at St Ann's hospital had closed and the unit at Chase Farm hospital

Are services responsive to people's needs?

Requires improvement

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

had been refurbished. Each new room had an en-suite bathroom and appropriate mattress and bedding. Patients had access to a communal area with appropriate seating. There was a small kitchen on site that staff could access to make hot drinks and snacks. Food was available from the hospital on site.

- Patients could access a telephone to contact family and friends, and there were facilities for visitors, including a separate waiting area. Staff advised that replacement clothing could be arranged for patients in emergencies.
- The transport of patients to the suite was usually by ambulance. At our last inspection in December 2015, patients were sometimes transported by police vehicles. At this inspection, the trust was monitoring how many times patients were transported by police vehicles.

Meeting the needs of all people who use the service

- Staff demonstrated that they made efforts to use appropriate interpreters and to take into account any needs expressed by the patient. Patients could have access to female staff if this was appropriate.
- The service had improved the delivery of service to patients under the age of 18. At our last inspection in December 2015, staff told us that the local accident and emergency department would not accept individuals in need of a place of safety. At this inspection, a small number of young people had been admitted to the place of safety since January 2017. No children under 16 had been accepted to the service. This was clearly stated in the unit's operational policy and procedure. Staff had received specialist training in caring for young people. As soon as a referral for a young person was received, staff escalated this to the manager and completed an incident report.
- Staff could access language line for telephone interpreters. Face to face interpreters could also be accessed. The unit also used trust staff with the appropriate language as a last resort. Staff could give information leaflets to patients in different languages.

Listening to and learning from concerns and complaints

- Staff gave patients and carers information about how to complain.
- The service did not have access to a dashboard showing the numbers of complaints received. The manager was able to tell us about complaints and compliments they had dealt with locally.

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

Mental health crisis services

Leadership

- Staff in the teams said that they did not see senior leaders from the trust and did not know who they all were.
- The trust had leadership development courses available for staff. The team leaders for the HTTs had not attended leadership training in the last year.
- At the last inspection in December 2015, the trusts had not ensured that managers with the appropriate leadership skills were in place to make the improvements needed in the home treatment. At this inspection, we found that many improvements had been made. However, we found that, especially in the Enfield team, changes had not been made.

Vision and strategy

- Staff had an understanding of the trust's visions and values.
- The trust had begun to reorganise its adult community pathways. Staff in the Barnet HTT said that the changes to the care pathway for patients had benefited the service.

Culture

- The trust had appointed two 'Freedom to Speak Up' guardians. Staff knew who these guardians were and what they do.
- Staff could nominate other staff for the staff achievement awards. The trust presented these awards monthly and at an awards evening each year.
- The trust supported staff with a support at work website. This directed staff to different resources according to their needs.
- Staff morale in the Enfield HTT was mixed and staff had put this concern on the team risk register. Staff told us that high sickness, high staff turnover and high caseloads had made them anxious and stressed.
- Staff in the Barnet and Haringey HTTs all said that they had good morale and that their manager supported them well. Staff in the Barnet and Haringey HTT said that there were no problems with caseloads and no concerns about staffing.
- Staff in the Haringey HTT said that they benefited from the mindfulness session before the start of their shift.

Governance

- The teams had addressed many areas we identified in our last inspection. A new lone working policy had been implemented, medicines management had improved and, in Barnet, the team had improved their daily meetings. However, in this inspection we identified some areas in which improvements were still needed. For example, the teams in Enfield and Haringey did not always update and record risk assessments, ensure they recorded physical health assessments, or ensure all staff received regular supervision. The trust did not have systems or process to effectively assess, monitor and improve the quality and safety of the service.
- Each HTT held governance meetings every month, which were attended by senior managers and clinicians. These governance meetings covered serious incidents, complaints and changes to NICE guidance. These meetings also discussed serious incidents that happened in the community mental health teams.
- Each team had a 'heat maps' to audit completion of assessment documents, care plans, communication with patients' GPs, physical health checks and other performance indicators. Each team showed an improvement in the performance indicators since the introduction of the 'heat' maps were introduced in September 2016, with most of the performance indicators matching the trust targets in the previous three months.
- The teams did not always learn from each other from incidents or share good practice.
- Each HTT manager attended the borough-wide 'Deep Dive' meetings which were held every three months. These meetings looked at issues that affected the delivery of mental health services for patients in the borough.

Management of risk, issues and performance

- Teams could add items to the trust risk register. Items on the risk register mostly reflected the concerns being raised by staff.

Commitment to quality improvement and innovation

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.

- The trust had started to implement a quality improvement methodology. For example, the Barnet team had started a project to improve medicines management. All staff were involved and could suggest improvements. One of these improvements was to assign an early morning staff member to do visits to patients that needed regular medication.

Health-based places of safety

Leadership

- The place of safety did not have an individual manager responsible for running the unit. The acute services manager led the service. The three senior qualified nurses from the dedicated team were each line managed by a different acute ward manager.
- The manager of the place of safety had the skills, knowledge and experience to lead the service, and could explain how the service operated. Leaders were visible in the service.

Vision and strategy

- The trust had consolidated its place of safety on one site. The trust was planning to increase the capacity of the place of safety by upgrading the 'old' suite and incorporating into the 'new' suite.
- The current arrangements for the health based place of safety had been in place for nine months at the time of this inspection. The trust was gathering a range of data which it could use to plan for future developments.
- The trust had contingency plans in place to address temporary closure of assessment rooms as a result of damage acquired during use.
- Staff held regular multi-agency meetings with external agencies including police, ambulance service and AMHPs. Minutes of these meetings were available. These demonstrated that relevant issues were being addressed in these forums and that trust staff with appropriate decision making powers attended.

Culture

- We spoke with staff from the dedicated team. They told us they felt respected and valued. They felt able to raise concerns. There was positive staff morale and staff were positive about their work in this service.

Governance

- Overall, there were systems in place to ensure that the suite was safe and clean, that there were enough staff, that staff were trained and supervised, that patients were assessed and treated well, that unit adhered to the MHA and MCA, that beds were managed well, that discharges were planned and that incidents were reported.
- Some areas of governance required strengthening. The manager and senior nurses were not able to access a dashboard that contained key performance information. Whilst a range of information was gathered by the service, for example, how the patient was transported and the length of time they waited to be seen by an AMHP, this information was not presented during multi-agency meetings.
- There were no staff or business meetings specifically for the dedicated staff team, bank or HTT staff who worked at the place of safety. This meant there was no system to routinely cascade information or share learning from incidents and complaints.

Management of risk, issues and performance

- Systems were in place for risks associated with the health based place of safety to be included in the acute directorate risk register and escalated to the trust wide risk register if appropriate.
- Plans were in place to provide the service in emergencies, for example, adverse weather.

Management of information

- Systems were in place to collect data and these were not over burdensome for front line staff. Staff had access to the equipment and systems needed to do their work.
- Information governance systems were in place including confidentiality of patient records. Staff made notifications to external bodies as needed.

Engagement and Involvement

- Communication systems, such as the trust intranet were in place to ensure staff had access to up to date information about the work of the trust.
- Staff had opportunities to give feedback on the service through surveys, for example, the trust's friends and family test. The trust were developing systems to enable patients and their carers to give feedback on the service provided by the place of safety.
- The service regularly participated in a multi-agency group with organisations involved in the operation of

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the place of safety, including police, commissioners and the local authority. Feedback from a recent joint meeting with AMHPs had identified that appropriate reading materials could be provided to patients whilst they are waiting for assessment on the unit.

Learning, continuous improvement and innovation

- Since the previous inspection in December 2015, the provider had transformed the provision of health-based places of safety. The revised model had led to improvements in how the unit was staffed and in the environment. Since the last inspection the trust had signed up to a system to identify the nearest place of safety when they did not have capacity to accept patients.
- At the time of this inspection, the service was not involved in quality improvement methodologies and was not participating in accreditation schemes. Whilst regular operational meetings were taking place with AMHPs, these forums would benefit from further development to include specific case studies where issues have occurred across the pathway.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing Staff must receive appropriate support as is necessary to enable them to carry out the duties they are employed to perform. The trust had not ensured that all staff received regular supervision. 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 Diagnostic and screening procedures Treatment of disease, disorder or injury	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. The trust had not ensured that the documentation of risk assessments on patient care records contained sufficient detail to reflect risks accurately. Staff did not always do all that was reasonably practicable to mitigate risks to patients and staff. The Enfield team did not ensure staff knew risks before they attended appointments with patients. This was in breach of regulation 12 (1)(2) (a) (b).

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 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.

This section is primarily information for the provider

Requirement notices

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).

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The trust had not established systems or process to effectively assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity. The trust did not support the team managers in Haringey and Enfield to provide effective leadership. This was in breach of Regulation 17(1)(2)(a).