Barnet, Enfield and Haringey Mental Health NHS Trust

Mental health crisis services and health-based places of safety

Inspection report

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Date of inspection visit: 15 May 2023 to 25 May 2023
Date of publication: 11/10/2023

Ratings

Overall rating for this service	Requires Improvement
Are services safe?	**Requires Improvement**
Are services effective?	**Good**
Are services caring?	**Good**
Are services responsive to people's needs?	**Requires Improvement**
Are services well-led?	**Good**

Our findings

Mental health crisis services and health-based places of safety

Requires Improvement 

We carried out this unannounced comprehensive inspection as part of our programme of inspection activity and because at our last inspection we rated the service as requires improvement.

The trust has 3 Crisis resolution and home treatment teams (CRHTT) and 1 Health Based Place of Safety (HBPoS). At this inspection we decided to visit 2 CRHTT in Enfield and Barnet and the HBPoS which is located centrally in Enfield.

Our rating of services stayed the same. We rated them as requires improvement because:

- The HBPoS and patient areas in the CRHTTs were visibly clean and well maintained. Staff managed infection risk well.
- The service had enough staff, who received basic training to keep patients safe from avoidable harm.
- The service managed safety incidents well and learned lessons from them. Staff collected safety information and used it to improve the service.
- Staff assessed risks to patients and acted on them. They provided effective care and treatment, and offered emotional support when patients needed it.
- Staff worked well together for the benefit of patients, supported them to make decisions about their care and provided information to enable them to live healthier lives. They were focused on the needs of patients receiving care.
- Staff treated patients with compassion and respected their privacy and dignity. Staff provided emotional support to patients, families, and carers.
- The services provided effective evidence based treatments for adults based on national guidance and best practice.
- Leaders ran teams well using reliable information systems. Staff felt respected, supported, and valued.
- Staff worked well with patients, families, and carers. All staff were committed to continually improving the service provided.

However:

- Although the trust had systems and processes in place to safely administer and record medicines use these were not embedded across all teams and we were not assured of the overall safety of medicines management.
- The completion of mandatory training was low and below the levels required in some teams visited. Staff in the health-based place of safety had low rates of compliance with adult basic life support, adult immediate life support and prevention and management of violence and aggression. The failure to meet the target for this training was potentially a risk to patient safety.
- Staff in Haringey crisis resolution and home treatment team had low rates of compliance with mandatory training in level 3 safeguarding adults and level 3 safeguarding children.

Our findings

- The Enfield crisis resolution and home treatment team had a team caseload of 52 on the day of the inspection. The team was working to reduce the size of the caseload, but it remained too high.
- The Enfield crisis resolution and home treatment team was failing to meet the trust's provisional target of 90% for a 4 hour turnaround for a face to face assessment of urgent patient referrals.

How we carried out the inspection

You can find further information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-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 this service.

The team that inspected the service consisted of a lead inspector, 2 additional inspectors, 1 specialist advisor, with experience working in mental health crisis services and an expert by experience, someone who has experience of care and treatment in mental health crisis services.

During the inspection visit, the inspection team:

- Visited 2 crisis resolution and home treatment teams (CRHTT) at Enfield and Barnet as well as the health-based place of safety (HBPoS) suite at Chalk Farm
- Attended handover meetings
- Spoke with the managers of all 3 services we visited
- Spoke with 21 staff members including consultant psychiatrists, junior doctors, clinical psychologists, occupational therapists, registered nurses, associate mental health workers and health care assistants
- Spoke with 5 patients and 4 carers or relatives
- Looked at the quality of the environment in patient areas at the crisis resolution and home treatment teams and the health-based place of safety.
- Reviewed 16 patients care and treatment records
- Reviewed documents related to the running of the service

What people who use the service say

Our findings

We spoke to 5 patients. The feedback we received was overwhelmingly positive. All patients said they received good care and treatment from staff. They described staff as brilliant, wonderful and said they really did care.

Patients told us that staff were supportive and caring and involved them in decisions about their care and treatment.

We spoke to 4 carers, and they were all positive about the support provided. They told us their relative was listened to, that staff were kind and caring and that they had been involved in all decisions about their relative's care and treatment plan.

Is the service safe?

Requires Improvement 

Our rating of safe stayed the same. We rated it as requires improvement.

Safe and clean environments

All clinical premises where patients received care were safe, clean, well equipped, well furnished, well maintained and fit for purpose. The physical environment of the health-based places of safety met the requirements of the Mental Health Act Code of Practice.

Staff completed monthly infection prevention and control audits for each of the care environments we visited. Staff described to us how they followed infection control guidelines. The trust provided staff with personal protective equipment to help prevent cross-infection.

Staff followed the provider's infection prevention and control guidelines, including handwashing. Staff checked whether patients had COVID-19 symptoms before going to visit them.

Staff saw most patients at home or used trust premises to meet with patients. We observed some clinical areas where patients were seen and observed them to be clean, well maintained, well-furnished and fit for purpose.

Staff made sure equipment was well maintained, clean and in working order. We reviewed cleaning audits for the 3 months prior to the inspection which showed high levels of compliance in the monthly infection control reports.

At the time of the inspection visit, the Enfield Crisis resolution and home treatment team (CRHTT) did not have a clinic room as it had been decommissioned for 3 years due to a faulty air conditioning unit. The team shared the clinic room with the health-based place of safety (HBPoS) which was in a different building. We raised this with the trust on the day of the inspection visit and they informed us that they had resolved the original issue and reopened the clinic room for use the following day.

Following the last inspection, we told the trust that they must ensure that all the facilities used by patients in the HBPoS were safe, with an appropriate standard of fixtures and fittings. This time we found that the 2 rooms in use were safe and had an appropriate standard of fixtures and fittings. Although 1 room had a ligature point on the toilet flush against the wall, this was known to staff, mitigated by observations and included on the ligature risk assessment.

Our findings

Although we observed the rooms to be quite bare and there was no TV or radio, patients did have access to a tablet set aside for their use if they wished. The manager told us that they had recently ordered a television which would be installed in the communal area.

Safe staffing

The service had enough staff, who received basic training to keep people safe from avoidable harm. However, staff were not always up-to-date with some mandatory training. The number of patients on the caseload of the mental health crisis teams, and of individual members of staff, was not too high to prevent staff from giving each patient the time they needed.

At the last inspection we were concerned about staff vacancy rates in the CRHTTs and informed the trust they must work to reduce staff vacancies in these teams. At this inspection we found this had that the service had enough nursing and support staff to keep patients safe, but their vacancy and turnover rates remained high and there was still an overreliance of bank and agency staff to maintain safe staffing levels.

Vacancy rates varied across the teams, but all still had high vacancy rates, although these were reducing in some teams. Enfield and Barnet CRHTT both had reducing vacancy rates amongst staff. Enfield CRHTT vacancy rate had reduced from 31% to 20% and Barnet from 43% to 36% in the 12 months prior to the inspection visit.

Haringey CRHTT and the HBPoS had both seen their vacancy rates increase over the same time period. Haringey CRHTT had increased from 37% to 45% and the HBPoS from -7% to 20%.

Managers mitigated their use of bank and agency staff by requesting staff familiar with the service. Managers made sure all bank and agency staff had a full induction and understood the service before starting their shift.

Staffing was on the divisional risk register for regular review and the trust had a strategy for managing the nursing and HCA (healthcare assistant) vacancies which included participation in overseas nursing recruitment, career development focus including apprenticeships, work experience and 'kick start' programme, fast tracking of HCAs and increased use of social media to support recruitment.

Managers supported staff who needed time off for ill health. Levels of turnover and sickness varied across the teams. Between May 2022 and April 2023 turnover rates were Haringey 32%; Enfield 18%; Barnet 20% and HBPoS 3%. Between May 2022 and April 2023 levels of sickness were low: Haringey 2%; Enfield 2%; Barnet 4%; and HBPoS 4%.

The service had enough medical staff. Staff told us they could get support from a psychiatrist quickly when they needed to. Out of hours staff had access to medical support from the duty doctor and on-call consultant psychiatrist.

Mandatory training

Although most staff were compliant with most of their mandatory training, there were significant shortfalls in some areas for HBPoS staff. For example, records showed that there was only 67 % compliance with Basic Life Support training, 71% compliance rate with Immediate Life Support training and only 60% compliance with Prevention and Management of Violence and Aggression (PMVA).

Assessing and managing risk to patients and staff

Staff assessed and managed risks to patients and themselves. They responded promptly to sudden deterioration in a patient's health. When necessary, staff working in the mental health crisis teams worked with patients and their families and carers to develop crisis plans. Staff followed good personal safety protocols.

Our findings

Assessment of patient risk

Staff completed risk assessments for each patient on admission, using the RAG (Red Amber Green) rating system, and reviewed this regularly, including after any incident.

The shift lead in each team screened referrals and allocated them for assessment. Staff discussed patient risks at daily morning planning meetings. Teams used a RAG system to prioritise patients based on risk. Red risk (high risk) patients were discussed everyday by the team and received at least one visit per day. Amber patients were considered lower risk and were usually visited every other day. Green risk patients were usually nearing discharge from the team or transfer to other services and were low risk. All new patients were initially given a red risk rating.

Staff carried out regular risk assessments, such as before they went to see a patient at home. They were very aware of the environments they were visiting. They assessed the risks before they left the office and again when they arrived at the patient's home.

We reviewed 17 patient care records across the three teams. We found a current risk assessment on all patient records we reviewed. Staff put in place plans to address identified risks.

Management of patient risk

Staff monitored risks to patients and developed plans to mitigate the risks. CRHT teams held a morning planning meeting, in which they discussed risks to patients and planned how to support them. We observed these meetings at all Enfield and Barnet CRHTT and saw that staff took appropriate action to respond to risk, such as by increasing the frequency of visits.

Staff at Enfield CRHTT recorded discussions on the team whiteboard. Risk was addressed by referring to the patient's assessment, care records and notes. The consultant and any other staff who had seen or interacted with the patient provided feedback and shared information.

The use of the whiteboard to record handover discussions meant that Enfield CRHTT staff had to use their own laptops to look up patient information which effected their ability to fully engage in discussions.

Barnet CRHTT were using an electronic dashboard displayed on a large screen in the handover room. We observed a morning handover and found that this worked well. The dashboard was updated live during the morning handover, all staff were engaged and able to contribute meaningfully. Managers told us the trust intended to implement this across all 3 CRHTTs.

Staff responded promptly to any sudden deterioration in a patient's health. At the health-based place of safety, staff asked the police to escort patients presenting any concerns about their physical health to an emergency department of a general hospital to receive medical clearance.

CRHTT staff had followed clear safety protocols. They assessed new patients in pairs and undertook a risk assessment which determined staffing requirements for future visits.

CRHTT staff had lone working devices to use to summon help in an emergency when they were out of the office. Staff all carried a mobile phone, and they informed the team base when they entered and left patients' homes.

CRHTT staff followed clear protocols when patients were not at home when staff visited them or did not attend appointments, including contacting the police if they were concerned for the patient's safety.

Our findings

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it, although the completion of training was below the target for the Haringey team.

All staff told us they had received training on how to recognise and report abuse. Staff knew how to recognise adults and children at risk of, or suffering, harm. They provided examples of when they had raised safeguarding concerns in respect of patients or their children. We observed staff identifying safeguarding concerns during the morning planning meetings. Staff knew who the trust leads for safeguarding adults and children were and how to contact them for advice.

Staff received training on how to recognise and report abuse, appropriate for their role. Most staff had completed their mandatory training in safeguarding with compliance rates for all 3 teams we visited at over 80%. This included 100% compliance rate for in the HBPoS and Barnet CRHTT and over 80% for Enfield CRHTT.

However, Haringey CRHTT, fell below trust targets with rates of 57% for safeguarding adults' level 3 and 75% for safeguarding children level 3.

Staff access to essential information

Staff working for the mental health crisis teams kept detailed records of patients' care and treatment. Records were clear, up-to-date and easily available to all staff providing care.

Patient notes were comprehensive, and all staff could access them easily. Records were stored securely on an electronic patient record system which was password protected.

Medicines management

The service did not always have robust systems and processes to safely prescribe, administer, record and store medicines. Staff working for the mental health crisis teams regularly reviewed the effects of medications on each patient's mental and physical health.

Staff reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines.

Staff and patients could access advice from a clinical pharmacist.

There was a daily meeting where patients' treatment including medicines were discussed by a multidisciplinary team of healthcare professionals. Patients in the CRHTTs were able to discuss their medication with staff when they visited them at home to ask for increase or reductions in dose or changes to prescribed medicines to meet their needs.

Staff stored and managed all medicines and prescribing documents safely. Access to medicine storage areas and cupboards was appropriately restricted in each service we inspected.

Staff used an electronic system to prescribe and record the administration of medicines. They also used another electronic system to document patients' notes and care records.

Staff had access to emergency medicines and resuscitation equipment. This was checked every day.

Consent to treatment documents were in place at the point of administration and adhered to for all patients in the service.

Our findings

Staff reviewed the effects of each patient's medicines on their physical health according to NICE guidance.

Staff learned from safety alerts and incidents to improve practice.

The service ensured people's behaviour was not controlled by excessive and inappropriate use of medicines.

However, the service did not have robust systems and processes to prescribe and administer medicines safely and we found that the approach to medicines management was variable across the 3 services inspected.

At the time of the inspection, Enfield CRHTT did not have their own dedicated clinic room and we were told this had been decommissioned 3 years previously due to a faulty air-conditioning unit. This meant that medicines were stored in 2 separate locations with daily medicines being stored in a pharmacy green bag in the decommissioned clinic room which was secure.

The team's controlled drugs (CDs) were kept on a nearby inpatient ward and staff attended daily to conduct checks. However, this situation presented a level of risk of medicines not being managed safely. We were concerned this arrangement could potentially lead to medicines not being stored or administered safely.

We raised this issue with the trust on the day and they confirmed the air-conditioning unit had been fixed and the infection prevention and control team had approved its use which meant the clinic room was functioning again the week of the inspection visit.

Medicines were not always stored appropriately so they remained safe and effective for use. For example, the HBPoS medicine stock list was not easily available for staff to access and the member of staff on the day was not aware that there was one.

We also observed expired medicines. For example, one medicine had an expiration date of February 2023 and there was also rapid tranquilisation medicine (used to help calm a person who is extremely distressed) with an expiration date of November 2022. This meant that there was a risk of patients being administered expired medicines.

At the last inspection we told the trust they should ensure that staff in the HBPoS recorded the legal authority under which medicine is given to patients for the purpose of rapid tranquilisation, this time we found that this was recorded appropriately in the patient's record.

Barnet CRHTT's controlled drugs (CD, medicines with additional storage requirements) were stored correctly but not always monitored safely. For example, we saw 1 example of a CD being delivered by pharmacy on 14 April 2023 with no checks until 24 April 2023 when it was administered to a patient.

We looked at patient drug charts and found 3 out of 10 reviewed at Barnet RCHTT were not dated which meant it was unclear when certain medicines had been stopped and meant that there was a potential risk of medicine being administered when it was no longer prescribed.

The service used thermometers to monitor fridge and ambient room temperatures. We saw examples of appropriate action being taken when temperatures went outside of the recommended range to ensure the medicines continued to be safe and effective for use.

Our findings

However, temperature checks of the fridge located in the HBPoS clinic room had insufficient oversight to ensure they were being done correctly. We raised this with the manager on the day who said they would implement an audit action plan to make sure checks were completed regularly.

Track record on safety

The service had a good track record on safety.

Reporting incidents and learning from when things go wrong

The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

Staff recognised incidents and knew when to report them. They gave us examples of incidents they had reported. Managers shared lessons learned from incidents with the whole team. Staff told us that incidents were discussed in safety huddles and clinical governance meetings. Staff told us about incidents that had occurred in the service and changes that had been implemented in response to lessons learned.

Incidents were investigated thoroughly and discussed at the team meetings. Patients and their families were involved in these investigations. Staff received feedback and from the investigation of these incidents, and support was offered and provided. Staff discussed the feedback and improvements to patient care at team meetings.

Staff understood the duty of candour. They were open and transparent, and they gave patients and families a full explanation if and when things went wrong. Staff said they apologised to patients and relatives when things went wrong.

Managers provided staff with a debrief after incidents and staff told us that they found these helpful.

There was evidence that changes had been made as a result of feedback. For example, A Did Not Attend (DNA) protocol had been developed in response to a serious incident. This set out clear guidance for staff on what to do in the event a patient did not attend an appointment.

Managers attended several weekly meetings. Managers attended clinical governance meetings with the governance facilitator, as well as with the head of nursing. Safety incidents were also discussed at team meetings.

Is the service effective?

Good 

Our rating of effective stayed the same. We rated it as good.

Assessment of needs and planning of care

Staff assessed the mental health needs of all patients. Staff working for the mental health crisis teams worked with patients and families and carers to develop individual care plans and updated them when needed. Care plans reflected the assessed needs, were personalised, holistic and recovery-oriented.

Our findings

We reviewed 10 patient care record across 2 CRHTTs. In Barnet all patient records we reviewed had a crisis care plan in place and stored on the record.

Staff at Enfield CRHTT told us that crisis plans were completed with the patient's involvement in their own homes and on paper. These were supposed to be taken back to the office and scanned into the patient record, but this did not always happen. Patients of Enfield CRHTT we spoke to confirmed they had copies of their crisis plan and we saw evidence in the patient record of crisis plans being discussed with the patient.

Staff undertook physical health assessments on patients. In most patient records we reviewed, staff had reviewed their physical health needs unless the patient was newly referred to the team.

The teams completed audits on physical health monthly which showed that a physical health check was completed after the initial assessment of a patient.

Wellbeing clinics, which provided outpatient treatment and support for the patients, supported the teams and received referrals from them. These clinics provided physical health checks and blood tests for patients prescribed antipsychotic medicines.

Staff formulated an initial care plan with patients when they were admitted into the service. Care plans were then brought to the next multi-disciplinary team meeting where a more comprehensive care plan was formulated. This was then be shared with the patient and their carers or family members. Staff regularly reviewed and updated care plans when patients' needs changed.

Most care plans we reviewed were standardised and not personalised. However, more detailed information was found in the patient risk assessment and progress notes.

Best practice in treatment and care

Staff working for the mental health crisis teams used recognised rating scales to assess and record severity and outcomes. Staff working for the crisis teams and in the health-based places of safety participated in clinical audit, benchmarking and quality improvement initiatives.

Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives.

Staff referred patients to other services or professionals to meet their needs when appropriate. For example, staff referred patients with substance misuse problems to the local substance misuse service.

Staff ensured patients had support for their physical health needs, either from their GP or community services.

Staff supported patients to live healthier lives. For example, they referred them to smoking cessation services or their GP for support or provided nicotine replacement therapy.

Staff used outcome measures to monitor the progress of patients. For example, DIALOG+ (a scale allowing patients to rate their satisfaction with 8 life domains and 3 treatment aspects on a 7-point scale and is designed to make clinician-patient interactions more therapeutically effective) and CORE34 (Clinical Outcomes in Routine Evaluation).

Our findings

Staff took part in clinical audits. Managers used results from audits to make improvements. For example, staff took part in clinical audits of risk assessments and care plans, physical health checks, medicines, infection control and safeguarding. Where gaps were identified these were addressed through action plans.

Staff took part in quality improvement initiatives. The Enfield CRHTT had implemented a project aimed at increasing the capturing of consent to treatment in progress notes from 30% to 60%.

The Barnet team had won a trust award for 'most effective QI project' for their clozapine checklist form. A lack of clarity around roles and responsibilities had led to a bottleneck in patient flow which was impacting on the team's caseload. Clarifying which teams undertook specific tasks and the creation of a coproduced check list with key stakeholders meant a reduction in admissions to inpatient beds for clozapine titration (the process of gradually increasing a patient's medicine to minimise side effects).

Skilled staff to deliver care

The mental health crisis teams included or had access to the full range of specialists required to meet the needs of patients under their care. Managers made sure that staff had the range of skills needed to provide high quality care. They supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.

Managers gave each new member of staff a full induction to the service before they started work.

Staff said they had been supported in their career progression by their manager and the trust. For example, one staff member had been supported to complete their nursing associate training. Staff who managed others were also able to access a 5 day training course for all new leaders.

Managers ensured staff had the right skills, qualifications and experience to meet the needs of the patients in their care, including bank and agency staff. Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. For example, the Barnet CRHTT ensured staff at all levels had opportunities to chair team meetings to develop their leadership skills. Crisis team staff had also recently undertaken specific training on bereavement and loss.

All teams held reflective practice group meetings, facilitated by a psychologist, that allowed staff to discuss their work experiences, although the frequency of these varied from team to team

The mental health crisis teams included or had access to a range of specialists required to meet the needs of patients under their care. At the last inspection we told the trust they should ensure that patients in the CRHTTs have access to psychological therapies. This time we found that all teams had access to psychology input. Barnet still needed to recruit a permanent post, but they had interim locum cover.

All staff told us they received an annual appraisal and regular monthly supervision.

Supervision rates for the 12 months prior to the inspection was over 90% for all 3 CRHT teams and the HBPoS. Agency staff were also offered regular supervision. Supervision was completed each month unless the staff member was sick or on leave. Staff said they had opportunities for professional development and set development goals as part of the appraisal process.

Our findings

At the last inspection, we told the trust they should ensure that yearly staff appraisals are conducted on time each year and records updated to show these conversations had taken place. This time we found that most staff in the CRHTT and HBPoS had annual appraisals and this data was clearly recorded.

Managers made sure staff attended regular team meetings or gave information to those who could not attend. Staff at the place of safety had regular team meetings.

Multi-disciplinary and interagency team work

Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. They had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.

Staff held regular multidisciplinary meetings to discuss patients and improve their care. Staff at the place of safety had monthly team meeting to review performance data on the service and discuss incidents and development.

Staff made sure they shared clear information about patients and any changes in their care, including during transfer of care. At the start of each shift, staff at the place of safety held a handover meeting to discuss patients held within the facility. Staff provided a discharge summary for the service that the patient was being discharged to.

We observed handover meetings in all 3 services we inspected and found them to be comprehensive and included all relevant information relating to risks, treatment plans and any other relevant information. All staff attending were engaged and appropriately challenged when discussing how best to support patients.

Staff at the health-based place of safety worked closely with bed managers, crisis teams, community mental health teams and acute admission wards. The team leader of the place of safety attended a monthly meeting with managers of other services involved in conveying patients to a place of safety. This included managers from the police, ambulance service, social services, approved mental health professionals and the emergency department of the local hospital.

The CRHT teams had effective working relationships with external teams and organisations. The manager of Barnet CRHTT had recently set up interface meetings with the other community mental health teams and the AMPH service to discuss transfers of care. These meetings meant they were able to identify and resolve barriers to transferring care quickly and meant the team's case load was reduced.

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

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice.

Staff in the health-based place of safety understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice.

Most staff received and kept up-to-date with training on the Mental Health Act and the Mental Health Act Code of Practice with rates of compliance with the mandatory training over 85% apart from Haringey CRHTT who only 64% complaint.

All staff we spoke to understood the Code of Practice guiding principles.

Our findings

Staff had access to support and advice on implementing the Mental Health Act and its Code of Practice. Staff knew who their Mental Health Act administrators were and when to ask them for support.

The service had clear, accessible, relevant and up-to-date policies and procedures that reflected all relevant legislation and the Mental Health Act Code of Practice. Staff could access policies and guidance through the trust's intranet.

At the last inspection we found that there were some long delays in arranging Mental Health Act assessments. However, data we reviewed showed that there were still significant delays in arranging Mental Health Act assessment. For example, in the year prior to the inspection, there were 10 occasions where it took over 14 days from referral to admission where a warrant was not required. This meant patients awaiting assessment and admission to hospital could be placed at an unacceptable level of risk.

The trust was undertaking strategic work to address this issue. This aimed to ensure 100% of patients requiring a Mental Health Act assessment were admitted within 4 days if a warrant was not required and within 13 days if a warrant was required, by March 2024.

At the last inspection we asked the trust to ensure that patients in the HBPoS are informed of their legal status, including when the period of detention has expired. This time we found staff did explain to each patient their legal status and their rights under the Mental Health Act in a way that they could understand, repeated as necessary and recorded it clearly in the patient's notes each time.

Staff consistently talked to patients about how the Mental Health Act applied to their situation when they arrived at the place of safety. We reviewed 6 records of patients, 2 of whom who were held beyond the permitted period of detention and found evidence to show that staff informed the patient of the change in their status when the permitted period elapsed.

Staff working in the HBPoS were reminded of their responsibilities in relation to the Mental Health Act in the monthly team meetings.

Good practice in applying the Mental Capacity Act

Staff supported patients to make decisions on their care for themselves. They understood the trust policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly for patients who might have impaired mental capacity.

There was a clear policy on the Mental Capacity Act (MCA) within the service.

Staff received training in the MCA. Records we looked at showed compliance with this training was over 80% for all teams apart from Haringey CRHTT was 73%.

Staff said they supported patients to make decisions on their care for themselves and patients we spoke to confirmed they were involved in making decisions about their care and treatment.

Following the last inspection, we told the trust that they should ensure staff in the CRHTTs understood and recorded a patient's capacity to consent. Enfield CRHTT had undertaken quality improvement work on capacity to consent with aim of ensuring assessment of capacity was recorded properly and improving the rates of capturing this within patient records.

Our findings

This time we found that staff were assessing and recording patients' capacity to consent in records.

Staff audited how they applied the MCA and identified and acted when they needed to make changes to improve. Monthly audits were undertaken of patient risk assessments and care plans, this included whether a capacity assessment had been undertaken. Where the capacity assessment had not been undertaken or recorded, this was rectified after the audit and this issue resolved.

Is the service caring?

Good  

Our rating of caring stayed the same. We rated it as good.

Kindness, privacy, dignity, respect, compassion and support

Staff treated patients with compassion and kindness. They respected patients' privacy and dignity. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.

Patients and carers told us staff treated patients with compassion and kindness. They respected patients' privacy and dignity. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.

We spoke with 5 patients and 4 carers across the three teams, and we observed staff speaking with patients over the telephone and whilst in the HBPoS. They were kind and respectful in all interactions.

Staff supported patients to understand and manage their own care treatment or condition. Staff gave patients help, emotional support and advice when they needed it. Patients said staff treated them well, took time to listen and were approachable.

All patients and carers we spoke said they felt involved in care planning, and staff were respectful and polite.

Involvement in care

Staff in the mental health crisis teams involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided. They ensured that patients had easy access to advocates when needed.

Staff informed and involved families and carers appropriately.

Involvement of patients

Patients told us staff involved patients in decisions about the service and gave them access to their care plans. Staff told us how they tried to involve patients in their care. Although not all patients we spoke to had copies of their care plan, they all told us they felt involved in discussions about their care and treatment.

Our findings

For example, one patient told us that they were given choices around their care and that they felt decisions had been made with them, not about them. Another patient said the doctor had spent over an hour with them discussing medication options.

Patients told us staff made sure they understood their care and treatment (and found ways to communicate with patients who had communication difficulties). Patients said that information was accessible to them and was explained to them by the staff.

Patients could give feedback on the service and their treatment and staff supported them to do this. Administration staff called patients and carers/relatives to get feedback about their experience of the crisis teams. Patients could access an online form to give feedback about their care.

Involvement of families and carers

Staff informed and involved families and carers appropriately.

Staff supported, informed and involved families or carers. Following the last inspection, we told the trust staff in the CRHTTs should discuss and record patients' consent to share information with family members. This time, in the 11 records we reviewed we found consistent evidence of proactive engagement with patients and family members, unless the patient had not consented to the sharing of information and that this was clearly recorded.

Staff considered the needs of relatives and carers and discussed these in the morning planning meetings we observed. Staff said they carried out carers assessments when appropriate and we observed this was discussed in the morning planning meeting.

Staff understood the importance of obtaining collateral information about patients from family members and friends.

Staff helped carers and families to give feedback on the service. Carers were contacted monthly for feedback via a carer survey. The manager of the Barnet CRHTT was working closely with the trust's consultant social worker to develop a carers event specific to the crisis teams. Carers were also signposted to the local carers centre for advice and support.

Is the service responsive?

Requires Improvement 

Our rating of responsive stayed the same. We rated it as requires improvement.

Access and discharge

The mental health crisis service was available 24-hours a day and was easy to access – including through a dedicated crisis telephone line. The referral criteria for the mental health crisis teams did not exclude patients who would have benefitted from care. Staff mostly assessed and treated people promptly although the Enfield home treatment was missing the target for assessing urgent referrals within 4 hours. Patients were regularly spending too long in the Health Based Place of Safety. Staff followed up people who missed appointments.

The service met the target times for seeing patients from referral to assessment and assessment to treatment. Staff saw urgent referrals quickly.

Our findings

The service had clear criteria to describe which patients they would offer services to. The Enfield team had worked with local GPs and liaison teams to highlight what an appropriate referral looked like. There were no waiting lists for the home treatment teams.

The mental health crisis service was available 24-hours a day and was easy to access, including through self-referral and a dedicated crisis telephone line. Staff assessed and treated people promptly. Staff followed up people who missed appointments. The team tried to contact people who did not attend appointments and offer support.

The team tried to engage with people who found it difficult, or were reluctant, to seek support from mental health services. Staff would do a joint visit with the care coordinator to try to engage with reluctant patients. Staff would also form a plan with community teams and involve families wherever possible to facilitate engagement.

Patients were offered some flexibility with appointment times available. Patients were given a timeframe for their appointment. If the appointment was cancelled by the service, the patient was usually made aware. If staff visited and the patient wasn't home, the staff would leave a note.

Social workers at the service supported patients. For example, supporting with housing or benefit entitlement. They could also complete Care Act assessments of a patient's care needs, to access additional support.

The service had clear criteria to describe which patients they would offer services to. The health-based place of safety accepted referrals for patients aged 18 or over. Patients younger than 18 who required a place of safety were taken to the emergency department of local hospitals. The service did not accept patients when there were concerns about their physical health. The police took these patients to an emergency department for medical clearance before taking them to the place of safety.

At the last inspection we told the trust they must ensure it continues to work to reduce the caseload for the Barnet CRHTT. This time we found that the team had a manageable caseload of an average 35 patients, having worked hard to address this issue.

The manager had worked with the trust quality improvement (QI) lead to achieve and sustain a reduction in the team's caseload. This work included the development of a ward coordinator role and an inpatient checklist to formalise processes and ways of working to ensure safe discharges. The introduction of interface meetings with the community teams and the AMHP service supported the patient pathway in and out of hospital quicker.

The consultant psychiatrist held teaching sessions on how to present a case to the multidisciplinary team which supported the learning of all staff and enabled them to feel confident in their own assessment skills. This meant that all staff were confident in using and applying the referral pathway.

On the day of the inspection, Barnet CRHTT had a caseload of 37. However, the Enfield CRHTT had a caseload of 52. Staff told us that many of these patients were delayed transfers of care to the community teams and were rag rated green. This meant that there continued to be high demand on the team and staff were working under pressure.

Crisis team staff saw patients referred urgently for a face to face assessment within 4 hours, and non-urgent referrals within 24 hours. The Barnet and Haringey teams were regularly achieving the urgent four-hour target.

However, Enfield CRHTT failed to meet the trust's provisional target of 90% 5 months out of 12 in the year prior to the inspection visit and in November 2022 met it only 60% of the time.

Our findings

All 3 CRHT teams met the non-urgent 24-hour time target of 80% every month apart from once in the 12 months prior to the inspection.

Following the last inspection, we told the trust they must work with partner organisations to ensure patients who require a Mental Health Act assessments (MHAA) were assessed without undue delay.

This time, we found that the trust had undertaken quality improvement work around MHAAs. This included the introduction of a digital dashboard in Barnet and Haringey, a checklist template for MHAA requests and the development of a prevention pathway.

The HBPoS manager worked in partnership with other teams and agencies to manage patient flow. For example, daily weekday meeting with representatives from local accident and emergency departments, community mental health and crisis teams to discuss potential admissions and discharges as well as a monthly meeting with bed managers, AMHPs (Approved Mental Health Professional), police, accident and emergency liaison to review the previous month including any incidents to see if there was any learning.

However, patients were frequently held in the place of safety for longer than the permitted period of detention. The trust did not always discharge patients from the place of safety within the 24-hour permitted period of detention.

Data we reviewed showed that the percentage of patients held beyond the time permitted had not reduced over the 12 months prior to the inspection and that 37 % of patient were held beyond the time limit allowed for an overage of 10 hours longer than permitted. Staff explained that delays were caused by a lack of availability of inpatient beds.

Facilities that promote comfort, dignity and privacy

The design, layout, and furnishings of treatment rooms supported patients' treatment, privacy and dignity.

The service had a full range of rooms and equipment to support treatment and care or could use rooms in other trust services.

The home treatment teams supported patients in their homes, as well as in community settings such as GP practices.

The HBPoS provided large rooms for patients with ensuite facilities and natural light. At the last inspection we found the closed-circuit television (CCTV) used for monitoring patients in their bedrooms was always switched on and we asked the trust to ensure CCTV was only used when required, based on an assessment of risks. This time we found the CCTV was in use the day of inspection visit, but records we reviewed showed patients were advised of its use in line with trust policy when they were admitted to the unit.

Following our last inspection, we informed the trust they must ensure that the facilities used by patients in the HBPoS were safe, with an appropriate standard of fixtures and fittings. This time we found that rooms were clean and deep cleaned between use. Patients had access to a tablet and the manager had ordered a television for use in the communal area.

Patients' engagement with the wider community

Staff supported patients with activities outside the service, such as work, education and family relationships.

Our findings

Staff connected patients to community teams and other agencies. For example, one patient was referred to an Iranian voluntary organisation following a home visit from the CRHTT. This organisation was able to provide culturally sensitive, practical support for housing and finances. The patient and their family told staff this had enabled them to feel less isolated in their community.

The teams supported patients who continued to work and could be flexible around appointment times, such as meeting outside of regular meeting hours.

The teams involved the families and carers of patients from their admission into the service. Staff did this by asking families and carers for further information about the patient and involved them in future care plans for the patient. Staff sought patients consent to do this and recorded this in the patient record.

Meeting the needs of all people who use the service

The service met the needs of all patients – including those with a protected characteristic. Staff helped patients with communication, advocacy and cultural and spiritual support.

The service provided information in a variety of accessible formats so the patients could understand more easily. For example, the service could provide information leaflets available in languages spoken by the patients and local community.

Staff signposted patients and carers to relevant local voluntary sector organisations for additional and longer-term support, for example to faith-based support groups, local crisis cafés and carers forums.

Staff discussed patients' specific needs in daily morning planning meetings. Staff made sure patients could access information on treatment, local services, and how to complain. Managers made sure staff and patients could get hold of language interpreters or British sign language interpreters when needed.

Staff said they could flag patients' individual communication needs via an alert on the patient electronic records system, if needed.

Listening to and learning from concerns and complaints

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and wider service.

Patients, relatives and carers knew how to complain or raise concerns. Staff gave patients a welcome pack when they were first seen by the service. The welcome pack contained information about how to raise a concern or complaint.

We spoke with 5 patients about their experience of the service. Although most patients said they were unsure how to make a complaint, they would speak to staff if they needed to, and all told us they would feel comfortable raising any concerns they had about the service.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. Staff we spoke with understood the policy on complaints and knew how to handle them. Themes and outcomes from complaints were shared and reflected upon with staff.

Managers investigated complaints and identified themes. Managers shared feedback from complaints with staff and learning was used to improve the service.

Our findings

The service had very low levels of formal complaints. From April 2022 to April 2023, the services received 2 formal complaints. Both related to Barnet CRHTT. One concerned another service and the other related to inadequate support provided and was partially upheld.

Managers spoke to patients to try and resolve the complaint informally initially. If the patient wanted to make a formal complaint, they would be put in contact with the patients experience team. Formal complaints were investigated by managers.

Is the service well-led?

Good 

Our rating of well-led stayed the same. We rated it as good.

Leadership

Leaders had the skills, knowledge and experience to perform their roles. They had a good understanding of the services they managed and were visible in the service and approachable for patients and staff.

All staff we spoke to said that the trust was a good place to work and said that the trust had supported their professional development. For example, one member of staff had begun work with the trust as a nursing assistant and the trust had supported their training through funding, and they were now a nursing associate.

The trust funded mental health associate training and we spoke to one trainee who said leaders had supported them to feel part of the team.

The trust had introduced a rotation scheme that enabled nurses to work in different areas of the trust to broaden their experience. The manager of Barnet CRHTT had supported staff career development by enabling them to gain work experience in other teams.

Staff felt they were valued by their managers and felt that their contribution to the service were recognised. Staff told us clinical leads regularly visited teams to check in and ask how they were doing.

Vision and strategy

Staff knew and understood the provider's vision and values and how they (were) applied to the work of their team.

The trust's values were on display in the team offices. These were compassion, respect, being positive and working together. We observed staff behaving in line with the trust's values.

Patients we spoke to told us staff were compassionate and respectful and listened to what they had to say.

Culture

Staff felt respected, supported and valued. They said the trust promoted equality and diversity in daily work and provided opportunities for development and career progression. They could raise any concerns without fear.

Our findings

Staff we spoke to told us they felt supported and valued at work by their immediate managers and by the wider organisation.

One staff member told us that they were well supported when they had been physically assaulted by a patient. They had received a letter from management expressing concern and asking how they could support them.

Staff told us they felt safe to raise any concerns without fear. The manager of Enfield CRHTT had arranged for the trust's Freedom to Speak Up Guardian to visit the team to talk about what they did to support staff.

Staff said they would speak to their manager if they had any concerns. Staff told us that when they had raised concerns that they had felt listened to and leaders responded to them.

Staff survey results for 2022 showed that most staff in the service line felt valued, with 87% saying they felt their immediate manager valued their work and 79% saying there were frequent opportunities for them to show initiative in their role. A further 77% said they would feel secure raising concerns about unsafe clinical practice and 64% said they felt supported to develop their potential.

Governance

Our findings from the other key questions demonstrated that performance and risk were managed well but that governance processes did not always operate effectively at team level.

Staff told us they attended regular clinical governance meetings at team level. Staff discussed learning from serious incidents and complaints at these meetings.

The service implemented improvements following serious incidents, such the introduction of a 'did not attend' protocol for the CRHTT based on the patient's rag rating. Managers of a service would assist in an investigation of incidents at another service, and the three team managers would meet regularly to discuss service issues and share information.

There were systems in place to ensure quality and safety. These included daily planning meetings to manage and discuss risk to patients, setting target times for the service and ensuring these were met.

Oversight of performance was maintained by regular clinical audits. The service used a smartphone application to complete audits which meant the data was inputted and analysed instantly so that staff could act on results immediately.

Managers monitored staff wellbeing and performance through regular supervision.

The teams undertook other regular audits to provide assurance on the systems in place such as risk assessments, care plans, environmental safety and serious incident action plans. Where audits showed a drop in standards, this was identified and rectified.

At the place of safety, staff held clinical governance meetings to review performance data relating to the service. The performance dashboard included data about the number of admissions, the discharge pathway, the number of breaches of the permitted time of detention, assessment times and incidents. Leaders had plans to try and reduce the amount of time people spent in the health-cased place of safety. This included a quality improvement project aimed at reducing delays in Mental Health Act assessments.

Our findings

However, we were concerned the systems and processes in place to ensure the safe management of medicines were not working effectively. This was we found areas of concern related to the safe storage, recording and administering of medicines at all 3 sites we visited during this inspection.

Management of risk, issues and performance

Teams had access to the information they needed to provide safe and effective care and used that information to good effect.

Service level risk registers were in place for the crisis teams and HBPoS. The main risk for the HBPoS related to the risk of breaches is 135/136 legislation due to difficulty in identifying inpatient beds.

The was a trust-wide risk related to recruitment challenges because of a lack of availability of suitable candidates in London and nationally for nursing and highly specialist roles. This was being managed through a trust-wide recruitment and retention strategy.

Risk was managed well by the services. Risk was constantly discussed at daily planning meetings and was at the forefront of any patient discussions. Managers knew about delays in patient's being assessed under the Mental Act, and they were working to reduce the time assessments took. Leaders in the Enfield team were working to reduce the team caseload through the introduction of the electronic dashboard.

Serious incidents were investigated, shared with the team, and learning implemented through action plans. Staff and service performance was managed well through regular supervision and clinical audits.

Information management

Staff collected analysed data about outcomes and performance and engaged actively in local and national quality improvement activities.

Staff collected data about outcomes and performance and engaged actively in local and national quality improvement activities.

Staff had access to the equipment and information technology they needed to do their work. This included mobile phones, laptops and lone working devices for staff safety on home visits.

Managers had access to the information on their team's performance collected through clinical audits. This included information on completion of patient risk assessments, care plans and community physical health assessments.

Engagement

Managers engaged actively other local health and social care providers to ensure that an integrated health and care system was commissioned and provided to meet the needs of the local population. Managers from the service participated actively in the work of the local transforming care partnership.

There were effective, multi-agency arrangements to agree and monitor the governance of the mental health crisis service and the health-based places of safety. Managers of the service worked actively with partner agencies (including the police, ambulance service, primary care and local acute medical services) to ensure that people in the area received help when they experienced a mental health crisis, regardless of the setting.

Our findings

Patients and carers were engaged through feedback forms and discharge surveys where they could share their feedback and how they felt about the service. Patients and carers were provided a welcome pack upon admission that explained how to feedback about the service and make a complaint if they wanted to. This also included a safeguarding safe line that patients could use to raise a concern.

Carers could provide feedback about the service as well as receive information about resources and support for their role, through the trust's carers networks and forums. Patients and carers said in discharge surveys that they felt their needs were met by the service.

The team leader at the place of safety met each month with managers from partner agencies including the police, ambulance service, emergency department and local authority. This meant that all the agencies involved in conveying patients to the place of safety had the opportunity to discuss and resolve any delays or difficulties they had experienced.

The manager of Barnet CRHTT had implemented interface meetings with partner teams which had support patient flow and reduced the team's caseload.

Learning, continuous improvement and innovation

Staff at the place of safety talked about ideas for improving the service. This included putting televisions in the communal area, expanding the service, reducing the number of breaches of the permitted period of detention and reducing restrictive practices.

The HBPoS had recently undertaken QI work to reduce restrictive practices. This project had an overall positive impact on the rates of incidents, seclusion and rapid tranquilisation as well as reducing rates of prone restraint.

The Enfield and Barnet CRHTTs were in the process of accreditation for the Home Treatment Accreditation Scheme (HTAS). This scheme run by the Royal College of Psychiatrists demonstrates a team has a high level of competence across 4 main standards including service provision, staff appraisal, supervision and training, assessment, care planning and transfer or discharge and interventions.

Our findings

Areas for improvement

Action the trust MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is because it was not doing something required by a regulation, but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the trust MUST take to improve:

- The trust must ensure that governance processes for medicines management are reviewed and embedded across crisis teams and the health-based place of safety to ensure the safe administration, recording and storage of medicines. Regulation 12 (1) (g)
- The trust must ensure that Enfield Crisis resolution and home treatment team addresses the failure to meet the trust's provisional target of 90% for a 4 hour turnaround for a face to face assessment of urgent patient referrals. Regulation 12 (1) (a) (b)
- The trust must continue its work improve access to beds and to stop patients in the health-based place of safety from being held beyond the 24-hour Section 136 detention period with no legal framework for holding them. Regulation 13 (1)(5)
- The trust must ensure that staff in the Health Based Place of Safety and Haringey Crisis resolution and home treatment team are up-to-date with all mandatory training. Regulation 18 (1) (a)

Action the trust Should take to improve:

- The trust should ensure work done in other areas of the crisis service to reduce team caseloads is embedded in the Enfield Crisis resolution and home treatment team.
- The trust should ensure that it continue work to reduce staff vacancies in the Haringey crisis resolution and home treatment team and the health-based place of safety.
- The trust should ensure that that it continues to work effectively with partner organisations to ensure patients who require a Mental Health Act assessments are assessed without undue delay to ensure their safety and that of others.

Our inspection team

The team that inspected the service consisted of a lead inspector, 2 additional inspectors, a specialist advisor, with experience working in mental health crisis services and an expert by experience, someone who has experience of mental health crisis services.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing