NOTICE OF MEETING

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

Monday 3rd February 11:00 a.m.
Hendon Town Hall, The Borroughs, Hendon, NW4 4BG

Contact: Andrew Charlwood

Direct line: 020 8359 2014
E-mail: Andrew.Charlwood@Barnet.gov.uk

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

5. BEH MHT DISCUSSION AND QUESTIONS ON CQC REPORTS (PAGES 1 - 10)

To discuss the three recent CQC reports and receive an update on the Improvement plans.

6. UPDATE ON NORTHGATE/NEW BEGINNINGS (PAGES 11 - 12)

To receive an update on Northgate/New Beginnings from Barnet, Enfield and Haringey Mental Health Trust.

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Dementia & Cognitive Impairment
Inpatient CQC Compliance and Assurance Action Plan -Updated 22/01/14

Regulation/Issue	Action	Lead (s)	Deliverables	Due Date	Progress
9.a.Legal rights of detained patients not ensured: i Capacity Assessments and Best Interest Decisions.	1. Agree standard process for DCI inpatient units on Capacity Assessments & Best Interests processes relating to decisions re: • Consent to admission • Consent to Treatment • Consent to care plans	Ian Morton & Jonathon Hare	1a.Written standard process on MCA produced, agreed and circulated.	31/12/13	Complete. Agreed at ISIG. IM has met with Ward managers and service managers for all 4 units re implementation.
			1b. Consent to admission and treatment capacity assessments on RiO for all new patients	12/12/13	Complete. All wards ensuring and auditing for all new admissions since 01/01/14. IM has discussed need for capactiy assessments prior to admission with Liaison team (NMH & BGH 13/01/14). Meetings and training being arranged with 3 CMHTs in February to ensure capacity assessments carried out before admission.
			1c Completed training needs survey of for all staff with an identified role in above process.	31/12/13	Formal survey not undertaken as clearly indicated that all inpatient nursingstaff require further input on MCA and DoLS.
	2. Ensure relevant staff identified and competent to carry out their role in this process		2. Evidence of additional training being delivered	31/01/14	On-going.. Ten Band 6 & 7 Staff attended LBE "train the trainers" for MCA/DoLS on 17/12/13. Agreed training programme starting with all qualified nursing staff in January 2014. Sessions delivered to all wards before the end of January. Staff being assessed on writing up capacity assessments and then followed up individually to ensure competence Dr Mandal ensuring junior Oaks doctors competent in addressing and recording capacity.
	3. Agree audit procedure for each ward to ensure standard process adhered to.		3. Clearly stated audit procedure for each ward to ensure capacity assessments and best interest decisions carried out.	31/12/13	Complete. Each ward has own audit procedure prior to all items being incorporated into monthly Quality Assurance process (currently being arranged by Clara Wessinger)

Dementia & Cognitive Impairment

Inpatient CQC Compliance and Assurance Action Plan -Updated 22/01/14

Regulation/Issue	Action	Lead (s)	Deliverables	Due Date	Progress
9.a Legal rights of detained patients not ensured ii. DoLS	1. Ensure screening of non MHA patients who lack capacity re do they need DoLS authorisation. 2. Ensure relevant staff identified and competent to carry out their role in this process 3. Agree audit procedure for each ward to ensure standard process adhered to.	Ian Morton & Jonathon Hare	1. Each of non MHA patient who lacks capacity to consent to admission has evidence of screening for DoLS recorded in Progress Notes. 2.All registered nurses trained in recognising potential DoLS. 3. Clearly stated audit procedure for each ward to ensure DoLS screening taking place.	12/12/13 31/3/14 2/12/13	Complete. All wards making entry in progress notes of DoLS Screen for patients within first week of admission. Current patients being reviewed - DoLS authorisations applied for relating to 1 Silver Birches patient and another pending for each of SB and CV. . On-going – Sessions on DoLS included in Round 3 of DCI Inpatient Staff Development Programme in Feb/March. 10 Band 6 & 7 Staff attended LBE “train the trainers” for MCA/DoLS on 17/12/13 Complete. Each ward has own audit procedure prior to all items being incorporated into monthly Quality Assurance process (currently being arranged by Clara Wessinger)
9.b. Blanket Restrictions	1. Inform patients and family carers that bedrooms routinely locked to safeguard patient’s possessions but that rooms can be accessed on request. 2. Ensure that in mild weather access to garden	Ward Managers	1a Written material on notice boards etc explaning policy. 1b. Paragraph in ward leaftets for patients and carers explaning policy. 1c. Evidence of discussion and agreement with patients / carers at initial meetings / CPA 2. Addition of this point to daily	18/12/13 31/03/14 31/01/14 18/12/13	Complete. Each ward has a notice in place explaining default position of keeping bedrooms locked to protect their property from confused patients who may go into their room but **not a blanket policy** as can be opened / kept open on request. All Cornwall Villa family members have been written to re above. On-going – not all wards have leaflets yet but para will be in place in all newly produced / reprinted leaflets On-going. All Cornwall Villa family members have been written to re above. Complete

Regulation/Issue	Action	Lead (s)	Deliverables	Due Date	Progress
	areas is possible for patients and visitors.		environmental checklist.		
15.a. Items stored in toilets and bathrooms . . . may be trip hazards	1. Ensure removal of all identified trip hazards from toilets and bathrooms.	Nina Wright & Edna Ezifuela	1a. Absence of trip hazards in toilet and bathroom areas on Silver Birches. 1b. Addition of trip hazards to daily environmental checklist	18/12/13	Complete Complete
15. b. Identified ligature risks not removed (BTH)	1. Re-assess ligature risks with head of non-clinical risk 2. Ensure removal of all identified ligature risks	Sue Pond & Siva Ramalingam	1. Description of all identified risks requiring attention and prioritisation for removal. 2. Absence of identified ligature risks on Bay Tree House	18/12/13 31/01/14	Complete. Risk assessment has taken place and priorities identified. On-going. All identified potential ligature points have been shortened sufficiently to neutralise risk. Estates indicate complete removal and replacement within 2 weeks
20.a. Gaps in the daily records.	1. Agree acceptable standard frequency of entries in progress notes. 2. Ensure all relevant staff are made aware of required frequency of recording in progress notes 3. Establish audit process to ensure agreed standard is being met.	ISIG Ward Managers Ward Managers	1. Clear standard statement re minimum levels of recording 2. Evidence of emails to staff, minutes of team meetings etc communicating standard 3. Audit records	18/12/13 31/1/14 31/1/14	Complete. Agreed at ISIG on 13/11/13 – minimum of once per shift for assessment and MHA patients and once per 24 hours for rest. On-going – will have been addressed at all 4 team meetings before end of January Complete. Each ward has own audit procedure prior to all items being incorporated into monthly Quality Assurance process (currently being arranged by Clara Wessinger)
20.b. Incomplete recording of restraint.	1. Ensure all nursing staff have access to template restraint record, are able to use it and are aware of requirement to use it. 2. Establish audit process to ensure agreed	Ward Managers Ward Managers	1. Evidence of emails to staff, minutes of team meetings etc communicating standard. 2. Audit records	18/12/13 31/1/14	Complete. Template distributed to Ward Managers and forwarded on to all staff. Complete. Each ward has own audit procedure prior to all items being incorporated into monthly Quality Assurance process (currently being arranged by Clara Wessinger

Dementia & Cognitive Impairment

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Regulation/Issue	Action	Lead (s)	Deliverables	Due Date	Progress
	standard is being met.				
20.c. Out of date Risk Assessments	1. Establish required frequency for updating of risk assessments 2. Ensure all relevant staff are made aware of required frequency for updating risk assessments. 3 Establish audit process to ensure agreed standard is being met.	ISIG Ward Managers Ward Managers	1. Statement re agreed frequency for updating risk assments 2. Evidence of emails to staff, minutes of team meetings etc communicating standard 3. Audit records	18/12/13 31/1/14 31/1/14	Complete agreed at ISIG on 27/11/13 – On-going – will have been addressed at all 4 team meetings before end of January Complete. Each ward has own audit procedure prior to all items being incorporated into monthly Quality Assurance process (currently being arranged by Clara Wessinger)
20.c. Out of date Care plans	1. Establish required frequency for updating of care plans 2. Ensure all relevant staff are made aware of required frequency for updating care plans. 3. Establish audit process to ensure agreed standard is being met.	ISIG Ward Managers Ward Managers	1. Statement re agreed frequency for updating care plans 2. Evidence of emails to staff, minutes of team meetings etc communicating standard 3. Audit records	18/12/13 31/1/14 31/1/14	Complete agreed at ISIG on 27/11/13 – On-going – will have been addressed at all 4 team meetings before end of January Complete. Each ward has own audit procedure prior to all items being incorporated into monthly Quality Assurance process (currently being arranged by Clara Wessinger)
10. Risks previously identified not addressed across the service.	1. Establish multi-disciplinary Inpatient Services Improvement Group (ISIG) 2.Implement 'Lean' methodology (Kanban and Task Management Boards) on all four inpatient areas to support continuous improvement and leader standard work.	Alan Beaton / Ian Morton	1. Minutes of meetings showing attendance from management, nursing, medical and OT colleagues. 2. Task Management Boards x4, Records of Improvement meetings x 4. Evidence of leader standard work.	13/11/13 01/04/14	Complete. Group commenced meeting in November 13. Currently meeting 2 weekly before moving to monthly. Addressing compliance actions (i.e. this action plan) initially. On-going. All 4 areas implementing task management boards and holding regular Improvement Group meetings.

Regulation/Issue	Action	Lead (s)	Deliverables	Due Date	Progress
	3. Expand current audit and peer review processes to cover issues identified above		3. Revised audit and peer review records incorporating all elements referred to above. Records of Dementia Care Mapping	31/01/14	On-going. Monthly (QA) audit process currently being revised to incorporate elements from this action plan. Further clarity needed re future arrangements for Peer Review
	4. Each consultant psychiatrist provides clinical leadership to Improvement work at ward level.		4. Minutes of Ward Improvement meetings	31/03/14	On-going. Initial discussions held with consultants x 2 on 11/12/13 re short Improvement work sessions attached to Ward Rounds. Further work needed (Job plans) if consultants to have necessary time to attend.

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Crisis and Emergency Service Line

CQC Compliance and Assurance Action Plan – Use of Seclusion Rooms /136 suites

Ref	Regulation/Issue	Action	Lead (s)	Deliverables	Due Date	Progress
1.	The Trust is failing to comply with Regulation 9(1)(a)(b)(i)(ii)(iii) of the Health and Social Care Act 2008 (regulated Activities) Regulations 2010. Two inspectors and a Mental Health Act Commissioner visited Haringey Ward and the s136 suite which is a designated 'place of safety' where people who are detained under s136 or s135(1) of the Mental Health Act are brought while awaiting a formal assessment at St Ann's Hospital to see if improvements following the inspection of 19 June where we found that people were not experiencing care, treatment and support that met their needs and protected their rights.	The registered person must take proper steps to ensure that each service user is protected against the risks of receiving care or treatment that is inappropriate or unsafe, by means of:- a) The carrying out of an assessment of the needs of the service user b) The planning and delivery of care and, where appropriate, treatment in such a way as to i) Meet the service users' individual needs ii) Ensure welfare and safety of the service user iii) Reflect, where appropriate, published research evidence and guidance issued by the approprpiate professional and expert bodies, as to good practice in relation to such care and treatment.	Haringey: Oliver Treacy Leon Rozewicz Bessie Laryea George Brew Ben Ejeka Dr Edelman Dr Cranitch Dr Ndukwe Dr Dutton Enfield: Oliver Treacy Leon Rozewicz Paula McKevitt Sean Edwards Rey Bermudez Bibi Paraouty Dr Greensides Dr Fenton Dr Liveras Barnet: Oliver Treacy Leon Rozewicz Jonathan Apeawini Ana Basheer Ade Adebare Dr Foster Dr Aziz Dr Naguib Clare Weissenger	• Evidence of assessment of need in place. • Evidence of care plan denoting treatment on a continuum in place. • Care plan assessment evidence observed in place / RiO notes. • Valid risk assessment in place. • Evidenced in RiO notes and in care plan. • Audit that demonstrates compliance with regulatory standards	31.01.14 31.01.14 31.01.14 31.01.14 31.01.14 Monthly until March 2014	

Crisis and Emergency Service Line

CQC Compliance and Assurance Action Plan – Use of Seclusion Rooms /136 suites

Ref	Regulation/Issue	Action	Lead (s)	Deliverables	Due Date	Progress
2.	We found that the two seclusion rooms on Haringey ward and the s136 suite had been used to admit patients when there were not enough bedrooms in the Trust. This meant that the provider had not made the changes which were indicated in the action plan which was sent to us following the inspection in June 2013 and continued to be non- compliant.	Met with service line management, ward managers and all service line consultants to discuss the CQC Notice and required staff actions. An action Plan will result from this meeting, co-ordinated by Oliver Treacy, Service Director.	Oliver Treacy Lee Bojtor Jackie liveras	The use of seclusion and 136 suites for anything other than their designated clinical purpose is prohibited with immediate effect.	Immediate	**Completed 12th December 2013**
3.	We found that some care was provided in an environment that did not meet the needs of individual patients.	Work with service line wards by site to determine how this is to be achieved. Service Managers to assure the SD that patients admitted to the wards are able to access designated bedrooms.	Paul McKevitt Bob Ryan Scott Kerr	There will be a 4 week period in which to review and cease the use of other rooms such as actvity and side rooms as patients bedrooms.	13.01.14	
4.	We found that people were cared for by staff who knew and understood their responsibilities. We found that most patients had care plans which were recorded and had up to date risk assessments although some patients told us they were not aware that they had care plans.	Individual care plans to be discussed with and understood by the patient and a cotemporaneous record maintained.	Haringey: Bessie Laryea George Brew Ben Ejeka Dr Edelman Dr Cranitch Dr Ndukwe Dr Dutton Enfield: Paula McKevitt Sean Edwards	Evidenced within the care plan and RiO that discussion with the patient had taken place and the the patient has received a copy of the care plan. An audit conducted by clinical audit to demonstrate compliance with the above will be the assuring evidence.	31.01.14 Ongoing Jan –Mar 2014	

Ref	Regulation/Issue	Action	Lead (s)	Deliverables	Due Date	Progress
			Rey Bermudez Bibi Paraouty Dr Greensides Dr Fenton Dr Liveras Barnet: Jonathan Apeawini Ana Basheer Ade Adebare Dr Foster Dr Aziz Dr Naguib			
5.	People told us that they did not have enough activities on the ward and staff told us that the activities which were timetabled to take place did not always take place. People also told us that they did not always know their rights and whether they were detained under the Mental Health Act (1983) or whether they had been admitted to the ward informally.	Ward programmes need to be organised, planned and delivered on a regular basis with visible evidence displayed. Evidence that all service users are aware of their rights under the MHA and where appropriate their informal status to be regularly monitored and audited by the ward clinician i.e. Drs/Nurses. Advice to be sought from the MHA office when necessary. Evidence to be provided.	Haringey: Scott Kerr Bessie Laryea George Brew Ben Ejeka Enfield: Paul McKevitt Paula McKevitt Sean Edwards Rey Bermudez Bibi Paraouty Barnet: Bob Ryan Jonathan Apeawini Ana Basheer Ade Adebare	A dynamic programme visibly in place organised by the ward managers. Programme fully implemented and evidence by February. Service user's representation to be consulted in agreeing the activity programme. Evidence of patient participation on RiO provided by Clinical Audit.	31.01.14 28.02.14 28.02.14 28.02.14	

Crisis and Emergency Service Line

CQC Compliance and Assurance Action Plan – Use of Seclusion Rooms /136 suites

Ref	Regulation/Issue	Action	Lead (s)	Deliverables	Due Date	Progress
6.	Capacity Meeting Demand	BEH working with CCGs to review capacity and demand across the health economy. The BEH/CCG tranformation board will be the preferred the vehicle for high level discussion. Commissioner to ensure LA's are delivering intervention that supports early discharge and social support for user of Mental Health Services.				

Barnet, Enfield and Haringey NHS
Mental Health NHS Trust

Overview of progress in the development of a Single Specialist Adolescent Pathway in Barnet Enfield and Haringey

Report for JHOSC on 3rd February 2014

1. *History/Drivers for Change*

1.1 Following the closure of the previous Northgate Clinic, following the decision taken by Barnet Enfield and Haringey CCGs (then PCTs) and a period of public consultation, the Adolescent Pathway was launched in September 2012.

1.2 The rationale for decommissioning the Northgate Clinic was that it was an expensive resource, delivering a service for a small number of adolescents, with a clinical model that was unclear and without a contemporary evidence base.

2. *The Adolescent Pathway*

2.1 The pathway consists of a 'mixed economy' Tier 4 (in-patient) 17 bed unit, the Beacon Centre, and borough based assertive outreach team. BEH-MHT invested £1.6 million capital to extend the existing in-patient unit (formerly the New Beginnings Unit) to extend bed provision from 12 to 17.

2.2 The Tier 4 component includes four High Dependency beds - one of the key drivers for service change being the placement of adolescents requiring admission to hospital to more secure settings in expensive and variable in quality private providers often far from our locality, with consequent delays in reintegration/return to the community. Following completion of the refurbishment, the new 17 bed unit was opened in June 2013 and renamed as the Beacon Centre.

2.3 The mixed economy in-patient provision consists of acute, treatment and high dependency provision, with intensive psychological therapy provision for individual adolescents and, where indicated, their families/carers.

2.4 The community component consists of borough based, multi-disciplinary teams that provide assertive outreach to adolescents with complex and often high risk mental health presentations – the ultimate aim being to support these adolescents in the community but where this is not possible to work seamlessly with the Tier 4 team to minimise the length of stay in hospital.

2.5 There are a range of psychological therapies – both group and individual, provided by within the Tier 4 and community teams. This includes therapeutic interventions for parents/carers as well as young people engaged with our service.

2.6 All parts of the pathway work closely and collaboratively with an extensive range of children and young people’s services, including social care, education, Youth Offending and community programmes/organisations.

3. ***Current Position***

3.1 Changes to the commissioning arrangements for Tier 4 CAMHS came into effect in April 2013 - with responsibility moving from local commissioners (CCGs) to a national arrangement led by NHS England. This means that the single pathway is commissioned from two sources, however we have managed to maintain the integrity of the pathway despite these changes.

3.2 However, these new commissioning arrangements are not without challenge – for example the NHS England process means that we are obligated to admit adolescents from out of area if we have capacity to do so.

3.3 Activity and demand for the adolescent service remains high, both in terms of increased referrals and consistently high levels of case complexity. As a new service, we are constantly evaluating what we do, and emerging themes, and at present we are collecting data on service activity to date.

4. ***Engagement with Service Users***

4.1 Engagement with our service users is integral to the continued development and evaluation of the adolescent service. Weekly forums for service users are held at the Beacon Centre, where they can feed back on their experience of the service and ideas for improvement.

4.2 We are currently in discussions with Barnardos with view to setting up an independent advocacy service for young people that will ‘in-reach’ into the Beacon Centre.

4.3 We also use formal outcome measures (CORC) that include feedback on service users and their families’ experience of the service.

4.4 The pathway will be subject to a full review this year and services users will be able to contribute to this process.

Shaun Collins
Assistant Director
Child and Adolescent Mental Health Services
Barnet, Enfield and Haringey Mental Health NHS Trust
29 January 2014