

Good


North East London NHS Foundation Trust

Mental health crisis services and health-based places of safety

Quality Report

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Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/unit/team)	Postcode of service (ward/unit/team)
RAT	Trust Head Office	Mental Health Direct	IG3 8XJ
RATY2	Sunflowers Court	Health Based Place of Safety	IG3 8XJ
RAT	Trust Head Office	Emergency Duty Team	IG3 8XJ
RAT	Trust Head Office	Barking and Dagenham, Home Treatment Team (HTT)	IG3 8XJ
RAT	Trust Head Office	Redbridge, Home Treatment Team (HTT)	IG3 8XJ
RAT	Trust Head Office	Waltham Forest, Home Treatment Team (HTT)	IG3 8XJ

Summary of findings

This report describes our judgement of the quality of care provided within this core service by North East London NHS Foundation Trust. Where relevant we provide detail of each location or area of service visited.

Our judgement is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from people who use services, the public and other organisations.

Where applicable, we have reported on each core service provided by North East London NHS Foundation Trust and these are brought together to inform our overall judgement of North East London NHS Foundation 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

Good 

Are services safe?

Good 

Are services effective?

Requires improvement 

Are services caring?

Good 

Are services responsive?

Good 

Are services well-led?

Good 

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 **good** because

- The service provided safe and clean environments for people who used it.
- Staff were experienced in managing crisis situations and services were designed to ensure that people were offered appropriate support in a timely manner.
- The service provided a good range of psychological therapies. The home treatment teams had staff trained in open dialogue, a talking therapy which encourages families to discuss sensitive issues arising from psychosis.
- Staff were caring and went the extra mile to ensure people were supported even if it meant adjusting their working hours.
- The service was appropriately accessible to people 24 hours a day. This is in line with the Mental Health Crisis Care Concordat's recommendations.

- The service had systems in place to keep themselves updated with local support agencies. This ensured they were able to provide an effective signposting service to support people with a range of social issues. The service was also committed to being inclusive toward people from black and minority ethnic backgrounds.

However:

- People who had been brought to the health-based place of safety did not always receive adequate assessment of their social needs before being discharged home. This meant that they could be returning to social situations detrimental to maintaining a healthy mental state.

Summary of findings

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

Are services safe?

We rated safe as **good** because:

- People who used services had access to safe and clean environments. Staff had access to appropriate alarm systems to ensure help could be summoned in emergencies.
- Team leaders were able to use extra staff, or move existing staff to maintain safety and meet the needs of people who used services. This protected staff from unsafe workloads.
- The staff in the teams had good access to advice from a psychiatrist. This ensured that all people had access to a medicine review appropriate to their mental health needs.
- The trust's acute directorate met daily to maintain an overview on current risk issues across the service. This was attended by all team leads and the director of acute operations.

However:

- Staff in some areas had a poor understanding of what should be reported as an incident. This could result in opportunities of learning from incidents being missed.
- The HBPOS had a potential ligature risk that could not be observed at all times. This meant that there was a risk of people in the HBPOS using this to harm themselves.

Good



Are services effective?

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

- Not all people, who had been assessed as having a mental disorder, had their social situations assessed by an approved mental health professional before being discharged from the health-based place of safety. This was not in line with the Mental Health Act Code of Practice.

However:

- Staff across the service completed comprehensive assessments of people's needs in a timely manner. This allowed other staff the opportunity to produce meaningful care plans with people who use services.
- People who used services had access to psychological therapies. Home treatment teams had staff trained in open dialogue, a talking therapy which encourages families to discuss sensitive issues around psychosis. They were also well informed about other local services that may be able to offer support. All teams actively kept updated on activities in the local area that offered support to people.

Requires improvement



Summary of findings

- Staff were well qualified and experienced. Supervision arrangements were good across the service. Staff completed training to improve their practice and they were given opportunities to progress within the trust.
- The service had good working relationships with other teams within the trust and other external agencies. This ensured people who used services were supported by the most appropriate services.

Are services caring?

We rated caring as **good** because:

- Staff were observed going the extra mile to ensure people, who were experiencing a crisis in their mental health, were supported with compassion and professionalism.
- The service was auditing their practice to ensure people were involved in their care plans. They could take laptops to people's homes to support this practice.
- The service identified carers and routinely offered carers assessments. The service also supported carers with their provision of open dialogue.

However:

- People who used services were not routinely invited to give feedback. This was significant as people expressed that non critical support could be overlooked.

Good



Are services responsive to people's needs?

We rated responsive as **good** because:

- The service covered a large population and was tailored to respond to crisis situations. It provided people with appropriate access 24 hours a day, which is in line with recommendations from the Mental Health Crisis Care Concordat. Teams were regularly meeting target times for assessing people and we saw evidence that this was continuing to improve.
- The service was committed to the trust's strategy of being inclusive to black and minority ethnic groups.
- Street triage had significantly reduced the number of people who needed to be taken to a place of safety by the police. They were able to assess the situation on the spot and offer less restrictive options for people.

However:

Good



Summary of findings

- People who used services had differing knowledge of how to complain. Information on how to make complaints was not always readily displayed.

Are services well-led?

We rated well-led as **good** because:

- The trust's visions and values were clearly displayed in all services. Staff agreed with them and told us they were discussed at meetings and supervision.
- All teams had clear objectives that had been identified from audits and feedback. All staff felt supported by their immediate line managers.
- Staff enjoyed their roles and there was an overall sense of peer support. Individual staff, who had personal challenges, were supported to promote their well-being.
- Staff were encouraged to contribute to service improvement.
- There was good structures in place, including team meetings and supervision, which ensured staff were listened to.

Good



Summary of findings

Information about the service

Crisis mental health services provided by North East London NHS Foundation Trust were available from home treatment teams (HTT). A HTT covered each of the boroughs of Redbridge, Barking and Dagenham, Havering and Waltham Forest. Barking and Dagenham and Havering shared a HTT.

The HTT was a specialist team of mental health professionals who provided short term support to people experiencing a mental health crisis. They aimed to prevent admission to a psychiatric hospital by providing treatment in the community, usually in people's own homes. The service was supported by the emergency duty team (EDT) and mental health direct (MHD) to allow it to operate 24 hours a day, seven days a week. The EDT provided emergency health and social care outside of normal office hours for all four boroughs. The service could provide Mental Health Act assessments by an approved mental health professionals (AMHP). The MHD service provided a dedicated 24 hour help and advice line for people experiencing mental health problems. Due to the low amount of inpatient mental health beds available to the population covered by the trust, the service was

supported by the acute crisis assessment team. They arranged and carried out urgent assessments and managed bed availability to allow HTT to manage their high caseloads effectively.

The trust had one health-based places of safety (HBPoS) that provided facilities for two patients. It was based at Goodmayes Hospital, where all acute inpatient wards and HTT were located. HBPoS is used for people detained under section 136 of the Mental Health Act. A section 136 is an emergency power given to the police. It allows a person to be removed from a public place to a place of safety for assessment if it appears to the police officer that the person is suffering

from a mental disorder. The health-based place of safety was also used when police have executed a warrant under section 135(1) of the Mental Health Act and is a safe place to carry out an assessment when required. A section 135(1) warrant is issued to police officers by the courts. It allows them to enter private premises to remove a person to a place of safety if there are concerns for their, or others, safety resulting from their mental state. A mental health assessment can then be arranged to assess their needs.

Our inspection team

Chair: Helen McKenzie, Executive Director of Nursing, Berkshire Healthcare NHS Foundation Trust.

Head of Inspection: Natasha Sloman, Care Quality Commission (CQC).

Team leader: Louise Phillips, inspection manager, Care Quality Commission.

The team that inspected the mental health crisis services and health-based places of safety comprised three Care Quality Commission inspectors, two specialist advisors with experience in mental health services and a Mental Health Act Reviewer.

Why we carried out this inspection

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

Summary of findings

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 two focus groups.

During the inspection visit, the inspection team:

- Visited three home treatment teams; the emergency duty team; the trust's health-based place of safety and mental health direct, a 24 hour mental health help and advice telephone service. We looked at the quality of the environments and observed how staff were caring for people who use services.

- Spoke with eight people who were using the service.
- Collected feedback from seven people who used the service from comment cards.
- Spoke with the team leaders for each of the teams.
- Spoke with 18 other staff members; including doctors, nurses, occupational therapists, psychologists, social workers and support, time and recovery workers.
- Attended and observed one handover meeting and two multi-disciplinary meetings.
- Attended and observed a group for people who use services.
- Attended and observed four home visits.
- Looked at 35 care records of patients.

Carried out a review of medication management for three teams and 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 seven comments cards from people and carers who use this service. Of these four were positive, two were negative and one was mixed. Positive themes related to excellent, respectful staff and negative themes concerned waiting times, being moved on too quickly and rude staff.

We attended a service user forum in the borough of Redbridge which was attended by 15 people. We heard some positive feedback from a person discharged from Redbridge home treatment team that day. Other feedback suggested the team had improved recently. People also commented it had been difficult to access services by telephone over the last year.

Good practice

We reviewed one care record for someone who was being offered open dialogue. This is a talking therapy which aims to break the stigma of psychosis by encouraging families to share their experiences of psychosis within a family. The service had trained eight staff across the home treatment service and were achieving positive outcomes. We were told a number of families were being offered open dialogue and the service planned to offer training to more staff.

The acute directorate operated with a small number of beds considering the population it served. This meant that all teams held very high caseloads to manage acute mental health issues in the community. The trust provided an acute crisis assessment team that was responsible for screening all admissions, managing bed flow and arranging approved mental health professionals for Mental Health Act assessments. The team was central to ensuring the service could respond effectively to the needs of people.

Summary of findings

Areas for improvement

Action the provider **MUST** take to improve

Action the provider **SHOULD** take to improve

North East London NHS Foundation Trust

Mental health crisis services and health-based places of safety

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Mental Health Direct	Trust Head Office
Health Based Place of Safety	Sunflowers Court
Emergency Duty Team	Trust Head Office
Barking and Dagenham, Home Treatment Team (HTT)	Trust Head Office
Redbridge, Home Treatment Team (HTT)	Trust Head Office
Waltham Forest, Home Treatment Team (HTT)	Trust Head Office

Mental Health Act responsibilities

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

Staff had a good knowledge of the Mental Health Act, particularly in areas which effected their practice, and training was mandatory for all staff.

People who were brought to the health-based place of safety under Section 136 of the Mental Health Act 1983

were made aware of their rights and this was appropriately recorded. They were also given good information and opportunity to access an independent mental health advocate.

The service had good access to Section 12 approved doctors, who had been trained and approved to carry out particular duties under the Mental Health Act, and approved mental health professionals (AMHP), which led to people being assessed in a responsive manner. However,

Detailed findings

people who had been assessed as having a mental disorder did not always have their social situation assessed by an AMHP before being sent home. This was in breach of paragraph 16.51 of The Mental Health Act Code of Practice.

Mental Capacity Act and Deprivation of Liberty Safeguards

Staff across the service had a good understanding of the Mental Capacity Act and its guiding principles. Training was mandatory but was only required to be undertaken on induction to the trust.

People's capacity was being adequately taken into consideration as they progressed through a service which

supports people who are acutely unwell. This meant that people's awareness and understanding may be impacted by their mental state when they enter the service, but would likely improve as they received treatment.

We observed minutes from recent home treatment team meetings that showed issues around people's capacity were discussed.

Are services safe?

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

* People are protected from physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse

Our findings

Safe and clean environment

- People using services were seen by home treatment team (HTT) staff on provider premises. Staff had access to personal alarms as well as alarms fitted in interview rooms.
- Teams that offered physical examinations had access to clean and tidy clinic rooms and necessary equipment that was well maintained and checked daily.
- We observed locked medicine cabinets for each HTT in the shared clinic room. People who used services had individually named medicines. Staff audited fridge temperatures to ensure they were suitable for storing medicine.

Safe staffing

- Redbridge HTT had seconded two band 6 staff to the Street Triage team. This service had been refunded and the service was now able to recruit into these roles.
- Waltham Forest HTT had vacancies for;
 - one band 5 nurse; and
 - one band 6 occupational therapist.
- Barking and Dagenham/Havering HTT had vacancies for;
 - two band 5 nurses; and
 - one support, time, recovery worker.
- In the home treatment teams, team leaders were able to increase staff numbers to ensure the caseload was managed safely. During our inspection the Waltham Forest HTT had a caseload of 65 and had six staff designated each shift to provide care via home visits.
- Bank staff and overtime for existing staff was mainly used to cover vacant shifts. Agency staff were given an induction and regular shifts so they were familiar with the service. This ensured safe and appropriate care was given.
- The service had a staff turnover rate of 8% and a sickness rate of 5% in the last 12 months.
- All teams had rapid access to a psychiatrist when required.
- Staff received mandatory training which included basic life support; safeguarding children and adults; Mental

Health Act and training to raise awareness of radicalisation (PREVENT). Staff in HTTs had an average mandatory training rate of 90%, with all teams achieving higher than 80%.

- Staff told us that they receive texts from the training department reminding them to attend mandatory training.

Assessing and managing risk to patients and staff

- We viewed 18 care records and all showed that staff had undertaken a risk assessment at the initial assessment. All staff rated risk as red, amber or green (red being high risk). Risk ratings were discussed daily at the multi-disciplinary team meetings.
- All HTTs displayed people's current risk on a board in the office. Staff assessed risk on all home visits we attended. Staff included a brief risk summary in all progress notes and risk assessments were updated after significant events. Crisis and contingency plans were consistently good across the service. Plans were individualised where appropriate and all contained generic information about accessing the trust's crisis services.
- The trust's acute directorate included the acute crisis and assessment team (ACAT) which operated 24 hours a day. Mental health professionals could contact ACAT to arrange urgent assessment for people in mental health crisis. The ACAT worked closely with HTT and had authorisation to take people onto their caseloads. This decreased waiting times for crisis assessments which could occur if HTT staff were engaged in supporting their existing caseload.
- The trust's acute directorate had a daily operations meeting that was attended by the director and deputy director of operations, ward matrons and HTT team leaders. It was a recent initiative aimed at keeping all concerned informed of any risk activity within the service. We attended this meeting and heard current patient safety, safeguarding issues, incidents, staffing levels and learning from incidents being discussed.
- Staff we spoke with had a good understanding of safeguarding procedures and 95% had received training. Safeguarding processes and contact numbers were displayed in all offices. All people who had children under 16 were routinely discussed at multi-disciplinary

Are services safe?

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

meetings to identify any safeguarding concerns. HTT caseload boards clearly indicated people with safeguarding concerns. Staff discussed safeguarding issues with their clinical leaders and knew who the trust safeguarding lead was.

- The trust did not expect staff to complete a genogram (a pictorial display of a person's family relationships and medical history) as part of a core assessment. However, all assessments we viewed included a comprehensive social network assessment.
- All teams had good lone working policies. People with identified risk were always seen at an office base or in pairs. Staff used a signing in and out board to communicate where they were going and what time they were due back. Staff would contact a designated staff if they were running late.
- Staff in HTT knew their lone working policy and were able to tell us that by contacting the team base and saying a certain phrase alerted staff that they needed assistance.
- The HTT had safe lockable bags to transport medicine. They also had access to cool bags for transporting medicine that needed to remain at a certain temperature.

Track record on safety

- Information provided by the trust showed there had been 13 serious incidents in the period from 1 November 2014 and 31 October 2015 relating to this service. The service had made safety improvements after reviewing these incidents. Examples included, introducing a daily acute operations meeting to ensure day to day risk was managed.

Reporting incidents and learning from when things go wrong

- Most staff across the service knew how to report incidents. Staff we spoke with had a high threshold for what to report, an example being their tolerance to verbal aggression and this led to low datix reporting. Minutes from Redbridge HTT team meeting showed that the team reported two incidents in the previous month. Other team meeting minutes showed that staff had not been recording safeguarding issues on datix; and incidents were not reported immediately. However, team leaders continued to ensure this issue was being addressed with staff.

- All teams had the opportunity to discuss incidents as this was an agenda item in all team meeting minutes. Staff felt that recently they were getting more feedback from serious incidents across the trust.
- Staff told us they were given opportunity to de-brief in meetings and supervision after serious incidents.

Health-based places of safety.

Safe and clean environment

- Staff had access to appropriate alarm systems for use in emergency.
- People using the health-based place of safety had access to a clean and tidy clinic room with well-maintained equipment allowing for physical examination and monitoring. All equipment was checked daily.
- The HBPOS had a potential ligature point that was sturdy enough to have something tied to it. This could not be viewed at all times by staff. People using this service intent on self-harm could use this to harm themselves. This was noted on the ligature audit as management controlled but did not give any specific details of what this meant. It also did not have a review date.
- The HBPOS had furniture on order after seeing a neighbouring trust using weighted furniture to reduce the risk of it being damaged.
- The HBPOS did not always have a bed. This meant that people did not have a safe place to lie down if required. However, staff used an accessible mattress and bed linen when this was required.

Safe staffing

- There was good staffing levels for the HBPOS. A band six or seven nurse and a support, time and recovery worker were allocated to the service 24 hours a day. They were supported by a clinical manager between 9am and 5pm Monday to Friday. The HBPOS was located near to inpatient wards so extra staff could be deployed quickly if necessary.
- Consultant psychiatrists were available to attend the HBPOS when needed.
- Staff that covered the HBPOS had an average mandatory training rate of 87%. Rates for prevention and

Are services safe?

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

management of violence and aggression (PMVA) training were 91%; rates for mental capacity act and deprivation of liberty safeguards training were 93% and rates for immediate life support training were 92%.

Assessing and managing risk to patients and staff

- Staff discussed risk issues with police when they made a referral over the phone. These risk issues were confirmed in person when the police arrived at the HBPoS. Police were asked to remain if risk was high. Staff told us that this is would be last resort as they have confidence in their own de-escalation skills.
- The street triage team worked with the police between the hours of 5pm and midnight. Street triage consisted of mental health professionals who provided on the spot advice to police officers who were dealing with people with possible mental health issues. They assessed risk and whether less restrictive options were appropriate. Staff told us that street triage had significantly reduced the number of people requiring the HBPoS.
- Staff and doctors had access to equipment to monitor people's physical health. If concerns were raised the person was transferred to a local acute hospital. Staff had access to pool cars to ensure this was done rapidly.

- Staff we spoke to had a good understanding of safeguarding procedures 92% had received training.
- Staff were aware of procedures to be followed in the event of people requiring rapid tranquilisation. These incidents were always reported appropriately..

Track record on safety

- Staff told us of a recent adverse event whereby someone set light to a bed. This incident was investigated and it was found that police had falsely claimed they had searched the person. Learning gained from this event made staff more vigilant around police search procedures.

Reporting incidents and learning from when things go wrong

- HBPoS staff had a good approach to incident recording. We saw that restraints, use of rapid tranquilisation, cultural issues, police concerns, safeguarding issues were all recorded on datix. A monthly spreadsheet was produced and discussed at monthly meetings attended by all staff involved in the HBPoS. Quarterly meetings with the boroughs police commanders also discussed these incidents.
- Staff told us they were supported and able to de-brief after 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

- Home treatment team (HTT) staff completed initial assessments that were focussed on risk issues and keeping people safe. People referred would have already been assessed by another mental health professional and deemed appropriate for acute services. The ACAT team were able to complete these assessments to ensure they were done in a timely manner.
- We looked at 38 care records for people who used the service. HTT care plans were well recorded and were focussed on crisis resolution. People who attended groups facilitated by the service had care plans to reflect this. People were given a generic 72hr care plan which clearly explained how the team would support them initially.
- HTT made plans for people's discharge but staff told us that people risk rated as green could be overlooked due to the need of others on the caseload. They felt that this led to caseloads being unnecessarily high as their resources did not stretch to facilitate appropriate discharge for people. This meant that people were not always receiving services, and therefore care plans, that reflected their level of need.
- The trust used RIO to record their care records. Staff found the system user friendly and had good understanding on how to use it to its full potential. Any paper documents were either uploaded on to RIO or scanned and uploaded to WinDIP, an electronic document management system. Staff were easily able to access records of people transferring from other services. Staff told us that accessing WinDIP could be time consuming.

All care records viewed included detailed progress notes. However, the service did not use a standard template so staff did not have a standard approach to recording care events. This made it difficult for staff to see whether people's care plans were implemented effectively; crisis issues were addressed and resolving; or discharge was being planned for

Best practice in treatment and care

- Home treatment team (HTT) staff were aware of The National Institute for Health and Care Excellence (NICE) guidelines around prescribing practice.
- We found medication reconciliation was routinely done as part of the admission process. We viewed three medicine charts whilst two staff were dispensing medicine in preparation for home visits. They were all completed correctly. We saw minutes from a Redbridge HTT meeting where a medicine incident had been discussed and learnt from. Pharmacists regularly visited and monitored medicine management. The HTT would administer controlled drugs to people and we were shown their policy on this. At the time of the inspection no controlled drugs were being managed by HTT
- Waltham Forest and Barking and Dagenham/Havering HTTs were involved in peer supported open dialogue, which is an intervention used to encourage families to talk about psychosis within the family. Eight staff had received training and were using this intervention across their caseloads. We viewed a case record that showed family members being supported to discuss sensitive issues related to mental health.
- Home treatment teams employed psychologists who were able to do focussed therapy with people. This allowed therapy, such as Open Dialogue, to continue even when their crisis had been resolved. Social workers within the team were available to support people whose crisis involved social issues. The trust's psychology department has a team (IMPART) which offers dialectical behaviour therapy for people with a diagnosis of personality disorder. Crisis services can refer to this team.
- All teams routinely offered physical health screening; this was clearly monitored on the caseload board. This ensured that any physical health issues were identified for people who may be too mentally unwell to engage with their GP.
- All teams followed clear guidelines when people started Clozapine treatment. After initial dose people were monitored for six hours to ensure there were no adverse reactions. We observed a Clozapine monitoring chart which showed physical observations were carried out one hour after each dose during the titration period.
- All teams used a clustering tool to rate severity of disorder. These automatically generated a review date. Redbridge HTT were in the early stages of introducing a clinical global impression scale to rate the response of HTT as an intervention.

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.

All teams audited length of admission, medicine charts and incident reporting. Staffing issues were also audited, such as training compliance, supervision and travel expenses.

Skilled staff to deliver care

- Staff in all teams were appropriately qualified and consisted of a range of professional backgrounds including nursing, medical, occupational therapy, psychology and social work. All teams had band 7 clinical leads for the different professions.
- Supervision and appraisal rates we viewed were high. The trust used the staff talent and review system that had been well received by staff. The trust were using this system as it supported staff to gain revalidation of their Nursing and Midwifery Council registration. All teams had supervision trees that ensured staff were supervised by a person more qualified in their discipline person appropriate person.
- Redbridge HTT had supervision trees displayed in their offices to remind staff of its importance.
- Home treatment team staff received specialist training to improve their practice. These included training in social systems, open dialogue and positive risk management. Staff had also attended a cultural away day as part of the trust commitment to raise awareness of issues relating to black and minority ethnic groups.
- No teams had nurse prescribers. Team leaders told us that medical staff were always available to prescribe medicine at short notice or in emergency.
- Band 2, 3 and 4 clinical staff across the service received the care certificate training, which is the benchmark for providing unqualified staff with the fundamental standards of care.
- The service had a good approach to appointing champions to take a lead in clinical areas. These were chosen on clinical experience and interest. For example social workers were chosen as safeguarding champions.
- The team leader of Redbridge HTT told us they were supported in dealing with staff issues. They were managed by other managers and updates were given by human resources every two weeks.

Multi-disciplinary and inter-agency team work

- All teams had monthly business meetings. We observed Redbridge HTTs two hour meeting. It comprehensively covered clinical issues and included a presentation by

the team consultant on the proposed use of a clinical global impression scale (a way of auditing the affect of HTT intervention on people). Staff attendance was good and staff interaction was meaningful.

- We observed the Waltham Forest HTT handover. Each person's notes were displayed on a projector and discussed in detail by members of the multi-disciplinary team. Risk assessments and care plans were updated during the handover.
- Staff from HTT, access, assessment and brief intervention teams, which is the single point of entry to secondary mental health services, and community recovery teams attended each others team meetings to discuss people who were transferring between services. This was a recent initiative in response to a serious incident.
- HTT routinely discharged people back to their care coordinator or keyworker with all parties present and agreeing to the discharge. This meant that the person experienced appropriate continuity of care as ongoing care plans could be discussed and agreed.
- HTT staff attended inpatient wards to assess patients who may be suitable for treatment at home rather than on the ward.
- HTT signposted people to similar agencies to address social issues. This was part of the crisis intervention and people would remain on HTT caseload.

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

- We found staff had good knowledge of the Mental Health Act. Staff had recently been required to complete Mental Health Act training as mandatory. Some staff we spoke to had attended this training but we were unable to obtain accurate figures.
- HTT staff told us that they would support people in the community whilst on extended Section 17 leave from the ward. These arrangements were rare and would be reviewed weekly. The team consultant liaised with the person's responsible clinician from the ward and if HTT involvement continued the section would be rescinded.
- HTT would joint work with a person's care coordinator from CRT if they were on a CTO. The care coordinator would remain the primary contact with HTT offering additional support.

Good practice in applying the Mental Capacity Act

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.

- Most staff we spoke with told us they had received training in the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards. Figures we received showed 75% compliance. Staff were not required to repeat this training, which meant their knowledge was not updated. Staff from HTTs had a good understanding of how to assess whether people had capacity. The consultant routinely recorded people's capacity at every review.
- We viewed minutes of a previous team meeting which showed Redbridge HTT had discussed capacity and recording on RIO. They concluded that the RIO function was limiting and had plans in place to be more aware of people's capacity.

Health-based places of safety.

Assessment of needs and planning of care

- We reviewed 50 records of people who had been detained under S136 of the Mental Health Act between 1 January 2016 to 31 March 2016. All assessments had been completed within 72hrs, the longest being 18hrs, the shortest 40 minutes. Staff told us that the acute crisis assessment team (ACAT) helped arrange approved mental health professionals (AMHP) and Section 12 approved doctors.
- ACAT also notified HTT of all S136 detentions and explored the most suitable option for people who agreed to admission.
- We observed 21 care records in detail and found that, in six cases, when people were discharged with follow-up, staff did not give sufficient details of what this entailed.
- We reviewed two care records where an AMHP had not assessed a person, deemed to have a mental disorder, before they were discharged home. This could lead to a vulnerable person returning to an unsuitable social situation. This practice did not comply with The Mental Health Act Code of Practice.

Best practice in treatment and care

- The trust had a recently updated policy in place regarding the process for using the health based place of safety (HBPoS). Staff had access to this in their office.
- Staff were aware of The National Institute for Health and Care Excellence (NICE) guidelines around physical health monitoring following rapid tranquilisation. They provided regular monitoring until people were fully alert.

- The mental health act administrators regularly audited HBPoS practice. This included length of waiting time for assessment, length of stay, outcomes following assessment and data around gender, ethnicity and age.

Skilled staff to deliver care

- Staff were suitably qualified and received training specific to the role. All staff were confident in communicating with people in distress. We were told that restraint was rarely used and the last time was two weeks ago. The service received 607 presentations in the last year which is an average of 12 a week.
- We spoke with staff that had completed training in dialectical behaviour therapy and used these skills, such as helping people manage their short-term distress, to support people experiencing emotional crisis.

Multi-disciplinary and inter-agency team work

- All staff who coordinated the HBPoS attended a monthly meeting with senior management from the acute directorate to review practice and discuss incidents.
- Senior staff attended quarterly meetings with police commanders to review practice and incidents. Issues such as police search protocol had been addressed at these meetings.
- Staff told us the introduction of street triage had significantly improved relations with the police. We were told that police had improved their contact to the HBPoS before arriving. This helped staff assess the potential for risk and make necessary preparations.

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

- People had been informed of their rights and this had been recorded in 20 out of 21 care records reviewed.
- The date and time of commencement of S136 was clearly recorded in all cases. All staff were aware the S136 started when the person arrived at the HBPoS.
- In three of the 21 care records we viewed, it was not clear whether the S136 had been applied in a public area.
- In five of the 21 care record we viewed the time that the S12 doctor and AMHP arrived was not clearly recorded.

Good practice in applying the Mental Capacity Act.

- Staff told us they would assume that a person had capacity. They had good understanding of when a person may be lacking capacity and how this could be

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.

tested. If medicine or physical observations were required, consent was gained and this was recorded on RIO. If consent could not be gained, and it was felt that

giving treatment was in the persons best interests, the on-site consultant would give consent. This was recorded as an incident on datix as well as recorded on RIO.

Are services caring?

Good 

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

Our findings

Kindness, dignity, respect and support

- We attended six home visits with home treatment teams (HTT). At all times staff were observed interacting with people who use services and their carers in a respectful and compassionate manner. This included staff resolving difficult situations.
- People we spoke with felt that staff were caring and supportive when they were in crisis. However, felt that they could be overlooked and receive minimal support when they are in need of general support. This view reflected feedback we had gathered prior to the inspection.
- Confidentiality was well maintained during assessments and home visits we observed. Staff in all teams' handovers and meetings discussed people in a positive, respectful manner.

The involvement of people in the care that they receive

- HTT had a policy of giving people copies of their care plan. This was clearly displayed on the caseload board and we observed staff being reminded to collect signed copies on home visits. They had access to laptops to assist people's involvement in their care plans during home visits. This practice was being audited by team leaders.
- HTT had a clear system on their caseload board which indicated an identified carer and whether they had been offered an assessment.
- Carer's groups were available in all four boroughs. We heard that CRT staff ran groups which were open to all carers.

- Barking and Dagenham/Havering and Waltham Forest HTTs were currently involved in peer supported open dialogue which supported people and their families discuss difficult issues related to psychosis.
- Information was available for people who used the service on access to advocacy.
- People we spoke with said they were informally invited to give feedback on services but teams did not routinely offer entry/exit survey to monitor people's experience or satisfaction.

Health-based places of safety.

Kindness, dignity, respect and support

- People were brought into the HBPOS via a private side entrance to maintain their privacy and dignity. Staff ensured that handcuffs were removed by police before people were brought into the HBPOS.
- People were offered refreshments on arrival at the HBPOS and on request.
- The nurse in charge was responsible making transportation arrangement between places of safety. They told us they never used police vehicles. Ambulances were used if medically required.

The involvement of people in the care they receive

- People had access to independent mental health advocates. Contact details for this service were displayed in the HBPOS. A list of solicitors was also available. People had access to a phone which they could use in private.
- Staff did not prioritise gaining feedback from people who had used the HBPOS. Staff told us that questionnaires to give feedback did exist; however, they were not readily available for people to access.

Are services responsive to people's needs?

Good 

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

Our findings

Access and discharge

- The Mental Health Crisis Care Concordat states “People in crisis should expect local mental health services to meet their needs appropriately at all times”. The trust successfully met this requirement through provision of home treatment teams, emergency duty team (EDT), acute crisis assessment team (ACAT) and Mental Health Direct
- The EDT were able to respond to emergency situations outside of normal working hours. The team consisted of four full-time approved mental health professionals (AMHP) and social workers with support from qualified bank staff. They were currently in the process of recruiting three qualified full-time staff.
- We heard from people who used services that recent issues with telephone systems across the trust had made accessing services difficult. Examples were given of people being unable to get through to the service for long periods and eventually giving up. They told us this had affected their confidence in the service. EDT told us they had given staff's mobile numbers to the trust switchboard so these could be passed to people. The trust informed us that a new telephone system had now been implemented.
- Home treatment teams were able to respond to referrals to the service within four hours. If HTT staff were not available, ACAT staff would complete assessments. ACAT gatekept all admissions to acute inpatient services. This meant that people were admitted to inpatient services if not deemed suitable for home treatment.
- All teams followed up people who did not attend appointments. This included phone calls and unannounced home visits, if risk was identified. If contact could not be made, letters were sent giving people a date to contact the team by. They were informed that if they did not contact the team they would be discharged back to their primary care team.
- People were asked to give contact numbers for people that could be contacted in emergencies. These numbers were used if the team had difficulties contacting people.
- HHT staff told us they occasionally had to cancel appointments due to other work commitments. They informed people of this as soon as possible and made arrangements for alternative contact.

- People had access to Mental Health Direct. This service operated 24 hours a day and was staffed by clinical staff who offered mental health help and advice. They helped people make contact with a mental health professional or advised them on what services were available to support them. Since January 2015 it had been independent from HTT, taking pressure off this service. Figures from February 2016 showed 1146 calls received (average of 40 per day). We viewed details of calls received and actions taken and found the service to be very beneficial to people.

The facilities promote recovery, comfort, dignity and confidentiality

- The HTT ran groups every day for people that included a free lunch. On Friday the group held a social activity that was funded by the team. They had access to two people carriers to transport people.
- The service displayed lots of information on treatments and local services. However, we found that information on how to complain was not always readily available to people.

Meeting the needs of all people who use the service

- The service did not have a policy to flag people who had a learning disability although all team leaders told us they did support this group. There was no policy to ensure reasonable readjustments would be made to accommodate their needs, however, all team leaders felt that their staff were mindful of this.
- All teams used interpreter services regularly and they were easily accessible. Across all teams we saw information leaflets in a variety of languages that met the needs of the community.

Listening to and learning from concerns and complaints

- Between 1 May 2014 and December 2015, the service had received four complaints. Of these, one had been upheld and one had been partially upheld.
- People who used services had differing knowledge of how to complain. Most felt confident to approach staff but had not seen information on how to complain.
- Team leaders informed us that complaints would be dealt with informally in most cases, and escalated to a formal complaint if not resolved.

Are services responsive to people's needs?

Good 

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

Health-based places of safety.

Access and discharge

- The health-based place of safety (HBPoS) was used regularly by people in need of mental health assessment. Between 1 April 2015 and 31 March 2016 it had been used 607 times.
- People were seen promptly by staff and a doctor to assess whether a mental disorder was present. If required, an assessment was arranged quickly. In all cases we viewed the assessment started within three hours.
- If people required inpatient care following assessment, this was always available. All in patient units were on site so admissions ran smoothly without delay.
- If HBPoS facilities were in use the trust were able to direct police to HBPoS in neighbouring boroughs.
- We observed six out of 21 care records where people were discharged from the S136 without detailed plans for support and follow up by mental health professionals, even in cases where mental disorder was present.

The facilities promote recovery, comfort, dignity and confidentiality

- People using the HBPoS had access to a safe where they could store their valuables. We saw that good procedure was followed to safeguard people's belongings.
- The HBPoS had a private side entrance so people being brought in would have their privacy and dignity maintained.
- Furniture was well-worn and there was a lack of chairs available. We were told that these had recently been damaged and new furniture was on order.

- A bed was not always available in the HBPoS and was only bought if clinically required. This meant people could not maintain comfort unless they specifically asked. People's rights under S136 were explained and documented in 20 out of 21 cases we viewed.
- Written information on people's rights was available.
- People had access to interpreter services via a contract with a neighbouring borough.

Meeting the needs of all people who use the service

- Street triage had helped reduce the number of S136 applications made across the four London boroughs it served.
- Young people used the same HBPoS facilities as adults. Of 228 records screened between 1 September 2015 to 31 March 2016, five related to people under the age of 18.
- We were told that a child and adolescent consultant and nurse attended from the on-site ward in all cases. This was only clearly recorded in one of the five cases.
- The trust did not routinely flag instances of people with learning disabilities who were referred to the HBPoS. Staff told us that they were mindful of the needs of these individuals and would make reasonable adjustments, such as prioritising the assessment and deploying staff from the learning disability ward if required.

Listening to and learning from concerns and complaints

- Between 1 May 2014 and December 2015, the service had received zero complaints.
- Incidents and informal complaints, such as complaints about police, were recorded on datix and discussed at regular meetings.

Are services well-led?

Good 

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

Our findings

Vision and values

- Staff we spoke with understood and agreed with the trust's vision and values. These were emphasised during the trust induction and were discussed during supervision.
- All team leaders had clear objectives for their teams and were aware of any challenges.
- Staff said that senior managers were visible within the organisation. The operational director attended daily meetings to help staff manage risk within the service.
- The service were very committed to the trusts strategy to be more inclusive toward black and minority ethnic groups. This was in line with the workforce race equality standard (WRES).
- The chief executive invited staff to attend breakfast meetings. Staff had attended this and found senior management very approachable.

Good governance

- The service had good governance systems in place to ensure effective and safe practice. Staff told us they prioritised direct care activities and this affected their focus on some issues, such as incident reporting and clinical audits.
- Supervision was prioritised and all staff took responsibility for their participation in this.
- The service displayed good safeguarding practice. Safeguarding champions were appointed and training rates were high.
- The service supported people with fluctuating mental states and gave consideration to assessing people's capacity whilst they were receiving care. Most staff had received training in the Mental Capacity Act. This training was mandatory, however, staff were not required to update their knowledge.
- The service had a key performance indicator of ensuring that people experiencing their first episode of psychosis was seen by the specialist psychosis team (EIP) within 14 days. We saw this being imposed in team meeting minutes.
- Team leaders told us that they had enough time and autonomy to manage their teams. They also felt confident approaching senior managers for support.

- Staff were aware of the trust and local risk registers. They were able to submit items to this and local risk registers were agenda items in team meetings.

Leadership, morale and staff engagement

- Staff we spoke with enjoyed working within crisis services. They told us the service was very busy and that the whole team worked hard to support each other. Team leaders would assist with clinical issues and we saw evidence of daily workloads being capped to ensure the well-being of staff.
- A number of staff we spoke with were currently completing training that supported leadership and career development.
- Staff told us that they received their work rota two months in advance. This allowed them to plan activities outside of work.
- Staff told us that they felt confident to whistleblow. They all said they would do this internally. They were not aware where they could raise concerns directly to the care quality commission to help maintain their anonymity.
- According to data collected in December 2015, 55% of staff across the trust would recommend the trust as a place to work. This is below the national average of 62%.
- Staff felt able to input into service development. We spoke with staff who were contributing to the trust prescribing policy.

Commitment to quality improvement and innovation

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Commitment to quality improvement and innovation

- Redbridge HTT had taken part in a crisis team fidelity study over the last year carried out by University College London. The team were rated on 39 core crisis team standards. Their baseline score was 138, which was above the national average of 120. Their score had increased to 140 after six months and 142 after 12 months. Areas that had been identified as requiring improvement were being addressed, for example, providing clear care plans to people.

Health-based places of safety.

Vision and values

- Staff we spoke with agreed with the trust's vision and values. These were emphasised during the trust induction and were discussed during supervision.

Good governance

- The service had good governance systems in place. The S136 policy had been recently updated and reflected the MHA Code of Practice.
- Management attended monthly meetings to review policy.
- The use of the HBPOS was well audited
- The HBPOS coordinator had robust systems in place to ensure extra staff could be deployed to support emergency situations.

Leadership, morale and staff engagement

- Staff enjoyed their roles and spoke highly of managers and colleagues.

Are services well-led?

Good 

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.

- Staff told us they were able to visit other HBPoS to see good practice. This had led to new weighted furniture being ordered. Staff had also been involved in creating a flowchart to improve communication with police.
- Street triage had been introduced one year ago in the boroughs covered by the trust. This initiative had reduced the number of S136 admissions to the HBPoS. Funding had recently been agreed for a second year.

Commitment to quality improvement and innovation

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

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Diagnostic and screening procedures

Treatment of disease, disorder or injury

Regulation

Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

People who were assessed to have a mental disorder were not always seen by an Approved Mental Health Practitioner before being discharged from Section 136 of The Mental Health Act 1983. This does not meet requirements under Mental Health Act Code of Practice; paragraph 16:51. This meant that a vulnerable person could be returning to an inappropriate social situation.

This is a breach of Regulation 12 2(b)

This section is primarily information for the provider

Enforcement actions

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.