North East London NHS Foundation Trust

Mental health crisis services and health-based places of safety

Quality Report

Trust Head Office,
CEME West Wing,
Marsh Way,
Rainham,
Essex,
RM13 8GQ
Tel: 08446001200
Website: www.nelft.nhs.uk

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Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RATX8	Trust Head Office, CEME	Acute crisis assessment team	IG3 8XJ

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

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

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

Summary of findings

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

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

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

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

Summary of findings

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Summary of findings

Overall summary

Following this focussed inspection of Mental Health Crisis Services and Health Based Places of Safety, we established that the trust now met the requirements outlined in the warning notice issued under Section 29A of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, which had been served in July 2019.

We had previously inspected this core service during a comprehensive inspection in June 2019. During that inspection we rated safe, responsive and well led as inadequate. Our overall rating for this core service went down and was rated as inadequate. We issued the trust with a warning notice under Section 29A of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, in relation to concerns identified with the safety and quality of acute crisis assessment team service. We required the trust to meet the requirements of the warning notice by 9 October 2019.

We undertook this focused inspection to check whether the provider had met the requirements. We did not rate the service as a result of this inspection. We found that improvements had been made to the acute crisis assessment team and that the trust now met the requirements outlined in the warning notice.

- The trust had acted to promote the safety of patients and staff. Patients were no longer left unsupervised at Sunflowers Court whilst they waited to be assessed, were being assessed, or waited to be admitted to the hospital. The trust had introduced robust arrangements to ensure patients were supervised at all times whilst waiting and appropriate waiting and assessment areas were now available.
- Improvements had been made to the way the acute crisis assessment team accessed staff with the necessary range of professional skills and experience, including doctors, when undertaking assessments of patients. This meant staff working in the acute crisis assessment team could now access appropriate multi-disciplinary staff for all assessments.
- Leaders had taken appropriate action to respond to the concerns that staff had raised in relation to 'walk in' patients who presented at Sunflowers Court requiring an assessment by the acute crisis assessment team. Leaders had also started to monitor how effective the acute crisis assessment team was.

However:

- The trust recognised that the acute care pathway remained under pressure and was carrying out a review of this with the aim of making improvements. This work, along with strengthened governance systems related specifically to the acute crisis assessment function, requires continued robust oversight to ensure that the current improvement is maintained, and future challenges are responded to quickly and safely.

Summary of findings

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

Are services safe?
During our last inspection in June 2019 the arrangements in place for the acute crisis assessment team to assess and admit patients to an inpatient bed were unsafe.

During this inspection improvements had been made to ensure patients were now safely supervised when waiting and that the potential risk of harm to patients and staff was adequately mitigated.

A new standard operating procedure had been implemented. This helped minimise the likelihood that patients would present to Sunflowers Court for an assessment by the acute crisis assessment team on an unplanned basis. The new procedure also ensured patients who might present for an unplanned assessment would be safely managed by staff.

Closed-circuit television monitoring had been improved across the building. This provided assurance that patients would be safely monitored if an incident occurred in which patients did find themselves unsupervised in secluded areas of the building.

Are services effective?
Not inspected

Are services caring?
Not inspected

Are services responsive to people's needs?
During our last inspection in June 2019 the multidisciplinary arrangements for the acute crisis assessment team were not effective. This included a need for improved access to and improved working relationships with doctors to ensure patients received comprehensive assessments to determine whether an inpatient admission would be necessary.

During this inspection improvements had been made to ensure doctors could be readily accessed for input into assessments. A clearer escalation protocol was now in place to ensure assessments could be seen by consultant psychiatrists easily. Improvements had been made to strengthen the consultant psychiatrist on-call rota and to ensure vacant out-of-hours junior doctor shifts were filled.

Summary of findings

Are services well-led?

During our last inspection in June 2019 leaders at all levels in the organisation were aware of the operational challenges for the acute crisis assessment model and how this potentially affected patient safety. Leaders had not responded promptly to address these concerns, despite them being known for a few months.

Whilst improvements had been made to the process for managing planned and unplanned assessments at this inspection, staff were aware of the need to continue to monitor the demands on the acute mental health care pathway. This was to enable potential adjustments or changes to the service model to be made in a timely way to respond to future changes in demand.

The trust had taken action to minimise the number of patients presenting unplanned at Sunflowers Court for an assessment by the acute crisis assessment team. This involved implementing a new standard operating procedure for planned and unplanned inpatient assessments and liaising with stakeholders including the emergency services to make them aware of the new procedures for assessments.

Staff monitored how effectively the new standard operating procedure was being implemented. The number of unexpected walk-in assessments at Sunflowers Court and the acute crisis assessment team staff response time when patients arrived at the location were now closely monitored.

Summary of findings

Information about the service

We visited the acute assessment and crisis team which covers the London Boroughs of Redbridge, Barking and Dagenham, Havering, and Waltham Forest. Referrals to the acute crisis assessment team come from wards or teams within the trust, including the psychiatry liaison service at the local acute hospitals, GPs and self-referrals from members of the public. The acute crisis assessment team operate a 24-hour, seven day a week service.

The acute crisis assessment team is a nurse-led team and provides assessments to prospective inpatients to determine whether an inpatient admission would be suitable. These assessments can take place at any time, including out-of-hours, and can be done on a planned or in-planned basis if patients presented themselves at Sunflowers Court unexpectedly. Sunflowers Court is the trusts main mental health inpatient hospital and is registered to provide assessment or medical treatment for persons detained under the Mental Health Act 1983, diagnostic and screening procedures, and treatment for disease, disorder or injury.

Our inspection team

Our inspection team comprised one CQC inspection manager and two CQC inspectors

Why we carried out this inspection

We carried out this unannounced focussed inspection to see if the provider had made the required improvements identified in the warning notice we served in July 2019, issued under Section 29A of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

How we carried out this inspection

This inspection consisted of an announced visit to undertake focus groups with doctors, an announced visit to undertake senior interviews, and an unannounced night visit to Sunflowers Court and the acute crisis assessment team.

During the inspection we:

- interviewed the integrated care director for the acute and rehabilitation directorate
- interviewed the two associate integrated care directors and associate medical director for the acute and rehabilitation directorate
- interviewed the acute crisis assessment team leader
- conducted three focus groups with all doctors working at Sunflowers Court and with Consultant Psychiatrists working in the community mental health teams that had an interface with the inpatient mental health service at Sunflowers Court
- interviewed three junior doctors
- interviewed a receptionist
- reviewed the general environment at Sunflowers Court including the two new acute crisis assessment team's assessment rooms.

We facilitated three focus groups with junior doctors working at Sunflowers Court, consultant psychiatrists working at Sunflowers Court and in community mental

Summary of findings

health teams, and with consultant psychiatrists working at Sunflowers Court and in community mental health teams who also had additional managerial and leadership responsibilities.

We also undertook an unannounced out-of-hours inspection visit at Sunflowers Court and the acute crisis assessment team. This was followed by a visit the following day where we interviewed senior staff working in the trust's Acute and Rehabilitation Directorate.

Areas for improvement

Action the provider SHOULD take to improve

The trust should keep its acute crisis assessment team model and staffing requirements under continual review so that action to strengthen the model can be taken promptly if pressure on the acute mental health care pathway changes in future.

North East London NHS Foundation Trust

Mental health crisis services and health-based places of safety

Detailed findings

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Acute crisis assessment team (ACAT)	Trust Head Office, CEME

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

Since our last inspection in June 2019 changes had been made to aspects of the physical environment at Sunflowers Court to help ensure staff could manage patients who attended for assessments by the acute crisis assessment team (ACAT) more safely.

Two new assessment rooms had been introduced on the ground floor near the main reception area. The rooms had been refurbished to a good standard. Although some potential ligature anchor points existed in these rooms, staff reported that patients would never be left unsupervised in these rooms. Alarm systems had been fitted in the assessment rooms. Staff reported that the use of the dedicated assessment rooms was going well and that there were no safety incidents relating to patients who attended for assessments to report, partly because of the environmental improvements that had been made.

Closed-circuit television monitoring had been improved in the reception area and communal corridor areas at Sunflowers Court. Reception staff closely monitored these cameras to help mitigate the risk of patients causing harm to themselves or others if they did happen to find themselves unsupervised in the communal areas of the hospital. Reception staff worked 24-hours a day.

Assessing and managing risk to patients and staff

During our inspection in June 2019 we identified that patients who presented as Sunflowers Court for an assessment by the ACAT team were left unsupervised whilst they waited. This potentially compromised their safety, the safety of other patients and of staff. During this inspection we found that this had improved. Patients were now safely supported whilst they waited and staff were always allocated to wait with patients who were waiting for an assessment.

Staffing levels in the ACAT team had been increased. Three new band 5 nurse posts in the team had been introduced and were currently being covered by one re-deployed band 5 nurse and bank shifts. Staff reported they were now better able to ensure all patients were directly supervised when they presented to Sunflowers Court for an assessment. If the ACAT team were particularly busy, support could be obtained from the bleep holder team to safely monitor these patients.

Since our last inspection in June 2019, one member of the ACAT team was now located at Whipps Cross hospital in Waltham Forest. This meant that patients presenting at the emergency department could now be assessed promptly by ACAT at Whipps Cross hospital rather than being redirected to Sunflowers Court, reducing the number of patients attending at Sunflowers Court for ACAT assessment.

All reception staff at Sunflowers Court had received training in managing visitor flow through the reception area and were aware of their responsibility to notify the ACAT team urgently if prospective patients attended for an unplanned assessment. The ACAT team also notified reception staff in advance if they were expecting a prospective patient for a planned assessment. Reception staff reported this system was working well.

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

Not inspected

Are services caring?

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

Our findings

Not inspected

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 waiting times

The ACAT team was made up of nursing staff who were available to assess patients as needed, 24-hours a day. The shift coordinator triaged referrals. Patients were then allocated to specific staff members who were then responsible for completing the patient's assessment. Where patients were referred out-of-hours, they attended the ACAT team base at Sunflowers Court, or their local emergency department.

During our last inspection in June 2019 the ACAT team did not have timely access to staff with the necessary range of professional skills and experience, including doctors. This affected their assessments and decision making when considering whether an inpatient admission was needed for patients.

Arrangements for ACAT staff to access a medical opinion had been strengthened since our last inspection. Although the ACAT team continued to consist of nursing staff with no doctors as part of its establishment, junior doctors at Sunflowers Court were now formally identified as the first port-of-call for conducting a medical review. As part of our inspection we conducted a focus group with junior doctors working at Sunflowers Court. Junior doctors reported they were comfortable picking up these assessments and that the new twilight doctor shift was successfully easing pressure on their role.

Improvements had been made to reduce the number of vacant out-of-hours junior doctor shifts. The trust had improved this by revising their payments system for overtime shifts which meant they were now less reliant on sourcing locum doctors from an external agency.

The new standard operating procedure for all unplanned and planned assessments detailed the escalation procedure for junior doctors to use if they required support from a consultant psychiatrist. Junior doctors and Consultant Psychiatrists reported this procedure was working well.

Improvements had been made to the consultant psychiatrist on-call rota. This now covered the ACAT function as well as the Section 136 suite (health-based place of safety) at Sunflowers Court. The pool of consultant psychiatrists participating in the rota was due to be expanded from November 2019, to include all inpatient and community consultants. One of the aims of this was to help build stronger relationships across the care pathway between community psychiatrists, the ACAT team and Section 136 suite staff.

Although the trust was not actively analysing data on how many ACAT assessments were conducted in collaboration with community mental health team colleagues, senior leaders assured us they manually reviewed whether assessments had been conducted collaboratively with community teams where patients were well known to mental health services already.

A 'trusted assessor' pilot scheme was being developed at the time of our inspection. Plans were for an assessor working in a community mental health service to access inpatient beds without needing to refer the patient to the ACAT team for a separate assessment. The trust planned to review the success of this pilot to consider different ways for community team colleagues to access inpatient beds in future.

During our last inspection in June 2019 junior doctors and consultant psychiatrists reported that they experienced professional tension when needing to work with the ACAT team as part of the decision-making process for admitting patients to an inpatient bed, leading to low morale and a feeling of being professionally under-mined. Complex and lengthy escalation processes were reported sometimes causing delays that resulted in potential harm to patients who needed an inpatient stay.

During this inspection we conducted focus groups with junior doctors working at sunflowers court and with consultant psychiatrists working both at sunflowers court and in the trust's community mental health teams. We received feedback that the need for an ACAT team assessment still felt like a 'bottle-neck' to accessing an inpatient bed for patients. However, some doctors reported this had started to change during the weeks leading up to our inspection. The ACAT team continued to initiate borough interface meetings with community mental health teams to help build relationships and understanding of pressures on the pathway. These meetings also looked at particular cases where the pathway had not run smoothly to try and learn from these.

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

Leadership

During our last inspection in June 2019 leaders at all levels in the service were aware of the potential risks to safety of patients and lack of cohesive multi-disciplinary working with the trust's ACAT model. However, leaders had not effectively addressed these concerns, despite them having been recognised for a few months. There was no system to monitor the safety and effectiveness of the ACAT service at the time.

Since the trust had been issued with the warning notice under Section 29A Of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, this had improved. We identified that leaders were now working to closely monitor and resolve issues with the ACAT model. This helped ensure the system was safe and responsive for patients attending for planned and un-planned assessments.

Culture

During our last inspection in June 2019, serious concerns had been raised by junior doctors and consultants who worked in partnership with the ACAT and these had not been sufficiently addressed and their professional views had not been adequately respected.

As part of this inspection we met with both junior doctors and consultant psychiatrists who worked closely with the ACAT. They reported some improvements to the way they were listened to and consulted with in relation to the new standard operating procedures. Junior doctors felt better supported through the introduction of a new twilight doctor shift at Sunflowers Court and changes in the way they were now paid for working additional shifts.

Governance

Whilst improvements had been made to the process for managing planned and unplanned assessments, staff were aware of the need to continue to monitor the demands on the acute mental health care pathway. This was to enable potential adjustments or changes to the service model to be made in a timely way to respond to future changes in demand. The trust was also leading a review of the acute mental health pathway. A half day workshop had been held in October 2019 for staff working across community and inpatient teams to look at the challenges on the pathway and to identify possible solutions, including potential revised models of care. Commissioners also attended this away day.

Since our last inspection the trust had worked to minimise the likelihood that patients would attend Sunflowers Court for an assessment without this being arranged in advance. A new standard operating procedure had been implemented, which detailed that patient should seek support from their community assessment and brief intervention team (AABIT) via their care coordinator, who would work closely with the ACAT to arrange an assessment. The trust had worked hard to implement this new procedure. This included advising the trusts mental health direct telephone advice line to ensure they were providing patients with accurate advice about how to get an assessment. The trust also continued to work closely with police and ambulance colleagues so they knew not to drop prospective patients off at Sunflowers Court unplanned.

Staff closely monitored the trust's progress with implementing the new standard operating procedure. Data analysis showed that the procedure was being adopted and that the number of unexpected walk-ins continued to decrease. Data was also being monitored to ensure a member of the ACAT team responded to all patients who presented at Sunflowers Court for an assessment within five minutes.