Barnet, Enfield and Haringey Mental Health NHS Trust

Mental Health Liaison Service

Quality Report

Barnet, Enfield and Haringey Mental Health NHS Trust Headquarters,
St Ann's Hospital, St Ann's Road, London N15 3TH.
Tel:02084426000
Website:www.beh-mht.nhs.uk

Date of inspection visit: 22 September 2016
Date of publication: 22/12/2016

Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RRPXX	Trust Headquarters	Mental health liaison service North Middlesex University Hospital	N18 1QX

This report describes our judgement of the quality of care provided within this core service by Barnet, Enfield and Haringey Mental Health NHS Trust. Where relevant we provide detail of each location or area of service visited.

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

Where applicable, we have reported on each core service provided by Barnet, Enfield and Haringey Mental Health NHS Trust and these are brought together to inform our overall judgement of Barnet, Enfield and Haringey Mental Health NHS Trust.

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

Contents

Summary of findings

Overall summary

We do not currently rate liaison psychiatry services.

We found the following areas of good practice:

- The mental health liaison service at North Middlesex Hospital comprised experienced and well-trained staff from the appropriate professional disciplines and a consultant psychiatrist was always available for advice. Staff worked together to meet patient needs and were well supported in their work role.
- The service had safe facilities provided by North Middlesex University Hospital in which to interview patients. Arrangements for out-of-hours cover were robust and effective.
- The mental health liaison service had an operational procedure developed with North Middlesex University Hospital. The procedure ensured the effective operation of the service and clarified the roles and responsibilities of each organisation. This ensured that the risks to patients and others were well-managed. There was joint learning from adverse incidents across both organisations.
- The mental health liaison service promoted the understanding of their role to North Middlesex University Hospital staff in ED and on the wards. Staff contributed to the development of good practice at the North Middlesex University Hospital in terms of meeting the needs of patients with mental health needs and their carer's.
- The mental health liaison service had a set of key performance indicators which were used to judge its performance. The service performed at slightly below the expected levels in terms of response times to referrals. The mental health liaison service managers worked with managers in North Middlesex University Hospital, Barnet, Enfield and Haringey Mental Health NHS Trust and other areas to analyse the challenges in meeting these KPIs.
- The mental health liaison service included professionals who were trained to carry out brief psychological interventions and advise North Middlesex University Hospital staff on the treatment and care of patients. Staff gave patients support to access advice from other organisations or on-going mental health support. The mental health liaison service sent details of their intervention to the patient's GP.
- The mental health liaison service promoted an understanding of the mental health needs of patients amongst North Middlesex University Hospital through training activities. The service had set up a forum to obtain feedback from users and carers and acted on their views.
- The service had been accredited by the mental health liaison accreditation network. The mental health liaison service had been awarded the Barnet, Enfield and Haringey Mental Health NHS Trust 'team of the year' in 2015 for its innovative multi-agency work.

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

- The mental health liaison service should continue to work with North Middlesex University Hospital and all relevant agencies to analyse its performance with the aim of ensuring key performance indicators are consistently met.
- The mental health liaison service should continue to work with North Middlesex University Hospital to ensure that there is an appropriate alarm system available in the mental health room.

Summary of findings

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

Are services safe?

We do not currently rate mental health liaison services.

We found the following areas of good practice:

- The mental health liaison service had developed an agreed process with North Middlesex University Hospital staff to manage risks. This aimed to ensure that North Middlesex University Hospital staff assessed and managed risks appropriately whilst patients were in the Emergency Department (ED). For example, staff recorded how ED staff should observe the patient to keep the patient and others safe. The mental health liaison service reviewed risks to patients at least twice each day at handover meetings and prioritised their work to ensure risks were managed.
- The mental health liaison service could safely assess mental health patients in ED in a room which, overall, was appropriately designed for use by mental health patients.
- The mental health liaison service staffing levels were appropriate to meet demand and staff vacancies were covered. Staff had received mandatory training.
- Staff understood their safeguarding role and liaised with the North Middlesex University Hospital lead nurse to ensue children's safeguarding issues were acted on.
- The mental health liaison service reported adverse incidents and worked with other teams and organisations to learn lessons and make changes to practice if necessary.

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

- The mental health liaison service should continue to work with North Middlesex University Hospital to ensure that there is an alarm system available in the mental health room which is not liable to be easily damaged.

Are services effective?

We do not currently rate mental health liaison services.

We found the following areas of good practice:

- The mental health liaison service comprised staff from the appropriate disciplines. Although key performance indicators were not fully met, overall, the service carried out assessments and brief interventions in a timely manner and prioritised their work effectively.

Summary of findings

- The team used record keeping systems which enabled them to obtain relevant background information about patients' background and previous contact with services. The team kept records of their interventions which could be accessed by colleagues in Barnet, Enfield and Haringey Mental Health NHS Trust in the case of patients who required ongoing support.
- A psychologist in the team was available to provide brief interventions to patients. The mental health liaison service referred patients for ongoing psychological support when this was appropriate.
- There were effective multidisciplinary meetings and handovers at which patients were discussed and risks reviewed. Outcome measures were in place. Staff were experienced and received training to ensure they were competent in their work role.
- The role of the mental health liaison service in relation to Mental Health Act assessments was clearly defined. The team actively assisted North Middlesex University Hospital to carry out their responsibilities under the Mental Capacity Act.

Are services caring?

We do not currently rate mental health liaison services.

We found the following areas of good practice:

- We spoke with mental health liaison service staff about the patients they were assessing and observed a handover meeting. Staff demonstrated a very detailed understanding of the needs of individual patients.
- Staff actively involved patients in assessing their needs and planning their care. Staff asked patients for their consent to information sharing.

Are services responsive to people's needs?

We do not currently rate mental health liaison services.

We found the following areas of good practice:

- The mental health liaison service provided a service seven days a week, 24 hours a day. There were clear target times for the response to referrals from ED and the wards. The service responded quickly to referrals when risks were high.

Summary of findings

- The mental health liaison service provided a service to any patient referred to them by North Middlesex University Hospital regardless of the patient's home address.
- Patients knew how to make a complaint.
- The mental health liaison service provided patients with a wide range of information about local services. The service used interpreters when appropriate.
- The mental health liaison service had set up a forum to obtain the views of patients and carers and had acted on the feedback received.

Are services well-led?

We do not currently rate mental health liaison services.

We found the following areas of good practice:

- Staff understood Barnet, Enfield and Haringey Mental Health NHS Trust values and mental health liaison service objectives reflected these values.
- The mental health liaison service operated according to a procedure developed with North Middlesex University Hospital. These operational procedures were effectively implemented and well understood by North Middlesex University Hospital staff. There were robust arrangements to ensure there were good working arrangements with other teams and organisations.
- Staff enjoyed their work role and told us their managers and colleagues were supportive. They knew about whistle blowing and said they felt comfortable raising any concerns.
- Staff worked with North Middlesex University Hospital staff to promote the service and recognition of patients' mental health needs. The team demonstrated a commitment to innovation and good practice. The team had won 'team of the year' from Barnet, Enfield and Haringey Mental Health NHS Trust in 2015 and had been accredited by the mental health liaison accreditation network.

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

- It was difficult for the mental health liaison service to always meet the KPIs in terms of response times when the service was very busy. At these times, the mental health liaison service concentrated on meeting the needs of patients with the most risks, and this impacted on the response time to patients who

Summary of findings

presented less risks. Additionally, external factors such as pressures on the approved mental health practitioner service and the high demand for mental health in-patient beds, impacted on KPIs.

Summary of findings

Information about the service

Barnet, Enfield and Haringey Mental Health NHS Trust provides a mental health liaison service at two general hospitals: North Middlesex University Hospital and Barnet General Hospital.

This inspection focused on the mental health liaison service provided at North Middlesex University Hospital. The service has been fully operational since January 2014. The stated aims of the mental health liaison service are to improve patient outcomes through:

• improved access to mental health care

• reduced emergency department waiting times for people with mental health needs

• reduced admissions, re-admissions and lengths of stay in acute care for people with mental health needs

• reduced use of acute beds by patients with dementia

• reduced risk of adverse events

• enhanced knowledge and skills of North Middlesex University Hospital staff in relation to mental health needs

• improved compliance of North Middlesex University Hospital with legal requirements under the Mental Health Act and Mental Capacity Act.

The service operates seven days a week and 24 hours a day. North Middlesex University Hospital staff in the emergency department (ED) and wards refer patients to the mental health liaison service for support with assessing and treating their mental health needs. The mental health liaison service mental health liaison service at North Middlesex University Hospital receives on average 350 referrals from North Middlesex University Hospital staff each month. About 66% of these referrals are of patients in ED and about 33% are of patients on a ward.

The mental health liaison service comprises a multidisciplinary team which is based in a small suite of offices on the North Middlesex University Hospital site; this is not accessed by patients. Mental health liaison service staff assess patients in a designated mental health interview room, or in mental health bays in the ED or on the wards.

The mental health liaison service provides brief assessments and interventions. Staff direct patients towards appropriate services for follow-up care and treatment. The mental health liaison service and North Middlesex University Hospital have developed an operational policy which sets out the role of the mental health liaison service and the responsibilities of and North Middlesex University Hospital in relation to the safety, assessment and treatment of patients.

The mental health liaison service has a target of a one hour response time for a patient referred from ED, a four hour response time to patients in the assessment unit attached to ED and a twenty four hour response time for a patient referred from a ward. The performance of the team against these targets is closely monitored through key performance indicators.

Our inspection team

The team which inspected the mental health liaison service consisted of two CQC inspectors and a specialist advisor. The specialist advisor was a nurse with experience of providing a mental health liaison service.

Summary of findings

Why we carried out this inspection

We inspected the mental health liaison service at North Middlesex University Hospital at the same time as a CQC inspection of acute services at North Middlesex University Hospital.

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 the service, and asked the provider Barnet, Enfield and Haringey Mental Health NHS Trust for information about the mental health liaison service.

During the inspection visit, the inspection team:

- visited the mental health liaison service at North Middlesex University Hospital and viewed the facilities used by the service when assessing patients in the emergency department mental health liaison service
- spoke with three nurses working in the mental health liaison service
- spoke with a psychologist working in the mental health liaison service
- attended and observed a mental health liaison service hand-over meeting when the assessment and treatment of patients was discussed and planned
- read information relating to the operation and performance of the service
- received feedback from CQC colleagues inspecting acute services at North Middlesex University Hospital about the views of North Middlesex University Hospital staff on the quality of care provided by the mental health liaison service
- spoke with the manager of the mental health liaison service.

What people who use the provider's services say

The service had obtained feedback on the service through a forum for patients and carers. In response to the views of carers a directory of resources had been developed so carers could more easily access support. In addition a support group for carers of patients using the early intervention service had been set up.

Good practice

- The North Middlesex University Hospital safeguarding lead nurse visited the mental health liaison service office each morning to check new referrals to the service and ensure there was appropriate follow up of any safeguarding children issues.

Summary of findings

- The mental health liaison service set up a forum to obtain feedback about the impact of the service from users and carers and obtain their views. Consequently, the mental health liaison service developed a directory of services for carers of patient with mental health needs and worked with North Middlesex University Hospital to develop a carers group.

Areas for improvement

Action the provider SHOULD take to improve

- The mental health liaison service should continue to work with North Middlesex University Hospital to ensure that there is an appropriate alarm system available in the mental health room.
- The mental health liaison service should continue to work with North Middlesex University Hospital and all relevant agencies to analyse its performance with the aim of ensuring targets in relation to waiting times are consistently met.

Barnet, Enfield and Haringey Mental Health NHS Trust

Mental Health Liaison Service

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Mental health liaison service North Middlesex University hospital	Barnet, Enfield and Haringey Mental Health NHS Trust

Mental Health Act responsibilities

- We do not rate responsibilities under the Mental Health Act (MHA) 1983.We use our findings as a determiner in reaching an overall judgement about the Provider.
- The mental health liaison service carried out assessments of patients in the emergency department (ED) at North Middlesex University Hospital. In general, if the mental health liaison service identified that a MHA assessment was required the service contacted the approved mental health practitioner service in Enfield, as North Middlesex University Hospital is located in the borough of Enfield. The mental health liaison service referred patients already known to Haringey mental health services to the Haringey approved mental health practitioner service.
- During normal working hours, a MHA section 12 Approved doctor in the mental health liaison service completed the first recommendation of the MHA assessment. The approved mental health practitioner service arranged the second opinion doctor. Out of hours, the nurses working in the mental health liaison service contacted the duty approved mental health practitioner who has the responsibility to liaise with the on call doctor to complete the first recommendation and to arrange a second opinion doctor. The mental health liaison service liaised with bed managers at Barnet, Enfield and Haringey Mental Health Trust for patients from the local area and with the bed managers from other mental health trusts when this was appropriate because the patient was already known to that trust.
- The approved mental health practitioner services had target times in terms of responding to requests from the mental health liaison service for MHA assessments. There were also targets in terms of the transfer of the care of patients from the ED or ward to a mental health resource. However, in practice, patients often had to wait for several hours for an approved mental health practitioner service and then for a further period of time

for an in-patient mental health bed. These delays were due to pressures on the approved mental health practitioner services and a shortage of mental health beds across London.

- Waiting times were closely monitored by both North Middlesex University Hospital and Barnet, Enfield and Haringey Mental Health NHS Trust and there were protocols in place in terms of escalating breaches of the agreed waiting times. Senior managers in both organisations became involved to ensure that all possible action was taken to transfer mental health patients promptly to a suitable resource.
- The responsibilities of North Middlesex University Hospital staff and the mental health liaison service in relation to the safety, care and treatment of patients whilst awaiting a MHA assessment, or a transfer of care to a mental health service, were clearly set out in a joint protocol. The North Middlesex University Hospital was responsible for the safety and care and treatment of the patient whilst they were at North Middlesex University Hospital, with the mental health liaison service providing professional advice and guidance to North Middlesex University Hospital staff on care and treatment.
- North Middlesex University Hospital was responsible for receiving and processing MHA paperwork in relation to patients whilst they were at North Middlesex University Hospital. The mental health liaison service and the MHA office at Barnet, Enfield and Haringey Mental Health NHS Trust provided advice and guidance on legal issues in relation to the MHA. mental health liaison service
- The mental health liaison service did not routinely assess patients brought to the by the police under section 136 of the MHA. In such cases, the assisted staff and the police with arranging the transfer of the person to a designated section 136 suite provided elsewhere by Barnet, Enfield and Haringey Mental Health NHS Trust. If it was not appropriate to immediately transfer a patient to a 136 suite, for example, if the patient required ongoing treatment for their physical health at North Middlesex Hospital, then the mental health liaison service conducted an assessment.
- The manager of the mental health liaison service attended monthly inter-agency meetings to review how organisations managed their MHA responsibilities and make any necessary improvements.

Mental Capacity Act and Deprivation of Liberty Safeguards

- All staff in the mental health liaison service had received training on the Mental Capacity Act (MCA). Information about the Act, including the principles, was displayed on a notice board in the team's office. Staff had a clear understanding in the MCA and upheld its principles in practice. For example, staff presumed that patients had the mental capacity to decide whether to consent to care and treatment or not, unless there were was evidence to the contrary.
- The mental health liaison service advised North Middlesex University Hospital staff on mental capacity issues. For example, wards referred patients with dementia to the mental health liaison service for an assessment of the patient's mental capacity to understand specific decisions about their long-term care. Additionally, the mental health liaison service was asked to advise on the mental capacity of patients with regard to potential use of the Deprivation of Liberty Safeguards. The mental health liaison service was able to access advice on any complexities in relation to the use of the MCA from expert colleagues in Barnet, Enfield and Haringey Mental Health NHS Trust.

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

- The mental health liaison service received referrals from North Middlesex University Hospital staff which included details of any assessed risks to patients or staff. In the case of referrals from the emergency department (ED), mental health liaison service staff assessed patients in mental health bays and a mental health room located in the emergency department. The mental health room was clean and appropriately designed and furnished. It had two doors, an observation panel and was free of ligature points. The room was appropriately furnished. ED staff could observe the room by means of CCTV cameras linked to monitors in the nursing station. If mental health liaison service staff considered they were at risk of harm from a patient, they saw the person with another mental health liaison service staff member and asked North Middlesex University Hospital security staff to stand by to intervene.
- Mental health liaison service staff did not have personal alarms. Mental health bays had a functioning emergency button. The mental health room had a strip alarm system. At the time of the inspection, this alarm had been damaged and was out of action. This had been the case for about two weeks previous to the inspection. North Middlesex University Hospital trust were in the process of installing a more robust alarm system. In the interim, the mental health liaison service mitigated risks through assessing in pairs, and ensuring there was enhanced observation of the room by North Middlesex University Hospital trust staff and security staff. The location of the room within the ED meant that assistance to mental health liaison service could be rapidly provided by North Middlesex University Hospital trust staff and security staff.
- The mental health liaison service also saw patients on the North Middlesex University Hospital wards. Staff told us referral information from the ward was reviewed to clarify whether there were any risks before seeing the patient. Where there were risks, North Middlesex University Hospital staff and the mental health liaison service jointly planned how risks could be mitigated.
- North Middlesex University Hospital trust staff were responsible for and for maintaining the cleanliness of clinical areas and equipment. The areas used by patients of the mental health liaison service appeared to be clean.

Safe staffing

- The mental health liaison service operated 24 hours a day seven days a week. During normal working hours, a psychiatrist, a specialist doctor, two foundation doctors and two graduate mental health workers were also in the team, as well as an administrator. Administration support to the team was currently under review by the Barnet, Enfield and Haringey Mental Health NHS Trust. From 8.30pm to 7.30pm, and at weekends, two nurses were on duty. Psychiatrist support and advice was available through the Barnet, Enfield and Haringey Mental Health NHS Trust on - call psychiatrist. Staff told us this worked well and they could access the support and advice they required. During the winter (October to March) an additional nurse post was commissioned for the service funded from the commissioners' 'winter pressures' budget.
- The service had a staff sickness rate of 2% over the 12 months previous to this inspection. In this period, due to staff vacancies, mental health liaison service had 71 shifts that needed to be filled by bank or agency staff; 67 of these shifts were filled, with four shifts not being filled. Data showed that staffing levels had been maintained at the established allocation at almost all times. Staff told us they prioritised patients at the highest risks at all times. So that when shifts were not filled the mental health liaison service was sometimes to respond to low risk patients in accordance with the agreed timescales. Recruitment to the team was taking place at the time of the inspection. Where bank or agency staff were used, as far as possible regular staff were used who were familiar with the mental health liaison service. Recruitment to the team was taking place at the time of the inspection.
- The service had a staff turnover rate of 25% in the previous 12 months. At the time of the inspection, the mental health liaison service had a staff allocation of 19.7 posts with 16.2 staff in post. This meant there were 3.5 vacancies at a vacancy rate of 18%, which was higher

Are services safe?

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

than the trust target of 11%. This had dropped from 26% in June and July 2016. The team was allocated ten nurses and there were no nurse vacancies at the time of the inspection.

- The mental health liaison service did not operate a waiting list. The team provided a rapid assessments and intervention service. Cases were not allocated to team members for on-going work, except in exceptional circumstances. For example, if it was known that the patient would be staying in North Middlesex University Hospital for an extended period due to their physical health needs, and the mental health liaison service would be advising North Middlesex University Hospital about their mental health needs on an on-going basis.
- The Barnet, Enfield and Haringey Mental Health NHS Trust target for the completion of mandatory training was 85%. The percentage of mental health liaison service staff completing mandatory training was as follows: equality and diversity (88%), fire safety (82%), health and safety(82%), infection control (82%), information governance (77%), safeguarding adults levels 1&2 (82%), safeguarding children levels 1&2 (94%), safeguarding children level 3 (77%). The manager monitored the take-up of mandatory training within the team. Plans were in place to ensure targets were met. Staff were due to book onto a safeguarding children level 3 course when places were available.

Assessing and managing risk to patients and staff

- The mental health liaison service had robust arrangements and agreed protocols with North Middlesex University Hospital to assess and manage risks to patients and staff. The 'Emergency Department (ED) Adult Mental Health Triage Form' was used by ED staff to assess and manage risks to mental health patients and others. The ED triage nurse used the form to gather information on a patient's risks in relation to self-harm, suicide and aggression to others. There was also information on the risk of a patient leaving ED. The form had information on the person's appearance and circumstances which could be used to help find them if they absconded from ED. It included prompt questions about the level of observation the person required whilst in ED and whether the person needed to be searched for weapons or ligatures.
- An ED doctor then assessed the patient and used a red, amber and green rating for risk and recorded how risks should be managed. For example, high risk patients were defined as: 'patients with serious mental health problems present, including possible psychosis; patients with strong/immediate plans to harm self/ others - may have already attempted to harm self or others; highly vulnerable patients and patients whose mental health very likely to deteriorate if left untreated.' ED staff were guided by the form to take these actions if the patient was high risk: **'**Call security for observation'; 'Refer to MH Liaison team immediately' and 'ED consultant, security and the police should be informed if this patient absconds'.
- The mental health liaison service had an operational policy dated June 2015, which was developed in conjunction with North Middlesex University Hospital. This made it clear that ED staff were responsible for providing a safe environment for the patient and ensuring the safety of the patient and others in ED. For example, in August 2016, North Middlesex University Hospital trust had provided additional nursing support to a patient whilst they were awaiting transfer to a suitable mental health resource, such as bed in a mental health hospital. The mental health liaison service team leader had provided a briefing session to security staff in relation to managing risks to patients and staff. In general these arrangements worked well. However, there had been adverse incidents when patients when patients who were waiting for a MHA assessment or a hospital bed had left North Middlesex University Hospital. The mental health liaison service team leader had provided a briefing session to security staff in relation to managing risks to patients and staff.
- We reviewed nine care and treatment records. Six were for patients referred from ED and three were for patients on the ward. Patients referred from the ED had been seen within in an hour. The mental health liaison service staff promptly completed risk assessments which were comprehensive, and included details of risks to the patient's health and safety and how they were to be managed. Staff had involved patients in the process of clarifying risks and had given patients a leaflet with details of the mental health liaison service and information about what to do in a crisis. In the case of patients on the ward, details of any risks were recorded and advice given to North Middlesex University Hospital

Are services safe?

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

staff was noted. North Middlesex University Hospital staff told inspectors that the mental health liaison service recorded details of risk management advice appropriately in their notes.

- Staff we spoke with demonstrated a good understanding of safeguarding issues. Staff had received training in safeguarding adults levels 1&2 (82%) and safeguarding children levels 1&2 (94%). The North Middlesex University Hospital safeguarding lead nurse visited the mental health liaison service office each morning to ensure any safeguarding children issues were followed up.
- The mental health liaison service was not responsible for the prescribing or management of medicines for patients whilst they were in the ED or wards at North Middlesex University Hospital; this was the responsibility of North Middlesex University Hospital staff. Psychiatrists in the mental health liaison service gave North Middlesex University Hospital staff advice on the use of medicines to treat the mental health needs of patients. For example, on the day of the inspection we observed a psychiatrist giving advice to a doctor about the dose and type of medicine to give a patient who they had assessed. North Middlesex University Hospital staff told inspectors that they received prompt and helpful support in relation to the assessment and treatment of patients with mental health needs.
- Mental health liaison service staff told us they followed the Barnet, Enfield and Haringey Mental Health NHS Trust protocols in relation to lone working and their personal safety. They told us they felt well supported in relation to their personal safety by their managers and North Middlesex University Hospital colleagues.

Track record on safety

- The mental health liaison service reported 51 incidents during the 12 months prior to this inspection. These incidents related to a variety of issues including verbal abuse from patients to staff and breaches of the agreed waiting times for patients at North Middlesex University Hospital awaiting admission to a mental health in-patient bed. Restraint was used on two patients within the last 6 months. The mental health liaison service had tried in to de-escalate the situation in both instances before restraint was used. There had been two serious incidents in this period. We read an investigation report in relation to one of these incidents which was thorough and had clear recommendations.
- After a serious incident where a patient with mental health needs left ED, the mental health liaison service and North Middlesex University Hospital agreed a joint clinical governance process for investigating and responding to such incidents. Subsequently, the 'Emergency Department Adult Mental Health Triage Form' was developed to assist ED staff to determine the level of risk and then decide what measures should be put in place to safeguard the patient and others whilst they were in ED.
- If patients do leave the emergency department before staff have completed an assessment from ED, staff have a record of their appearance and possible places they could go to give immediately to the police. This process was followed after a patient left ED in August 2016.

Reporting incidents and learning from when things go wrong

- Mental health liaison service staff told us that they knew which incidents to report and how to report them. Staff said they were able to discuss any concerns about incidents with colleagues and escalate matters to their manager. Staff could report incidents directly onto Barnet, Enfield and Haringey Mental Health NHS Trust electronic incident records.
- Incidents were investigated appropriately. For example, we read an investigation report carried out by Barnet, Enfield and Haringey Mental Health NHS Trust in January 2016 in relation to two instances of extended delays for patients at North Middlesex University Hospital awaiting transfer to mental health in-patient beds. This report recommended that Barnet, Enfield and Haringey Mental Health NHS Trust liaise with North Middlesex University Hospital regarding the provision of crisis beds within North Middlesex University Hospital. During the inspection we heard that there were dedicated spaces within the North Middlesex University Hospital ED assessment unit which were suitable for mental health patients and could be used when there was an extended delay in finding an appropriate bed for a patient.

Are services safe?

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

- The and North Middlesex University Hospital collected detailed information on any breaches of the national target of a four hour wait in the ED in relation patients referred to the mental health liaison service. This data aimed to identify the causes of such delays. Some delays were classified as the responsibility of North Middlesex University Hospital, such as late referral to the mental health liaison service or the patient receiving active treatment. The delays classified as attributable to mental health liaison service were delays in regard to MHA assessments and delays in transfer to a mental health bed. In August 2016, of 204 patients referred to mental health liaison service from ED there were 68 breaches. Of these 68 breaches, 21 were classified as the responsibility of mental health liaison service: 11 of these were due to patient awaiting a mental health bed and six were due to patients awaiting a MHA assessment. From a review of figures from previous months it was not possible to identify any particular trends. The mental health liaison service liaised with other teams within Barnet, Enfield and Haringey Mental Health NHS Trust and partner organisations to seek to minimise unnecessary delays in MHA assessments and transfers of care.
- Staff told us they received support from their managers after incidents. The manager held an initial debrief meeting with staff involved in the incident. Where necessary, immediate actions were taken to ensure the safety and welfare of staff. Once the investigation of the incident was completed, the mental health liaison service manager organised further discussion at team meetings and the team's monthly clinical governance meetings. This included discussion about any lessons learnt and any changes that needed to be made to practice or procedures. Following the recommendations of a serious incident report, the North Middlesex University Hospital trust and Barnet, Enfield and Haringey Mental Health NHS Trust set up quarterly joint clinical governance meetings to review incidents which involved senior clinicians and managers from both trusts in order to maximise the opportunity for learning and improvement planning across both organisations.

Are services effective?

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

- We reviewed nine care records. These demonstrated that mental health liaison service staff had carried out initial assessments and brief interventions within the timescales agreed with North Middlesex University Hospital. Staff had visited the patient at the ED or on the ward and asked them about the issues which had brought them to hospital and their current needs. The staff member had also obtained a description of the patient's mental health needs from the perspective of North Middlesex University Hospital staff and from other people if the patient was accompanied. Staff used this information, together with the background information they had obtained on referral, to clarify whether the person was in need of on-going support with their mental health. The assessments reviewed were sufficiently detailed in order to clarify whether a further more comprehensive assessment was required.
- If the mental health liaison service assessed the patient as requiring ongoing support, in most instances the mental health liaison service made a referral to the Barnet Enfield and Haringey Mental Health trust crisis team. The mental health liaison service ensured the crisis team followed up these referrals. The mental health liaison service staff member obtained the patient's consent to the referral and contacted the crisis team to make a verbal handover and to assist the crisis team to make an initial crisis plan which took effect as soon as the person was discharged from the ED. The mental health liaison service inputted core assessment information on the person's background and needs into the Barnet, Enfield and Haringey Mental Health NHS Trust database, which could be accessed by the crisis team to ensure there was continuity of care.
- In the case of patients in ED who were identified by ED staff as high risk at the point of referral, the mental health liaison service commenced a comprehensive assessment. These assessments included details of the patient's contact with mental health services, social history, current mental state, risks to self and others and the risk of deterioration leading to possible MHA detention. The assessments we reviewed were appropriately comprehensive and detailed.
- Mental health liaison service staff were easily able to access information about patients referred to them by North Middlesex University Hospital. They used the Barnet, Enfield and Haringey Mental Health NHS Trust database to access information on patients and input details of their interventions. This facilitated continuity of care for patients when they were discharged from North Middlesex University Hospital. In the case of patients who did not require ongoing mental health needs, mental health liaison service recorded details of the assessment and advice given to the patient of a database shared with North Middlesex University Hospital staff. Information about these interventions were sent to the patient's GP when they were discharged from hospital. The mental health liaison service had a protocol with North Middlesex University Hospital which required mental health liaison service staff to input details of their interventions into North Middlesex University Hospital paper records.

Best practice in treatment and care

- The mental health liaison service did not prescribe medicines to patients on the wards or in ED. North Middlesex University Hospital staff were responsible for ensuring appropriate prescribing. Psychiatrists in the mental health liaison service were available to advise North Middlesex University Hospital staff on best practice in terms of prescribing for mental health conditions.
- The mental health liaison service staff included a psychologist. The psychologist provided brief interventions such as cognitive behavioural therapy and motivational interviewing around anxiety and depression. The service referred patients who required on-going psychological support to the Barnet, Enfield and Haringey Mental Health NHS Trust improving access to psychological therapies service. The team also made referrals to the personality disorder service when appropriate.
- The mental health liaison service ensured that those patients referred to them who did not require ongoing support with their mental health needs received support and advice. The team were knowledgeable about local resources and had a wide range of leaflets and information on local support services which they

Are services effective?

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.

gave to patients. Records showed staff had signposted patients appropriately to organisations which provided advice and support on matters such as housing and welfare benefits.

- In terms of assessment and care planning, mental health liaison service staff primarily provided an assessment service. Patients with ongoing mental health needs were referred onto other services such as the crisis service or a mental health in-patient service. The mental health liaison service provided information to assist these services to plan how they would deliver care to the patients they referred.
- North Middlesex University Hospital retained responsibility for meeting the physical health needs of patients referred to the mental health liaison service. North Middlesex University Hospital staff told us the mental health liaison service supported them to meet patients' physical health needs when necessary, by providing advice on how North Middlesex University Hospital staff could best engage the patient.
- Staff used outcome measures in relation to any brief treatment interventions undertaken with patients. The main outcome measures for the mental health liaison service were based on response times to referrals from North Middlesex University Hospital. The managers of the service and the team had a good knowledge of the performance of the service in relation to these measures. These outcome measures showed that the team was performing at slightly below the target levels in terms of their response times to referrals.
- Team members had undertaken clinical audits. For example, a doctor had audited the admission rates of patients seen by the

Skilled staff to deliver care

- The team comprised an appropriate range of mental health disciplines to carry out assessments and brief interventions. The team had a team leader, nurses, support workers, a psychologist, consultant psychiatrists and other doctors. Out of normal working hours the service was provided by two nurses supported by the on-call Barnet, Enfield and Haringey Mental Health NHS Trust psychiatrist. Staff in the service were experienced and well qualified. There was a protocol in place for the induction of new staff and agency or bank staff.
- Staff told us they received regular supervision and had appraisals. Supervision records confirmed this. They said they received the support and advice they need to develop in their work role. Clinical staff received appropriate and relevant advice, training and development. Staff told us there were opportunities for learning within the team through study days and clinical discussion. Staff also accessed Barnet, Enfield and Haringey Mental Health NHS Trust training opportunities. Staff said they had the opportunity to develop their competence in relation to relevant topics such as mental health assessments, suicide awareness, risk to self and others and use of legal frameworks. Each month a half day development session was arranged. Recently the team had held sessions on safeguarding and on drug and alcohol symptoms and mental health.
- Specialist training was available, for example, the psychologist had been trained in cognitive behaviour therapy for suicide prevention and had attended a workshop on patients with medically unexplained symptoms. Clinicians in the mental health liaison service had access to peer support through Barnet, Enfield and Haringey Mental Health NHS Trust and the team had a lead consultant psychiatrist. Mechanisms were in place to ensure staff could always contact a senor clinician for advice.

Multi-disciplinary and inter-agency team work

- The mental health liaison service held handover meetings twice each day to review and plan their response to referrals. Staff used a whiteboard to record the current stage of interventions with the patient and ensure target timescales were met. For example, there was clarification about the stage of any MHA assessments which were taking place and of the progress made in terms of any transfers of patients to in-patient mental health beds. We observed a handover meeting during the inspection. A psychiatrist, psychologist, three nurses and three mental health support workers attended the meeting. The team prioritised referrals for action according to the level of risk and all staff contributed appropriately to the discussion.
- The mental health liaison service ensured there was effective handover to other mental health teams by recording details of their interventions on the Barnet, Enfield and Haringey Mental Health NHS Trust database.

Are services effective?

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

The manager of the mental health liaison service met each month with managers of the Barnet, Enfield and Haringey Mental Health NHS Trust crisis team to develop operational links. In the case of patients from other areas, the mental health liaison service sent details of assessments and interventions to the receiving service. The team recorded details of their assessments and interventions on North Middlesex University Hospital patient notes so that North Middlesex University Hospital staff were clear about the progress of assessments and discharge plans for the patient.

- The had a protocol for handing over information to primary care through sending discharge letters to GPs. Working links with children's safeguarding were strong through the involvement of the North Middlesex University Hospital designated nurse, who visited the mental health liaison service each day to identify and act on information. Mental health liaison service staff told us that colleagues from other teams in Barnet, Enfield and Haringey Mental Health NHS Trust contacted them when patients known to them were admitted to North Middlesex University Hospital. This enabled the mental health liaison service to work with North Middlesex University Hospital staff to ensure the patient's needs were holistically met whilst they were in hospital and helped facilitate a timely discharge of the patient.
- The service had a monthly clinical governance meeting. This meeting included a case presentation and staff training for an hour. The service had a monthly business meeting where no clinical issues were discussed and plans made for team development.
- The mental health liaison service worked with North Middlesex University staff to promote the awareness of mental health issues and encourage referrals to the team. They attended ward meetings and staff meetings to talk about their role.

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

- The mental health liaison service carried out assessments of patients in the emergency department (ED) at North Middlesex University Hospital. In general, if the mental health liaison service identified that a MHA assessment was required the service contacted the approved mental health practitioner service in Enfield, as North Middlesex University Hospital is located in the borough of Enfield. The mental health liaison service referred patients already known to Haringey mental health services to the Haringey approved mental health practitioner service.
- During normal working hours, a MHA section 12 Approved doctor in the mental health liaison service completed the first recommendation of the MHA assessment. The approved mental health practitioner service arranged the second opinion doctor. Out of hours, the nurses working in the mental health liaison service contacted the duty approved mental health practitioner who has the responsibility to liaise with the on call doctor to complete the first recommendation and to arrange a second opinion doctor. The mental health liaison service liaised with bed managers at Barnet, Enfield and Haringey Mental Health Trust for patients from the local area and with the bed managers from other mental health trusts when this was appropriate because the patient was already known to that trust.
- The approved mental health practitioner services had target times in terms of responding to requests from the mental health liaison service for MHA assessments. There were also targets in terms of the transfer of the care of patients from the ED or ward to a mental health resource. However, in practice, patients often had to wait for several hours for an approved mental health practitioner service and then for a further period of time for an in-patient mental health bed. These delays were due to pressures on the approved mental health practitioner services and a shortage of mental health beds across London.
- Waiting times were closely monitored by both North Middlesex University Hospital and Barnet, Enfield and Haringey Mental Health NHS Trust and there were protocols in place in terms of escalating breaches of the agreed waiting times. Senior managers in both organisations became involved to ensure that all possible action was taken to transfer mental health patients promptly to a suitable resource.
- The responsibilities of North Middlesex University Hospital staff and the mental health liaison service in relation to the safety, care and treatment of patients whilst awaiting a MHA assessment, or a transfer of care to a mental health service, were clearly set out in a joint

Are services effective?

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.

protocol. The North Middlesex University Hospital was responsible for the safety and care and treatment of the patient whilst they were at North Middlesex University Hospital, with the mental health liaison service providing professional advice and guidance to North Middlesex University Hospital staff on care and treatment.

- North Middlesex University Hospital was responsible for receiving and processing MHA paperwork in relation to patients whilst they were at North Middlesex University Hospital. The mental health liaison service and the MHA office at Barnet, Enfield and Haringey Mental Health NHS Trust provided advice and guidance on legal issues in relation to the MHA.
- The mental health liaison service did not routinely assess patients brought to the North Middlesex Hospital by the police under section 136 of the MHA. In such cases, the mental health liaison service assisted staff and the police with arranging the transfer of the person to a designated section 136 suite provided elsewhere by Barnet, Enfield and Haringey Mental Health NHS Trust. If it was not appropriate to immediately transfer a patient to a 136 suite, for example, if the patient required ongoing treatment for their physical health at North Middlesex University Hospital, then the mental health liaison service conducted an assessment.
- The manager of the mental health liaison service attended monthly inter-agency meetings to review how organisations managed their MHA responsibilities and make any necessary improvements.

Good practice in applying the Mental Capacity Act

- All staff in the mental health liaison service had received training on the Mental Capacity Act (MCA). Information about the Act, including the principles, was displayed on a notice board in the team's office. Staff had a clear understanding in the MCA and upheld its principles in practice. For example, staff presumed that patients had the mental capacity to decide whether to consent to care and treatment or not, unless there were was evidence to the contrary.
- The mental health liaison service advised North Middlesex University Hospital staff on mental capacity issues. For example, wards referred patients with dementia to the mental health liaison service for an assessment of the patient's mental capacity to understand specific decisions about their long-term care. Additionally, the mental health liaison service gave advice on the mental capacity of patients with regard to potential use of the Deprivation of Liberty Safeguards. The mental health liaison service was able to access advice on any complexities in relation to the use of the MCA from expert colleagues in Barnet, Enfield and Haringey Mental Health NHS Trust.

Are services caring?

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

Our findings

Kindness, dignity, respect and support

- We were unable to directly observe staff inter-acting with patients during the inspection. Staff we spoke with demonstrated a caring and supportive attitude towards patients when talking about their interactions with them.
- From our observation of the handover meeting and from talking to staff it was clear that staff understood the needs of the patients they worked with. Records demonstrated that staff took into account the individual circumstances of patients when planning patient care.
- Staff explained to us how they ensured their work with patients was kept confidential. They told us about the steps they took in ED and on the wards to ensure their discussions with patients were not overheard.

The involvement of people in the care that they receive

- The nine care records we reviewed showed that staff sought to involve patients in planning their discharge and care and treatment. It was clear that staff had worked constructively with patients to discuss their needs and took into account their views when planning ongoing treatment. This information was then passed onto services providing ongoing support. Staff had explained to patients how their needs would be met once they were discharged from the service.
- The mental health liaison service organised a patients and carers meeting, the PACCT meeting, once a month. Carers organisations attended as did other services in the trust. The purpose of the meeting was to build better relationships with carers and patients. In response to feedback from carers, the mental health liaison service had developed a directory of resources providing support for carers. Additionally, a new carers group had been set up to support the carers of patients using the early intervention service.

Are services responsive to people's needs?

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

Our findings

Access and discharge

- The mental health liaison service accepted for any patient over 16 years at North Middlesex University Hospital regardless of their home address. The mental health liaison service liaised with Barnet, Enfield and Haringey Mental Health NHS Trust colleagues to ensure the mental health needs of patients under 16 years were met. For example, the mental health liaison service arranged for a consultant psychiatrist in child and adolescent psychiatry to come to North Middlesex University Hospital to assess and advise on treatment when this was appropriate. In the case of patients who had consumed alcohol or drugs, the mental health liaison service did not assess patients whilst they were intoxicated.
- The mental health liaison service had an operational policy agreed with North Middlesex University Hospital which fully explained the operation of the service during the normal working day and out of hours. The policy covered referrals to the mental health liaison service and timescales for response and explained how the mental health liaison service worked in conjunction with other mental health services and primary care. Staff told us this policy was effective in explaining the role of the team and how it worked with North Middlesex University Hospital staff and other agencies.
- The mental health liaison service was proactive in seeking to engage with people who were reluctant to engage with mental health services. Staff told us that sometimes patients wanted to go home from the ED immediately after assessment and treatment by North Middlesex University Hospital staff and did not wish to wait for up to an hour (the target timescale) for an assessment from the mental health liaison service. There was an agreed protocol with North Middlesex University Hospital in relation to the follow up of any patients who discharged themselves from North Middlesex University Hospital before their mental health needs were assessed or whilst awaiting a MHA assessment or an acute bed. We read the report an incident which showed that this procedure and been put into practice and ensured that there was follow up to a patient who went home from ED unexpectedly.

The facilities promote recovery, comfort, dignity and confidentiality

- The facilities used by mental health patients in the ED were clean and comfortable. ED staff could observe the room by means of CCTV cameras linked to monitors in the nursing station.
- Patients could use a bathroom in ED and North Middlesex University Hospital could provide food and access to a telephone to patients if their stay was prolonged.

Meeting the needs of all the people who use the service

- The mental health liaison service used North Middlesex University facilities which were accessible for people with disabilities.
- The mental health liaison service had access to a telephone interpreting service when working with patients whose first language was not English. Staff were knowledgeable about local resources and were able to locate information written in languages other than English if this was required.
- The mental health liaison service staff we spoke with were aware of the rights of patients. Mental health liaison service staff also ensured that North Middlesex University Hospital staff were aware of the legal status of patients who were in the process of having their needs assessed or awaiting a Mental Health Act assessment. The manager of the mental health liaison service met regularly with ED staff and security staff about the duty of care towards patients who had been assessed as being at risk to themselves and others due to their mental health needs, but who wished to leave North Middlesex University Hospital. It was well understood by all agencies that patients had a legal right to leave North Middlesex University Hospital unless they were subject to detention under the Mental Health Act.

Listening to and learning from complaints

- The mental health liaison service set up the 'patient and carers community team meeting' (PACCT) in early 2016 as a means of gathering feedback about the service. Patients who had used the service were invited to attend this forum via a poster attached to their GP letter. Patients and Carers were also told via word of mouth following contact with mental health liaison service staff

Are services responsive to people's needs?

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

and staff were encouraged to list names of potential attendees which were then contacted and invited. The mental health liaison service also invited representatives from carers and service user support organisations.

- In response to feedback from service users and carers, the PACCT group helped to facilitate the development of a separate support group for carers of patients using the early intervention service and a directory of local Mental Health Carer's resources.
- There had been no formal complaints about the service in the 12 months before the inspection.

Are services well-led?

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

Our findings

Vision and values

- Mental health liaison service staff told us they were familiar with Barnet, Enfield and Haringey Mental Health NHS Trust values. These were 'putting patients and carers first, showing kindness and compassion, being honest and open, creating a safe, friendly and caring environment, striving for excellence and supporting our staff'. Staff said that their managers ensured the mental health liaison service operated in a way that reflected these values.
- Staff said that senior managers from both Barnet, Enfield and Haringey Mental Health NHS Trust and North Middlesex University Hospital had visited the mental health liaison service. They felt these managers recognised the important role of the service and were committed to ensure both organisations supported the service to develop and improve patient outcomes.

Good governance

- The mental health liaison service was managed effectively. The manager ensured staff received effective supervision and training. In general, the team operated at the planned staffing levels. The manager arranged cover from suitable bank and agency staff when necessary. Incidents were reported and lessons learnt. Barnet, Enfield and Haringey Mental Health NHS Trust worked with North Middlesex University Hospital and other agencies to ensure that legal requirements of the MHA were met. The mental health liaison service staff understood and implemented safeguarding procedures. The service organised handover meetings and clinical governance meetings to discuss and plan their work with patients.
- The performance of the mental health liaison service was gauged through a set of key performance indicators (KPIs). KPIs on the mental health liaison service speed of response to referrals were the most closely monitored. There was a KPI for the mental health liaison service to start an assessment within one hour for 95% of referrals from the ED. Actual performance was at 85% for this KPI in August 2016. The service had not achieved the 95% target for this KPI since November 2015. The KPI dropped to 71% in June 2016 but had been rising steadily since then. Staff in the mental health liaison service explained this variation in performance as being due to the fact that rate of referrals to the team was unpredictable. They said the service's actions in relation to a patient with complex needs could be time consuming and tie-up more than one member of the team. For example, work undertaken would include supporting North Middlesex University Hospital to manage the safety of the patient and others, contacting the Approved Mental Health Practitioner service and contacting the Barnet, Enfield and Haringey Mental Health NHS Trust bed management service. This then had a knock on effect in terms of delaying the mental health liaison service response to other patients they were due to assess. In addition, because the team responded immediately to patients with the highest need, there were sometimes delays in assessing patients who had lesser needs. Staff in the mental health liaison service told us that in practice the impact on patient outcomes of this under-performance was minimal because of the prioritisation system used by the team. Those patients at highest risk were always seen promptly.
- There was a KPI set at 90% that mental health liaison service staff should send a letter to the patient's GP within seven days of discharge. Staff told us they did aim to send these letters as soon as they knew a patient had been discharged from the hospital but actual performance against this target was not monitored.
- The manager of the mental health liaison service said he was well supported in his role by his senior manager. The manager said that he felt he had sufficient authority to manage the team. At the time of the inspection administrative support to the team was under review by Barnet, Enfield and Haringey Mental Health NHS Trust.
- Staff told us the mental health liaison service operational policy was well-understood by North Middlesex University Hospital staff and colleagues with Barnet, Enfield and Haringey Mental Health NHS Trust. Staff in the team regularly visited wards and teams within CMHT to ensure staff understood the mental health liaison service role.

Leadership, morale and staff engagement

- The service was well-led. Staff said the manager and clinical lead were positive role models, who always supported them in their work and ensured relationships

Are services well-led?

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

within the team and with other organisations were constructive. Staff said that they felt they were valued by their North Middlesex University Hospital colleagues for the work they undertook. The mental health liaison service had been awarded the Barnet, Enfield and Haringey Mental Health NHS Trust 'team of the year' in 2015 in recognition of the team's performance and partnership working.

- Staff told us managers ensured that the team worked collaboratively in order to meet team objectives. They said they could rely on managers and colleagues to provide practical support in terms of jointly assessing patient need and arranging resources for patients. For example, in the case of a complex situation with a patient, staff including the manager and clinical lead, in the team took on different roles, such as supporting North Middlesex University Hospital staff in managing risks and making referrals for ongoing support. Staff told us their managers represented the service well when liaising with North Middlesex University Hospital and Barnet, Enfield and Haringey Mental Health NHS Trust colleagues and ensured that any difficulties in working relationships were resolved.
- Staff were aware of the whistleblowing process and felt they could raise a concern without victimisation. There were no bullying or harassment cases within the team
- The manager told us that the sickness rate was low in terms of short term-sickness but the team had some long-term sickness.
- Staff said managers ensured staff raised the profile of the mental health service with North Middlesex University Hospital staff and ensured North Middlesex University Hospital were well informed about the MH needs of patients. Staff were supported to attend ward meetings and arrange learning activities for North Middlesex University Hospital staff on the role of the team and issues such as working with patients with dementia.

Commitment to quality innovation and improvement

- Staff told us their managers ensured there was a culture within the team which promoted learning and innovation. Staff said supported the team to develop the service. For example, a team member was in the process of working with North Middlesex University Hospital staff to develop a care pathway for frequent attenders at the ED. Staff told us that the clinical lead tried to make handover meetings educational and always looked for learning opportunities .
- The mental health liaison service had received accreditation from the mental health liaison accreditation network. This had involved an assessment of the service in terms of collaborative working, patient outcomes and quality, audit and governance. The mental health liaison service had met the required standards and had taken steps to develop the service in response to the feedback during the accreditation process. For example, the service set up a forum to enable patients and carers to give feedback on the mental health liaison service and learn about mental health resources. The forum identified unmet needs and contributed to service development. The forum to facilitate the implementation of a separate trust-based carer group and contributed to the development of a directory of local mental health resources for carers.