NOTICE OF MEETING

NORTH CENTRAL LONDON SECTOR JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE – BARNET, ENFIELD AND HARINGEY SUB GROUP

Contact: Robert Mack

Direct line: 020 8489 2921
E-mail: rob.mack@haringey.gov.uk

Friday 13 September 2013 13:30 a.m.
Civic Centre, High Road, Wood Green,
London N22 8LE

Councillors: Alison Cornelius and Graham Old (L.B.Barnet), Alev Cazimoglu and Anne Marie Pearce (L.B.Enfield), Gideon Bull (Chair) and Dave Winskill (L.B.Haringey)

AGENDA

1. WELCOME AND APOLOGIES FOR ABSENCE

2. DECLARATIONS OF INTEREST (PAGES 1 - 2)

Members of the Committee are invited to identify any personal or prejudicial interests relevant to items on the agenda. A definition of personal and prejudicial interests is attached.

3. BARNET, ENFIELD AND HARINGEY MENTAL HEALTH TRUST - RESPONSE TO CQC INSPECTION REPORTS (PAGES 3 - 96)

To consider the following three recent CQC inspection reports relating to Barnet, Enfield and Haringey Mental Health Trust and the action plans in response to them;
(i). St. Ann's Hospital ;
(ii). Chase Farm Hospital (The Oaks Ward); and
(iii).Trust HQ (Community Mental Health Teams).

4. SERVICE RE-DESIGN & TRANSFORMATION (PAGES 97 - 110)

To consider and comment on BEH MHT's Service Re-Design and Transformation project.

6 September 2013

Agenda Item 2

DECLARING INTERESTS FLOWCHART - QUESTIONS TO ASK YOURSELF

What matters are being discussed at the meeting?

Do any relate to my interests whether already registered or not?

NO → You can participate in the meeting and vote

YES

Personal interest

Is a particular matter close to me?

Does it affect:

- me or my partner;
- my relatives or their partners;
- my friends or close associates;
- either me, my family or close associates:
  - job and business;
  - employers, firms you or they are a partner of and companies you or they are a Director of
  - or them to any position;
  - corporate bodies in which you or they have a shareholding of more than £25,000 (nominal value);
- my entries in the register of interests

more than it would affect the majority of people in the ward affected by the decision, or in the authority's area or constituency?

NO

NO

YES

You may have a **personal interest**

Declare your personal interest in the matter. You can remain in meeting, speak and vote unless the interest is also prejudicial; or
If your interest arises solely from your membership of, or position of control or management on any other public body or body to which you were nominated by the authority e.g. Governing Body, ALMO, you only need declare your personal interest if and when you speak on the matter, again providing it is not prejudicial.

Prejudicial interest

Does the matter affect your financial interests or relate to a licensing, planning or other regulatory matter; and
Would a member of the public (knowing the relevant facts) reasonably think that your personal interest was so significant that it would prejudice your judgement of public interest?

YES

You may have a **prejudicial interest**

YES

Do the public have speaking rights at the meeting?

YES

You should declare the interest but can remain in the meeting to speak. Once you have finished speaking (or the meeting decides you have finished - if earlier) you must withdraw from the meeting by leaving the room.

NO

You should declare the interest and withdraw from the meeting by leaving the room. You cannot speak or vote on the matter and must not seek to improperly influence the decision.

Note: If in any doubt about a potential interest, members are asked to seek advice from Democratic Services in advance of the meeting.

This page is intentionally left blank

Inspection Report

We are the regulator: *Our job is to check whether hospitals, care homes and care services are meeting essential standards.*

St Ann's Hospital

St Ann's Road, Tottenham, London, N15 3TH

Tel: 02084425732

Date of Inspection: 19 June 2013

Date of Publication: August 2013

We inspected the following standards as part of a routine inspection. This is what we found:

Respecting and involving people who use services	✓ Met this standard
Care and welfare of people who use services	✗ Action needed
Safeguarding people who use services from abuse	✓ Met this standard
Management of medicines	✓ Met this standard
Staffing	✓ Met this standard
Assessing and monitoring the quality of service provision	✓ Met this standard
Records	✓ Met this standard

Details about this location

Registered Provider	Barnet, Enfield and Haringey Mental Health NHS Trust
Overview of the service	Barnet, Enfield and Haringey Mental Health NHS Trust provides a range of services from St Ann's Hospital. These include community health services and inpatient treatment. The inpatient wards at this hospital are Haringey Assessment ward, for the assessment of men and women who are acutely ill, Finsbury ward for men, Downhills ward for women and Phoenix ward for people who have an eating disorder.
Type of services	Community healthcare service Community based services for people with a learning disability Community based services for people with mental health needs Hospital services for people with mental health needs, learning disabilities and problems with substance misuse Community based services for people who misuse substances
Regulated activities	Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury

Contents

When you read this report, you may find it useful to read the sections towards the back called 'About CQC inspections' and 'How we define our judgements'.

Summary of this inspection

Why we carried out this inspection

This was a routine inspection to check that essential standards of quality and safety referred to on the front page were being met. We sometimes describe this as a scheduled inspection.

This was an unannounced inspection.

How we carried out this inspection

We looked at the personal care or treatment records of people who use the service, carried out a visit on 19 June 2013, observed how people were being cared for and checked how people were cared for at each stage of their treatment and care. We talked with people who use the service, talked with carers and / or family members, talked with staff and reviewed information given to us by the provider. We reviewed information sent to us by commissioners of services.

We were accompanied by a Mental Health Act commissioner who met with patients who are detained or receiving supervised community treatment under the Mental Health Act 1983.

What people told us and what we found

Six inspectors and a Mental Health Act Commissioner visited Haringey Assessment Ward, Finsbury Ward for male patients and Downhills Ward for female patients at St Ann's Hospital. Most people told us they were given information on their arrival and that they were helped to make choices while they were on the ward.

Most people we spoke with told us they received care which they found helpful. We spoke with two relatives of people on Downhills Ward who told us they had not been told when their family members had moved wards or hospitals. One person told us they had been given no advance warning about moving between hospitals in the Trust. Three members of staff raised concerns with us about the Trust's use of seclusion rooms to admit patients to when there were no beds available. We found one patient who was admitted informally had been told that "a section would be activated" if they tried to leave. We found that people who were not detained may be at risk of experiencing the same restrictions as detained patients without any legal protection.

We found that most people told us they felt safe on the wards and that staff had a good understanding of safeguarding and the procedures which they needed to take when there were concerns raised.

We found that the Trust had adopted improved recording and auditing systems when restraint and seclusion was used. We found people and staff were able to feedback information to improve the running of the service.

You can see our judgements on the front page of this report.

What we have told the provider to do

We have asked the provider to send us a report by 11 September 2013, setting out the action they will take to meet the standards. We will check to make sure that this action is taken.

Where providers are not meeting essential standards, we have a range of enforcement powers we can use to protect the health, safety and welfare of people who use this service (and others, where appropriate). When we propose to take enforcement action, our decision is open to challenge by the provider through a variety of internal and external appeal processes. We will publish a further report on any action we take.

More information about the provider

Please see our website www.cqc.org.uk for more information, including our most recent judgements against the essential standards. You can contact us using the telephone number on the back of the report if you have additional questions.

There is a glossary at the back of this report which has definitions for words and phrases we use in the report.

Our judgements for each standard inspected

Respecting and involving people who use services ✓ Met this standard

People should be treated with respect, involved in discussions about their care and treatment and able to influence how the service is run

Our judgement

The provider was meeting this standard.

People's privacy, dignity and independence were respected.

Reasons for our judgement

People who use the service understood the care and treatment choices available to them. Most people we spoke with told us staff had explained their treatment to them. On all the wards we visited we saw that people were involved in meetings where their care was planned and that staff generally involved family members. The three wards we visited had regular community meetings where people were able to express their views about care provided on the ward. Staff told us that people were given copies of their care plans. We saw evidence in progress notes that most people were given their care plans.

People who use the service were given appropriate information and support regarding their care or treatment. We saw information on all the wards about what was happening on the ward. People were given information about their medication and their treatment.

On Downhills ward one person told us "I was not introduced to people when I arrived". There was no information leaflet holder on this ward as we were told it had been removed when there were plans for the ward to close. This meant that people on Downhills did not have access to information in all formats that was evident on the other two wards that we visited. We saw that there was information available on Finsbury and Haringey Assessment Ward. The provider may find it useful to note that the lack of information available for people admitted to Downhills Ward may lead to the risk of people not having a comprehensive understanding of the care and treatment which they are receiving.

People's diversity, values and human rights were respected. We saw on Haringey Assessment Ward that there was a separate male and female corridor. There was also a specific lounge for women so they could choose whether to mix with men. This lounge was locked on the morning of our visit.
When we arrived on Downhills Ward, two of the toilets were locked and when we asked why this was, staff said the toilet in the bathroom was locked as it was a risk. The provider may find it useful to note that the lack of availability of all the toilet facilities on a ward may lead to a lack of dignity in care provided.

People we spoke with told us they had a choice of food which met their cultural and religious needs. One person told us they chose Halal food.

Staff on all the wards we visited explained that they had access to interpreters when they were required and were able to use these services to meet the needs of people who did not speak English.

Care and welfare of people who use services ✖ Action needed

People should get safe and appropriate care that meets their needs and supports their rights

Our judgement

The provider was not meeting this standard.

People did not experience care, treatment and support that met their needs and protected their rights.

We have judged that this has a moderate impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

We spoke with six people on Finsbury Ward. They all spoke positively about the staff. One person on Finsbury Ward spoke particularly positively about the support that they had been given there over a number of years and said they always got involved in activities.

We saw a letter from a patient who had just been discharged from Downhills Ward who said of the staff on the ward "I have met with compassion and a sincere kindness" and said "all the staff stuck with me and were willing to get to know me." One person on the ward told us "some of the nurses are nice and patient". Another person said "the nurses are really good".

All the wards we visited had protected patient engagement time in the afternoon when members of staff spend time with the patients on the ward. We saw this happening when we visited. On Downhills Ward we saw recording on the progress notes of the contents of conversations which happened at this time.
One patient on Downhills Ward said "The OT [occupational therapist] is excellent – very helpful".

We saw that activities were taking place on and off the ward while we were attending. One member of staff said "the activities are really good". We saw people participate and being encouraged to participate in therapeutic activities.
We observed a lunch time for Downhills and Finsbury Ward. We saw that people were given the option of different food, however we saw that most staff did not sit down with the patients and watched them as they ate.

One member of staff on Haringey Assessment Ward told us there were not enough beds for the number of patients needing to be admitted. They told us the Trust was using seclusion rooms to admit patients into temporarily until beds were found. Seclusion rooms are for nursing patients in isolation for short periods when they are a risk to others. These rooms are not furnished except for a mattress. They are not intended to be used as bedrooms. Another member of staff told us there were "problems with bed issues across

the trust and use of seclusion rooms".

We asked the Trust to provide us with the number of days that the seclusion rooms on Haringey Assessment Ward had been used to admit patients. We saw that this happened on 29 nights between 6th May 2013 and 24th June 2013 in two seclusion rooms on Haringey Assessment Ward. One member of staff told us "It shouldn't be happening but it is still happening". Another member of staff told us "We sometimes move people for non-clinical needs." We were told that "We might use the seclusion room as a temporary sleeping area". One member of staff told us that there had been an occasion when they had woken a patient sleeping in the seclusion room when it had been used to admit someone because there had been a need to use it as a seclusion room. This practice affected the dignity and wellbeing of people who used this service.

A member of staff told us that when someone is in the seclusion room who does not need to be secluded, there is supposed to be an open door policy but the door is locked due to risk and patients can ask to leave.
The use of the seclusion room as a bedroom affected the dignity of patients who were admitted to the hospital.

Two relatives told us that their family members had moved from a different hospital without them being given notice or with very short notice. One person told us "I was moved from [another hospital in the Trust] very suddenly". When we looked at the progress notes we saw one person was transferred to the hospital after 10pm. This meant people were not given information in a timely manner about when they needed to move between hospitals and that their families were not always aware when people had been moved.

On Downhills Ward, one person told us they had transferred to St Ann's Hospital from another hospital in the same Trust and had not had their clothes and personal items like toothpaste. A relative told us that their family member had been moved from one ward to another without any explanation. We looked at the progress notes and saw that the transfer to Downhills had taken place at 5.45pm on one evening and a voicemail message was left on the family's phone at 8pm to inform them. Another person told us "I was told to leave [another hospital in the Trust] very quickly. The nurses told me to get in a cab". Patients' dignity may be affected if their personal items are not transferred with them and if they, and their family are not informed with as much notice as possible, when they move to a different hospital or ward within the Trust.

Most of the risk assessments and care plans we checked on the three wards were up to date and showed that risks had been identified. We found that most care plans showed that people had been involved in making decisions about their own care needs.

Some records referred to decisions being taken under the Mental Capacity Act 2005, for example, "lacks capacity to agree to medication – medication given in [their] best interest" but there was no evidence that a Mental Capacity Assessment had been undertaken to check if a person was able to understand the reason for their medication.
We saw one person who was an informal patient, which means they were not formally detained under the Mental Health Act whose medical notes read that they were told when meeting with the medical team that "if [they] insists on leaving the ward, the section would be 'activated' because the medical recommendations have been made". The Mental Health Act Code of Practice 4.12 says "The threat of detention must not be used to induce a patient to consent to admission to hospital or to treatment and is likely to invalidate any apparent consent". The progress notes indicated that a patient had been told they would

be 'sectioned' if they insisted on leaving the ward which is contrary to the Mental Health Act Code of Practice.

We saw on another record where someone was given s17 leave, which is leave that is authorised for people who are detained under the Mental Health Act, on the day their detention expired. When a patient is not detained they are free to leave when they choose and do not need authorised leave.

One member of staff on Downhills Ward told us that people's rights under the Mental Health Act are explained on admission but there are "times when someone is informal but unwell and we explain that they can't go out without an escort". Another member of staff on Downhills Ward said, of informal patients "we don't let them go if they are unwell".

A member of staff on Haringey Assessment Ward told us that "admission notes sometimes show [informal patients] did not consent to informal admission" and that "sometimes people are informal inappropriately." There is a risk that people who are not subject to the protection of a formal admission under the Mental Health Act (1983) may be experiencing the effect of being detained on a 'de facto' as they are not free to leave the ward whenever they choose.

On Finsbury Ward and Haringey Assessment Ward people had access to personal lockers if they chose to use them and could use a central office to store valuables. On Downhills Ward people did not have access to any lockable space. One person told us "there is nowhere to lock things in the room". Another patient on Downhills Ward told us "my ashtray has gone missing". Another person told us "things always go missing, there is nowhere to keep things safe". The Mental Health Act Code of Practice 16.7 states that "Hospitals should provide adequate lockable facilities (with staff override) for the storage of the clothing and other personal possessions which patients may keep with them on the ward". The absence of such facilities was causing distress to some of the patients we spoke with on Downhills ward. The lack of any personal lockable space on Downhills Ward meant that patients on that ward did not feel that their personal belongings were held safely by the Trust.

All the wards carried out physical health checks for patients. On Downhills Ward we saw one patient went to regular appointments at a hospital clinic with staff support.

Safeguarding people who use services from abuse ✓ Met this standard

People should be protected from abuse and staff should respect their human rights

Our judgement

The provider was meeting this standard.

People who use the service were protected from the risk of abuse, because the provider had taken reasonable steps to identify the possibility of abuse and prevent abuse from happening.

Reasons for our judgement

People who use the service were protected from the risk of abuse, because the provider had taken reasonable steps to identify the possibility of abuse and prevent abuse from happening.

Most of the staff we spoke to on the three wards told us they had training on the protection of vulnerable adults as a part of their annual mandatory training delivered by the Trust. The staff we spoke with had a good understanding of how to recognise abuse and what to do in situations where they suspected there might be abuse.

Most people we spoke with told us they felt safe however two people on Downhills Ward and one person on Haringey Assessment Ward told us they did not feel safe on the ward. One person on Downhills Ward said, "I am not sleeping because I'm scared of the lack of security".

Staff had completed training on the prevention and management of violence and aggression. We saw that restraint, when it was used, had been audited by the Trust and carried out in accordance with the Mental Health Act Code of Practice. Incidents of restraint were mostly recorded appropriately to ensure that they could be monitored. This meant that people were protected against the risk of restraint being unlawful or excessive.

We saw information on the wards which displayed safeguarding protocols, policy and key contacts. This meant that staff and patients could check what to do if they were worried about abuse.

Management of medicines ✓ Met this standard

People should be given the medicines they need when they need them, and in a safe way

Our judgement

The provider was meeting this standard.

People were protected against the risks associated with medicines because the provider had appropriate arrangements in place to manage medicines.

Reasons for our judgement

We asked people if they had information about their medication and had been told about the side effects. Most people we spoke with told us that they had. Staff told us they gave people leaflets about medication so that people could read and understand the information.

On Finsbury Ward we looked at the way medication was stored and recorded. We found that the recording was completed appropriately. We checked a sample of patient medication charts and found that all the required records were in place. Controlled drugs were stored and managed safely. We found that two staff gave out and recorded controlled drugs as required for safety. Where patients needed routine urine or blood tests we found that these were carried out.

At our last inspection we found that people were bringing illicit drugs on to the wards. We did not find evidence of this at this inspection. A substance misuse worker worked on the wards to support people who had addictions to alcohol or drugs. We saw the worker test patients for illicit drug use and also give them advice and support.

One patient was not allowed to leave when they took drugs. We saw that a substance misuse worker carried out a drugs test for this patient and when they were found to be drug free, staff counselled them and the doctor agreed that they could have leave from the ward. This was evidence that staff were trying to reduce patients' use of illicit drugs.

Some medication on Finsbury Ward needed to be stored below 25C. We saw that the temperature was recorded at 26.3C and we saw that for the previous three months, between April and June, the temperature of the area where the medication was stored had consistently been recorded as over 25C but the ward had continued to store medication at above the recommended temperature.

The provider may find it useful to note that failure to make appropriate arrangements for the safe storage of medication at the recommended storage temperature means there is a risk that the efficacy of the medication could not be guaranteed.

Staffing ✓ Met this standard

There should be enough members of staff to keep people safe and meet their health and welfare needs

Our judgement

The provider was meeting this standard.

There were enough qualified, skilled and experienced staff to meet people's needs.

Reasons for our judgement

One person on Downhills Ward told us "some of the nurses are kind and patient." One of the medical staff on Haringey Assessment Ward told us they felt supported by the nursing staff. One relative provided feedback "All the staff on Downhills are really good staff - we really appreciate their time, effort and patience in getting [patient] well again."

When we arrived on Finsbury Ward there were no permanent staff on duty, apart from the Deputy Manager and there was a high use of bank staff. We were told that most of these bank staff have been working long term on the ward and had a good understanding of the needs of the people on the ward.

We found the staff rotas of the wards which we visited were consistent with staff on duty and with the correct numbers of staff that had been determined by the Trust as needed on each ward. There were correct numbers of nurses supported by health care assistants. Each ward had a permanent, experienced ward manager and a deputy ward manager. Patients benefited from occupational therapists, a substance misuse worker and psychologist who all visited the wards to work with patients.

All wards had domestic staff to carry out the cleaning of the wards. We noted on Finsbury Ward that domestic staff did not make beds and nursing staff carried out this duty. There was a short period of time when two staff were making beds and another staff member was busy, where a group of patients were not being supervised by staff and an extra member of staff from another ward had to assist for fifteen minutes with supervising patients in the lounge and garden.

The provider may find it useful to note that nursing staff spending time making beds may mean they are not available to support patients at that time.

On Finsbury Ward one member of administrative staff who had a significant amount of contact with patients, which they managed well, told us that they had not had any specific training around the client group they were working with.
The provider may find it useful to note that the lack of training around mental health needs for administrative staff who deal directly with patients may lead to the risk of staff not having the knowledge and skills that they need to support patients.

Assessing and monitoring the quality of service provision ✓ Met this standard

The service should have quality checking systems to manage risks and assure the health, welfare and safety of people who receive care

Our judgement

The provider was meeting this standard.

The provider had an effective system to regularly assess and monitor the quality of service that people receive.

Reasons for our judgement

People who use the service, their representatives and staff were asked for their views about their care and treatment and they were acted on. We reviewed information held by the Trust and looked at ways that information from the wards were collected and acted upon by the Trust to work towards improving services.

The Trust carried out regular checks on the wards at St Ann's Hospital where managers looked at the systems which they had in place and carried out audits on specified areas of care such as medication, use of seclusion and restraint and quality of care plans. We saw recent audits which had taken place and that information had been discussed at the Trust 'deep dive' meetings which looked at how each ward was performing and advised ward managers on any improvements they needed to make.

We saw that patients and staff had opportunities to raise concerns and give their views to the Trust through regular community meetings and through team meetings. Staff on the wards gave patients regular opportunities to give individual feedback on their experience and this was passed to senior management.

In relation to the auditing of records for restraint and seclusion, we saw that since our last inspection the Trust had improved auditing processes and these had picked up where improvements could be made on the wards.

Records ✓ Met this standard

People's personal records, including medical records, should be accurate and kept safe and confidential

Our judgement

The provider was meeting this standard.

People were protected from the risks of unsafe or inappropriate care and treatment because accurate and appropriate records were maintained.

Reasons for our judgement

At our last inspection, we found that the records in relation to restraint and seclusion were not adequate as they did not provide enough evidence of safe treatment when a patient was being restrained or nursed in seclusion . We looked at a sample of records of restraint which had been carried out on the wards in St Ann's Hospital. We found that records did not indicate what type of restraint had been used but the team leader had carried out audits and highlighted this area for improvement. We found that all incidents of restraint were audited by managers in the Trust. We also checked the records for seclusion. We found that the majority of records we checked were completed in accordance with the Mental Health Act Code of Practice and showed evidence of safe, appropriate care when patients were nursed in seclusion rooms. We showed the team leader two exampes of where the recording could be improved. One example was where staff had used a subjective term to describe a patient's condition. The other was where staff had recorded that a patient was asleep in the seclusion room without recording how they had checked the patient was asleep. Other records showed staff recorded that they saw the patient breathing or saw chest movements. The team leader said they would be advising staff on the importance of consistently clear records on the patient's condition while they were medicated and placed in seclusion.

Audit forms used to check incidents of restraint had no space for patient details, names of auditor or date of the restraint. Staff had added patient identity and date of restraint onto the form. The provider may find it useful to note that poorly designed recording forms may lead to staff not keeping required records appropriately and a lack of written evidence of appropriate safe care.

Most of the care plans and risk management plans we saw were completed appropriately. On Downhills Ward we found that two people who had been on the ward for over the 72 hour period when care plans and risk management plans should be written up, did not have up to date care plans or risk management plans. This meant that there was a risk that people's needs might not be identified and addressed and that their views may not be incorporated into their care plans. The provider may find it useful to note that the lack of up to date care plans and risk management plans may lead to the risk of patients not having their needs met.

This section is primarily information for the provider

Action we have told the provider to take

Compliance actions

The table below shows the essential standards of quality and safety that **were not being met**. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activities	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	**Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010** **Care and welfare of people who use services**
	How the regulation was not being met: Patients were not protected against the risk of receiving care or treatment that is inappropriate because staff did not always know the status of patients so they were at risk of unlawful treatment. Planning and delivery of care did not always meet people's needs as when there were not enough beds, the Trust admitted into seclusion rooms which were not designed to be patient bedrooms. Patients on Downhills ward did not have access to secure locked space for their belongings.

This report is requested under regulation 10(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider's report should be sent to us by 11 September 2013.

CQC should be informed when compliance actions are complete.

We will check to make sure that action has been taken to meet the standards and will report on our judgements.

About CQC inspections

We are the regulator of health and social care in England.

All providers of regulated health and social care services have a legal responsibility to make sure they are meeting essential standards of quality and safety. These are the standards everyone should be able to expect when they receive care.

The essential standards are described in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. We regulate against these standards, which we sometimes describe as "government standards".

We carry out unannounced inspections of all care homes, acute hospitals and domiciliary care services in England at least once a year to judge whether or not the essential standards are being met. We carry out inspections of other services less often. All of our inspections are unannounced unless there is a good reason to let the provider know we are coming.

There are 16 essential standards that relate most directly to the quality and safety of care and these are grouped into five key areas. When we inspect we could check all or part of any of the 16 standards at any time depending on the individual circumstances of the service. Because of this we often check different standards at different times.

When we inspect, we always visit and we do things like observe how people are cared for, and we talk to people who use the service, to their carers and to staff. We also review information we have gathered about the provider, check the service's records and check whether the right systems and processes are in place.

We focus on whether or not the provider is meeting the standards and we are guided by whether people are experiencing the outcomes they should be able to expect when the standards are being met. By outcomes we mean the impact care has on the health, safety and welfare of people who use the service, and the experience they have whilst receiving it.

Our inspectors judge if any action is required by the provider of the service to improve the standard of care being provided. Where providers are non-compliant with the regulations, we take enforcement action against them. If we require a service to take action, or if we take enforcement action, we re-inspect it before its next routine inspection was due. This could mean we re-inspect a service several times in one year. We also might decide to re-inspect a service if new concerns emerge about it before the next routine inspection.

In between inspections we continually monitor information we have about providers. The information comes from the public, the provider, other organisations, and from care workers.

You can tell us about your experience of this provider on our website.

How we define our judgements

The following pages show our findings and regulatory judgement for each essential standard or part of the standard that we inspected. Our judgements are based on the ongoing review and analysis of the information gathered by CQC about this provider and the evidence collected during this inspection.

We reach one of the following judgements for each essential standard inspected.

✓ **Met this standard**	This means that the standard was being met in that the provider was compliant with the regulation. If we find that standards were met, we take no regulatory action but we may make comments that may be useful to the provider and to the public about minor improvements that could be made.
✖ **Action needed**	This means that the standard was not being met in that the provider was non-compliant with the regulation. We may have set a compliance action requiring the provider to produce a report setting out how and by when changes will be made to make sure they comply with the standard. We monitor the implementation of action plans in these reports and, if necessary, take further action. We may have identified a breach of a regulation which is more serious, and we will make sure action is taken. We will report on this when it is complete.
✖ **Enforcement action taken**	If the breach of the regulation was more serious, or there have been several or continual breaches, we have a range of actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers include issuing a warning notice; restricting or suspending the services a provider can offer, or the number of people it can care for; issuing fines and formal cautions; in extreme cases, cancelling a provider or managers registration or prosecuting a manager or provider. These enforcement powers are set out in law and mean that we can take swift, targeted action where services are failing people.

How we define our judgements (continued)

Where we find non-compliance with a regulation (or part of a regulation), we state which part of the regulation has been breached. Only where there is non compliance with one or more of Regulations 9-24 of the Regulated Activity Regulations, will our report include a judgement about the level of impact on people who use the service (and others, if appropriate to the regulation). This could be a minor, moderate or major impact.

Minor impact - people who use the service experienced poor care that had an impact on their health, safety or welfare or there was a risk of this happening. The impact was not significant and the matter could be managed or resolved quickly.

Moderate impact - people who use the service experienced poor care that had a significant effect on their health, safety or welfare or there was a risk of this happening. The matter may need to be resolved quickly.

Major impact - people who use the service experienced poor care that had a serious current or long term impact on their health, safety and welfare, or there was a risk of this happening. The matter needs to be resolved quickly

We decide the most appropriate action to take to ensure that the necessary changes are made. We always follow up to check whether action has been taken to meet the standards.

Glossary of terms we use in this report

Essential standard

The essential standards of quality and safety are described in our *Guidance about compliance: Essential standards of quality and safety*. They consist of a significant number of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. These regulations describe the essential standards of quality and safety that people who use health and adult social care services have a right to expect. A full list of the standards can be found within the *Guidance about compliance*. The 16 essential standards are:

Respecting and involving people who use services - Outcome 1 (Regulation 17)
Consent to care and treatment - Outcome 2 (Regulation 18)
Care and welfare of people who use services - Outcome 4 (Regulation 9)
Meeting Nutritional Needs - Outcome 5 (Regulation 14)
Cooperating with other providers - Outcome 6 (Regulation 24)
Safeguarding people who use services from abuse - Outcome 7 (Regulation 11)
Cleanliness and infection control - Outcome 8 (Regulation 12)
Management of medicines - Outcome 9 (Regulation 13)
Safety and suitability of premises - Outcome 10 (Regulation 15)
Safety, availability and suitability of equipment - Outcome 11 (Regulation 16)
Requirements relating to workers - Outcome 12 (Regulation 21)
Staffing - Outcome 13 (Regulation 22)
Supporting Staff - Outcome 14 (Regulation 23)
Assessing and monitoring the quality of service provision - Outcome 16 (Regulation 10)
Complaints - Outcome 17 (Regulation 19)
Records - Outcome 21 (Regulation 20)

Regulated activity

These are prescribed activities related to care and treatment that require registration with CQC. These are set out in legislation, and reflect the services provided.

Glossary of terms we use in this report (continued)

(Registered) Provider

There are several legal terms relating to the providers of services. These include registered person, service provider and registered manager. The term 'provider' means anyone with a legal responsibility for ensuring that the requirements of the law are carried out. On our website we often refer to providers as a 'service'.

Regulations

We regulate against the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009.

Responsive inspection

This is carried out at any time in relation to identified concerns.

Routine inspection

This is planned and could occur at any time. We sometimes describe this as a scheduled inspection.

Themed inspection

This is targeted to look at specific standards, sectors or types of care.

Contact us

Phone:	03000 616161
Email:	enquiries@cqc.org.uk
Write to us at:	Care Quality Commission Citygate Gallowgate Newcastle upon Tyne NE1 4PA
Website:	www.cqc.org.uk

Inspection Report

We are the regulator: *Our job is to check whether hospitals, care homes and care services are meeting essential standards.*

Chase Farm Hospital

The Ridgeway, Enfield, EN2 8JL

Tel: 08451114000

Date of Inspection: 27 March 2013

Date of Publication: May 2013

We inspected the following standards in response to concerns that standards weren't being met. This is what we found:

Care and welfare of people who use services	✖ Action needed
Safeguarding people who use services from abuse	✓ Met this standard
Staffing	✓ Met this standard
Records	✖ Action needed

Details about this location

Registered Provider	Barnet, Enfield and Haringey Mental Health NHS Trust
Overview of the service	Barnet, Enfield and Haringey Mental Health NHS Trust provides a range of mental health services at Chase Farm hospital. These include the following inpatient services: acute assessment wards for adults, continuing care wards for people with dementia and cognitive impairment, forensic wards, a specialist forensic ward for people with a learning disability, a rehabilitation ward, and a forensic intensive care service for people in the boroughs of Barnet, Enfield, Haringey, Camden and Islington.
Type of services	Community healthcare service Community based services for people with a learning disability Community based services for people with mental health needs Hospital services for people with mental health needs, learning disabilities and problems with substance misuse
Regulated activities	Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Nursing care Treatment of disease, disorder or injury

Contents

When you read this report, you may find it useful to read the sections towards the back called 'About CQC inspections' and 'How we define our judgements'.

Summary of this inspection

Why we carried out this inspection

We carried out this inspection in response to concerns that one or more of the essential standards of quality and safety were not being met.

This was an unannounced inspection.

How we carried out this inspection

We looked at the personal care or treatment records of people who use the service, carried out a visit on 27 March 2013, observed how people were being cared for and checked how people were cared for at each stage of their treatment and care. We talked with people who use the service, talked with carers and / or family members, talked with staff and talked with other authorities. We were accompanied by a specialist advisor.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

We were accompanied by a Mental Health Act commissioner who met with patients who are detained or receiving supervised community treatment under the Mental Health Act 1983.

We were supported on this inspection by an expert-by-experience. This is a person who has personal experience of using or caring for someone who uses this type of care service.

What people told us and what we found

During the inspection we visited three wards that support older people. We spent the whole day on The Oaks ward, which is an admission unit providing assessment and care for older adults over 65 with mental health problems (both functional and dementia patients), before visiting again in the evening to observe the night shift. We also visited Cornwall Villa ward in the morning and Silver Birches ward in the afternoon and evening. Both of these wards provide continuing care and rehabilitation to older adults with severe and enduring mental health needs.

Most patients and relatives we spoke with were positive about the care provided on the wards. Some felt that the communication between themselves and the ward staff could be improved.

We observed the staff supporting the patients and saw some examples of positive interaction but also noted some areas where these could be improved.

We found that people were generally having their care needs met. Some activities were taking place, but these were not always planned in a manner that met people's individual needs. People did not always get the support they needed to eat and drink.

Where people who use the service needed to be restrained, we found that staff had been

trained, understood this was only to be used after other means of addressing the situation had been exhausted, were able to describe how they would do this safely and were correctly recording its use. This protected patients against the risk of unlawful or excessive control or restraint because the provider had made suitable arrangements.

We found that people were not always having their capacity to make significant decisions assessed under the Mental Capacity Act (2005). As most of the patients on the wards were informal and had restrictions in place, this would be the main legislation to offer protection. Decisions taken were also not always recorded in their records.

There were usually enough staff working on the wards to meet people's needs. We noted there was a high level of staff sickness and that the trust had to use large numbers of temporary bank and agency staff to ensure shifts were filled. This meant that at the time of the inspection many staff working on the wards did not have long term experience of caring for these patients. The trust was trying to arrange for the same temporary staff to work where possible to provide some consistency of care.

People's personal records, including medical records, were not accurate and fit for purpose. Some care plans had not been updated and one person, who had been on the unit for more than a month, did not have a care plan.

You can see our judgements on the front page of this report.

What we have told the provider to do

We have asked the provider to send us a report by 31 May 2013, setting out the action they will take to meet the standards. We will check to make sure that this action is taken.

Where providers are not meeting essential standards, we have a range of enforcement powers we can use to protect the health, safety and welfare of people who use this service (and others, where appropriate). When we propose to take enforcement action, our decision is open to challenge by the provider through a variety of internal and external appeal processes. We will publish a further report on any action we take.

More information about the provider

Please see our website www.cqc.org.uk for more information, including our most recent judgements against the essential standards. You can contact us using the telephone number on the back of the report if you have additional questions.

There is a glossary at the back of this report which has definitions for words and phrases we use in the report.

Our judgements for each standard inspected

Care and welfare of people who use services ✖ Action needed

People should get safe and appropriate care that meets their needs and supports their rights

Our judgement

The provider was not meeting this standard.

The registered person had not taken the steps to ensure that each patient was protected against the risks of receiving inappropriate care and treatment by ensuring, where appropriate, that their capacity had been assessed and decisions were made in their best interests. Activities were provided but did not always meet people's individual needs.

The provider was failing to meet regulation 9, - (1) (a) & (b) (i) (ii) of the Health and Social Care Act 2008.

We have judged that this has a moderate impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

Provision of care and staff interactions with the patients

Throughout the day we visited we undertook ongoing observations, spoke to people using the service and spoke with their relatives. In general, patients appeared to be clean and wearing suitable clothing. When patients needed support by staff to ensure their personal hygiene was appropriate they received this support. When we spoke with patients they were generally positive about the service, although some did not like it. We were told the following:

"The nurses are being nice."
"It's better than being on your own in the house."
"It is not very nice here."
"I think the staff are now much better"

We spoke with the relatives of five people. They were mostly happy with the quality of care their relative was receiving, although one person felt communication from the ward staff towards them could be better.

When we were in the lounge on The Oaks during the day, we observed some positive interactions between staff and patients. We also noted a member of staff asking one patient personal questions about their mood, continence and sleep in the communal area. This was inappropriate as it did not respect the person's privacy.

We looked at the care plans for patients on the three wards. Most had evidence of patient's health being monitored in the form of routine clinical testing, regular medical reviews, identification of nutritional intake needs, and involvement of occupational therapy and physiotherapy. When we looked at the risk assessment for one patient on Cornwall Villa ward, we noted it acknowledged risks of absconding, sexual assault, and self harm. The provider may find it useful to note we were unable to find the risk management plans which would have clearly explained to staff what steps they needed to take to manage these risks. The care plans did not refer to them either.

The environment

We spent the whole day on The Oaks before visiting again after 8 30 pm to observe the night shift. On the day of our visit there were 24 people on the unit. All bedrooms are en suite. The ward is extremely large and appears institutional, offering very little to create a comfortable or stimulating environment for the patients. For example, when we looked in the main lounge all of the seats were placed against the wall, rather than being set in clusters that would allow people to sit in small groups.

The ward is designed to offer separate sleeping accommodation for the men and women. On the day of our visit there was one female with a bedroom located on the male area of the ward. We were told that when this occurs, the patients are given rooms nearest to the night nurse station to allow for closer observation.

The doors of the bedrooms have glass viewing panels that can be obscured or opened using an external lever. There was no means for the patient to operate this privacy screen from the inside or any curtains. This meant that privacy was controlled only from outside of the room.

We checked that call bells were working and they were. We observed during our visit that staff responded promptly to any call bells that were ringing.

When we visited Silver Birches ward we noted that the environment was clinical in nature. There were limited facilities to offer stimulation to the patients. Separate sleeping accommodation was available for men and women.

When we visited Cornwall Villa ward it was clean and tidy. We noted that many bedrooms were sparse in their decoration, although some rooms had photographs and family mementos.

The provider may wish to note that the ward environments do not provide a comfortable or stimulating place for patients to stay. The viewing panels also potentially compromise patient's privacy and dignity.

Activities and staff interaction

When we visited the three wards we found that although there were some activities being undertaken, many people were not involved in these. The activities offered to people were not personalised to meet their individual needs.

When we arrived on The Oaks classical music was playing in the main lounge. Later this was changed to more contemporary non-classical music. When we asked staff why the music had been changed, they told us that one of the patients on the unit liked this music.

When we asked this person what music they liked they told us they liked Mozart and Beethoven.

In the morning we observed the timetabled arts and crafts session in the activity room. This was provided by a nurse and one person attended the activity. The activity did not have a structure and was largely focussed on a one-to-one conversation. Later in the day another patient told us they liked arts and crafts but they had not been at the session, which raised issues about how people living on the ward are informed about sessions and encouraged to participate.

During the afternoon we observed the ward's "music and dance" activity session provided by the physiotherapy assistant. Over the course of the activity nine people on the unit were involved at some point. In general, they seemed to be engaged in the activity and enjoying it, which was very positive.

Throughout the day we did not see any evidence of people who wanted to stay in their rooms being encouraged or supported to engage in activities.

When we looked in people's care plans, individual preferences for activities were not always recorded. When they had been recorded, patients were not always being supported to undertake these activities. For example, one person was recorded as liking puzzles, board games and indoor gardening, but we did not see them having these activities provided. The provider may find it useful to note the ward did not have a clear programme to develop individual rehabilitation, recreation or reminiscence programmes for patients.

When we visited The Oaks in the evening we arrived at 8.30pm and most people were already in their bedrooms. They were mainly lying on their beds. The staff told us that the television was broken but added that, when it was working, more people come to the lounge area. We saw no activities being provided to patients during our visit, other than hot drinks being served. Patients were smoking outside, in their bedrooms or sat within the reception area.

During our morning visit to Cornwall Villa ward we saw that the ward had a programme of activities. We observed the common areas in the ward. We saw some patients had drawings in front of them, for colouring, and another patient was being encouraged to handle everyday common objects. However, we also noted that many patients did not interact with staff for long periods.

During the afternoon visit to Silver Birches ward we did not observe any formal activities being undertaken. We saw little positive engagement occurring between staff and patients, such as staff engaging someone in an individual activity. When we spoke to the relative of a patient on this ward they told us that they felt there were not enough activities for people to undertake on the ward.

When we visited again in the evening at 8 30 pm the atmosphere on the ward was calm. Most people were dressed in their pyjamas, but were either sitting in the lounges or walking around the ward.

Support at meal times

On the inspection we observed the support provided to people who needed assistance to eat meals. We found that not all the people who had been assessed as requiring help to eat meals were provided with that assistance.

On The Oaks ward we observed lunch. The meal was served from a hatch between the kitchen and dining room. People who were unable to come to the hatch were given a verbal choice, although we noted that they were not given a visual choice. We have been told by the trust that food trolleys are being introduced but, at the time of our visit, these were not in operation. We observed one person was left with their food in front of them.

When we looked at their care plan we noted that staff need to sit with this person and support them to eat. We also saw one nurse stand over someone, cut their food up, say 'let it cool down' and walk away. We then observed this person try and eat alone before the nurse came back about 10 minutes later and sat down to help her eat. There was no conversation between patients or between nursing staff and patients during lunch. The provider may find it useful to note that some people, who had been assessed as requiring assistance to take their diet, were not provided with that assistance during the lunch period that we observed.

When we observed lunch on Cornwall Villa ward, we saw that no patient who needed assistance was left unattended.

Mental Capacity Act (2005)

At the time of our inspection most of the patients on the three wards we visited were not detained under the Mental Health Act. We could see that people who use services had restrictions in place, such as not being able to leave the ward when this had not been authorised by the Court of Protection or by a Supervisory Body under the Deprivation of Liberty Safeguards. We found that most patients were not able to make informed decisions about their care and treatment. There was little or no evidence in patients' files that capacity assessments had been done in respect of living on the ward, treatment or care. These patients, therefore, lacked the protection of any legal framework. It would also appear that the considerations and consultations necessary for the capacity assessments and for the Best Interest assessments had not taken place.

On The Oaks we noted that there was little evidence of capacity assessments being undertaken or documented. For example, in the records for one person, 'admit under Mental Capacity Act' was recorded, but there was no evidence of a mental capacity assessment on record. On Silver Birches and Cornwall Villa we found there was very little or no documentation in patient's files regarding capacity assessments and best interest assessments.

Safeguarding people who use services from abuse ✓ Met this standard

People should be protected from abuse and staff should respect their human rights

Our judgement

The provider was meeting this standard.

People who use the service were protected from the risk of abuse, because the provider had taken reasonable steps to identify the possibility of abuse and prevent abuse from happening.

Reasons for our judgement

People who use the service were protected from the risk of abuse because the provider had taken reasonable steps to identify the possibility of abuse and prevent abuse from happening. When we spoke to staff, on all three wards we visited they demonstrated a good knowledge of their responsibilities in relation to safeguarding. When we spoke to senior staff, they demonstrated that they were aware of when concerns are raised and understood the safeguarding procedures that should be followed.

People who use the service were protected against the risk of unlawful or excessive control or restraint because the provider had made suitable arrangements.

On The Oaks ward we were told all nursing staff were trained in managing aggression and violence, using the recognised Prevention and Management of Violence and Aggression (PMVA) training. They are provided with a three day training course, which is refreshed on a three-yearly basis.

We were told by the service manager that seclusion is not used on the unit. When we looked at a sample of six prescription charts, they did not show evidence of inappropriate use of tranquilisers to chemically restrain patients.

Violent incidents were recorded on the incident register, which is monitored by the management team and feedback is provided within team meetings and supervision sessions.

Where patients were noted to present with challenging behaviour, care plans were in place to seek to manage the aggression. We were told by the service manager that restraint in the form of seclusion was not used. Physical restraint, if required, was used in line with the PMVA training. Detailed incident records are maintained, including recording the staff involved, antecedent behaviour and specific limbs held by each staff member involved. When we spoke to staff they were able to describe how they would do this accurately.

The provider may find it useful to note that for one person, who had been restrained, and who we were told lacked capacity, had no documented evidence of having been assessed through the Mental Capacity Act (2005).

Staffing ✓ Met this standard

There should be enough members of staff to keep people safe and meet their health and welfare needs

Our judgement

The provider was meeting this standard.

There were usually enough qualified, skilled and experienced staff to meet people's needs.

Reasons for our judgement

During this inspection we visited three wards. The trust was using a model of staffing which involved staff working long days. This meant day staff worked from 07:00 to 19:30 and night staff work from 19:00 to 07:30.

On The Oaks ward there were 25 members of nursing staff covering the ward. We were told that the normal ward staffing numbers during the day were three qualified nurses and three healthcare assistants. During the night it was two qualified nurses and two healthcare assistants. The ward also had access to an occupational therapist three mornings per week, an occupational therapy assistant five days per week and a physiotherapist four days per week. On the day we visited there were two members of qualified nursing staff and four healthcare assistants working during the day. We were told that there were only two qualified nurses because of staff sickness. When we looked at the staff roster for the day of our visit we noted there were nine members of staff who were on sick leave. When we spoke to the service manager, they told us that five of those members of staff were on long-term sick leave.

We also looked at the staff roster for the previous week on the ward (Monday 18 March – Sunday 24 March). This showed that there were a high number of shifts that had required filling. There were in total 32 shifts for healthcare assistants and nurses that had required temporary staff to fill them. We saw evidence that these shifts had been filled.

Following the inspection the trust provided us with an overview of the duty roster for the ward. This showed that in the month of March there had been four days when a majority of the staff had been temporary and four days when 50% of the staff had been temporary. On all days there had been at least one member of temporary staff. Agency staff members had been required to fill many of these shifts. In total, of the 383 shifts undertaken during the month 142 had been undertaken by temporary staff. This was 37% of all the shifts. Some of these shifts were in addition to the ward's normal staffing to support people who required one-to-one observation.

When we spoke to managers they told us they tried to use the same members of temporary staff to help ensure continuity of care.

On Monday 18 March during the day shift on The Oaks there had been four shifts that had required filling (one registered nurse and three healthcare assistants) and during the night there had been three shifts that had required filling (one registered nurse and two healthcare assistants). This meant that although the trust was ensuring staff were available to undertake shifts, they may not have known the individual needs of people on the ward.

When we spoke with staff they told us that temporary members of staff were used regularly and they often got the same members of staff coming back. Some staff told us that it was difficult when staff, who were booked, did not turn up for shifts. On the day of our visit, there was one member of agency staff working in the evening where it was their first time on the ward.

On Silver Birches ward we found there were enough staff to meet patient's needs. We noted that there were agency staff during the day shift. When we visited in the evening, there was one bank member of staff and one from an agency, out of the two qualified nurses and four healthcare assistants on duty. We noted that the ward had a number of ongoing vacancies. There were 2.5 vacancies at registered nurse band 5 level and two vacancies at Healthcare assistant band 3 level.

On Cornwall Villa ward we observed there was a good presence of staff in the common areas. Occupational Therapy staff were available and there were also nurse led activities.

During this inspection we found there were usually enough qualified, skilled and experienced staff to meet people's needs. When we visited the three wards there were sufficient staff to meet the needs of people. However, the provider may find it useful to note that we found that there was a high level of sickness of the wards we visited and that there was also a high number of temporary bank and agency staff being used. This meant that the staff working may not always know the specific needs of the patients on the wards. This could also create opportunities for inconsistent delivery and recording of care.

Records ✖ Action needed

People's personal records, including medical records, should be accurate and kept safe and confidential

Our judgement

The provider was not meeting this standard.

People were not protected from the risks of unsafe or inappropriate care and treatment because accurate and appropriate records were not maintained. Some people using the service did not have care plans that were up-to-date.

The provider was failing to meet regulation 20 (1) (a) of the Health and Social Care Act 2008.

We have judged that this has a moderate impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

People's personal records including medical records were not accurate and fit for purpose.

On The Oaks ward we looked at the records for seven people. We were told that there was an expectation that staff would keep a record of each patient's progress at least once during each shift and care plans would be updated at least monthly. One person who had been on the ward for over a month did not have a care plan in place. A further two people did not have care plans that were up-to-date. When we spoke with the service manager they told us staff know how to support patients because they are discussed at their 'whiteboard meetings' and that this information is not always reflected in the care plan. However, the lack of a care plan in place, combined with the large number of temporary staff working on the ward meant that this presented a risk to patients using the unit as their individual needs may not be met.

Trained nursing staff are identified for each shift to have specific responsibility to monitor fluid and food intake of patients considered to be at nutritional risk. We looked at the fluid/food intake charts for eleven patients and these were all completed fully. When we looked at them again in the mid afternoon, a staff member was completing the entire intake up to that point in the day at that moment in time. This may mean that there is a risk of inaccurate information being recorded.

Action we have told the provider to take

Compliance actions

The table below shows the essential standards of quality and safety that **were not being met**. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activities	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Nursing care Treatment of disease, disorder or injury	**Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010** **Care and welfare of people who use services**
	How the regulation was not being met: The registered person had not taken the steps to ensure that each patient was protected against the risks of receiving inappropriate care and treatment by ensuring, where appropriate, that their capacity had been assessed and decisions were made in their best interests. The provider was failing to meet regulation 9, - (1) (a) & (b) (i) (ii) of the Health and Social Care Act 2008.

Regulated activities	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Nursing care Treatment of disease, disorder or injury	**Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010** **Records**
	How the regulation was not being met: People were not protected from the risks of unsafe or inappropriate care and treatment because accurate and appropriate records were not maintained. Some people using the service did not have care plans that were up-to-date. The provider was failing to meet regulation 20 (1) (a) of the Health and Social Care Act 2008.

This report is requested under regulation 10(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider's report should be sent to us by 31 May 2013.

CQC should be informed when compliance actions are complete.

We will check to make sure that action has been taken to meet the standards and will report on our judgements.

About CQC inspections

We are the regulator of health and social care in England.

All providers of regulated health and social care services have a legal responsibility to make sure they are meeting essential standards of quality and safety. These are the standards everyone should be able to expect when they receive care.

The essential standards are described in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. We regulate against these standards, which we sometimes describe as “government standards”.

We carry out unannounced inspections of all care homes, acute hospitals and domiciliary care services in England at least once a year to judge whether or not the essential standards are being met. We carry out inspections of other services less often. All of our inspections are unannounced unless there is a good reason to let the provider know we are coming.

There are 16 essential standards that relate most directly to the quality and safety of care and these are grouped into five key areas. When we inspect we could check all or part of any of the 16 standards at any time depending on the individual circumstances of the service. Because of this we often check different standards at different times.

When we inspect, we always visit and we do things like observe how people are cared for, and we talk to people who use the service, to their carers and to staff. We also review information we have gathered about the provider, check the service’s records and check whether the right systems and processes are in place.

We focus on whether or not the provider is meeting the standards and we are guided by whether people are experiencing the outcomes they should be able to expect when the standards are being met. By outcomes we mean the impact care has on the health, safety and welfare of people who use the service, and the experience they have whilst receiving it.

Our inspectors judge if any action is required by the provider of the service to improve the standard of care being provided. Where providers are non-compliant with the regulations, we take enforcement action against them. If we require a service to take action, or if we take enforcement action, we re-inspect it before its next routine inspection was due. This could mean we re-inspect a service several times in one year. We also might decide to re-inspect a service if new concerns emerge about it before the next routine inspection.

In between inspections we continually monitor information we have about providers. The information comes from the public, the provider, other organisations, and from care workers.

You can tell us about your experience of this provider on our website.

How we define our judgements

The following pages show our findings and regulatory judgement for each essential standard or part of the standard that we inspected. Our judgements are based on the ongoing review and analysis of the information gathered by CQC about this provider and the evidence collected during this inspection.

We reach one of the following judgements for each essential standard inspected.

✓ **Met this standard**	This means that the standard was being met in that the provider was compliant with the regulation. If we find that standards were met, we take no regulatory action but we may make comments that may be useful to the provider and to the public about minor improvements that could be made.
✖ **Action needed**	This means that the standard was not being met in that the provider was non-compliant with the regulation. We may have set a compliance action requiring the provider to produce a report setting out how and by when changes will be made to make sure they comply with the standard. We monitor the implementation of action plans in these reports and, if necessary, take further action. We may have identified a breach of a regulation which is more serious, and we will make sure action is taken. We will report on this when it is complete.
✖ **Enforcement action taken**	If the breach of the regulation was more serious, or there have been several or continual breaches, we have a range of actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers include issuing a warning notice; restricting or suspending the services a provider can offer, or the number of people it can care for; issuing fines and formal cautions; in extreme cases, cancelling a provider or managers registration or prosecuting a manager or provider. These enforcement powers are set out in law and mean that we can take swift, targeted action where services are failing people.

How we define our judgements (continued)

Where we find non-compliance with a regulation (or part of a regulation), we state which part of the regulation has been breached. Only where there is non compliance with one or more of Regulations 9-24 of the Regulated Activity Regulations, will our report include a judgement about the level of impact on people who use the service (and others, if appropriate to the regulation). This could be a minor, moderate or major impact.

Minor impact – people who use the service experienced poor care that had an impact on their health, safety or welfare or there was a risk of this happening. The impact was not significant and the matter could be managed or resolved quickly.

Moderate impact – people who use the service experienced poor care that had a significant effect on their health, safety or welfare or there was a risk of this happening. The matter may need to be resolved quickly.

Major impact – people who use the service experienced poor care that had a serious current or long term impact on their health, safety and welfare, or there was a risk of this happening. The matter needs to be resolved quickly

We decide the most appropriate action to take to ensure that the necessary changes are made. We always follow up to check whether action has been taken to meet the standards.

Glossary of terms we use in this report

Essential standard

The essential standards of quality and safety are described in our *Guidance about compliance: Essential standards of quality and safety*. They consist of a significant number of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. These regulations describe the essential standards of quality and safety that people who use health and adult social care services have a right to expect. A full list of the standards can be found within the *Guidance about compliance*. The 16 essential standards are:

Respecting and involving people who use services - Outcome 1 (Regulation 17)
Consent to care and treatment - Outcome 2 (Regulation 18)
Care and welfare of people who use services - Outcome 4 (Regulation 9)
Meeting Nutritional Needs - Outcome 5 (Regulation 14)
Cooperating with other providers - Outcome 6 (Regulation 24)
Safeguarding people who use services from abuse - Outcome 7 (Regulation 11)
Cleanliness and infection control - Outcome 8 (Regulation 12)
Management of medicines - Outcome 9 (Regulation 13)
Safety and suitability of premises - Outcome 10 (Regulation 15)
Safety, availability and suitability of equipment - Outcome 11 (Regulation 16)
Requirements relating to workers - Outcome 12 (Regulation 21)
Staffing - Outcome 13 (Regulation 22)
Supporting Staff - Outcome 14 (Regulation 23)
Assessing and monitoring the quality of service provision - Outcome 16 (Regulation 10)
Complaints - Outcome 17 (Regulation 19)
Records - Outcome 21 (Regulation 20)

Regulated activity

These are prescribed activities related to care and treatment that require registration with CQC. These are set out in legislation, and reflect the services provided.

Glossary of terms we use in this report (continued)

(Registered) Provider

There are several legal terms relating to the providers of services. These include registered person, service provider and registered manager. The term 'provider' means anyone with a legal responsibility for ensuring that the requirements of the law are carried out. On our website we often refer to providers as a 'service'.

Regulations

We regulate against the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009.

Responsive inspection

This is carried out at any time in relation to identified concerns.

Routine inspection

This is planned and could occur at any time. We sometimes describe this as a scheduled inspection.

Themed inspection

This is targeted to look at specific standards, sectors or types of care.

Contact us

Phone:	03000 616161
Email:	enquiries@cqc.org.uk
Write to us at:	Care Quality Commission Citygate Gallowgate Newcastle upon Tyne NE1 4PA
Website:	www.cqc.org.uk

This page is intentionally left blank

0The Oaks Service Improvement Plan
Updated: 06/08/13

Background

This Service Improvement Plan has been developed following an agreement between the Barnet, Enfield and Haringey Mental Health NHS Trust and the LBE to work together to improve the quality of patient care within the Oaks Ward at the Chase Farm Hospital. The process was triggered by a number of Safeguarding alerts raised between July 2012 and December 2012, all noting a wide range of concerns but with a similar theme relating to dignity in care, and general care and welfare concerns raised by CQC. In view of these concerns, the Oaks reached the threshold for the Safeguarding adults provider concerns process. Most concerns were related to practices on the ward that could place patients at risk of significant harm for example:

- Mixing patients with functional mental illness and dementia care needs on the one ward;
- The size of the unit; (Does this mean the physical size or the number of beds?)
- Low numbers of permanent staff with an over-reliance on bank staff and inappropriate staff mix;
- The absence of a dedicated clinical leader;
- Low staff morale, leading to high rates of sickness, absences,
- Recruitment and retention difficulties and reliance on agency staff;
- Concerns around training and induction for agency staff;
- Concerns about staff supervision;
- Poor quality of record keeping and ineffective therapeutic care such as absence of nursing plans and restraint records
- Inadequate implementation of operational policies and procedures particularly around dignity in care, MCA and DoLS.
- Poor quality of care and welfare around engagement with patients, family and friends of the patients and the quality of activities

Although the Trust had an on-going improvement plan in place since 27 April 2013 it was agreed that partnership working with the LBE under the Safeguarding Protocols would provide a more robust response to the numerous concerns raised. This service plan therefore integrates the Trust's plans relevant to the patients of the Oaks ward and the safeguarding concerns drawn from investigations of the alerts, the outcomes of the CQC inspection of March 2013, the independent health and social care reviews and fact finding, and feedback from family and friends of the Oaks.

Description

The Oaks ward is a 25 bedded acute in-patient unit that provides an assessment and treatment for older people with functional and organic mental disorders for residents of the boroughs of Barnet, Enfield, and Haringey. The patient population on this ward is described as diverse in age and in complexity of their health care needs. These include both mental and physical needs with most subject to the MHA. Many in-patients are subject to the contingencies of the MCA as part of their care because of changing levels of mental capacity that affect their ability to consent to care and treatment.

0The Oaks Service Improvement Plan
Updated: 06/08/13

The process to oversee the improvements is by a Provider Concerns strategy group led by Louise Lingwood, Independent Chair; quality assured by Carole Bruce Gordon, Enfield CCG; Roger Cornish, Barnet CCG; and Richard Christou, Haringey CCG. Georgina Diba is the Safeguarding Adults document / single point for information. The process will be guided by the agreed Terms of Reference for the Provider Concerns Process for the Oaks and a commitment to equal opportunities / fairness in practice framework.

In addition the Health Commissioners have agreed that the health and service elements will be monitored to delivery via the monthly Clinical Quality Review Group. This group has formally invited representation from London Borough of Enfield to attend for this agenda item from July 2013.

0The Oaks Service Improvement Plan
Updated: 06/08/13

No.	Action	Lead (s)	Deliverables	Due Date	Progress	Improved outcomes/ Benefits	RAG
	A) Model of Care & Environment: *Concerns expressed about size of unit (25 beds) and caring for people with a functional mental illness and dementia within the same environment.*						
1.	**To reduce the number of beds on the ward:** - To separate out functional and organic provision on The Oaks and reduce the size of the unit in terms of bed numbers. - Diverting admissions for people with dementia to spare capacity on Silver Birches Ward , reducing the size of the Oaks from 25 beds to 21 beds (with separate 6 bed unit) - The 6 bed unit will have a flexible operational policy so that if demand for dementia beds significantly increases we can flex this space to accommodate dementia assessment patients	Oliver Treacy (Service Director)/ Alan Beaton (Assistant Diretor)	Silver Birches to commence as dementia assessment unit Reduce Oaks beds to 21 beds (two units of 15 and 6 beds) for patients with functional illness Updated operational policies and staff briefed Agreement from CCGs re new model for Oaks and Silver Birches Communicate plan, new in-patient model & pathways	31 July 203 15 Aug 2013 31 July 2013 July 2013 31 July 2013	ETA for completion of refurbishment is now 2/8/13. Two beds have been closed. The Oaks now has 23 beds instead of 25. Patients with dementia start transfer at rate of 1 patient per week to SB on w/c 05/08/13. Beds to be closed as vacated at 1 per week. Expectation to have reduced Oaks bed in 1 month (by 05/09/13), but could be earlier. Drafts are prepared and for sign off by OMG on 8/8/13 Approval given at meeting with Ian Kent and borough commissioners. Ian Kent to attend local implementation group A memo will be drafted by Alan Beaton to inform internal staff	Higher staff to patient ratio Improved pathways Avoids mix of patient diagnostic categories Targets specialist interventions for each diagnostic category Improved flexibility of capacity using two units on the Oaks (15 bed and 6 bed unit)	AMBER

0The Oaks Service Improvement Plan
Updated: 06/08/13

No.	Action	Lead (s)	Deliverables	Due Date	Progress	Improved outcomes/ Benefits	RAG
2.	**To develop Silver Birches, a dementia assessment unit**	Sue Pond (Service Manager)/Ian Morton (Consultant Nurse) /Janet Carrick (Consultant Psychiatrist)/ Edna Eziefula (Ward Manager)	Patients with dementia requiring admission will be admitted to Silver Birches from August 2013 rather than to The Oaks Review admission and assessment protocols on Silver Birches Updated operational policy and staff briefed	5 Aug 2013 31 July 2013	Refurb completes 2/8/13. SB to start as admission ward on 5/8/13. We have the rooms available now to use but are closed off during the day until work fully completes on the 2/8/13 Operational policies and assessment schedules have been agreed and approved by SB project management group	Improved patient experience and outcomes with specialist dementia unit	AMBER
3.	**To improve the structure and layout of The Oaks building to improve design, function, and ambience**	Oliver Treacy (Service Director)/ Alan Beaton (Assistant Director)	Architect drawings of new scheme agreed to be developed Submission of capital bid with costings Complete Structural changes to unit Improve arrangement of furniture and soften environment	31 July 2013 31 July 2013 1/12/13(EST) 30 June 2013	5th meeting with architect occurred on 4/7/13 Business Case submitted on 12/7/13. Awaiting approval Earliest start date for work would be October 2013 Changes implemented since CQC report Wooden bookcases have been used to demarcate and separate out seating areas. New garden furniture installed.	Splits up 21 beds into two smaller units: easier to manage units Improved reception and better layout of unit	AMBER

0The Oaks Service Improvement Plan
Updated: 06/08/13

No.	Action	Lead (s)	Deliverables	Due Date	Progress	Improved outcomes/ Benefits	RAG
			Comprehensive CCTV installed on Oaks	31 July 2013	COMPLETED. 20 cameras installed in all general areas + garden (not in bed rooms and toilets)		
	B) Clinical Leadership & Staffing: *The Ward Manager position is currently vacant and the unit would benefit from increased senior nurse capacity at band 6. The ward does not have a fulltime dedicated Consultant Psychaitrist.*						
4	**To determine and agree clinical leadership responsibility and accountability and then implement for the Oaks team**	DoN CD, AD, SD Mary Sexton, Ken Courtenay , Alan Beaton, Oliver Treacy	OT to convene a meeting with CD, AD,DoN to agree leadership principles surrounding the strategic operational and leadership responsibility by clinicians	15 July 2013	Interm position current consultants and interim ward manager clinical leading the ward. Meeting planned for 15th August 2013.	Critical to re-opening of unit Clear lines of clinical responsibility and accountability	AMBER AMBER
4a	**To appoint a dedicated full time consultant psychiatrist for The Oaks**	Ken Courtenay (Clinical Director)	A dedicated consultant psychiatrist for ward	31 July 2013	Appointed to locum position. Commencing post on 5/8/13	Critical to re-opening of unit Improved consistency of care and full time senior presence on unit	AMBER (GREEN per 5th August)
			Substantive Consultant Psychiatrist in post	31 Dec 2013	Substantive JD being developed before seeking RCPsych approval	Improved medical leadership and capacity	
	To appoint a speciality doctor to full-time post to support the consultant psychiatrist and ward staff	K. Courtenay (Clinical Director)	Immediate appointment of locum Staff grade doctor input to the ward	June 2013	COMPLETED. Locum Staff Grade in post	Improved support for junior doctors Improved consitency in medical provision to unit	
		K. Courtenay	Substantive staff grade doctor in post	31 Nov 2013	Preparing JD	Enhanced team working	

0The Oaks Service Improvement Plan
Updated: 06/08/13

No.	Action	Lead (s)	Deliverables	Due Date	Progress	Improved outcomes/ Benefits	RAG
4b	**To recruit to vacant Ward Manager**	Alan Beaton (Assistant Director)	Values based job description to be agreed for ward managers post Ward Manager post to be advertised. Director of Nursing to be on Panel for appointment of ward manager	31 Aug 2013 30 Sept 2013 Oct 2013	Service manager to remain on ward as substantive ward managerwith immediate effect	ON HOLD	GREEN
4c	**To create and appoint an additional band 6 Charge Nurse position (dual RMN/RGN desirable) to provide increased senior nurse cover over the 24hr period** **To review the working patterns and its suitability for the Oaks** **Skillmix review**	Henk Vermeulen (Service Manager & Interim Ward Manager) Alan Beaton Henk Vermeulen Alan Beaton/Stephen Cook	Interim Band 6 Charge Nurse in post Workable shift pattern system to suit dependency at the Oaks Staffing levels meet needs/dependency	30 June 2013 31 Oct 2013 31 Aug 2013 31 Aug 2013	Internal interim position now in place. Recruitment to substantive position to start by w/c 8/7/13 Staff survey report on working patterns completed. Paper to OMG on 8/8/13. This will feed into the skill mix review. Report to be prepared on skill mix review and actions being taken	Critical to re-opening of unit Increased senior nurse availability during the 24 hour period Increased RGN input to the unit Ensuring that the most effective nursing shift patterns are in operation within the unit Effective skillmix Critical to re-opening of unit	AMBER
4e	**To implement a standard induction process for temporary staff**	Henk Vermeulen	New induction process in place	31 July 2013	Completed and in place by 31 July. Discussed in Team Meeting of 31st July and has been implemented	Standardise induction process for temporary staff to cover critical elements	GREEN

0The Oaks Service Improvement Plan
Updated: 06/08/13

No.	Action	Lead (s)	Deliverables	Due Date	Progress	Improved outcomes/ Benefits	RAG
						Improved health and safety	
	C) Therapeutic Care & Record Keeping: *Concerns raised regarding the quality of therapeutic engagement on the ward; the support and engagement of family carers; and the quality of care plans, risk assessments and application of the Mental Capacity Act are not being delivered within Trust and Regulatory standards.*						
5	**To review and implement revised clinical review processes** **To ensure that the whiteboard review process is the primary focus for clinical and decison making at ward level**	Ian Morton (Consultant Nurse) / Marc Lester (Consultant Psychiatrist & Interim Medical Director) / Henk Vermeulen (Interim Ward Manager) Ward Manager, Ward Consultant	Plan in place to change clinical review processes from MDT ward round and daily white board process to combined daily white board process taking advantage of full time Consultant Psychiatrist on unit Whiteboard meeting, primary decision making for day to day care of patients on the wards	12 August 2013 31 Aug 2013	Draft proposal received. Changes will be implemented after new consultant starts in August 2013. Start date for this action will be 12th August. NewMDT Daily Clinical Review Process in place Awaiting appointment of full time consultant who will attend daily review meetings.,meanwhile these meetings are led by the Nurse Consuktant IM	Critical to re-opening of unit Active management of integrated and streamlined inpatient care pathway Improved organisation of care and improved patient experience and outcomes	AMBER
6	**To provide inpatient nursing staff with an ongoing development programme focused on privacy and dignity**	Ian Morton (Consultant Nurse)	Regular training programme delivered (to include relevant training on physical health issues and	Ongoing	Commenced in October 2012. Fortnightly ful-day study days for a cross section of	Improved staff knowledge and implementation of practice standards	GREEN ONGOING

0The Oaks Service Improvement Plan
Updated: 06/08/13

No.	Action	Lead (s)	Deliverables	Due Date	Progress	Improved outcomes/ Benefits	RAG
	and value based personal care	Henk Vermeulen (ward manager)	training required to support each ward's activities programme / therapeutic engagement)		staff across the four wards: 4 groups, study day repeated 4 times over two months. Essence of Care Respect and Dignity session held on Team Day of 29 July	Enhanced patient experience Patients rights protected	
7	**To ensure that Care Plans, Risk Assessments and Mental Capacity Assessments are delivered within the standards outlined in the Clinical Practice Alerts**	Henk Vermeulen (Service Manager & Interim Ward Manager)	-Careplans, Risk Assessments and Mental Capacity Standards met -Monthly audit conducted for 6 months with expected 100% compliance with the standards as set out within the Clinical Practice Alerts -2 Monthly Essential Standards Outcome Service Peer Review conducted achieving >=96% compliance -Monthly Oaks 'Deep Dive' meeting to monitor action plan and compliance with standards.	31 May 2013 – 31 Dec 2013	Care Plans, Risk Assesments all updated – completed All patients reviewed regarding relevant mental capacity issues and assessments completed All Oaks staff received additional briefings on MCA by Nurse Consultant during May and June. Increased peer review audit inspection to commence at end of July. Includes 6 outcomes Peer review for outcomes 2,4,7, 9 and 13 was held on 1st August. Results: Outcome 2: 100% Outcome 4: 99% Outcome 7: 97% Outcome 9: 98%	Critical to re-opening of unit Improved practice standards Safe and effective patient care Compliance with legal frameworks and protecting patients rights	AMBER

0The Oaks Service Improvement Plan
Updated: 06/08/13

No.	Action	Lead (s)	Deliverables	Due Date	Progress	Improved outcomes/ Benefits	RAG
	To benchmark clinical care on The Oaks	K. Courtenay (Clinical Director) Ward consultant psychiatrist	-Registration with AIMS-OP Completion of benchmarking process - Completion of benchmarking process	30 Sep 2013 30 Nov 2013	Outcome 13: 100% Updated monthly QA process for DCI now includes falls and TV risk assessments	Application of a recognised standard to improve patient care and support continuous improvement within the unit	
8	**To review and enhance therapeutic activity programme**	Ian Morton (Consultant Nurse) & Henk Vermeulen (Service Manager & Interim Ward Manager)	-Revised programme in place -Balance of group and individual activities -Monitoring / measurement of group & individual activity -Review OT provision -Additional Physiotherapy resource identified for group and inidividual work -Additional exercise group facilitator identified for chair-based exercise groups - Explore use of volunteers / Healthwatch in activities during evenings	30 May 2013 Ongoing Ongoing 31 July 2013 30 Sept 2013 30 Sept 2013	Completed. Additional activities added including sessions from Gym Instructor, OT assistant. OT and Psychology. Group and inidividual activities added. New programme published on ward. New inpatient OT structure agreed. Recruiting to vacant positions Substantive 0.5wte Band 7 Physio and 0.6wte Band 3 Physio Assistant (Across four wards) – Still waiting for start date for additional Physiotherapy. ECS leading on this Attempts made by Ward Manager to explore this via Healthwatch and	Improved patient experience and outcomes Improved quality of assessments to inform management plan Improved MDT input to care planning and implementation Enhanced skill mix to provide more holistic care with improved patient experience and outcomes	AMBER

0The Oaks Service Improvement Plan
Updated: 06/08/13

No.	Action	Lead (s)	Deliverables	Due Date	Progress	Improved outcomes/ Benefits	RAG
					Enfield CCG, but is yet to be contacted back about this. Tried Age UK Enfield, who don't work into the ward with volunteers. Tried Enfield Voluntary Action who referred to the Volunteer Service Manager at CFH site, Mr Vishu Sharma. Ward Manager to liaise with him. (has not been available yet)		
9	**To improve working with informal carers through piloting an early assessment of carers needs through offering a meeting with Consultant Nurse/Admiral Nurse within 7 days of admission**	Ian Morton (Consultant Nurse) / Kate Green (Admiral Nurse)	-Standard incorporated within monthly quality assurance demonstrates 96% compliance -Carry out regular 6 monthly family/carer satisfaction survey	30 June 2013 Ongoing	Standard agenda developed for meeting with family carers (Includes collecting views of family, how to make a complaint, ward processes etc.) Meetings commenced. From 12 August this will link in with admission CPA meeting. Revised satisfaction survey tool agreed, will go out by 31 August – putting onto Meridian system. Outcome overseen by team's Clinical Governance	Improved carer experience: better informed assessment and carer engagement Improved openness and transparency of clinical care	AMBER

0The Oaks Service Improvement Plan
Updated: 06/08/13

No.	Action	Lead (s)	Deliverables	Due Date	Progress	Improved outcomes/ Benefits	RAG
					meetings.		
			-Implement additional method on ward for visitors to provide immediate feedback	31 July 2013	Surveys were sent out to relatives satisfaction questionnaire in June 2013. 2 responses so far: outcomes were positive with both carers indicating that they were given enough information about the services available incl resources / support for carers, staff listen carefully and take views into account, needs of carer are discussed, staff treat person they care for with dignity and respect. Last survey completed in November 2012.		
			- Implementation of 'You said – We did' notice board in entrance area	31 August 2013	In place.		
10	**To carry out a review of the physical health needs of patients on the Oaks**	Ward manager Consultant Psychiatrist	All current inpatients have a current physical health assessment. All careplans reflect identified physical health needs.	31 July 2013	Completed. All patients on Oaks physical health needs have been re-asssed Preparing report on sample of 4 cases in relation to physical health needs Physical health care to be	Critical to re-opening of unit Assurance provided that level of physical health needs are being met by the Oaks. Improved care and treatment of physical	AMBER

0The Oaks Service Improvement Plan
Updated: 06/08/13

No.	Action	Lead (s)	Deliverables	Due Date	Progress	Improved outcomes/ Benefits	RAG
					monitored along side psychological interventions dynamically as routine .	health needs	
12	**BEH via audit to make regular checks to ensure that safeguarding procedures are followed and that staff are proficient.**	Veronica Flood Nurse Consultant Ward manager	Design and implement a qualitative assessment tool for staff that quantify their understanding of safeguarding .	31 Aug 2013	Peer Service Reviews already in place for outcome 7, which was held on 1st August. Result for this outcome was 100% Qualitative tool to be developed by VF, mapped to Bournemouth competencies. VF following up with CW. Meeting between VF and HV took place on 5th August. Outcome 7 staff assessment tool was checked against competency for staff group (A) as per Bournemouth competency framework. Assessment tool for Outcome 7 does check knowledge of staff group (A) with regard to all competencies. Further recommendation would be that band 6 and 7 inpatient staff attend level 2 Safeguarding Training (Safeguarding	Critical to re-opening of unit Assurance and improvements achieved in relation to safeguarding processes Improved safeguards of patients	AMBER

0The Oaks Service Improvement Plan
Updated: 06/08/13

No.	Action	Lead (s)	Deliverables	Due Date	Progress	Improved outcomes/ Benefits	RAG
					Investigator), as they would fall under Bournemouth competency staff group B		
13	**To ensure that agreed restraint guidelines are being followed on The Oaks in line with established protocol and procedures, see attached URL**	Steve Cook	Regular monitoring in place that demonstrates compliance with restraint competency.	Ongoing	The relevant bi-monthly inspection will be completed 3 times over the next 6 months NB. All staff receive 3 days PMVA training every 3 years as part of mandatory training. COMPLETED: First review done by practice standard lead on 25/07/13. Result was 72%. Improvement need particularly with regard to place of recording restraint: - Risk assessment - Care Plan - Progress Notes (for physical observations) - Patient review by doctor within set	Critical to re-opening of unit Improved understanding, awareness and implementation of restraint guidelines and procedures Improved safety for patients and staff	AMBER

0The Oaks Service Improvement Plan
Updated: 06/08/13

No.	Action	Lead (s)	Deliverables	Due Date	Progress	Improved outcomes/ Benefits	RAG
					timeframe - Exact documentation of what restraint techniques were used and in what order Outcome audit was discussed in team meeting of 31st July. Ward Manager created documentation format for staff to use following restraint, to ensure no documentation actions are missed in reporting.		
14	**To implement DCI falls protocol**	Ian Morton Henk Vermeulen	-Falls assessment in place for all new admissions -Post-falls protocol in place -QA and peer review process meets minimum 96% compliance -Incorporate training on falls prevention into the next staff development programme cohort	31 July 2013 2 monthly review Sept to Oct 2013	Completed w/c 15/7/13 Next Oaks Team Training day on 29 July 2013 on challenging behaviour and falls	Critical to re-opening of unit Effective interventions for patients at risk of falls and a reduction of falls on unit	GREEN

CareQuality Commission

Inspection Report

We are the regulator: *Our job is to check whether hospitals, care homes and care services are meeting essential standards.*

Trust Headquarters

St Ann's Road, Tottenham, London, N15 3TH

Tel: 02084425732

Date of Inspections: 21 May 2013
17 May 2013
16 May 2013
14 May 2013

Date of Publication: July 2013

We inspected the following standards as part of a routine inspection. This is what we found:

Respecting and involving people who use services	✓ Met this standard
Care and welfare of people who use services	✗ Action needed
Cooperating with other providers	✓ Met this standard
Management of medicines	✗ Action needed
Staffing	✓ Met this standard
Assessing and monitoring the quality of service provision	✓ Met this standard
Records	✗ Action needed

Details about this location

Registered Provider	Barnet, Enfield and Haringey Mental Health NHS Trust
Overview of the service	Barnet, Enfield and Haringey Mental Health NHS Trust operates community mental health teams of various types in the boroughs of Barnet, Enfield and Haringey. These teams provide care and treatment to people experiencing mental health issues in the community. We inspected one team in each borough, offering different services to people. We inspected the Enfield East Community Support and Recovery Team, the Barnet Primary Care Mental Health Team and the Haringey Home Treatment Team.
Type of services	Community based services for people with mental health needs Hospital services for people with mental health needs, learning disabilities and problems with substance misuse Community based services for people who misuse substances
Regulated activities	Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Family planning Nursing care Treatment of disease, disorder or injury

Contents

When you read this report, you may find it useful to read the sections towards the back called 'About CQC inspections' and 'How we define our judgements'.

Summary of this inspection

Why we carried out this inspection

This was a routine inspection to check that essential standards of quality and safety referred to on the front page were being met. We sometimes describe this as a scheduled inspection.

This was an announced inspection.

How we carried out this inspection

We looked at the personal care or treatment records of people who use the service, carried out a visit on 14 May 2013, 16 May 2013, 17 May 2013 and 21 May 2013, observed how people were being cared for and checked how people were cared for at each stage of their treatment and care. We spoke with one or more advocates for people who use services, talked with people who use the service, talked with carers and / or family members and talked with staff. We received feedback from people using comment cards, reviewed information given to us by the provider, took advice from our pharmacist and talked with local groups of people in the community or voluntary sector. We used information from local Healthwatch to inform our inspection.

We were supported on this inspection by an expert-by-experience. This is a person who has personal experience of using or caring for someone who uses this type of care service.

We also observed staff meetings, met with the Team manager and consultant psychiatrist for each team and met with the Executive Director for Nursing, Quality and Governance.

What people told us and what we found

We spent 4 days meeting patients and staff at 3 community teams; Barnet Primary Care Mental Health Team, Enfield East Community Support and Recovery Team and Haringey Home Treatment Team.

People were mostly positive about the staff treating them. Some comments were; "I am treated with dignity and respect. They also cheer me up which is important" and "Their general attitude is helpful and friendly and they seem to care a lot." People using the Haringey Home Treatment team were less positive about the service. Some felt that there was a lack of consistency in staff visiting them, they were unable to choose when staff visited and staff did not spend enough time with them.

Haringey users were not protected from risks associated with medicines because the provider did not have appropriate arrangements in place.

The teams we inspected worked well with other teams in the Trust and with other providers. We found good examples of joint working with substance misuse teams, inpatient wards, GPs, social care providers and other hospitals. The Trust was working to improve joint working with GPs as they had identified this as an area which needed improving.

Systematic governance arrangements were in place. Where risks had been identified, the Trust had carried out audits and internal and external reviews then produced action plans to make improvements. We found that action plans were monitored to check progress.

Up to date records were not always maintained.

You can see our judgements on the front page of this report.

What we have told the provider to do

We have asked the provider to send us a report by 03 August 2013, setting out the action they will take to meet the standards. We will check to make sure that this action is taken.

Where providers are not meeting essential standards, we have a range of enforcement powers we can use to protect the health, safety and welfare of people who use this service (and others, where appropriate). When we propose to take enforcement action, our decision is open to challenge by the provider through a variety of internal and external appeal processes. We will publish a further report on any action we take.

More information about the provider

Please see our website www.cqc.org.uk for more information, including our most recent judgements against the essential standards. You can contact us using the telephone number on the back of the report if you have additional questions.

There is a glossary at the back of this report which has definitions for words and phrases we use in the report.

Our judgements for each standard inspected

Respecting and involving people who use services ✓ Met this standard

People should be treated with respect, involved in discussions about their care and treatment and able to influence how the service is run

Our judgement

The provider was meeting this standard.

People's privacy, dignity and independence were respected. Their views and experiences were taken into account in the way the service was provided and delivered in relation to their care. People using the Haringey Home Treatment Team were less satisfied than people using the other two teams in relation to dignity, independence and their views being taken into account.

Reasons for our judgement

People who use the service were given appropriate information and support regarding their care or treatment.
People expressed their views and were involved in making decisions about their care and treatment in the Enfield Community Support and Recovery Team and the Barnet Primary Care Mental health Team. One person in Enfield said, "I am treated with respect and dignity and have been listened to."

Care plans and progress notes on Rio, the Trust's electronic record keeping system, showed patients' views which was evidence that staff had worked with the patient taking their views into account.

One staff member in Barnet told us, "I ask clients about their goals and aspirations, which includes their achievements." From discussion with staff about particular patients and from reading records we saw that people were encouraged to take responsibility and make decisions for themselves and be as independent as possible. Staff provided them with information and advice to help them make decisions.

People who used the service of the Haringey Home Treatment Team had mixed views. One person told us they were treated with respect and said, "They speak to me very kindly". Another said they felt staff came into their home with "a role of authority" rather than involving them and treating them with consideration and respect. These two quotes represent the mixed views of people using that team.

Care and welfare of people who use services ✖ Action needed

People should get safe and appropriate care that meets their needs and supports their rights

Our judgement

The provider was not meeting this standard.

People mostly experienced care, treatment and support that met their needs and protected their rights. People using the Haringey Home Treatment team did not always consider that their care met their needs.

We have judged that this has a moderate impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

We found that people were satisfied with the service they received from the Enfield and Barnet teams. Comments from people using the Enfield team included; "Their general attitude is helpful and friendly and they seem to care a lot" and "I am treated with dignity and respect. They also cheer me up which is important."

We saw that most risk assessments and care plans were completed. In Barnet, there was one case where a risk assessment indicated that there was no risk of harm which did not reflect the GP's concerns so was not correct.

People using the Haringey Home Treatment team had mixed views on the care provided. Positive comments included; "they are polite and courteous", "they are a very good home treatment team, they are the best." Other comments were;"They don't spend much time chatting but I know they have a lot to do." "they don't have the time for me" and "different person comes too often." Most negative comments were about staff not spending enough time with people, not agreeing a time to visit and lack of consistency because too many different staff went to visit people. People said that they had no choice about the time staff would visit them, that when staff told them they would come at a certain time they were late and there were 2 examples when staff had not turned up to visit somebody at a weekend as planned.

We followed up these concerns by talking to the team manager and some staff, by observing three staff meetings and by inspecting a sample of care and treatment records. We found that people's concerns were valid. There was no agreed amount of time for staff to spend with people. There was no evidence that people could choose what time staff visited. The team used a whiteboard to record patient information. Of the 77 patients at the time of the inspection, the board showed only 1 person had an agreed time when staff would visit. We noted that the staff member visiting this patient left the office 15 minutes after the time they were supposed to arrive there. We found it would not be practical to give each patient an exact time to visit but a lack of any agreed time period caused some

patients distress. We saw an improvement plan for this team which had stated that consistency of staff visiting would be implemented. This had not happened. One staff told us "all staff visit all patients." Some patients did not like this.

A GP had referred a patient to the Barnet team for urgent assessment and we found this had not been carried out 5 weeks later. We saw that staff had phoned to offer an urgent assessment and the person declined. The person said they would like a named worker to call them. We saw that nobody called the person for 4 weeks. We spoke to the person and they said they would still like to be seen by the mental health worker. There was no good reason for the delay.

We looked to see if the 3 teams assessed carers' needs where they were caring for a patient of the team. We found some good examples where staff had carried out a carer's assessment and provided support and information to them. We found 3 examples where a carer's assessment had not been carried out when it would have been appropriate to do so. There were 2 examples in the Barnet team where there was no evidence that staff asked the patient's relative if they were caring for them. In Enfield there was an example where records showed a partner of a patient requested an assessment of their needs in September 2012. Records in November 2012 and February 2013 showed this assessment was needed but it had still not been carried out at the time of our inspection. This delay in assessing carers' needs could lead to a risk of people's needs not being met.

We checked between 4 and 8 care plans in each team office. We saw that risks were assessed, plans were in place and records were made of appointments with the patient to show what care had been provided.
Haringey Home Treatment team had recently introduced a patient pack which staff took with them to patients' homes. This pack held important information about patients; risk assessment, care plan and medication chart. We looked at 4 patient packs. We saw that only 1 had a completed care plan. One had a partly complete care plan. The other 2 had blank forms. This meant that staff had to look at electronic care plans before going to visit patients. Most patients said they did not have a copy of their care plan.

Team managers told us they took the cultural needs of people into account when providing care. They would use interpreters where a patient did not speak English well. All staff had knowledge of services for people with specific cultural backgrounds so they were able to give this information to patients.

There were arrangements in place to deal with foreseeable emergencies. People said staff informed them of what to do in an emergency. People told us they had phone numbers for emergencies. The Trust had an intake team where emergency referrals were received. This team triaged the referrals to prioritise the urgent cases and pass them to the appropriate teams.

The week of our inspection the Trust introduced a new team within the Barnet Primary Care Mental Health Team called the "Urgent Care Team." This team had 3 staff from 9am to 9pm who would respond to calls from GPs for urgent assessment of a patient. We saw records of the work this team had completed in the first few days and we spoke to 2 of the staff. We found that they had been able to respond quickly to urgent requests from a GP to carry out a mental health assessment at the GP practice and had attended a GP practice within an hour to assess the patient. There was a back up team in Enfield to respond if the Barnet team were dealing with one emergency when another occurred.

The Home Treatment Team devised an emergency procedure dated 17 May 2013 for staff

to follow if they were unable to contact a patient. This procedure was clear.

Cooperating with other providers ✓ Met this standard

People should get safe and coordinated care when they move between different services

Our judgement

The provider was meeting this standard.

People's health, safety and welfare was protected when more than one provider was involved in their care and treatment, or when they moved between different services. This was because the provider worked in co-operation with others.

Reasons for our judgement

We saw from Trust records that the Trust had not met their objective last year for communication with GPs but were making progress.

Some people in Barnet reported concerns that where patients were discharged to the care of their GP there was sometimes a lack of specialist care available to those people. GPs in Barnet had reported that they had difficulty accessing urgent services in a timely way. The Trust was working towards a single phone number for all emergencies. In the meantime, the Trust had set up a consultant advice phone line where a psychiatrist would answer calls from GPs for an hour each day to give advice on patients with mental health needs. The Barnet Primary Care Mental Health Team had introduced an urgent care team the week before the inspection to respond more quickly to GPs in emergencies. At the time of the inspection it was was working well and the Trust had made arrangements for how they would monitor if this service was effective in meeting GPs' requests.

We saw all three teams were working with GPs, local authorities, housing departments and specialist services to meet patients' needs. All three teams made referrals to other services to meet patients' needs.

We observed staff in all three teams liaising with other services sharing information and planning to transfer responsibility for a patient to another service. We saw in Haringey Home Treatment Team that other professionals from within the Trust attended meetings and worked closely with the team to meet a person's needs. We saw substance misuse workers and doctors working with the Home Treatment team to share information and plan care and treatment for individuals.

Staff from the Enfield East Community Support and Recovery Team attended discharge planning meetings for their patients when they were in hospital to ensure their care after discharge was properly planned. The Haringey Home Treatment Team worked closely with the bed management team at St Ann's hospital to plan admissions and discharges to and from St Ann's hospital wards. The manager of this team said he met with staff from the Recovery House (service which provides residential support to people who need a short period of additional care or treatment) once a month to discuss patients' needs and

plan their discharge including what other services they would need.

Staff in the Haringey team said that they were working on working more collaboratively with GPs and ensuring GPs were kept informed of when their patients were under the care of the Home Treatment Team and what treatment and medication were being provided. We saw some examples of these letters to GPs.

In Barnet, we saw staff wrote to GPs telling them what action they had taken once they received their referral.

Staff in all three teams told us they did not discharge any patient and leave them with no service. They showed examples of cases where they had referred people for specialist help or had provided them with information and advice.

We found examples of good practice where information was clearly shared between inpatient services and the community teams to help people have a smooth transition from hospital to care at home.

Management of medicines ✖ Action needed

People should be given the medicines they need when they need them, and in a safe way

Our judgement

The provider was not meeting this standard.

People using the Haringey Home Treatment Team were not protected against the risks associated with medicines because the provider did not have appropriate arrangements in place to manage medicines.

We have judged that this has a moderate impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

We found that each team had access to a doctor who could prescribe medication at all times if patients needed this.

At Enfield East Community Support and Recovery Team we discussed medication with some staff and patients and looked at care and treatment records. We found that staff had good understanding of the Trust's medication policies.

One new staff member told us that they took medication to a patient's home in a locked bag and took a sharps box for disposing of the needle after giving an injection. They said that there was an adequate supply of lockable bags and sharps boxes in the clinical room. This matched the Trust's written policy on transporting medication to people's homes.

We did not check medication charts at the Enfield team's office. We saw from a sample of care plans that staff asked people their views on the medication prescribed to them and their views were recorded in their care plan which was good practice. A number of patients had regular injections for their mental health condition. We found that they were able to choose where their injection was administered. They could attend a well-being clinic, a clinic at the team's office or a nurse would visit them at home to give the injection. We observed a clinic taking place. Information about medication was displayed on the walls of the clinic.

At the Barnet Primary Care Mental Health Team, we found that staff gave information to people about their medicines and we found evidence that staff visited people and explained to them the importance of taking medication to improve their mental health. Staff had visited a GP with a patient to discuss their medication and to see what support they needed to take their prescribed medication.

In the Haringey Home Treatment team we found concerns about medication. The Trust policy for transporting medicines was not adhered to. There were no lockable bags or

small sharps boxes in the clinical treatment for staff to transport medicines safely.

We found nurses in the team had been provided with medicines management training and were assessed for their competency in administering and managing people's medicines. They completed a workbook and the manager explained to us how he ensured they were competent. The non nursing staff in the team had not been provided with suitable training on managing medicines. Some staff had no training and were expected to transport medication and supervise patients taking medication. Their competency had not been assessed.

Medication charts showed some staff's lack of understanding on how to complete the charts accurately with three different codes being used to record when staff supervised people taking medication. Non nursinig staff did not sign the chart in most cases so it was not known who had given the medication. There were errors on 2 charts where staff recorded that a person had self-administered (taken their own medication) when this was not part of their treatment plan and when staff had not been able to see that person to confirm they had taken the medication. One chart showed a person had self-administered their medicine when their care records showed that staff had supervised them taking it. Pharmacy audits had taken place where charts were checked. However we found errors that had not been picked up in the Trust's own audits. These errors included one week's record missing from a patient's medication chart and wrong codes recorded so it was not possible to confirm that a person had taken medication prescribed for their mental illness.

There were a few people where the team took their medication to them every day to supervise them taking it. On one of the days of our inspection only 1 visit had taken place before 11.45am so this meant people were not able to have their morning medication in the morning. People gave mixed feedback to us. Two people said they were happy that staff brought their medication to them and agreed that staff should support them to take it. Four people said they were not happy with the way their medication was managed. Three said they did not like strangers visiting with medication and one said they felt suspicious of the medication because they did not know the staff bringing it.

We did see evidence that the team monitored people's response to newly prescribed medication and carried out physical checks for the person.

The team had a whiteboard recording current patients and their medication needs, to inform staff whether the team was supplying medication to a patient and whether the team was to supervise the person taking medication. We checked 4 files and found the whiteboard was not up to date. For example, the board indicated staff were to supervise 1 person taking medication, and the patient progress notes did not record that staff had supervised their medication.The board had not been updated as people's needs changed.

Appropriate arrangements were in place in relation to obtaining medicines. Staff told us that the hospital pharmacy responded quickly to prescription requests. We saw that all prescribed medicines were available but one person's medication had been delivered a day late.

Medicines were kept safely. We found that all medicines were stored securely, and in line with manufacturer's recommendations.

There was insufficient evidence that medication was safely administered. Some people under the care of the Haringey Home Treatment Team were not able to keep and take their own medication therefore medication was given by qualified nurses, or staff from the

team who were not nurses took the medicine to them and witnessed them take it. The errors we found meant that people were at risk of not being given the medication for their health conditions safely as prescribed.

The service had obtained information on whether people had any allergies, and this had been recorded on people's medication charts to ensure safe prescribing of medicines.
.

Staffing ✓ Met this standard

There should be enough members of staff to keep people safe and meet their health and welfare needs

Our judgement

The provider was meeting this standard.

There were enough qualified, skilled and experienced staff to meet people's needs in the Barnet and Enfield teams. The Haringey team reported that there were not enough staff. We did not find direct evidence of staff shortages but we have raised this as a concern for the provider to address further and report back to us. Insufficient numbers of staff may have a negative impact on patient care.

Reasons for our judgement

The Trust sent us information about the staffing in each community team and the number of vacancies. We discussed staffing with each team manager and one or two staff members from each team.

We found that the Barnet and Enfield teams had enough suitably qualified and experienced staff to meet their patients' needs.

The team manager of the Haringey Home Treatment Team told us that the team had eight staff vacancies. The Trust said this was not the case. Two staff told us that the workload was too much for the number of staff available and the number of patients. Staff told us that they were expected to visit about five patients a day but that there had been occasions recently when they had to visit more people and they did not have time to keep their records up to date within the hours allocated to them. The provider may find it useful to note that insufficient numbers of suitably qualifed and experienced staff may lead to patients' needs not being met.

There were no negative comments about staffing from users of the Enfield and Barnet teams but a few people using the Haringey team told us they felt staff did not have enough time to spend with them. Two people said they thought staff were in a rush and were busy. Two people said that staff told them they were busy and answered their mobile phone to other patients while they were with them. One person said staff did not have time to chat but that they appreciated they were very busy.

The provider may find it useful to note that patients and staff in the Haringey home treatment team reported that there were not enough staff to spend sufficient therapeutic time with people. A failure to address this concern may have a negative impact on patient care.

Assessing and monitoring the quality of service provision ✓ Met this standard

The service should have quality checking systems to manage risks and assure the health, welfare and safety of people who receive care

Our judgement

The provider was meeting this standard.

The provider had an effective system to regularly assess and monitor the quality of service that people receive.

Reasons for our judgement

The provider had systems designed to enable them to regularly assess and monitor the quality of the services provided and identify, assess and manage risks relating to the health, welfare and safety of service users .

We saw a good audit tool which was used to monitor the quality of care plans and risk assessments to ensure these were comprehensive. All three team managers completed these audits monthly and sent to Trust headquarters for quality monitoring.

Governance systems were in place in the Trust. We saw the risk management strategy, the quality strategy, the terms of reference of the Governance and Risk Management Committee and minutes of various service line governance meetings. We saw from the March 2013 Clinical Quality and Safety report that the Trust had made some improvements to its governance arrangements.

People who use the service, their representatives and staff were asked for their views about their care and treatment. The results of patient surveys were sent to the Trust's clinical audit department and any concerns led to action plans being developed to improve patient satisfaction. We did not look at examples of these at this inspection.

Staff told us the Chief Executive officer of the Trust held "Listening in action" meetings with groups of staff to hear their views and concerns. Staff felt this was positive. One person said they felt lucky to have a Chief Executive "who really listens to us." We found that each team had targets for staff completing patient satisfaction interviews with patients every month. All three team managers said these targets were met.

All staff were aware of the Trust's auditing programme and knew that results of audits were discussed at "deep dive" meetings which team managers attended. We saw that these meetings resulted in action plans and the Trust monitored teams' compliance with the action plans to ensure they made necessary improvements. Team managers gave feedback to staff on the outcome of "deep dive" meetings at the team clinical governance meetings. We observed one of these meetings and saw that the team manager reported on the outcome of deep dive meetings and learning from incidents. They also advised

staff on action their team was expected to take to make improvements.

The Trust told us that after a series of patient suicides, the Haringey Home Treatment Team had been under scrutiny. They found concerns about the quality of service provied and a performance improvement plan was implemented to improve the performance of the team. We saw this plan and records of the Trust's monitoring of the plan.

The Executive Director of Nursing, Quality and Governance told us that the Board were aware of the concerns about the team and received reports on the progress of the improvement plan. She told us that the Haringey Home Treatment Team was on the Trust's risk register and that this would ensure regular monitoring of risks.

We saw that decisions about risks and actions were made by appropriate staff at the appropriate level. We also saw evidence that the Trust took action when they found staff were not carrying out their duties to meet patients' needs.

We read some audits for each team including the Trust's internal audits of compliance with the essential standards that we inspect against. We saw reports of the findings of these audits which gave senior management team a clear picture of which teams and services were meeting standards and which needed to improve.

There was evidence that learning from incidents / investigations took place and some appropriate changes had been implemented. The performance improvement plan for the Haringey Home Treatment Team demonstrated this and the senior staff within the team were able to show us examples of improvements made. We also chose some improvements from the improvement plan to observe and found that some action had been implemented, for example senior staff attendance at planning meetings and staff attending patient reviews. We also saw that some actions had not been implemented, for example, having smaller consistent staff teams visiting patients for continuity of care. It was not clear whether senior staff knew that this had not been implemented yet or what action was to be taken to allow that action to take place.

Another NHS Trust had carried out an exercise with Barnet Enfield and Haringey Mental Health Trust to look at their reporting of serious incidents and how the Trust learned from incidents that had happened. We did not request to see the findings of this report.

The provider took account of complaints and comments and took some action to improve the service. We discussed complaints received with team managers. We asked what action had been taken and we were told about improvements made as a result of complaints. We found that some patients had complained about the Haringey Home Treatment Team's management of medication. Although there was evidence that a number of recent improvements had taken place in the team's management of medication this was not yet at a good standard. We heard from patients that the teams responded to their complaints. One person said they had complained about a member of staff and as a result that staff member did not work with them again at their request.

The Trust was able to provide us with records of the complaints and outcomes of the complaints for each community mental health team in the three boroughs.

We saw audits carried out which confirmed that learning from incidents and investigations took place and appropriate changes were implemented leading to improvements in the service. We saw that in Barnet the Primary Care Mental Health Team was working to improve the service to GPs.

Records ✖ Action needed

People's personal records, including medical records, should be accurate and kept safe and confidential

Our judgement

The provider was not meeting this standard.

People were not always protected from the risks of unsafe or inappropriate care and treatment because accurate and appropriate records were not always maintained. The Trust's IT system had some negative impact on patient care due to difficulties in accessing or updating records at times.

We have judged that this has a minor impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

Difficulties caused by a new IT system did not, in some cases, provide Trust professionals with sufficient information to protect people against the risk of unsafe or inappropriate care.

We found some staff had been unable to access patient records when they needed to. One staff member told us that this had caused them to have a backlog of records to update which they had to do in their own time. One doctor told us they had patients in the waiting room but could not access their records that day. The inability to access patient records at all times meant there was a risk that patients may not receive treatment and care that met their assessed needs. We saw that the Trust was working closely with the IT provider to try and improve the problems and we saw IT staff visiting one team to help the manager with some problems. Some staff said that the record keeping requirements had changed and that they had not been informed of a change to the format for patient risk assessments.

Staff told us that there was a delay in some newly recruited staff receiving the card they need to access the electronic record keeping system and some bank staff were not given cards. This meant that some staff could not read patient records or record the work they had done with patients.

We found some examples of good quality record keeping where patients had comprehensive care plans reflecting their own wishes, risk assessments and detailed notes of care and treatment and all meetings and appointments with the patient.

We found some examples of inadequate record keeping. We looked at one patient's records in the Enfield team and saw there was a safeguarding concern about this patient. There was no record of action taken to address the concern. We spoke to the team manager who was able to tell us that appropriate action has been taken but had not yet been recorded.

In Barnet, we looked at seven patients' records in detail. Two of them did not have up to date records. We spoke to staff and found that these patients had been seen by the team but the appointments had not yet been recorded a few days later. One person told us their GP was waiting for a letter from this team before they would refer them to another service they needed.

In the above cases staff had worked with patients to provide appropriate care. The concern was about the lack of timely recording of the care provided.

We found inconsistent use of the Trust's recording system. Different teams and different staff within the same team recorded information in different places. Care plans were not always recorded in the same place on the system. We did not know if staff had been provided with enough training in where to record patients' care plans and the care and treatment they had carried out with patients. This meant that some sections of patients' records could not always be located promptly when required.

This section is primarily information for the provider

Action we have told the provider to take

Compliance actions

The table below shows the essential standards of quality and safety that **were not being met**. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Treatment of disease, disorder or injury	**Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010** **Care and welfare of people who use services**
	How the regulation was not being met: The provider was not consistently delivering care and treatment in such a way to meet service users' individual needs and ensure their safety and welfare.
Regulated activity	Regulation
Treatment of disease, disorder or injury	**Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010** **Management of medicines**
	How the regulation was not being met: The provider was not protecting the people using the Haringey Home Treatment team against the risks associated with unsafe use and management of medicines, because there were not suitable arrangements for the recording and safe administration of medicines. This is because medication adminstration records were not always accurate and some staff had not been trained in medicines management.
Regulated activity	Regulation
Treatment of disease, disorder or injury	**Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010** **Records**

This section is primarily information for the provider

	How the regulation was not being met: The provider was not fully protecting people against the risks of unsafe or inappropriate care and treatment arising from a lack of proper information about them, as some records were not able to be located promptly when required.

This report is requested under regulation 10(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider's report should be sent to us by 03 August 2013.

CQC should be informed when compliance actions are complete.

We will check to make sure that action has been taken to meet the standards and will report on our judgements.

About CQC inspections

We are the regulator of health and social care in England.

All providers of regulated health and social care services have a legal responsibility to make sure they are meeting essential standards of quality and safety. These are the standards everyone should be able to expect when they receive care.

The essential standards are described in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. We regulate against these standards, which we sometimes describe as "government standards".

We carry out unannounced inspections of all care homes, acute hospitals and domiciliary care services in England at least once a year to judge whether or not the essential standards are being met. We carry out inspections of other services less often. All of our inspections are unannounced unless there is a good reason to let the provider know we are coming.

There are 16 essential standards that relate most directly to the quality and safety of care and these are grouped into five key areas. When we inspect we could check all or part of any of the 16 standards at any time depending on the individual circumstances of the service. Because of this we often check different standards at different times.

When we inspect, we always visit and we do things like observe how people are cared for, and we talk to people who use the service, to their carers and to staff. We also review information we have gathered about the provider, check the service's records and check whether the right systems and processes are in place.

We focus on whether or not the provider is meeting the standards and we are guided by whether people are experiencing the outcomes they should be able to expect when the standards are being met. By outcomes we mean the impact care has on the health, safety and welfare of people who use the service, and the experience they have whilst receiving it.

Our inspectors judge if any action is required by the provider of the service to improve the standard of care being provided. Where providers are non-compliant with the regulations, we take enforcement action against them. If we require a service to take action, or if we take enforcement action, we re-inspect it before its next routine inspection was due. This could mean we re-inspect a service several times in one year. We also might decide to re-inspect a service if new concerns emerge about it before the next routine inspection.

In between inspections we continually monitor information we have about providers. The information comes from the public, the provider, other organisations, and from care workers.

You can tell us about your experience of this provider on our website.

How we define our judgements

The following pages show our findings and regulatory judgement for each essential standard or part of the standard that we inspected. Our judgements are based on the ongoing review and analysis of the information gathered by CQC about this provider and the evidence collected during this inspection.

We reach one of the following judgements for each essential standard inspected.

✓ **Met this standard**	This means that the standard was being met in that the provider was compliant with the regulation. If we find that standards were met, we take no regulatory action but we may make comments that may be useful to the provider and to the public about minor improvements that could be made.
✖ **Action needed**	This means that the standard was not being met in that the provider was non-compliant with the regulation. We may have set a compliance action requiring the provider to produce a report setting out how and by when changes will be made to make sure they comply with the standard. We monitor the implementation of action plans in these reports and, if necessary, take further action. We may have identified a breach of a regulation which is more serious, and we will make sure action is taken. We will report on this when it is complete.
✖ **Enforcement action taken**	If the breach of the regulation was more serious, or there have been several or continual breaches, we have a range of actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers include issuing a warning notice; restricting or suspending the services a provider can offer, or the number of people it can care for; issuing fines and formal cautions; in extreme cases, cancelling a provider or managers registration or prosecuting a manager or provider. These enforcement powers are set out in law and mean that we can take swift, targeted action where services are failing people.

How we define our judgements (continued)

Where we find non-compliance with a regulation (or part of a regulation), we state which part of the regulation has been breached. Only where there is non compliance with one or more of Regulations 9-24 of the Regulated Activity Regulations, will our report include a judgement about the level of impact on people who use the service (and others, if appropriate to the regulation). This could be a minor, moderate or major impact.

Minor impact – people who use the service experienced poor care that had an impact on their health, safety or welfare or there was a risk of this happening. The impact was not significant and the matter could be managed or resolved quickly.

Moderate impact – people who use the service experienced poor care that had a significant effect on their health, safety or welfare or there was a risk of this happening. The matter may need to be resolved quickly.

Major impact – people who use the service experienced poor care that had a serious current or long term impact on their health, safety and welfare, or there was a risk of this happening. The matter needs to be resolved quickly

We decide the most appropriate action to take to ensure that the necessary changes are made. We always follow up to check whether action has been taken to meet the standards.

Glossary of terms we use in this report

Essential standard

The essential standards of quality and safety are described in our *Guidance about compliance: Essential standards of quality and safety*. They consist of a significant number of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. These regulations describe the essential standards of quality and safety that people who use health and adult social care services have a right to expect. A full list of the standards can be found within the *Guidance about compliance*. The 16 essential standards are:

Respecting and involving people who use services - Outcome 1 (Regulation 17)
Consent to care and treatment - Outcome 2 (Regulation 18)
Care and welfare of people who use services - Outcome 4 (Regulation 9)
Meeting Nutritional Needs - Outcome 5 (Regulation 14)
Cooperating with other providers - Outcome 6 (Regulation 24)
Safeguarding people who use services from abuse - Outcome 7 (Regulation 11)
Cleanliness and infection control - Outcome 8 (Regulation 12)
Management of medicines - Outcome 9 (Regulation 13)
Safety and suitability of premises - Outcome 10 (Regulation 15)
Safety, availability and suitability of equipment - Outcome 11 (Regulation 16)
Requirements relating to workers - Outcome 12 (Regulation 21)
Staffing - Outcome 13 (Regulation 22)
Supporting Staff - Outcome 14 (Regulation 23)
Assessing and monitoring the quality of service provision - Outcome 16 (Regulation 10)
Complaints - Outcome 17 (Regulation 19)
Records - Outcome 21 (Regulation 20)

Regulated activity

These are prescribed activities related to care and treatment that require registration with CQC. These are set out in legislation, and reflect the services provided.

Glossary of terms we use in this report (continued)

(Registered) Provider

There are several legal terms relating to the providers of services. These include registered person, service provider and registered manager. The term 'provider' means anyone with a legal responsibility for ensuring that the requirements of the law are carried out. On our website we often refer to providers as a 'service'.

Regulations

We regulate against the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009.

Responsive inspection

This is carried out at any time in relation to identified concerns.

Routine inspection

This is planned and could occur at any time. We sometimes describe this as a scheduled inspection.

Themed inspection

This is targeted to look at specific standards, sectors or types of care.

Contact us

Phone:	03000 616161
Email:	enquiries@cqc.org.uk
Write to us at:	Care Quality Commission Citygate Gallowgate Newcastle upon Tyne NE1 4PA
Website:	www.cqc.org.uk

This page is intentionally left blank

CQC Compliance and Assurance Action Plan – 15.8.13

CQC Outcome	Action	Lead (s)	Required Outcomes	Due Date	Progress
Enfield East CSRT					
4	All new referrals are now presented within the East Enfield Community Support & Recovery Team Business Meeting with consideration being given to whether a carer's assessment is required. The patient's electronic record is updated and an entry made within the notes of the meeting. An appropriate worker is identified to carry out the carers assessment.	Avi Nundoo Sally Lindsay	Carers assessments will now be tracked through the Team Business Meeting to ensure that they happen in a timely manner.	Ongoing with effect from July 2013	Completed.
21	All team members in the East Enfield Community Support & Recovery Team have been reminded of their responsibilities in ensuring that relevant clinical information is uploaded onto the electronic information system in a timely manner. Additional training to familiarise staff with London Safeguarding Procedures and the documentation required to support the procedures has been arranged to take place in September 2013.	Avi Nundoo	Regular monitoring of uploaded relevant clinical information by the safeguarding champions.	September 2013	3 members of staff have been identified to access this training and act as 'Safeguarding Champions' within the Team.

CQC Outcome	Action	Lead (s)	Required Outcomes	Due Date	Progress
Barnet PCMHT					
9	Risk assessments All staff members receive supervision which will address risk assessment and management to ensure accuracy of referral information and that this is updated and documented promptly without delay, as per trust protocol. Random checks on risk assessments and documentation in staff management and clinical supervision will further strengthen and provide assurance on compliance. Trust wide mandatory training on risk and safeguarding is on- going to ensure that all staff are up to date with their mandatory training. This will be monitored through our training matrix.	Team Manager, Senior Practitioner, Lead Clinician	Patient feedback on delivery of services is monitored on a continual basis. The consenting service users complete the questionnaire and all results are collated and published.	Sept 2013	Supervision in place for all staff. Current Mandatory Training compliance is 71%.
	Delay in contacting service users Service users are contacted in a timely manner once referrals are allocated to clinicians. There may be times when staff resources may be compromised due to sickness or A/L. The team will ensure steps are taken to reallocate cases if necessary to avoid any delay to service users receiving care and treatment. A pilot is taking place within the PCMHT "Urgent Care Team" to prioritise urgent cases.	Team Manager, Senior Practitioner, Lead Clinician	All service users who access PCMHT have any delays mitigated as demonstrated via audit. Failure to update information and risk assessments will be recorded on the Datix system to monitor and identifying areas of risks. Performance issues are being fed back through Senior management meetings which will identify issues arising from service user and GP feedback.	Sept 2013 Ongoing Sept 2013	There is presently a service reorganisation /consultation taking place throughout the trust, with an aim of having a more responsive service which clearly identifies those service users most in need of an urgent response. All of the above will be monitored by senior staff on a weekly basis by feeding back to clinicians at the weekly team meeting to ensure improvements are made.

CQC Outcome	Action	Lead (s)	Required Outcomes	Due Date	Progress
	Barnet PCMHT				
	Carers assessments • Supervision will ensure that staff do include carers views as part of the overall assessment process. • Continued training and monitoring, supervision, and promotion of staff awareness. • Lead clinician to monitor all carers assessment monthly to set targets of ten per month • To provide updated leaflets for carers which explain procedures, and learn from the feedback to improve our provision	Team Manager, Senior Practitioner, Lead Clinician	All identified carers will be offered access to a carers assessment. Documentation will evidence carer assessments are occurring	Aug 2013 Oct 2013	Completion and returns of Quality Assurance and Patient /carer experience audits on a monthly basis will continue to be monitored.
21	All clinicians are made aware of their responsibility to protect service users against unsafe inappropriate care and treatment from lack of proper information regarding assessment documented on the RIO system. Regular monitoring of caseload documentation. Individual supervision processes that identify missing data and information will be discussed within the weekly team meeting, and monthly clinical governance meetings to address areas of concern and identify ways to achieve positive outcomes.	Team Manager, Senior Practitioner, Lead Clinician	• All clinicians to be compliant with the Trust protocol on documentation. • Robust Audits demonstrate methods that improved standards and compliance with record keeping. • Clinicians will regularly monitor caseloads daily and ensure that documentation of assessments are recorded on RiO.	Aug 2013 Sept 2013 Sept 2013	Current resources available are already within the trust policies and procedures, to ensure all staff are aware of specific areas in regards to information and recording. All clinician have a duty to review and assess their case load regularly on RIO and identify missing data. Senior staff will continue to supervise staff and monitor documentation. There is a weekly PCMHT caseload report sent by the Performance manager to the team that identifies clinicians who need to update information.

CQC Outcome	Action	Lead (s)	Required Outcomes	Due Date	Progress
	Haringey HTT				
4	• Duration of Planning meetings to be reduced so as to allow HTT staff more time to carry out visits and spend longer with patients. • HTT will contact patients who are due to be seen on the day of the visit and agree a window of time when the visit will take place • HTT staff will update the Service user if there is anticipated delays and revise the expected time of arrival and confirm this with the service user. • HTT shift lead will, as part of the allocation, attempt to ensure that staff with prior knowledge of individual service users will be allocated to visit them. This will reduce the numbers of different staff who may be allocated to do a visit. • Patient pack revised and updated with instruction that all staff to comply with maintenance of same. • HTT manager to contact patients to ascertain their views on the visits that have taken place. • Patients to be asked to complete Patient Experience questionnaire to feedback their perception. These are entered in Meridian and reported weekly. • HTT manager and Principal Practitioner to audit Patient packs weekly to assure they are being used appropriately and have the requisite information	Bob Ryan	• Supervision of staff will demonstrate that staff are Key workers to ensure they comply with best practice. • HTT manager/Principal to audit compliance with patients receiving a copy of their care plan • HTT will establish an agreed minimum time for duration of visit and any reasons for any visits shorter than this will be recorded in patient notes. • The Allocated HTT Key worker will visit the patient at a minimum of weekly. • All patients to have a copy of their care plan and same to be recorded on RIO.	Aug 2013 Sept 2013 Sept 2013 Aug 2013 Aug 2013	• HTT manager/Principal Practitioner is present at planning meetings and is overseeing the team in relation to allocation of duties • Improved staffing in HTT where there are significant vacancies at the present time. We are recruiting locum staff to support this in interim with a move to substantive appointment once restructure of team is complete. • HTT patients being assertively reviewed and those that do not require Home Treatment to be discharged to other services thus reducing caseload and enabling effective use of staff time/resource.

CQC Outcome	Action	Lead (s)	Required Outcomes	Due Date	Progress
	Haringey HTT				
9	• The HTT manager to order lockable medicines transport bags for staff to transport medication safely and ensure that there are adequate supply of small sharps bins available • All staff working with HTT including OT, Psychologist and Band 3-4 support workers to have training in the management of medication. HTT Manager has arranged training sessions with Pharmacist and further sessions to be arranged. • Service manager has requested from Practice standard lead (CK) to develop a Medication workbook for untrained nursing staff and Social worker and OT staff to enhance skills in medication management • During review and handover meetings Shift Leads must ensure that service users receive their presrcibed medication at the correct time. HTT manager/Shift lead to release staff to ensure compliance. • Medication charts will be carried by staff when visiting patients to ensure that records are maintained in accordance with Policy • Team Lead/HTT pharmacist to complete joint audits on monthly basis . • Pharmacy Lead to review auditing process to identify and reduce errors in the system • The HTT Manager/Principal Practitioners will ensure completion of recorded audits to ensure	Bob Ryan	• Evidence that all staff aware of their role and responsibilities. All medicines to be carried in lockable cases at all times. • Prescription charts to be present with staff in the event of any supervision/administration of medicines. • Prescription charts to be signed so that they inform clinicians re compliance and concordance. • All staff via supervision will be made aware of their role and responsibility in relation to medication management. Poor performance will be managed via Trust Policies and processes • Effective liaison arrangements with Pharmacy to ensure regular and sustained	Sept 2013 Aug 2013 Aug 2013 Aug 2013 Sept 2013	• Allocation of Team leads for monitoring of medication management. • Charts are being checked daily to ensure compliance.

CQC Outcome	Action	Lead (s)	Required Outcomes	Due Date	Progress
	Haringey HTT				
	adherence with standards and policy.Audits to be available for scrutiny. • Pharmacy to complete audits on medicine cards and the compliance to the Medication Management Policy. • Additional training sessions with Pharmacy for unqualified and non-nursing staff. • Shift leads, as part of shift planning, aware of responsibility in medication being given at due time and allocate staff accordingly.		monitoring of medication management are in place. • HTT Manager to appoint Team Lead in medication management to support with auditing process. • Non-adherence with standards and policy will be managed through robust Clinical Governance and supervision processes. Audits will be scruntised as part of Clinical Governance and through Deep Dive meetings. • Evidence to be presented to the Executive Director of Nursing, Quality and Governance that the service is fully compliant with the Management of Medicines Policy and advise the CQC.	Sept 2013 Ongoing Sept 2013	

CQC Outcome	Action	Lead (s)	Required Outcomes	Due Date	Progress
	Haringey HTT				
21	• Report any and all IT problems that impact on access to Patient records to Service desk. • Training for new staff on the Electronic Patient Record to be arranged on joining the team. • HTT Manager /Principal Practitioner to review staff knowledge on where information is recorded on RIO and to ensure that staff are aware of where specific information is to be recorded. Staff to attend for additional training if deemed appropriate and necessary. • All HTT patients to have care plans using the approved format and consistently applied by all responsible staff in the team. • HTT manager to interrogate records with staff as part of the supervision process and assure that documentation is of high quality and recorded in line with Trust policy. • HTT Manager to ensure any variations are discussed in team and Clinical Governance meetings as a regular agenda item. • Adequate Business Continuity forms to be available in HTT to accommodate a disruption to service so that records are updated when system restored. • Continuing improvement to the IT systems. • Timely reporting of Problems with IT systems • Regular quality supervision of staff where records	Bob Ryan	• Complete Datix on any occasions that there is disruption in access to record so as to alert management in the Trust. • All staff will be aware of the Continuity plans when there is disruption to service and complete appropriate Blackout forms. • HTT manager to review records with staff in supervision to ensure appropriate and accurate documentation is being achieved. • Any disruption to access is reported via Trust incident reporting system. • Key Information – Demographics care Plan, Risk assessment to be printed and available in patient's paper record and accessed daily but especially in	Aug 2013 Aug 2013 Oct 2013 Aug 2013 Aug 2013	

CQC Outcome	Action	Lead (s)	Required Outcomes	Due Date	Progress
Haringey HTT					
	are interrogated.		event of downtime.		

Service Transformation Project

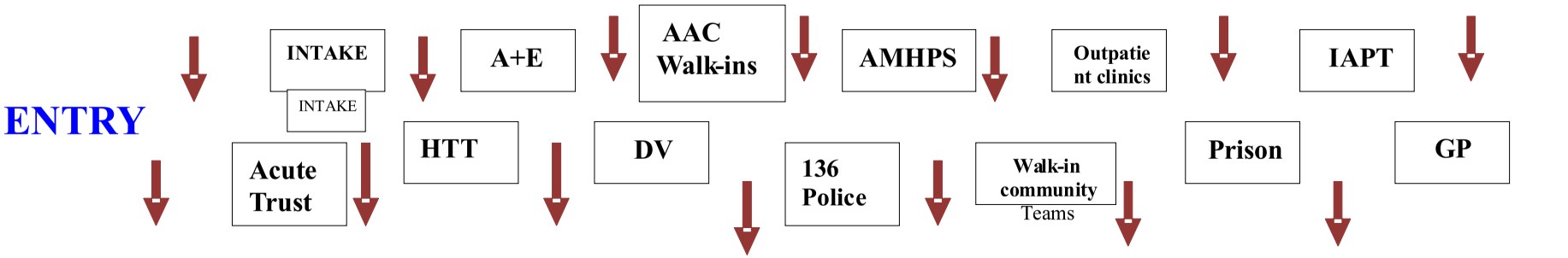
Jackie Liveras

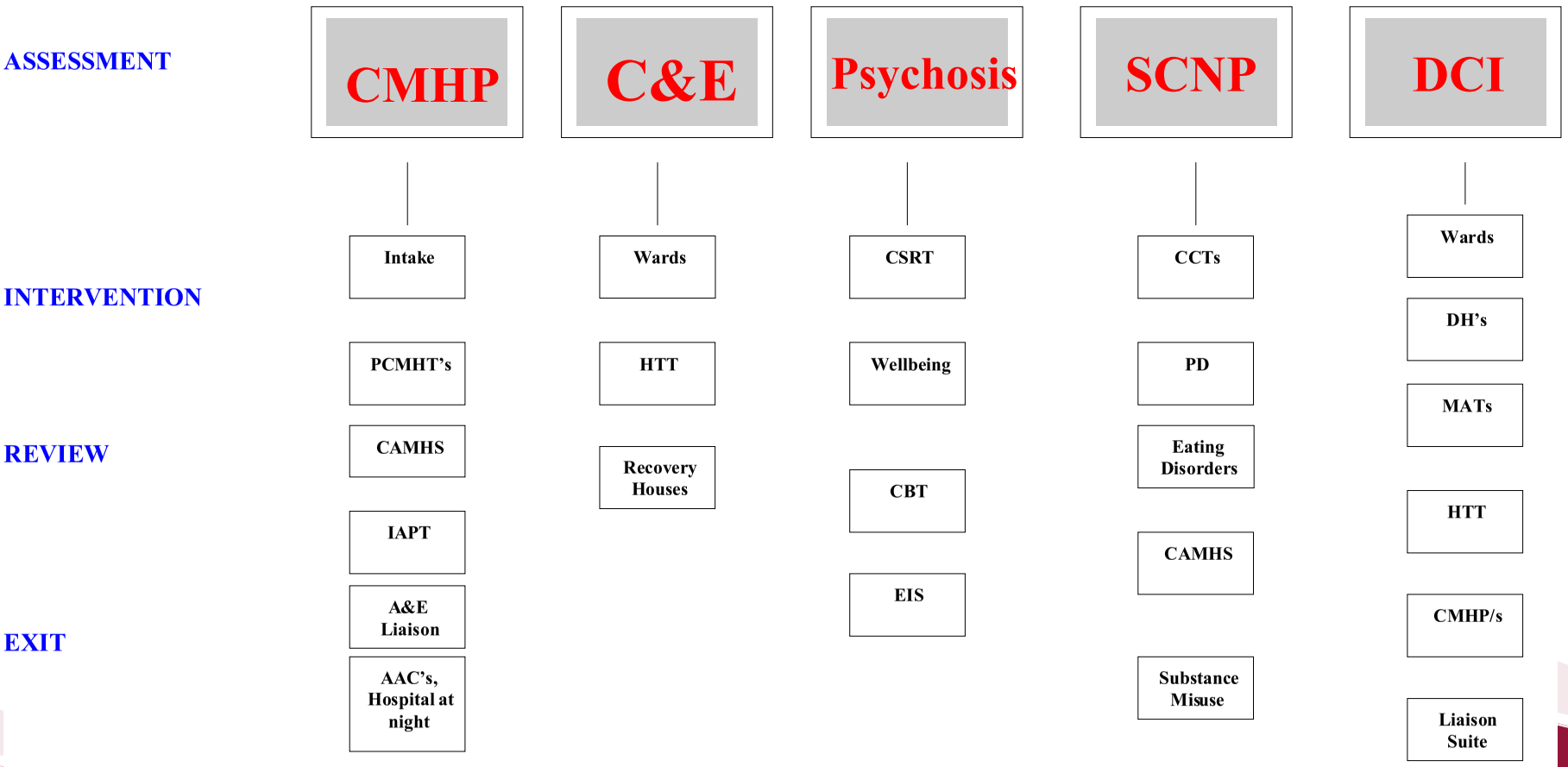
Assistant Director

4th September 2013

Barnet, Enfield and Haringey NHS
Mental Health NHS Trust

Existing Pathway





Service Transformation – Outline of changes to teams

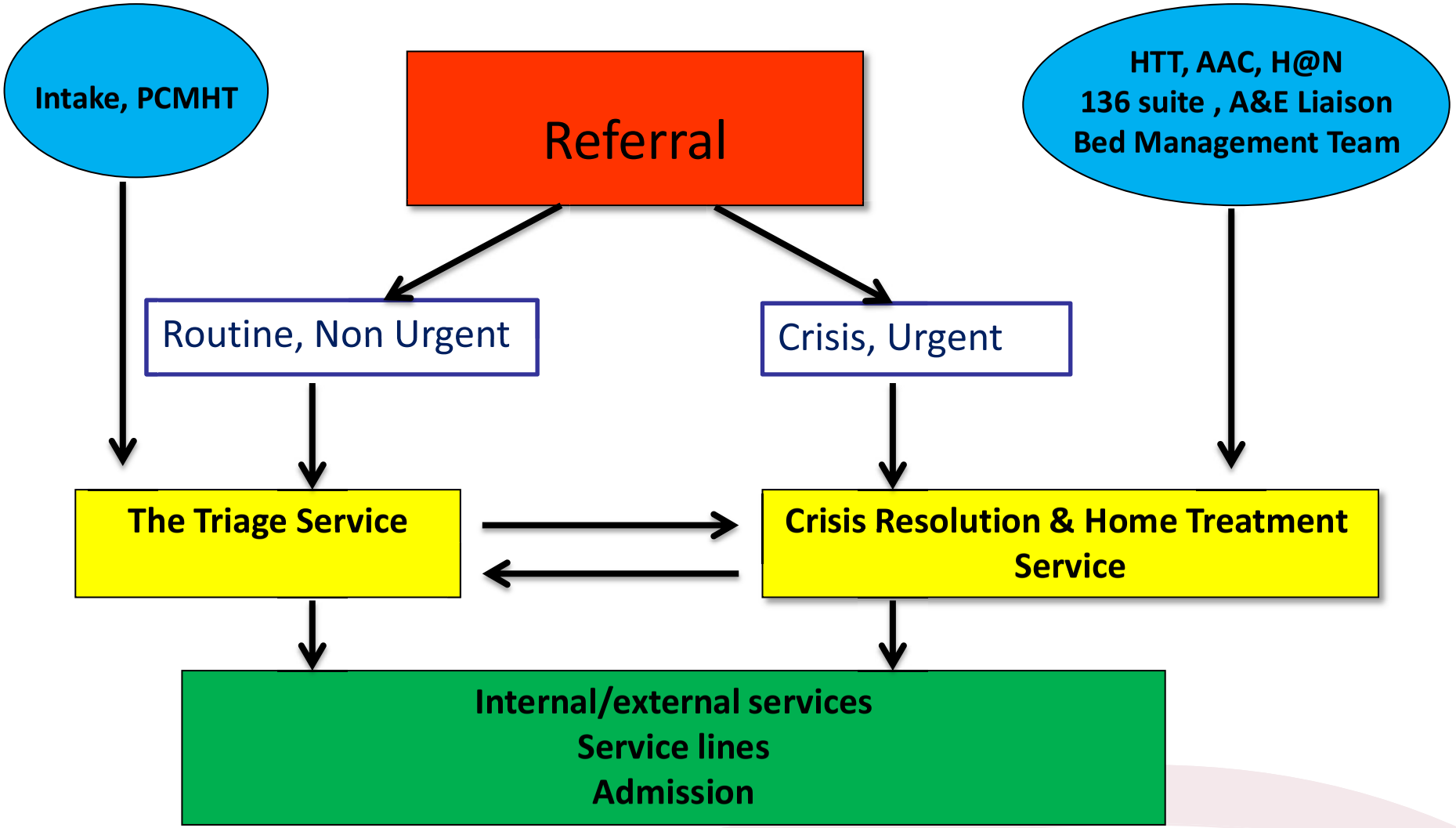
Current Set-up:

- PCMHTs * 3
- Intake Team
- NMH Liaison
- Hospital @ Night
- Enfield & Haringey AAC
- Home Treatment Teams * 3
- Bed Management

New Model:

- Triage Service * 3
- Crisis Resolution & Home Treatment Service * 3
- Integrated Bed Management Team
- Night CRHT Manager integrated into Hospital @ Night service
- “Legacy” resource to SCNPD
- “Legacy” resource to Psychosis

Service Transformation



Modelling Approach to Triage and CRHT

- Capacity models used for both Triage and CRHT
- CRHT split between Initial Assessment and Treatments
- Used last year's activity data for referrals and contacts
- Productivity based KPIs have been developed and agreed
- Reviewed current skill mix
- Staff availability and shift patterns reflected in the model
- Sensible and prudent approach has been used

Triage – key assumptions and KPI's

- Referrals to Triage based on 2012 activity – 17,244 per year
- 13 assessments per week per clinician
- Average number of assessments assumed to be one per service user up to maximum of four
- No caseload
- Assumed 210 working shifts per clinician WTE per year
- Admin review has increased overall model from 29.70 WTE previously to 36.20 WTE required

Crisis Resolution – Assessment – key assumptions and KPI's

- Number of crisis referrals in a year = 5,500 (+10% safety)
- All assessments double handed – 4/5 assessments both qualified staff, 1/5 assessments one qualified and one unqualified
- Standard 2 hours per assessment
- Allowance of 45 minutes travel time
- One hour admin time.
- Staff availability based on standard 204 days worked per annum.
- Expected – two assessment per worked shift.

Crisis Resolution – Home Treatments – key assumptions and KPI's

- Estimated number of treatments visits in a year = 52,000
- Six week treatment period – average of 30 visits per patient
- Standard 30 minutes for face-to-face contact
- Allowance of 45 minutes travel time
- 15 minutes for admin time
- Around 5 treatments per WTE per worked shift

Change Management Process

- Staff selection for the new posts in the new structure will be either by slotting in or ring fenced interviews
- **Slotting in** – Staff will be slotted in if 70% plus of their current responsibilities can be identified within the new post job description
- **Ring fenced interviews** – when there are fewer posts in the new structure compared to current staff provision than staff will be at risk or when the job description is 30% different to the role they are currently carrying out
- **Selection Procedure –** The selection procedure for the new posts will be competency based interviews

Communication & Engagement

- Main messages
  - The new service will bring improved quality and patient experience
  - Easy and uncomplicated access to services for referrers
  - The AACs will be closed, crisis response will be on an outreach basis
  - The Triage Service will be an assessment only service

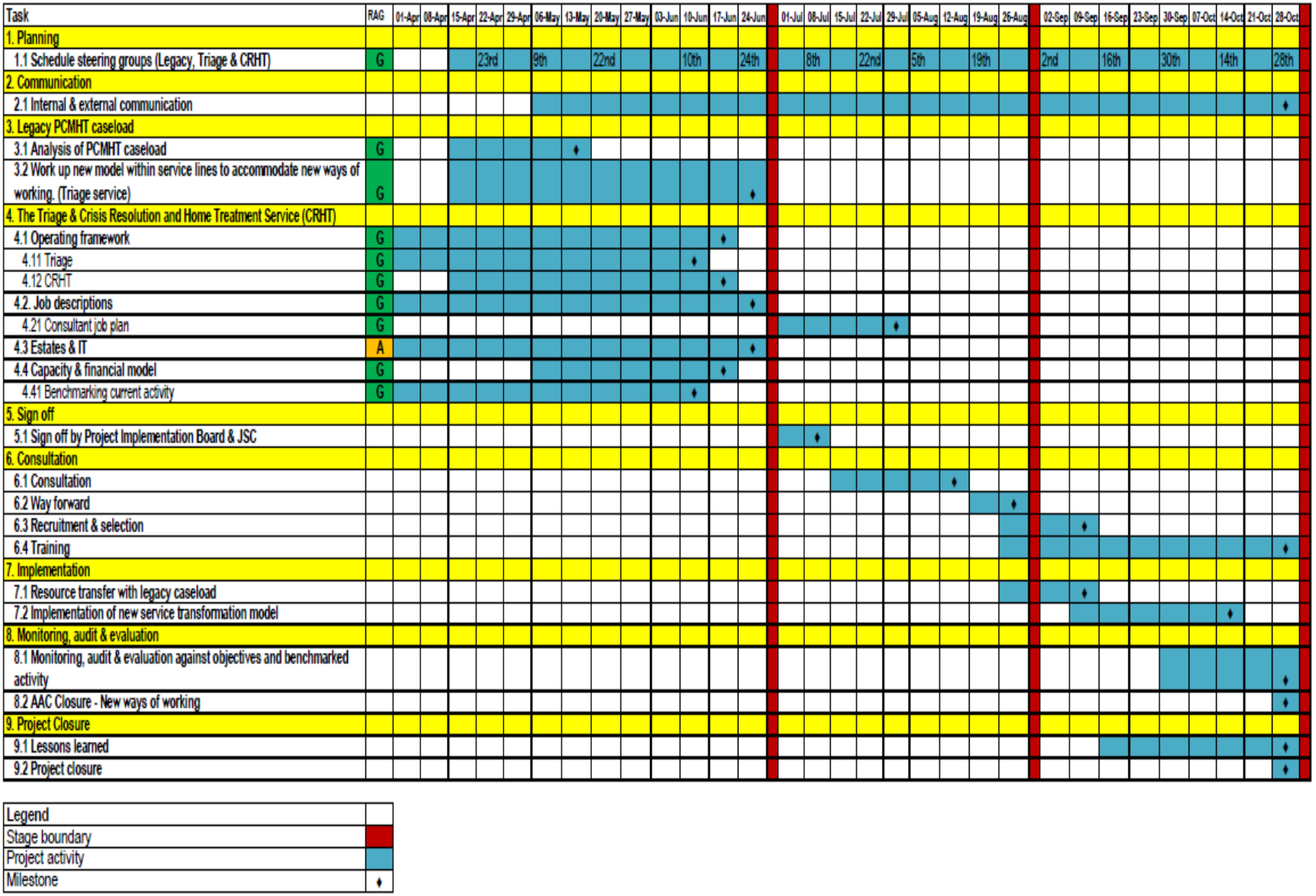
- Communication Strategy will include
  - Face to face briefings
  - Regular Newsletters
  - Web/intranet and social media
  - Press releases/briefings

Communication & Engagement

- Stakeholder engagement on-going
  - Service user groups – EMU, HUN, Barnet Voice
  - Staff
  - GPs
  - CCGs
  - Other partners e.g. acute trusts, LAS

- On-going communication around planned closure of the AACs
  - July to November 2013 to key stakeholders, Local MPs, elected members, partners.

Service Transformation Programme Plan



Next Steps

- JSC 9th July - Complete
- CCG's Board Presentations - Complete
- Consultation begins 15th July - Complete
- Consultation ends 17th August - Complete
- Way Forward document circulate 2nd September - Complete
- Competency based interviews selection procedure for all Bands, including admin commencing 9th September
- Slotting in Band's 3 & 4 unqualified staff
- Slotting in Band 3 admin
- Training to be arranged

This page is intentionally left blank