NOTICE OF MEETING

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

Contact: Andrew Charlwood

Monday 3rd February 11.00 a.m.
Hendon Town Hall, The Borroughs, Hendon, NW4 4BG

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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

Members of the Committee should consider whether they have any dsicloseable pecuniary interests or prejudicial interests relevant to items on the agenda. A Member with a disclosable pecuniary interest or a prejudicial interest in a matter who attends a meeting at which the matter is considered:

a) must disclose the interest at the start of the meeting or when the interest becomes apparent, and
b) may not participate in any discussion or vote on the matter and must withdraw from the meeting room.

A member who discloses at a meeting a disclosable pecuniary interest which is not registered in their borough's Register of Members' Interests or the subject of a pending disclosure must notify their Monitoring Officer of the interest within 28 days of the disclosure.

3. BARNET, ENFIELD & HARINGEY MENTAL HEALTH TRUST KEY ISSUES (PAGES 1 - 12)

To receive a presentation on key issues facing BEH MHT

Maria Kane, Chief Executive, BEH MHT

4. BARNET, ENFIELD AND HARINGEY CLINICAL COMMISSIONING GROUPS (PAGES 13 - 20)

To receive a joint presentation from Barnet, Enfield and Haringey CCG's on key issues facing commissioners.

Liz Wise, Chief Officer, Enfield CCG

5. BEH MHT DISCUSSION AND QUESTIONS ON CQC REPORTS (PAGES 21 - 100)

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

6. UPDATE ON NORTHGATE/NEW BEGINNINGS

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

Barnet, Enfield and Haringey Mental Health NHS Trust

Presentation to Joint Health Overview and Scrutiny Committee

3 February 2014

Maria Kane

Chief Executive

Introduction

- The Trust and CCGs welcome this opportunity to discuss local mental health services with the JHOSC
- The Trust will give a short presentation summarising our progress over the last 12 months and the key issues we currently face, including our response to the recent reports from the CQC
- The CCGs will then give a short presentation on the wider issues and then there will be time for questions and discussion

Overall Summary

- The Trust continues its focus on improving services for patients, providing high quality, safe and compassionate care is our top priority
- We have consistently met our operational and financial performance targets for the last five years
- We have a clear long term strategy based on supporting people with mental health needs, integrating mental and physical health services and reducing the need for patients with both mental and physical health conditions from being admitted to hospital wherever possible
- We now face a very difficult situation of continuing to provide safe services with major increases in the numbers and acuity of patients, with no additional funding available
- This is placing our services under considerable pressure, particularly our inpatient services. We have increasing concerns about the quality and financial risks this is causing

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Progress over the last year

We have made good progress in many areas over the last year:

- **Continued improvements in quality and patients' experience**
  - Lots of positive patient feedback e.g. for our MH Recovery Houses
  - Positive feedback from a number of independent reviews of quality
  - However, some concerns have been raised by the CQC
- **Significant improvements in feedback from staff**
  - Amongst the best MHTs in the country in 2012 for having highly motivated staff and indications from the 2013 Survey are also positive
- **Development of Trust Clinical Strategy**
  - We have developed a clear Clinical Strategy, supported by local CCGs and local authorities
- **Continued improvements in service performance**
  - We have met all the key national and local performance standards, including our challenging cost improvement programme target

Progress over the last year

Some of the other key issues over the last year have been:

- **Responding to the Francis Report**
  - Trust Board has confirmed its top priority is ensuring consistently high quality care, delivered with kindness and compassion
- **Progress in redevelopment of St Ann's Hospital in Haringey**
  - Successful public engagement processes have built support for our plans for significant improvements to address the current poor facilities
  - Outline planning application due to be submitted to LB Haringey soon
- **Developing our services**
  - Were one of only three national Personality Disorders Pilots
  - Won additional Forensic service contracts, including mental healthcare for Feltham Young Offenders Institution, Pentonville and Brixton Prisons and additional Court Diversion services
  - Our Memory Services in Enfield and Haringey were recognised nationally for excellent care by the Royal College of Psychiatrists

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Progress over the last year

- **Integrating physical and mental health services**
  - We have continued to integrate our mental health services with our community health services in Enfield
  - The overall aim is to improve care for people with long term health conditions and help reduce admissions to acute hospitals
    - e.g. Enfield Care Home Project and establishment of the new Rapid Assessment, Intervention and Discharge (RAID) service with Barnet & Chase Farm and the North Middlesex Hospitals
- **Developing our staff**
  - We have continued to support and develop our staff in order to improve patient care - e.g. our major Listening into Action initiative
- **Funding of our services**
  - We have been working with our local CCGs to address the historic relatively low levels of funding for local mental health and community health services compared to other parts of London

Improving accessibility and support for local GPs

- The Trust has developed a range of initiatives to improve access for patients, carers and GPs
- We now have:
  - A new Urgent Care service, responding urgently to patients in a mental health crisis and visiting them wherever they are, rather than requiring them to come to one of our sites
  - A new Triage service, which provides a single point of access for all non urgent referrals to adult mental health services
- We have also been focusing on improving our support for local GPs and have:
  - Established a daily GP advice line staffed by Trust Consultants
  - Developed our Primary Care Academy for local GPs and other primary care staff

Key issues facing the Trust – Activity and Funding

- The numbers of patients the Trust is caring for has increased by 11% over the last three years, while funding has gone down by 13% in real terms
- The population of the three boroughs we service has increase by c. 130,000, leading to increased demands on our services
- In particular, there have been major increases in the numbers of dementia patients and in the numbers of patients being Sectioned
- The recent increase in activity has resulted in much increased pressures on our mental health inpatient beds across all three boroughs. The Trust has opened additional beds and is using private placements to cope with increased demand
- This increased capacity will cost the Trust an additional c. £5m this year, which is not funded by commissioners
- Historically, there has been relatively low proportions of local commissioners' total budget spent on mental health care. This is improving, but two of the three of the Trust's local commissioners still spend less than the London average

Key issues facing the Trust – Quality

- The Trust is concerned about the impact of the increased numbers of patients on the quality of care without additional funding
- Our inpatient wards have been operating at full occupancy all the time
- National guidance is that bed occupancy levels of c. 85-90% are optimal for high quality patient care
- Due to the current demand on the Trust's inpatient beds, the Trust had been occasionally using seclusion rooms to accommodate patients if a bed was not available in the Trust or at other NHS providers in London or further afield
- This is not good clinical practice and the CQC have now issued an Enforcement Notice. The Trust has implemented a complete ban on the inappropriate use of seclusion rooms, but this has led to a direct increase in the need to use private placements, which is not ideal for patients and incurs additional costs

Key issues facing the Trust – Quality

- The Trust also received a report in November from the CQC about its older people's services based on the Chase Farm site.
- The CQC noted major improvements in care at The Oaks Unit, but raised one moderate concern and three minor concerns about other older people's services, noting that learning from improvements in The Oaks had not been extended to other areas and that there were inconsistencies of care
- The Trust is taking these issues very seriously and has developed an action plan, which is regularly monitored by local commissioners
- As part of the ongoing cycle of regulatory inspection, the CQC also recently visited Magnolia Ward at St Michael's Hospital in Enfield (intermediate care) and the Trust's Recovery Houses in Enfield and Haringey – all received positive reports from the CQC and were found to be fully compliant

Conclusions

- The Trust's absolute priority is ensuring high quality, safe services for patients, and has continued to make a range of improvements over the last year
- The Trust cannot continue to safely meet the increases in the numbers of patients being referred without additional funding and / or changing the way services are delivered and managing overall activity levels.
- At present, the Trust is bearing 100% of the clinical and financial risk around this, which is not sustainable
- The Trust is currently working closely with the local Clinical Commissioning Groups on these issues, in order to agree the best way forward which allows the Trust to continue to improve its services and support local people with mental and physical health needs
- A joint piece of work has been commissioned around this, which will be outlined in the CCGs' presentation

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Mental Health
CCG Finance and Quality Issues

Liz Wise, Chief Officer

Current Level of CCG Investment into BEHMHT

- Contract Value 2013/14
  - NHS Enfield £30,576,536
  - NHS Barnet £27,028,609
  - NHS Haringey £31,053,098

- All CCG Financially Challenged in Achieving Recurring Financial Balance

BENCHMARKING DATA ADULTS AND OLDER ADULTS

- Last Financial Benchmarking Exercise 2011/12
- Weighted Investment Per Head

Adults	**Older Adults**
Haringey £202.7	Haringey £416.5
Barnet £172.6	Barnet £158.8
Enfield £188.5	Enfield £238.3

- BEHMHT Remain Financially Challenged/Potential Financial Deficit

NB: Figures reflect both Health and Social Care Funding

NEXT STEPS

- CCG/BEHMHT Jointly Commissioned Project with Mental Health Strategies:
  - Benchmark the current levels of Investment
  - Assess the viability of the current level of service against the funding available and commissioner expectations
  - Financial viability of delivering the Trusts Clinical Strategy and 3 Borough Commissioner Strategy

- Identify Options available to the Trust and Commissioners to align service provision to funding levels

  - Managing Activity
  - Decommissioning of Services
  - Estates Rationalisation
  - Other service transformations
  - Identify further efficiencies

- Final report by 14th March 2014

Quality Issues – A Joint Approach

- Clinical Quality Review Group:
  - Monthly Standing Committee
  - Commissioners/Trusts/Quality Leads/GP Leads

- Annual Workplan:
  - Action Plans
  - Complaints
  - Incidents
  - CQC Visits
  - Patient Experience
  - Francis Report Action Plan

Specific Issues

- Inappropriate use of Seclusion Rooms
  - Joint meeting of Trust and Commissioners
  - Shared Action Plan/Bed Management/Escalation Reports
  - End the Practice
  - Monitored at CQRG

- Quality of care on Older Adults Wards
  - Task and Finish Service Improvement Group established
  - Initial focus on Oaks Unit
  - Agreed to extend remit to all Older Adults at Chase Farm
  - Joint Trust/Commissioner papers to CQRG and Governing Body demonstrating service improvement and ongoing assurance

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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: 20 August 2013
19 August 2013

Date of Publication: October 2013

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

Care and welfare of people who use services	✓ Met this standard
Cooperating with other providers	✓ 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 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. This was an inspection of mental health services provided in police custody suites in Camden by Camlet Lodge Forensic Services.
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 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 August 2013 and 20 August 2013, observed how people were being cared for and talked with staff.

What people told us and what we found

This was an inspection of mental health services provided in police custody suites in the London Borough of Camden by Camlet Lodge Forensic Services. We spoke to police custody staff and doctors who worked alongside the mental health service. We were told that a good service was being provided by the service that met people's needs. We found the service carried out comprehensive assessments and met people's mental health needs. We also found that the service cooperated, liaised and shared information with other providers. This meant that people's needs were more likely to be met.

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

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 ✓ Met this standard

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

Our judgement

The provider was meeting this standard.

Peoples' needs were assessed and treatment was planned and delivered in line with individual need.

Reasons for our judgement

People experienced care, treatment and support that met their needs. The mental health nurse told us that they were called out by police custody staff when the initial police risk assessment and screening process picked up that someone's mental health required assessment.

We observed an assessment that was carried out jointly by the mental health nurse and the visiting forensic medical examiner (FME [the FME is a doctor who attends custody when a person needs medical assistance]). It was conducted in a way that showed respect for the person who was in some distress. For instance, giving time to listen to their story and treating them with calmness and patience. The mental health element of the assessment included social, mental health and risk. This gave a more holistic view of the person and their needs.

The expectation was that the service attended custody within an hour of referral. This was not recorded or measured, but when we spoke to custody staff we were told this was met most of the time. We also observed the service arrive at custody within an hour of being requested.

We were told by staff that while in the custody suite they discussed other cases with custody staff where a behaviour may suggest a mental health issue that had not been picked up in the initial police assessment. We were given examples where this informal approach had picked up further cases. Custody staff told us that they felt the service was responsive to the needs of people.

While the FME wrote up basic findings on the police recording system, the mental health nurse's notes were written up on to the trust's electronic recording system which was not shared with custody staff. We were told by the mental health nurse that information would be shared with custody verbally, and on a risk and need to know basis.

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 needs were met when more than one provider was involved in their care because the provider worked in co-operation with others.

Reasons for our judgement

People's needs were met when more than one provider was involved in their care because the provider worked in co-operation with others. A handover of information took place between the forensic medical examiner (FME) and mental health nurse on duty. This was to ensure that recently assessed cases had been appropriately referred on to community services such as GP and community mental health team.

The mental health nurse from the service told us that, in order to gain a clearer picture about the person's needs, they would regularly contact other service providers in order to gather relevant information. We observed background information being gathered from other services on a person being assessed. Information was received from a psychiatric hospital and a GP. This was so that information shared between services such as diagnosis and current medication could help to meet individual need.

Depending on what course of action was being taken by the police such as charging or releasing, the service shared their assessment with appropriate onward services. This included the court diversion scheme (a mental health service that ensures people receive appropriate treatment in court), GPs and community mental health teams. This meant that people's mental health needs were more likely to be met.

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

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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.*

St Ann's Hospital

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

Tel: 02084425732

Date of Inspection: 22 November 2013

Date of Publication: January 2014

We inspected the following standards to check that action had been taken to meet them. This is what we found:

Care and welfare of people who use services	✖ Enforcement action taken

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

We carried out this inspection to check whether St Ann's Hospital had taken action to meet the following essential standards:

- Care and welfare of people who use services

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 22 November 2013, observed how people were being cared for and talked with people who use the service. We talked with staff and reviewed information given to us by the provider.

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

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.

We spoke with seven members of nursing and medical staff on Haringey Assessment Ward, one member of staff on duty on the s136 suite, we checked the records of six patients on the ward at the time of the inspection and spoke with seven patients. We also requested further information from the Trust after the inspection.

We found that some care was provided in an environment that did not meet the needs of individual patients. 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.

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. Some 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.

We checked the two seclusion rooms on the ward and looked at the general ward

environment. We found that the two seclusion rooms on Haringey Assessment 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.

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

What we have told the provider to do

We have taken enforcement action against St Ann's Hospital to protect the health, safety and welfare of people using this service.

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	✖ Enforcement action taken

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

Our judgement

The provider was not meeting this standard.

Care and treatment was not planned and delivered in a way that was intended to ensure people's safety and welfare.

We have judged that this has a major impact on people who use the service and have taken enforcement action against this provider. Please see the 'Enforcement action' section within this report.

Reasons for our judgement

During this inspection we visited Haringey Assessment Ward and the s136 suite at St Ann's Hospital. The s136 suite is an area of the hospital which is a designated 'place of safety' where people are taken for a period of up to 72 hours, to wait for a Mental Health Act Assessment.

When we visited St Ann's Hospital on 19 June 2013 we found that planning and delivery of care did not always meet people's needs as when there were not enough beds, Barnet, Enfield and Haringey Mental Health NHS Trust admitted patients to seclusion rooms on Haringey Ward. These rooms were not designed to be used as bedrooms and this practice compromised the dignity and wellbeing of people who used the service. We also found that some patients were not protected against the risk of receiving care or treatment which was inappropriate because staff were not always aware of the legal status of patients so there was a risk that people may be treated unlawfully.

During this inspection, we spoke with seven patients some of whom were detained under the Mental Health Act and some of whom were informal patients which meant they had chosen to remain on the ward for treatment and were free to leave. Some people told us they were not aware of their legal status while they were on the ward. One person, who was not detained, told us "I am not clear if I am informal or detained", another person who was detained told us "I have been here for three days and no one has sat with me and told me about my 'section'", another person, who was not detained told us "I don't know if I'm on 'section' as the doctor told me I cannot go out".

We asked staff how they ensured that people who were detained and people who were not

detained knew their rights. We were told that there was written information available for people who had been detained under the Mental Health Act (1983) and people were told what their rights were to appeal against their detention. We were told that there was no information specifically to give to people who were not detained to explain their rights to them.

We saw that there was a notice in the nurses' office which explained that informal patients were free to leave the ward at any time however this notice was not on display in any of the areas which were accessible to patients. The lack of information available to patients who are not formally detained on the ward means that there is a risk that people will not be aware of their rights to leave the ward when they are not detained under the Mental Health Act.

We asked the ward consultant about how they ensured that people who were not detained were aware of their rights to leave the ward and how the staff team ensured that when there was a risk involved that people were aware that they did not have the right to leave, at will. The consultant told us that people had care plans which indicated any restrictions that they may have agreed to relating to remaining on the ward. We looked at the care plans for six people. We found that one person, who was not detained, did not have a care plan. This meant that it could not be evidenced that they agreed to care, treatment and support which they were receiving on the ward or that their consent to remain on the ward informally could be confirmed. There was a risk that people may not be clear about their legal status on the ward.

Most people told us the staff were very busy on the ward. Two people, who were patients on the ward, told us the staff were rude to them and one person told us that the staff ignore them and another person said the medical staff do not listen to them. One person told us "I have no complaints". One person told us that there was no access to illicit substances on the ward.

We looked at the records for six people. Most people had care plans and risk assessments which were up to date. Three people told us they either did not have a care plan or did not know whether they had a care plan. This meant that some people had not been aware of the care planning process and had not been engaged with it. One person said "Nobody talked with me about my difficulties or to discuss what help I might need to cope better at home." Another person said "I do not have a key worker and I do not have a care plan... noone has told me how my medication helps."

On most of the records we looked at we saw that there was an indication of capacity to consent to admission or treatment as appropriate. On one care plan we saw that it said that "allocated nurse on duty to spend at least 20/30 mins with [patient] and allow [them] to ventilate thoughts and feelings." We did not see that this was evidenced in the daily recording.

Some patients told us that there were not frequent activities on the ward. One person said "There are no activities - nothing happens except pool and TV and some patients get bored", another person said "lack of activity is the worst thing." We saw that there was an activity timetable in the lounge of the ward. A member of staff told us this timetable was out of date and "The OT [occupational therapist] hasn't updated the schedule - someone needs to phone to find out if there are any activities on". Another member of staff told us "Activities don't happen because we are short staffed" and another said "We don't have a lot of activities as we just have a pool table and football - we liaise with OTs twice a week".

We saw no evidence that any structured activities were arranged during the course of our inspection visit when we spent a day on the ward.

We looked at people's daily records and saw that some activities were recorded for some people on most days however this was not consistently recorded for all people. The ward had 'Protected Engagement Time' (PET)between 3.30pm and 4.30pm. We asked staff what happened during this time. We were told that staff sit and chat to patients, play board games and that some patients have leave from the ward or have 1:1 time. One member of staff said "during the engagement time, we ask them what they [patients] want to do - the problem is we don't have a lot of activities". Another member of staff told us, about PET, "it's the same as what happens normally." We did not see evidence in the daily records that PET was being used to meet individual needs of patients. This means that there was not a consistent programme of meaningful activities available to all patients on the ward if they chose to participate.

We looked at the two seclusion rooms on Haringey Ward. Seclusion rooms are for nursing patients in isolation for short periods, when they are a risk to others. The Mental Health Act (1983) Code of Practice 15.43 states "Seclusion is the supervised confinement of a patient in a room, which may be locked. Its sole aim is to contain severely disturbed behaviour which is likely to cause harm to others." At our last inspection on 19 June 2013 we found that sometimes these rooms had been used to admit patients when there were no other beds available in the Trust. This practice had been raised as a concern to us by members of staff during the last inspection. The two seclusion rooms shared a toilet. They are rooms which contain raised mattresses and no other fixtures or fittings. We were told that by staff on the ward that they were not aware of any occasions when both seclusion rooms were used at the same time. When patients were admitted to the seclusion room when there was not the clinical need to be secluded, we were told that the door was left open.

There was a locked door between the seclusion rooms and the main ward area which included the lounge, dining room, kitchen, bathrooms and showers so people were not be able to access these areas independently. We were told by the staff that people could knock on the door of the nursing office to gain access to the main ward area. One seclusion room had constant CCTV which could not be turned off by the staff. The CCTV for the other seclusion room was broken. There were intercoms for both seclusion rooms which allowed nursing staff to communicate with people who were being secluded. These intercom systems could not be initiated by patients. The Mental Health Act Code of Practice (1983) 15.60 states that "The room used for seclusion should... be quiet but not soundproofed and should have some means of calling for attention (operation of which should be explained to the patient)." The lack of a patient-initiated contact from the seclusion rooms and the reliance on a member of staff looking at the CCTV images meant that this was not the case. When patients were admitted to the seclusion room when there was not the clinical need to be secluded, they would not be able to shut the door to enable privacy as the door could not be opened from the inside and if someone shut the door, they would be locked in the room.

We asked staff how often people were admitted to the seclusion room when they did not require seclusion. Staff told us that it happened occasionally. We asked staff about how they prepared a seclusion room if it was to be decommissioned and used as a bedroom. Staff told us they ensured that the room was cleaned and they put bedding on the raised mattress. They ensured the door was open and they told us they explained to patients that they were not 'in seclusion' and that a bed would be found for them as soon as possible. After the previous inspection the Trust provided us with an action plan which stated that

seclusion rooms were not being used to admit patients however we found at this inspection that this was not the case and that this had continued to happen.

We were provided with information from the Trust about the use of seclusion rooms to admit patients when there were no other beds available for people. From this information we saw that between 28 August 2013 and 17 November 2013 the seclusion rooms had been used as bedrooms for thirty nights. On eleven occasions they had been used for more than twenty four hours which included one person who was admitted to a seclusion room for a period of five nights when there were no other beds available. This affects the welfare and dignity of people as seclusion rooms are not intended or designed to be used as bedrooms.

We saw that the Trust had a procedure to ensure a risk assessment took place regarding patients who needed to be admitted and made a clinical decision on this basis. We saw the records for one person who had had a risk assessment as they had been admitted to a seclusion room. The risk assessment we saw was sparse and did not address risk factors which were specific to the individual. It did not clearly define either the risks present nor incorporate a risk management plan. It did not clarify that the patient had been admitted to the seclusion room as an admission, rather than because they had a clinical need to be secluded, nor did the daily entry notes indicate clearly how long they remained in the seclusion room before being transferred to a bedroom. This meant that the process of assessing risks present to each individual for the temporary use of rooms which were not designed to be bedrooms was not robust enough to protect patients from the risk of inappropriate care and treatment.

During this inspection we looked at the s136 suite which is a room set aside from a ward which is used as a 'place of safety' for people to come while they are waiting for assessments under the Mental Health Act (1983). It is always staffed by a nurse. The nurse on duty told us that it had been used for patients to sleep in when bedrooms were not available. The s136 suite had an intercom system which was not able to be activated by the patient and relied on a member of staff observing the patient. In the s136 suite there was a mattress. There was no place to sit down apart from on the mattress. We requested information from the Trust regarding times when this room was used as an additional bedroom outside its function as a nominated place of safety. We found that it had been used in this way on eight occasions since the last inspection. We found that this was not appropriate to ensure the dignity or protection of people who need to be admitted to psychiatric inpatient care and this practice meant that there was a risk that people would not receive the appropriate care and treatment.

We have issued a warning notice to the Trust which was served on 13 December 2013.

This section is primarily information for the provider

✖ Enforcement action we have taken to protect the health, safety and welfare of people using this service

Enforcement actions we have taken

The table below shows enforcement action we have taken because the provider was not meeting the essential standards of quality and safety (or parts of the standards) as shown below.

We have served a warning notice to be met by 31 March 2014 This action has been taken in relation to:	
Regulated activities	Regulation or section of the Act
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: The provider had not planned and delivered care and treatment in such a way to ensure the welfare and safety of the service user and to meet the service user's individual needs as they had a policy of admitting people to seclusion rooms and to the rooom known as the s136 suite which were not appropriately furnished or designed as patient bedrooms. (Regulation 9 (1) (a) (b) (i) (ii) (iii) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010)

For more information about the enforcement action we can take, please see our *Enforcement policy* on our website.

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

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CareQuality Commission

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 Inspections: 26 September 2013
25 September 2013

Date of Publication: November 2013

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

Care and welfare of people who use services	✖ Action needed
Management of medicines	✓ Met this standard
Safety and suitability of premises	✖ Action needed
Staffing	✓ Met this standard
Assessing and monitoring the quality of service provision	✖ Action needed
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

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 25 September 2013 and 26 September 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 were accompanied by a pharmacist, reviewed information sent to us by other authorities and talked with other authorities.

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 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

We carried out this inspection to look at the progress had been made since we last visited the older adults mental health wards based at Chase Farm Hospital. When we last visited on 27 March 2013 we found that the Trust was failing to meet regulations 9 and 20 of the Health and Social Care Act because the Trust had not protected patients against the risk of receiving inappropriate care and treatment by ensuring, where appropriate, that their capacity had been assessed and decisions were made in their best interests. It had also not ensured that all records were appropriately maintained.

This inspection was carried out by three inspectors, an expert advisor, an expert by experience and a pharmacist inspector.

During this inspection, conducted on 25 and 26 September, we visited four wards which were The Oaks, which is an admission and assessment ward for older adults who have functional and organic mental health needs which, at the time of our inspection, was in the process of changing to a ward which will cater for older people with functional mental health needs, Silver Birches, which was a continuing care ward for people with dementia and was in the process of changing to an admission and assessment ward for people with organic mental health needs, including dementia, Cornwall Villas which was a dementia continuing care ward and Bay Tree House which was a rehabilitation and 'step down' ward

for older adults with functional mental health needs which had some continuing care beds. The Oaks, Silver Birches and Cornwall Villas are at the Chase Farm Hospital site. Bay Tree House is registered to Chase Farm and located about a mile away from the hospital site.

We visited The Oaks and Silver Birches in the morning and afternoon of 25 September before returning in the evening to observe the night shift. We visited Cornwall Villas in the morning of 25 September and Bay Tree House on the afternoon of the 26 September.

We found that most staff interaction with patients was good but we saw some examples which could still be improved.

Understanding and use of the Mental Health Act (1983) and the Mental Capacity Act (2005) varied between the wards. In some areas we saw that it was used and documented well but on other wards we found that there was a risk that people were subject to restrictions without having access to legal processes and protection.

We found that medication was safely stored and administered.

The Trust had adequate staff on the wards however in some areas there was a high use of agency staff. The Trust had systems in place for monitoring and improving the service but these were not used effectively to improve care across all wards for older adults. We saw that many improvements had been put in place on The Oaks ward where concerns had been raised previously, however we identified similar concerns in other wards.

Personal records, including medical records, were not accurate or fit for purpose. Although we saw records on The Oaks, were comprehensive, on some other wards we found significant gaps in records and some records which were not up to date.

Our overall findings from this inspection are that there are significant improvements in the care provided to patients on The Oaks but that there is non-compliance in many of the same areas on the other wards for older adults. This shows poor leadership as lessons from the failings in one part of the hospital are not being robustly applied across other wards even within the same service area.

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 19 December 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.

Care and treatment was not planned and delivered in a way that was intended to ensure people's safety and welfare.

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

When we visited previously on 27 March 2013 we found that the Trust was not meeting this standard. This was because the Trust was failing to ensure patients' capacity was being assessed and that patients were supported appropriately at all times.

Provision of personal care

Throughout the days we visited we undertook ongoing observations, spoke with people using the service and spoke with their relatives. In general, patients appeared to be clean and appropriately dressed and looked cared for. 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. The following are examples of what we were told by patients or their relatives:

"Yeah. Is okay here." (The Oaks.)
"Basically it's ok as hospital wards go" (Silver Birches.)
"Nurses are ok." (Silver Birches.)
"I like it here"; and "The staff look out for us". (Cornwall Villa.)
"The care is fantastic. When I leave here I have no worries about how my husband is looked after." (Cornwall Villa.)
"I'm not really that happy, but I guess it is okay. I was previously on The Oaks. I really did not like it there." (Bay Tree House.)

When we visited the Oaks we attended the daily 'White Board' meeting, where a multidisciplinary team led by the ward consultant discussed each patient. We observed that appropriate discussion of each person's care plan and progress took place, including a discussion of each patient's medication, discharge plans, physical health and legal

status. We saw planners were being kept to ensure that patients received all the tests they required on the appropriate days.

At the time of the inspection The Oaks ward still had patients with functional and organic conditions. The Trust was in the process of moving to a model of single specialties on the wards.

When we visited Cornwall Villas ward we observed that patients had care plans in place describing their individual needs. We observed that most patients were wearing continence pads. When we looked at people's individual care records we found that patients had not received individual assessments regarding their need to wear these. Also when we looked at the records of how people had been supported to wash, it was not indicated whether it had been a bath, a shower or a strip wash.

Activities and staff interaction

During our inspection we saw staff interacting in a positive manner with patients on all the wards we visited. However, we also saw examples of poor interaction and that many patients were not engaged in activities throughout our inspection. We also found some examples of activities that were scheduled to take place that were not happening in practice.The lack of interaction between nursing staff and patients may mean that some people are not stimulated and supported through their inpatient stay.

During our inspection of Silver Birches we observed most staff to be caring on this ward. We saw examples of good interaction. For example, whilst we were observing patient interactions, a Music Therapist visited. She spent some time showing patients a "sound bowl" (an unusual musical instrument). We saw one patient engage and attempt to play the instrument and reminisced about its similarity to an African instrument that she knew.

However, we did see examples of poor interaction with patients. We saw one member of staff refer to a patient as "good girl." This infantile language was inappropriate. Staff were observed to remain with the care areas so that patients were not left unsupervised. However, we noted that at times there was minimal interaction between these staff and patients.

There were activity timetables up in each of the units however some of the activities which were written were not taking place for example, on the day we visited, the activity timetable indicated that 'spiritual activites' would be taking place but the nurses on duty told us that the priest who was scheduled to visit was not visiting. The activity timetable had not changed to take account of this.

During our time on Cornwall Villas we observed good interaction between staff and patients. For example, we observed a member of staff taking time to sit and comfort someone who had become distressed and begun shouting.

During our inspection of The Oaks we saw some examples of good interaction, although individual interaction between staff and patients was limited. In the afternoon we observed a music group taking place. Three patients were involved in this activity, although we noted that other patients on the ward were not being engaged in this activity. In general we saw limited interaction between patients and staff. We saw one Healthcare Assistant who took time to engage with each patient as they were doing there tea round. This was good. However, we also saw examples of staff sitting near patients without

interacting with them. We also observed one member of staff telling a patient that they had made a mess, which was inappropriate.

When we visited Bay Tree House we spoke with 10 patients. Most told us they found the access to activities to be good. One person explained they attended church on Sunday and they liked this. Another person told us they attended activities at a Day Centre run by the trust. During our inspection we saw people being accompanied for a walk in the community by a member of staff. A community meeting was undertaken during the afternoon of our inspection.

Support at meal times

During our inspection we observed the support patients received in eating their meals. We saw examples of good support, with staff taking time to sit and support patients. We also saw examples of where the organisation of meals did not meet the needs of the patients and where interaction was poor .

We observed lunch on one unit of Silver Birches ward. Patients had meals which were heated by microwave in each unit. We saw that patients were offered a choice by being shown the precooked meals in their packaging. As each meal had to be cooked individually in the microwave, this meant the process was slow and unwieldy. We saw patients were brought into the dining room individually to choose their meal and wait for it to be cooked. Patients were observed to wander off whilst waiting for their meal to be cooked. At one point we saw a member of staff pulling a patient into the dining room by their wrists. Another member of staff came and two of them walked the patient into the dining room. The staff then left the patient there and walked away. After sitting for 10 minutes with no one interacting with them, the person got up and left the room. One patient took a sandwich from a trolley while waiting for the meal they had chosen to be cooked. The arrangements for meals on Silver Birches meant that patients could not eat together at the same time, could not see the cooked food in order to make choices and caused confusion as patients were waiting for their meal to be served whilst watching other people eat their food.

When meals were served staff did not always explain to patients what they were. For example, one person was only told "that's for you" as a meal was put in front of them. Patients were not always offered a choice of drink.

On Cornwall Villa we saw three members of staff supporting patients in a 1:1 capacity. We saw that when patients required assistance with eating they received it.

We observed lunch on The Oaks. We saw examples of good support. We saw one member of staff engaging with patients in an excellent manner. They took time to sit with the person and assist them with their meal. However, we also noted that when a member of staff was going to give a person a banana, another member of staff loudly said that you should not give a diabetic patient a banana. This was inappropriate.

The ward manager was keeping a record of patients to ensure that all patients received there meal. Different colour trays were being used to highlight the level of support patients required with eating. We saw that patients who had requested Kosher meals were receiving these.

When we visited Bay Tree House we observed dinner. We saw that staff offered people a

choice of food and explained what it was. When patients required assistance with eating they were receiving this. When we asked patients on this ward whether they liked the food, most told us they did. They told us they were offered a choice. Some patients told us they would like more fresh fruit.

Mental Capacity

When we visited the wards last time we found that 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.

When we visited The Oaks ward this time we looked at the records for three patients. In these files appropriate capacity assessments had been completed and consideration had been made of patients' capacity in their care planning process. We saw that there was an understanding of the appropriate use of the Mental Capacity Act and this was reflected in the records we saw.

When we visited Silver Birches ward we looked at the records for seven patients. We saw that there were capacity assessments which had been recorded relating to peoples' capacity to manage their personal care needed and we saw some evidence that this was being monitored daily however it was not always necessary or appropriate for capacity decisions to be documented on a daily basis.

We did not see any capacity assessments or indication in the progress notes that consideration had been made about decisions which related to more significant factors such as peoples' capacity to consent to admission to hospital or to the treatment or medication which they were receiving. For example we saw progress notes which said "[patient] has no capacity to attend [their] self-hygiene. [They] get everything done for them". The provider may find it useful to note that, on the basis of the records we saw and the conversation we had with staff, we found that staff were not always assessing the capacity of patients to make decisions appropriately.

All the patients on Silver Birches at the time of our inspection, had been admitted to hospital informally and they were not detained under the Mental Health Act. No one was subject to an authorisation to deprive them of their liberty under the Deprivation of Liberty Safeguards (DoLs) We saw one record of a patient where a decision had been made to detain them under the Mental Health Act. The assessing practitioner had made the decision that they lacked capacity to consent to admission and met the criteria for formal admission and had recorded this however on their arrival on the Silver Birches, they were admitted as an 'informal' patient and the doctor wrote "agreed we would keep [patient] as an informal patient and if necessary use a DoLs". This indicates that there is a lack of understanding of the difference between the way that the Mental Capacity Act and the Mental Health Act are used in psychiatric inpatient settings and means that this person is at risk of being unlawfully deprived of their liberty without recourse to the protection provided in the Mental Health Act or the Mental Capacity Act and there is a risk that their rights under Article 5 of the Human Rights Act were breached. We informed the ward staff of this during our inspection. There was no record of a best interests decision being made in relation to this patient where people involved with their care, including their family were involved or the process by which they were able to remain on the ward 'informally'.

For another person who had been admitted to the ward under section 2 of the Mental Health Act, the decision made to take them off 'section' was recorded by stating "[patient]

clearly does not have capacity to make decisions regarding his care but equally does not need to be detained in hospital under the MHA. Therefore I have taken [them] off [their] section but [they] will remain in hospital for [their] best interests" We could find no record of a capacity assessment and best interests meeting in relation to this and how the criteria for admission had changed since they were admitted. It was not clear why this person was no longer being treated under the Mental Health Act (1983). This means that people who may not have the capacity to consent to admission or treatment and who needed treatment were not protected by legislative frameworks within the Mental Health Act or the Mental Capacity Act.

We spoke with staff and asked them what they would do if an informal patient wished to leave the ward. Some staff told us that people would be allowed to leave, but only with 1:1 support from staff as they were vulnerable. Whilst supporting a vulnerable person would be appropriate, staff should be aware that informal patients should be allowed to leave should they wish to if they are not formally detained or an application has not been made to deprive them of their liberty.

Patients on Silver Birches were at risk of being deprived of their liberty without the protection of legislation under the Mental Health Act or the Mental Capacity Act because staff were not aware of patients' rights for legal protection.

We checked the records on Cornwall Villas and Bay Tree House and found that people were assessed and treated appropriately with consideration of the Mental Capacity Act.

Blanket Restrictive Practices

When we inspected Cornwall Villas and Silver Birches we found that all the bedroom doors were locked from the outside. On both wards we were told that this was because patients could not remember which was their room and might wander into another person's room. On Silver Birches we saw the doors from the lounges to an enclosed garden were locked even though the weather was nice. These are examples of blanket restrictive practices that do not reflect individual patient's needs.

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 assessed the management of medicines on four wards, The Oaks, Silver Birches, Cornwall Villas and Bay Tree House, by reviewing people's medicines charts, seeing how medicines were prescribed, administered and stored, and speaking with staff and patients. Appropriate arrangements were in place in relation to obtaining medicines. Staff on the wards told us that the pharmacy department had an effective system in place so that newly prescribed medicines were obtained without delay and people did not have to wait to receive treatment. We saw that most of the medicines prescribed for people were held on the wards as stock items, to avoid delays in starting treatment.

Patients were prescribed and administered medicines safely. We saw evidence that when patients were admitted to the hospital, checks were made to ensure that they continued to get the medicines that they were taking at home. We saw that these medicines checks were carried out promptly once people had been admitted. We saw that prescribers were following prescribing guidelines and the Trusts medicines policy. On three wards, people's allergy information was obtained and recorded promptly. On one ward, this information was missing on a number of medicines charts, however staff told us that they had this information on older charts but had not transcribed it onto the latest chart.

Appropriate arrangements were in place in relation to the recording of medicines. We looked at medicines charts on four wards and saw that nursing staff had signed for medicines given, providing evidence that medicines had been given as prescribed. There were no gaps on charts, so it was clear when medicines had been given. If any doses of medicines had been omitted for any reason, staff made a note to explain why. Doctors had written out the prescription clearly, and additional information was added to medicines charts by pharmacy staff to further clarify the prescription and add supplementary information for staff such as when medicines needed to be taken in relation to food, to reduce the likelihood of side effects.

Medicines were safely administered. Staff told us that people were not allowed to self-administer any medicines because of their mental health needs, therefore staff administered all medicines. We observed staff giving people their medicines, and saw that this was done safely, with records completed at the time. We also saw that people were

prescribed medicines for their physical health needs and minor ailments, as well as for their mental health needs. When people required treatment under the Mental Health Act, the appropriate treatment consent forms were in place. We noted that on Bay Tree House, one person had been detained under the Mental Health Act; however the appropriate treatment consent form was not kept with the medicines chart. This meant that staff could not check that this person had been prescribed medicines that had been legally authorised. We discussed this with staff on the day of the inspection, and this was rectified straight away.

Medicines, including controlled drugs, were stored securely in locked cupboards and trolleys, and staff were monitoring the temperature of medicines storage areas and medicines fridges to ensure that medicines were being kept at the correct temperatures to remain fit for use. We noted that on one ward, the temperature of the medicines storage room should have been 25˚C or below, however records showed that the temperature had been over 25˚C on 21 out of 25 days in September 2013. We asked the ward manager to look into this. We also noted that on two wards, some oxygen cylinders were not stored securely, as they were leaned against a wall, which meant they were at risk of falling over.

Medicines were disposed of regularly on three of the four wards. On Bay Tree House, we found a number of expired medicines and oxygen cylinders, and also medicines which were no longer prescribed or were for people no longer on the ward. We discussed this with the Ward Manager, and they told us they would address this immediately.

Safety and suitability of premises ✖ Action needed

People should be cared for in safe and accessible surroundings that support their health and welfare

Our judgement

The provider was not meeting this standard.

People who use the service, staff and visitors were not protected against the risks of unsafe or unsuitable premises.

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

The environment of the wards varied significantly. We found that there was some refurbishment which had taken place and some of which was planned for the near future. There were some wards where we saw that issues relating to the physical environment and particularly items which had broken, were not being promptly repaired.

Silver Birches

Silver Birches Ward had 23 beds. It was split into three units, Emerald and Sapphire for male patients and Ruby for female patients. It is a continuing care ward which was in the process of changing to an admission and assessment ward for people with organic mental health needs.
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In general the environment of the ward looked worn. Signs had been removed from doors and the residual glue was still evident. A door knob had been removed from an entrance to Ruby area, leaving the rough wood under surface and screw holes unfilled or decorated.

Patients were able to move freely between the units. Each unit had a lounge with a doorway to the garden area. The garden is enclosed by hedging and we were told that patients were able to access the garden when the weather was good. There was fine weather on the day of inspection but the garden areas were not used and the doors from the lounge areas were locked.

In the lounges,the televisions were mounted flat against the wall in the corner, making themdifficult to be viewed comfortably from some parts of the lounge. On Ruby the television was broken. This meant that we observed some people who were looking at the space where the television had been. The staff put a radio in the lounge area. When we asked staff about when this was going to be fixed, we were told it had been broken for three weeks. In another lounge we saw a television, which people were watching but had no sound on. We asked someone watching the television if they wanted to hear the sound and they told us they did.

In the Sapphire wing a light was broken in the lounge. The assisted shower rooms were not in use.
In the Ruby wing there was a wheelchair stored in the toilet, directly between the toilet and waste bin so if anyone wanted to sit on the toilet seat they would need to move the wheelchair. This may have presented a risk of falls.

When we were shown into rooms we did not see any personal memorabilia about the patients' lives or memories. There were no names of people's doors to help people to understand and orientate themselves to their environment.

In general the ward was clinical in nature and lacked enhancements for patients with dementia to interact with, such as rummage boxes.

The Oaks

When we visited The Oaks last time we noted that in the lounge area all the chairs were pushed against the wall. When we visited this time, the lounge had been divided up into smaller seating groups, which encouraged greater interaction.

We also previously noted, the large physical size if the ward made it difficult to manage the client group. The trust now has plans to redevelop the ward to make it into two smaller spaces. The ward had already been reduced to 22 beds, although the night before the inspection one bed had been reopened in the night, meaning 23 were open.

Cornwall Villas

The ward had 23 beds. It was not specifically designed for people with dementia. We noted that none of the rooms had pictures or visual aids to help orientate people to their environment. .

Bay Tree House

Bay Tree House is located about a mile from the main hospital site in a quiet location. It has 23 beds. It is primarily a rehabilitation ward for older adults with functional mental health needs, although some continuing care patients are on the ward. In addition to the main lounge area, there were single sex spaces available so that women could choose whether to sit separately. When we spoke with people they told us they liked the ward, with the garden space being especially valued.

In the bathrooms emergency pull cords had been replaced by buttons. We were told that this was because they presented a ligature risk. However, not all cords had been removed so this risk was still present.

We noted that some of the bedrooms were decorated very sparsely. When we asked patients if they were allowed to personalise their rooms, they told us they were.

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

When we visited on 27 March 2013 we found that the Trust was meeting this standard, but we found there was a high level of sickness on the wards we visited. There were also a high number of temporary bank and agency staff being used. This meant that there was a risk that staff working may not always know the specific needs of the patients on the wards. When we visited in September 2013 we found that the Trust was actively recruiting staff but some areas still had high numbers of agency staff working.

During the inspection we noted staff were working a long day shift pattern, from seven in the morning until seven-thirty in the evening. When we spoke with staff most told us they found this very tiring and that towards the end of the day this made it difficult for them to do their job.

The Oaks

Since we last visited The Oaks, a dedicated ward consultant had been appointed to be responsible for all the patients during their time on the ward. Staff told us they felt this had been a positive step. When we visited we saw them undertaking a daily 'White Board Meeting' discussion of the patients on the ward.

On the day of our visit there were three qualified members of nursing staff and three healthcare assistants. Two were bank staff and two were from an agency. We were told that since the last inspection the ward had undertaken recruitment and that agency usage was reducing.

When we spoke with staff on the ward they told us that morale on the ward had previously been poor but they felt it was now improving.

Silver Birches

We were told that the establishment for the ward is designed to ensure that there is minimum staffing of three trained nurses and three healthcare assistants (HCAs) during the day and two trained nurses and two healthcare assistants during the night.

When we visited the ward, the ward manager, two qualified nurses and 10 HCAs were working. When we spoke with staff, they told us they felt this was adequate to meet the needs of the patients. In total seven of the staff were agency staff. There were four patients who were receiving 1:1 support. We were told that the ward was recruiting new staff and had interviews set up for the afternoon on the day of the inspection. When we spoke with a relative they told us , "A lot of agency staff have 'I don't care' attitudes and they are short of their own staff. Sometimes staff sit on their phones." There were high numbers of agency staff being used to meet the needs of patients. These staff may not know the needs of the patients as well as permanent staff do so there is a risk that people may not receive the care which they need.

The ward did not have a dedicated consultant.

Cornwall Villas

On the day of the inspection there were three members of qualified nursing staff and three healthcare assistants. One member of staff was dual general nursing and mental health nursing qualified, which meant they could provide skills in supporting people's general health needs. At night there are two qualified staff and two healthcare assistants

Staff told us they felt there were adequate staff to meet the needs of the patients and that if they needed extra staff for 1:1 observations they were able to get these.

The ward did not have a dedicated consultant. We were told that the consultant came for two out of four ward rounds a month. A junior doctor is on the ward daily.

Bay Tree House

On the day we visited the ward there were three qualified nurses and two healthcare assistants working, in addition to the ward manager. Two were Bank staff and one was from an agency. When we spoke with patients they told us they felt the staffing was adequate, although some expressed concern that at night there were only three members of staff.

The ward is supported by a consultant, who undertakes a weekly ward round, and a specialist registrar. When we asked the nursing staff about the medical cover the ward received, they said it was good.

The Service Manager for this ward was currently also covering the role of ward manager on The Oaks.

Assessing and monitoring the quality of service provision ✖ Action needed

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 not meeting this standard.

The provider did not have an effective system to regularly assess and monitor the quality of service that people receive.

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

When we visited the wards previously on 27 March 2013 we found that the Trust was failing to meet regulations 9 and 20. In response to this report the Trust produced a service improvement plan for The Oaks ward. When we visited we looked at the progress the Trust had made against this plan. In general, there was evidence of positive progress on The Oaks ward. The Trust was looking to change the model of care on the ward and change the environment. We saw there was a clear plan to achieve this. There was an aim to separate functional and organic provision and reduce the number of beds prior to rebuilding the ward. At the time of our visit, there was still a mix of patients on the ward, although the number of dementia assessment patients had been reduced and Silver Birches had begun to be used as an assessment ward. We saw that the action taken by the Trust to improve the Oaks had had a positive impact on the patients who were there.

The plan had outlined a need to train staff in particular behaviours which may be challenging to the service. We were told that the Trust had developed a programme of allowing one day every two months for staff development. Training sessions, including role play, had been designed to allow staff to work through how they would respond to situations. Training had also been provided on wound care and privacy and dignity.

The plan had identified the need to monitor people's physical health needs. When we visited we saw people were having regular monitoring as required. Their physical health needs were also discussed at the daily multi-disciplinary 'White Board Meetings'.

A need to increase the leadership on the ward had been identified. A dedicated consultant had been appointed to the ward. The service manager was currently acting as ward manager. Recruitment had taken place on the ward and the sickness rate had been reduced. Staff told us morale on the ward had improved.

We saw that the Trust was doing work to gather the views of patients' carers. In August 2013 a carers' survey was undertaken on The Oaks, to gather the opinions of carers to

people who were on the ward. The responses that had been received to this survey were generally positive. For example, one person had commented "[…] is settled and that is a relief to me." We saw that the answers to this survey had been analysed and themes had been identified which would drive further improvement.

There was evidence the Trust was monitoring its quality of service. In the week prior to our inspection, the Trust had undertaken an internal review of The Oaks to assess its progress. When we visited Cornwall Villa Ward we saw an example of a service peer review which had been undertaken on the ward. In this a non-ward member of staff had undertaken a review to look at the ward's compliance against the national minimum standards.

When we visited Silver Birches ward we were told there was a monthly improvement group away day where the ward manager/service manager meet and discuss service improvement. At the last meeting they discussed behaviours which may present as challenging to the service. Staff told us they felt this had led to improvements in how they managed situations which arose. All staff attend these groups where the first part is a meeting and second part is a practice development area.

Although we noted that the Trust has made good progress in addressing areas of concern we identified on The Oaks ward during our previous inspection, we also found similar issues to ones that had previously been identified on The Oaks in other wards. For example, in two of the wards we visited we found missing patient's records and some use and understanding of the Mental Capacity Act was not appropriate. In addition, we found on-going examples of poor staff interaction, activities planned but not taking place, arrangements for meals which did not meet the needs of the patients and examples of blanket restrictions. We also found poorly maintained environments and equipment that needed to be repaired. An effective quality assurance system would ensure that lessons learnt are implemented not only on the ward where the original concerns are identified but across other services in the Trust.

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 maintained.

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

When we visited on 27 March 2013 we found that the Trust was not meeting this standard. This was because people's personal records including medical records were not accurate and fit for purpose. When we visited The Oaks ward we had found not all patients care plans were being updated at least once monthly and that one person did not have a care plan at all.

When we visited The Oaks on 25 September, we looked at the records for three patients. In these we saw that the care plans had been updated regularly and that when risks had been identified appropriate strategies had been put in place to manage these. We did not see any gaps in the daily updates. We noted there had been an improvement in the notes on this ward since we last visited. We looked at the records for patients who had been subject to restraint on the ward. These had all been completed appropriately.

When we visited Silver Birches ward we looked at the records for seven patients. We found that for six of these patients there was at least one day in the previous month for which there was no daily notes. For one person there were five days for which no notes had been made.

We noted that in one person's file they had assaulted a fellow patient in early August. When we looked at this person's risk assessments it did not record their potential risk to other patients and had not been updated since 08 July 2013.

Another person's care plan had not been updated since 19 June 2013. When we looked at this plan it noted that a walking chart was required. When we asked staff why this had not been completed they told us it was no longer required as the person could not walk. The plan had not been updated to reflect this.

On Silver Birches ward we asked staff to show us hard copies of patient's care plans. We wanted to see these as we wanted to see examples of what agency staff could refer to when they were delivering care, as they did not have access to the RiO notes system.

The files we were shown did not contain care plans. This was a concern as the ward had seven members of agency staff on the day we visited who would not therefore have had access to the prescribed care guidance for their duties.

When we visited Bay Tree House we looked at the records for seven patients. For all of them there were multiple days on which there were no notes for the patients. For example, for two peoples there were six days in the previous month were there had been no daily notes recorded. For another person there were eighteen days in the month prior to our inspection where there had been no daily notes recorded. This included a consecutive period of five days where there were no daily records. This means that there was a risk that important information about people's nursing needs was not recorded and passed on to members of staff.

When we asked to see the records of a safeguarding alert that had been made, these were not available. We checked the records of one instance of restraint that had taken place. We saw that it was not recorded completely on the daily progress notes as the time and duration of the restraint was not indicated. We checked with the Trust and saw that this information had been recorded centrally however the audit of the records which we saw indicated that the time and duration of the restraint had been recorded and therefore the audit contained a false declaration. This means there is a risk that internal auditing may not be accurate.

One person had not had their risk assessment updated since 28 April 2013 and their last care plan was dated 01 December 2012. The notes for this person mention concerns about physical health needs symptoms, for which they had been referred to a consultant. There was nothing in their risk assessment which reflected these physical health concerns.

When we looked at the management of people's medications we noted that on two wards, a few peoples' care plans did not make reference to their medical conditions. For example, one person had hypertension and had been prescribed medicines to reduce their blood pressure; however there was no evidence that this person's blood pressure had been monitored since 10th June 2013. Staff told us that this person was refusing to have their blood pressure monitored. The records did not make this clear.

Although we found that the Trust had made improvements in the areas were we had raised concerns when we last visited, we found that in other wards personal records were not being completed at all times and that risk assessments were not always being updated as appropriate.

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
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 steps to ensure that each service user was protected against the risks of receiving care or treatment that was inappropriate or unsafe by not planning and delivering care and, where appropriate, treatment, in such a way to ensure the welfare and safety of the service user as the legal rights of someone who is experiencing the effect of being detained without a legal framework were not ensured and the use of blanket restrictions. (Regulation 9 (1) (b) (ii) of the Health and Social Care Act (2008 (Regulated Activities) Regulations 2010).
Regulated activities	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures	**Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010** **Safety and suitability of premises**
	How the regulation was not being met: The registered person had not ensured that service users and others having access to premises where a regulated activity is carried on are protected against the risks associated with unsafe or unsuitable premises by means of adequate maintenance and,

This section is primarily information for the provider

Nursing care Treatment of disease, disorder or injury	where applicable, the proper operation of the premises as there were some items which were stored in toilets and bathrooms to which people had access and may be trip hazards and items which were identified to us as ligature risks had not been removed. (Regulation 15 (1) (c) (i) of the Health and Social Care Act 2008 (Regulated Activies) Regulations 2010)
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 10 HSCA 2008 (Regulated Activities) Regulations 2010** **Assessing and monitoring the quality of service provision**
	How the regulation was not being met: The registered person had not protected service users and others who may be at risk, against the risks of inappropriate or unsafe care and treatment by means of the effective operation of systems designed to enable the registered person to identify, assess and manage risks relating to the health, welfare and safety of service users and others who may be at risk from the carrying on of the regulated activity as risks which had been identified previously had not been addressed across the service. (Regulation 10 (1) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010).
Regulated activities	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Nursing care Treatment of	**Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010** **Records**
	How the regulation was not being met: The registered person had not ensured that patients were protected against the risks of unsafe or inappropriate care or treatment arising from the lack of proper information about them by means of maintaining accurate records which should include appropriate information and documents in relation to the care and treatment provided to each service user as there were gaps

This section is primarily information for the provider

disease, disorder or injury	in the daily records and some information recorded was out of date. (Regulation 20 (1) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010).

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 19 December 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

13 Dec
10am

Putting the Community First

London Borough
of Barnet

Councillor Helena Hart
Cabinet Member for Public Health

North London Business Park,
Oakleigh Road South,
London,
N11 1NP.
cllr.h.hart@barnet.gov.uk

6th December 2013

Dr Alpesh Patel
Chairman of Enfield CCG
Holbrook House,
Cockfosters Road,
Barnet,
EN4 0DR.

Dear Dr Patel,

I am writing to you as the service commissioner of the Barnet, Enfield and Haringey Mental Health NHS Trust to express my utter dismay at the findings of the latest published Care Quality Commission Report into the mental health services provided at the Chase Farm Hospital site in Enfield.

Vulnerable residents of Barnet rely upon these services, so to learn that actions are still required to meet the minimum requirements in 4 out of the 6 essential standards of quality and safety is a cause for major concern. The fact that the four areas in question i.e. the care and welfare of service users, assessing and monitoring the quality of service provision, the safety and suitability of premises and the maintenance of medical records are so critical in providing care to such disadvantaged people lends yet further urgency to ensuring a speedy resolution to this quite unacceptable situation.

I have to say I was truly appalled to see that most patients on one ward were forced to wear incontinence pads despite the fact that there were no individual assessments regarding their necessity. Further accounts of patients being pulled by their wrists, or being left unattended in the dining area suggest serious failings in the decency of care and quite frankly reminded me of the horrendous situation that had been allowed to develop at Winterbourne View.

Since Winterbourne View so much has been said and written about the quality of care that patients receive that our expectations are rightly that situations such as those referred to should simply not be allowed to occur.

I look forward to learning how the issues raised by the CQC's Report are to be urgently addressed and expect, in my capacity as Cabinet Member for Public Health in Barnet, to be kept fully updated henceforth.

Yours sincerely,

Helena Hart.

Cllr Helena Hart

(Cabinet Member for Public Health, London Borough of Barnet)

Cc:
Michael Fox – Chairman, BEH Mental Health NHS Trust
Dr. Debbie Frost – Chair, Barnet CCG
Dr. Anne Rainsberry – Regional Director (London), NHS England
Cllr Richard Cornelius – Leader, London Borough of Barnet
Cllr Doug Taylor – Leader, London Borough of Enfield
Cllr Claire Kober – Leader, London Borough of Haringey

Barnet, Enfield and Haringey NHS
Mental Health NHS Trust

Trust Headquarters
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Tel: 020 8442 5849
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Councillor Helena Hart
Cabinet Member for Public Health
London Borough of Barnet

By e-mail

13 December 2013

Dear Cllr Hart

I am writing in response to your letter of 6 December 2013, which my office received on 11 December. Your letter raised concerns following the recent Care Quality Commission (CQC) report about the Trust's older people's mental health services based on the Chase Farm Hospital site in Enfield.

I wanted to write to provide assurance on the steps that are being taken to address the issues raised by the CQC. However, I also felt it important to write to express my concern about aspects of your letter, which I am sorry to say I found inaccurate and unhelpful.

As you know, the CQC visited our older people's mental health services based on the Chase Farm Hospital site and identified a number of issues that need to be addressed. I can personally assure you that the Trust Board is very sighted on these issues and is taking them very seriously. An action plan has been developed, which has been shared with our local Clinical Commissioning Groups and the NHS Trust Development Authority in London. There is absolutely no complacency about any of the issues the CQC have raised; they are being addressed at high level by the Trust's Medical Director and Director of Nursing, Quality and Governance.

It is very important however, to understand this report in context. Your letter has been selective in the issues it focused on and, frankly, portrays an inaccurate view of these key services. In particular, it is very inappropriate to compare our services for older people with the situation at Winterbourne View. I find the comparison of our older people's services with the situation at Winterbourne View completely unacceptable. The CQC's report raises a number of important issues, which are being addressed, however, it does not portray "serious failings in the decency of care" or anything approaching this.

Rather than responding in detail to your points in writing, I think it would be beneficial to arrange to meet face to face, along with my Chief Executive, Medical Director and Director of Nursing, Quality and Governance, so that we can explain the nature of the services being referred to, set out the context of the comments made in the CQC report and detail the actions underway to address the issues identified by the CQC. I am very keen to do this as a matter of urgency, as I feel that your letter has inaccurately portrayed the current situation and raised anxieties about these services which are not warranted.

I will also be forwarding a copy of your letter to the CQC as I am sure that they will be concerned that the measured and constructive report they produced on these services has been misinterpreted in such an unhelpful way and has been publicised widely without understanding the detailed context and the actions the Trust already has underway.

My office will be in contact with your office very soon to arrange a meeting as quickly as possible. I want to ensure that you are appropriately briefed and understand the actual situation so that patents, carers, the public, commissioners and other stakeholders are not inappropriately misinformed about these services.

Yours sincerely

Michael Fox
Chairman

CC:
Dr Alpesh Patel – Chair, Enfield CCG
Dr Debbie Frost – Chair, Barnet CCG
Dr Anne Rainsberry – Regional Director (London), NHS England
Cllr Richard Cornelius – Leader, London Borough of Barnet
Cllr Doug Taylor – Leader, London Borough of Enfield
Cllr Claire Kober – Leader, London Borough of Haringey

ENFIELD Council

Dr Alpesh Patel
Chairman, Enfield CCG
Holbrook House
Cockfosters Road
Barnet
EN4 0DR

Please reply to : Mike Ahuja
Head of Corporate Scrutiny & Outreach
1st Floor, Civic Centre

E-mail : mike.ahuja@enfield.gov.uk

Phone : 0208 379 5044
My Ref :
Your Ref :
Date : 17 December 2013

Dear Dr Patel,

Barnet, Enfield and Haringey Mental Health NHS Trust – Care Quality Commission Report

I write to you further to the publication of the Care Quality Commission's Report into the mental health services provided at the Chase Farm Hospital site.

Whilst the improvements that have been made since the previous inspection in March are welcomed and some examples of excellent care provision have been cited, it is disappointing to read that a number of standards were not met (four out of six) and that the apparent lack of an effective quality assurance system has resulted in improvements in one ward not being robustly applied across all wards.

It is also of concern to note that there were examples of a lack of understanding of the way the Mental Health Act and Mental Capacity Act are used in psychiatric inpatient settings, poorly planned mealtimes, incomplete capacity assessments, patient records and risk assessments and poor staff interaction.

As Chair of the Health and Wellbeing Scrutiny Panel in Enfield, I am concerned about the future provision of mental health services in Enfield. Services appear

James Rolfe
Director of Finance, Resources and Customer Services
Enfield Council
Civic Centre, Silver Street
Enfield EN1 3XY

Phone: 020 8379 1000
Website: www.enfield.gov.uk

to be at breaking point and demand currently far outweighs the level of resources available. I look forward to hearing how the CCG intends to assure itself, therefore, that the issues raised in the CQC Report are being addressed and that the required standards of care will continue to be delivered at the Chase Farm site.

I hope you will agree that, as commissioners, such measures are critical to ensure that some of the Borough's most vulnerable residents receive the quality of care they deserve.

I look forward to your response.

Yours sincerely

Councillor Alev Cazimoglu
Chair of the Health and Wellbeing Scrutiny Panel

c.c.
Liz Wise - Chief Officer, Enfield CCG
Michael Fox – Chair, Barnet Enfield and Haringey Mental Health NHS Trust
Maria Kane – Chief Executive, Barnet Enfield and Haringey Mental Health NHS Trust
Cllr Doug Taylor – Leader, London Borough of Enfield
Cllr Richard Cornelius – Leader, London Borough of Barnet
Cllr Claire Kober - Leader, London Borough of Haringey
Rob Leak – Chief Executive, London Borough of Enfield
Ray James – Director of Health, Housing and Adult Social Care, London Borough of Enfield

NHS
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Clinical Commissioning Group

Holbrook House
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17 December 2013

Councillor Alev Cazimoglu
Chair of the Health & Wellbeing Scrutiny Panel
Enfield Council
Civic Centre
Silver Street
Enfield
EN1 3XY

Dear Councillor Cazimoglu

Re: CQC Report into Mental Health Services at Chase Farm

Thank you for your letter dated 17 December 2013 regarding the above. Firstly can I assure you of our concern following publication of the Care Quality Commission (CQC) report in November 2013.

The matter was raised formally with Barnet, Enfield and Haringey Mental Health Trust at our Clinical Quality Review Meeting held with them on 14 November 2013. We were given assurances by the Trust that they had put in place mechanisms to replicate the much improved clinical practice on the Oaks Unit, as highlighted in the CQC Inspection Report, at the other Units - Cornwall Villas, Silver Birches and Bay Tree House.

The background to this matter involved concerns raised in a previous CQC report relating solely to the Oaks Unit. In response to this report commissioners and the Trust developed a joint improvement plan, which is monitored at a regular meeting involving commissioners as well as managers and clinicians from the Trust. As you will have seen from the CQC Report published in November it is now accepted that there have been significant improvements in the quality of service in the Oaks Unit, and attention therefore needs to be turned to the other 3 units.

We have agreed with the Trust that the remit of the regular Improvement Meeting for the Oaks will be extended to cover these other facilities. The first meeting of this group will take place on 18 December. An improvement plan will be developed and its implementation rigorously and regularly monitored.

I attach for your information a paper on the Oaks which was discussed at Enfield CCG's Governing Body meeting in September 2013. This enabled the CCG to be assured on improvements in practice in advance of the CQC inspection in September 2013. We will now follow a similar process with regard to other units.

As you are aware, Enfield CCG has a strategic commitment to re-providing these services in fit for purpose community facilities. These plans would leave a smaller Dementia Assessment and Treatment Service on the Chase Farm site, for those unable to be supported in the community, such as those requiring detention under mental health legislation. We are currently in the process of drawing up the service specification and business case to take this initiative forward. I will ensure that you are kept fully informed with regard to these developments.

Yours sincerely,

Dr Alpesh Patel
Chair
Enfield Clinical Commissioning Group

Copy: Michael Fox, Chair, Barnet, Enfield & Haringey MHT
Maria Kane, Chief Executive, Barnet, Enfield & Haringey MHT
Cllr Richard Cornelius, Leader, London Borough of Barnet
Cllr Doug Taylor, Leader, London Borough of Enfield
Cllr Claire Kober, Leader, London Borough of Haringey
Rob Leak, Chief Executive, London Borough of Enfield
Ray James, Director of Health, Housing and Adult Social Care, LBE
Liz Wise, Chief Officer, Enfield CCG

Enfield Clinical Commissioning Group

Agenda Item:

Paper Ref:

MEETING:	**NHS Enfield Clinical Commissioning Group Governing Body**
DATE:	
TITLE:	**Quality assurance deficits regarding the Oaks Ward**
LEAD BOARD MEMBER:	**Aimee Fairbairns, Director of Service Quality and Integrated Governance**
AUTHOR:	**Ian Kent**
CONTACT DETAILS:	**Aimee.fairbairnes@enfieldccg.nhs.uk** **Ian.kent@enfieldccg.nhs.uk**

SUMMARY:

This report provides an update and assurance to the Governing Body on progress in relation to concerns raised on the Oaks Ward at BEHMHT.

The Oaks Ward is a 25 bedded mixed sex assessment and treatment Ward for patients over the age of 65 with mental health problems, depression, psychotic illness, behaviours that challenge or dementia, located on the Chase Farm Hospital site.
The ward admits patients from Barnet, Enfield and Haringey.
The attached Briefing Paper summarises the nature of the concerns regarding the Unit, details the process for gaining Assurance and outlines the next steps.

SUPPORTING PAPERS:

- **Terms of reference Oaks Operational/Commissioner Task and Finish Group**
- **Final Report of the Independent Review into the Care Provided by the Oaks Chase Farm Hospital June 2013.**
- **Meeting Minutes BEHMHT Clinical Quality Review Group (CQRG).**
- **CQC Inspection Report 27th March 2013, published May 2013**
- **Safeguarding Adults Risk management Plan, published 12th July 2013**
- **Oaks Operational Task and Finish Group meeting minutes**
- **Provider Concerns meeting minutes**
- **Report on pathway visits to the Oaks**
- **Safeguarding Adults: The Oaks Priority Risk Management Plan**
- **Barnet, Enfield and Haringey Mental Health Trust Oaks Ward Improvement Plan**
- **Summary Communications Plan.**
- **Oaks Integrated Improvement Plan (TFG LBE BEHMHT).**

RECOMMENDED ACTION:

The Governing Body are asked to note and discuss the report

Objective(s) / Plans supported by this paper: The key objective is to Commission safe and clinically effective services.

Patient & Public Involvement (PPI): Provider Concerns forum regularly discusses Quality and Safety issues at its meetings and these were represented at the Task and Finish Group by Enfield Mental Health Commissioner.

Equality Impact Analysis: N/A

Risks: All Risks were identified in the Improvement Plan and RAG rated, all of these are now rated amber or green and regularly monitored at the Task and Finish Group.

Resource Implications: None identified

Audit Trail: The Oaks Integrated Improvement Plan has been discussed at the BEHMHT CQRG, Q&RSG LBE Provider Concerns Meeting.

Next Steps:

The Task and Finish Group will continue to meet until the end of October 2013, and will discuss how to embed and sustain improved practice to ensure continued assurance, before handing back the Assurance Process to the CQRG.

Walk the Pathway visits to be repeated quarterly with a focus on record keeping, physical health assessments, clinical leadership, patient engagement and the environment.

Training Workshops have begun with the involvement of the Enfield CCG Quality Lead, these will cover Record Keeping, Physical Health Assessments, Mental Capacity Act, Care Planning, Risk Assessment and Dignity in Care.

Carers assessments and ward based surveys of patients, carers and friends to monitor users views of the quality of care provided.

BEH has earmarked capital funds to generally upgrade the ward and improve the layout. This work will commence in October 2013.

A CQUIN target will be developed for the 2014/15 Contract relating to effective Care Planning with payment dependent on demonstrable evidence of patient and carer involvement, short and long term goals which are measurable and are underpinned by the Recovery Model.

IK 12/09/2013

NHS
Enfield
Clinical Commissioning Group

THE OAKS UNIT

BRIEFING PAPER

1. Background

The OAKs ward is a 25 bedded acute inpatient unit that provides assessment and treatment of older people with functional and organic disorders for the residents of Barnet, Enfield and Haringey. The patients have a range of physical and mental health needs, and are subject to provisions of the Mental Health Act and Mental Capacity Act

Concerns about the quality and safety of the service were triggered by a number of safeguarding alerts between July and December 2012 and general care and welfare concerns raised by the CQC, all had similar themes relating to dignity and safety in the care provided. In detail these were as follows:

- The mix of patients with functional illness and dementia
- The number of beds on the unit
- Low numbers of permanent staff and over reliance on bank or agency staff
- Absence of a dedicated clinical leader
- Low staff morale and high absence
- Recruitment and retention problems
- Concern about staff supervision and induction arrangements
- Poor quality of record keeping
- Inadequate implementation of some key operational policies
- Poor engagement with families, carers and quality of activities available

In response the Trust convened a meeting with a range of external stakeholders, managers and clinicians in February 2013 to discuss these matters and try to agree a way forward. It was agreed that a detailed action plan was required but that the issue of the size of the ward and the mix of patients were key to making sustainable improvements.

These changes would have a potentially significant impact for the Trust in both managing demand and the internal management process of this vulnerable patient group. It was therefore agreed in the first instance that the Trust would seek how to address these matters internally and come back to Commissioners with a proposal to discuss.

2. Recent Developments

The Trust attended the Tri Borough Commissioner meeting in June 2013 and presented a proposal which essentially did reduce the size of the ward and ended the practice of mixing

patients with functional and organic illnesses. Some issues relating to demand management and financial transparency were raised but essentially the proposal was approved and it was agreed to establish a Project Group to oversee the process and the improvement plan relating to all the other matters that had been raised outlined earlier in this report.

Following this agreement quality and safeguarding concerns continued to be raised and these culminated in a conference call on the 4th July 2013, this call included commissioners, The Trust and Local Authority representatives. During this call it was confirmed that the Trust was taking steps to temporarily suspend admissions from the following week to enable them to effectively implement the Improvement Plan. A number of other actions were agreed including expediting a number of assurance visits to the unit and be incorporated into the plan.

It was subsequently agreed that a Task and Finish Provider and Commissioner Group would be established, meeting initially weekly to oversee the implementation of the Improvement Plan, this meeting was first convened on the 10th July 2013.

3. Current Position

At the meeting on the 10th July 2013 the Improvement Plan and suspension of admissions were discussed, and it was agreed this could only take place when either suitable alternatives for admission had been found and/or the Trust had created additional capacity internally. In addition a number of critical matters in the action plan were highlighted which would require significant progress to either avoid suspending admissions or lifting suspension if it occurred. These were as follows:

- To determine and agree clinical leadership and responsibility for the unit
- Appoint a dedicated full time psychiatrist
- Appoint an additional Band 6 Charge nurse position RGN/RMN
- Undertake a skill mix review
- Implement revised clinical review processes
- Ensure care plans, risk assessment etc. are delivered within the standards outlined in the Clinical Practice Alerts.
- Carry out a review of the physical health needs of patients on the unit.
- Regular audits to ensure that safeguarding procedures are followed.
- Ensure that restraint guidelines are being followed within established protocols.
- Implement the falls protocol.

It was agreed that the suspension of admission would proceed on the 31st July 2013 contingent upon the rate of progress in these key areas and the identification of suitable alternatives for admission.
The meeting on 31st July 2013 discussed only these key matters and was assured that significant progress was being made. In addition the Trust reported that it had been unable to source any local alternatives for this patient group ,which would entail significant travelling to unknown units, raising the possibility of similar quality and safety concerns. In light of these two developments it was agreed not to suspend admissions to the unit.

4. Next steps

The Task and Finish Group has continued to meet, recently moved to a fortnightly basis and at its most recent meeting on the 28th August all of the actions in the Improvement Plan are rated green or amber. In addition the numbers of beds on the unit has been reduced by 2 with the expectation of a further reduction of one bed per month and Silver Birches ward has opened as the dementia assessment unit giving the flexibility to gradually end the mix of patients on the Oaks, i.e. the two key actions agreed at the stakeholders meeting in February and approved by Commissioners in June, had been achieved.

Furthermore a number of external assurance visits agreed during the Conference Call have been undertaken which have not raised major issues questioning the continued functioning of the unit.

The Task and Finish Groups next meeting is on the 18th September 2013 to review progress and then agree at the end of October to review the actions with the longest timelines. At this meeting the issue of sustainability and embedding improved practices will be highlighted before handing back oversight to the Clinical Quality Review Group.

Ian Kent
30/8/13

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Barnet, Enfield and Haringey NHS
Mental Health NHS Trust

23 December 2013

Trust Headquarters
St Ann's Hospital
St Ann's Road
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Email: maria.kane@beh-mht.nhs.uk

Councillor Alev Cazimoglu
Chair of Health and Wellbeing Panel
London Borough of Enfield

By e-mail

Dear Alev

Response re Care Quality Commission Report on older people's mental health services on the Chase Farm Hospital site

I am writing in response to your letter of 17 December 2013 to Alpesh Patel about the Care Quality Commission's (CQC) recent report on the Trust's older people's mental health services on the Chase Farm Hospital site.

As you know, the CQC's recent visit to The Oaks Ward for older people confirmed that the intensive work the Trust has done on the ward has fully addressed the issues they had raised previously. They also visited the Trust's other older people's units and identified a number of other issues which need to be addressed.

I can personally assure you that the Trust is very focused on resolving these issues and takes this feedback very seriously. An action plan has been developed, which has been shared with the local Clinical Commissioning Groups and the NHS Trust Development Authority.

I do think it is important, however, to understand the CQC's report in context. You may have seen the recent letter from Cllr Helena Hart, Cabinet Member for Public Health at the London Borough of Barnet. Cllr Hart's letter portrays an inaccurate view of our older people's services and our Chairman has written to her to emphasise that her letter takes the CQC's comments out of context and presents a biased picture of our services.

The CQC's report gives a series of measured and constructive comments about action required, which the Trust is now focusing on. However, Cllr Hart's letter misinterpreted the CQC's comments in an unhelpful way. We are therefore arranging to meet with her directly as soon as possible to ensure that she is appropriately briefed and understands the actual situation so that patents, carers, the public, commissioners and other stakeholders are not inappropriately misinformed about these services.

I am very keen to make sure that you are also fully briefed on the situation and to that end I am sure it would be useful for us to arrange to meet in the New Year. I would welcome the opportunity to brief you further on the specific issues in our older people's units and also on the wider situation across all our services, which, as you are fully aware, are currently under significant pressure with increased activity levels and reduced funding in real terms.

I appreciate your continued interest in all our services and your desire to seek to improve our services further for the benefit of Enfield patients. I look forward to catching up with you in the New Year.

With best wishes for a great Christmas.

Yours sincerely

Maria Kane
Chief Executive

CC:
Dr Alpesh Patel – Chair, Enfield CCG
Liz Wise – Chief Officer, Enfield CCG
Cllr Doug Taylor – Leader, London Borough of Enfield
Cllr Richard Cornelius – Leader, London Borough of Barnet
Cllr Claire Kober – Leader, London Borough of Haringey
Rob Leak – Chief Executive, London Borough of Enfield
Ray James - Director of Health, Housing and Adult Social Care, London Borough of Enfield

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

Dementia & Cognitive Impairment

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

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 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

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

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.

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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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