Barnet, Enfield and Haringey Mental Health NHS Trust

Quality Report

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Core services inspected	CQC registered location	CQC location ID
Acute wards for adults of working age and psychiatric intensive care units	Chase Farm Hospital Edgware General Hospital St Ann's Hospital	RRP16 RRP23 RRP46
Forensic inpatient wards	Chase Farm Hospital	RRP16
Child and adolescent mental health wards	Edgware General Hospital	RRP23
Wards for older people with mental health problems	Chase Farm Hospital Barnet General Hospital	RRP16 RRP01
Mental health crisis services and health-based places of safety	Chase Farm Hospital St Ann's Hospital Trust HQ	RRP16 RRP46 RRPXX
Community based mental health services for adults of working age	Trust HQ	RRPX
Community based mental health services for older people	Trust HQ	RRPX
Specialist community mental health services for children and young people	Trust HQ	RRPX
Community health services for children, young people and families	Trust HQ	RRPX

Summary of findings

Community health services for adults	Trust HQ	RRPX
Community health inpatient services	Magnolia Unit	RRPX1

This report describes our judgement of the quality of care at this provider. It is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from people who use services, the public and other organisations.

Summary of findings

Ratings

We are introducing ratings as an important element of our new approach to inspection and regulation. Our ratings will always be based on a combination of what we find at inspection, what people tell us, our Intelligent Monitoring data and local information from the provider and other organisations. We will award them on a four-point scale: outstanding; good; requires improvement; or inadequate.

Overall rating for services at this Provider	Requires improvement 
Are Mental Health Services safe?	**Requires improvement** 
Are Mental Health Services effective?	**Requires improvement** 
Are Mental Health Services caring?	**Good** 
Are Mental Health Services responsive?	**Requires improvement** 
Are Mental Health Services well-led?	**Requires improvement** 

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

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

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

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

Summary of findings

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Overall summary

We have given an overall rating to Barnet, Enfield and Haringey Mental Health NHS Trust of **requires improvement.**

We have rated five of the eleven core services that we inspected as requires improvement, five as good and the forensic services as outstanding. The services that require improvement are the acute mental health admission wards for adults, the community based mental health services (mainly the community recovery teams), the child and adolescent mental health ward the Beacon Centre, the specialist community mental health services for children and young people and crisis mental health services which include the home treatment teams. The Enfield community services had an overall rating of good.

At the start of the inspection, the chief executive of the trust gave a presentation about the areas they were proud of and the challenges faced by the trust. Our inspection findings reflected most of the priorities identified by the trust. This demonstrated that the senior trust managers had identified many of the problems that they needed to address. However, we believe that there is still a great deal to do for services to be a consistently high standard. We found that these challenges are greater in the borough of Haringey where more improvements are needed. We have also concluded that at St Ann's the physical environment of the three inpatient mental health wards is not fit for purpose due to it's age and layout. This impacts on the trusts ability to deliver safe services within this environment.

The main areas for improvement were as follows:

- The trust had a substantial problem with staff recruitment and there was a high use of temporary staff that was impacting on the consistency of care. There were too few regular staff to consistently guarantee safety and quality in the acute mental health wards, the child and adolescent ward and in the Enfield health visiting services. There were staffing problems in some other areas but these are not as severe.
- A significant number of new or interim managers provided important support roles or directly led teams providing care. Permanent managers with strong leadership skills were needed to improve and sustain standards of care.
- The management of risk was very variable across the mental health services. In some cases this was because staff had not considered individual risk or updated records following specific incidents. Sometimes the record keeping needed to improve. This meant that there was a possibility of staff not safely supporting patients with their individual risks.
- The trust did not operate lone working arrangements robustly in some of the community mental health services. Staff safety was potentially compromised.
- Patients had absconded from mental health inpatient wards whilst detained under the Mental Health Act. These incidents and the learning from them were not being addressed.
- Staff in acute mental health inpatient wards did not always recognise when a patient's physical health was deteriorating and ensure they received timely input.
- The trusts communication with primary care needed to improve, not only when patients were being discharged from inpatient services, but also throughout their ongoing care and treatment.
- The telephones and IT systems did not support effective working by staff in the community. Whilst the trust was working on this there was more to be done.

Despite these problems there was much for the trust to be proud of. The senior executive team were committed to improving services and to providing a high standard of care for patients receiving treatment from the trust. Staff working for the trust valued the leadership provided by the senior team, especially the chief executive.

The main areas which were positive were as follows:

- Most of the staff we met were very caring, professional and worked tirelessly to support the patients using the services provided by the trust.
- The trust was continuously looking at how the patients using their services could be supported with their 'enablement' and new projects with other external providers were happening.

Summary of findings

- The trust had improved the arrangements for patients to access the Enfield community health services.
- The trust was working to reduce the use of physical interventions. The use of restraint was low and on the forensic wards they made good use of relational security to minimise the use of restraint and seclusion.
- Staff had access to a wide range of opportunities for learning and development, which was helping many staff to make progress with their career whilst also improving the care they delivered to people using the services.
- Staff morale was good and most staff said how much they enjoyed working for the trust.
- Staff felt able to raise concerns and most had done so where needed.
- The trust had a robust governance process that identified areas of concern and monitored progress in addressing these matters.

The trust had recently introduced a new management structure for services based on borough lines and this was well received. There was ongoing work to improve patient, carer and staff engagement in the work of the trust. These and the many other positive developments need time to consolidate.

We will be working with the trust to agree an action plan to assist them in improving the standards of care and treatment.

Summary of findings

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

We always ask the following five questions of the services.

Are services safe?

Requires improvement

We rated safe as **requires improvement** for the following reasons:

In acute wards for adults of working age we found:

- The location of seclusion rooms meant that patients safety, privacy and dignity could be compromised.
- Individual risk assessments were not detailed, did not include all risks and were not updated following incidents.
- Clinic rooms at St Ann's did not always provide a safe environment for medicine storage and administration, medical equipment needed cleaning and on Downhills ward medical emergency equipment could not be reached easily in an emergency.
- The ward layouts at Chase Farm and St Ann's had blind spots on bedroom corridors that could be improved through the use of mirrors.
- The wards did not always have enough staff and used a lot of agency staff. On some wards leave was cancelled or postponed. At St Ann's there was a high level of violence and aggression on Downhills ward.
- Ward ligature risk assessments did not include information on actions taken to mitigate risks, dates for work completion and the responsible person.
- Patients were absconding from inpatient wards and whilst individual risk assessments were in place a clear action plan to reduce the overall numbers of absconsions had not been developed.
- The use of rapid tranquillization was not always recognised to ensure patients received the appropriate health checks afterwards.
- Some staff did not always learn from incidents that happened on the wards and across the trust.

In the child and adolescent mental health ward we found:

- There was a high staff vacancy rate and turnover of staff. As a consequence there was high use of bank and agency staff, many had not worked on the unit before. The impact on patient care was clear. Leave was cancelled and young people complained that they did not know who their named nurse was.
- There was often not enough staff working on each shift. Prior to the inspection the average fill rate for each shift on the ward was 91%.

Summary of findings

In the community based mental health services for adults of working age we found:

- Interview rooms were not all fitted with alarms and in some CSRTs there were insufficient personal alarms for staff to access when using these rooms.
- Staff were not all following lone working protocols. Trust mobile phones did not always work, which meant that staff were relying upon personal phones to check back in with base.
- There were examples of poor medication storage, medication being transported unsafely and staff not taking with medication administration cards when administering medication in peoples' homes.
- The Haringey CSRT's clinic room was small and unsafe.
- Haringey East CSRT cover arrangements meant that care co-ordinator caseloads could unexpectedly double and were not safe.
- CSRTS had not always updated risk assessments. Staff did not always monitor risks for patients on the waiting list for the service.

In the mental health crisis services and health based places of safety we found:

- The lone-working policy was not robust across the teams.
- The documentation of risk assessments and risk management plans on patient electronic records lacked sufficient detail across the three sites.
- Team caseloads were high across all teams.
- In Enfield and Haringey, less than 50% of staff were up-to-date with mandatory training in adult basic life support.

In specialist community mental health services for children and young people we found:

- Services did not have a formal system for regularly monitoring people on the waiting list to detect an increase in the level of risk.
- Staff were not following the lone working policy as well as they should be.
- Not all incidents that should have been reported were being reported. Staff did not receive feedback from incidents and complaints as a group.

In the community health services for children, young people and families we found:

- Health visitors were carrying higher a higher than recommended case load per health visitor. Unfilled shifts due to sickness, absence and vacancies were often not covered by

Summary of findings

bank or agency staff. The trust was not able to deliver all aspects of the 'healthy child programme'. They delivered 3 of the 5 mandated contacts. The ante-natal contact and 8-12 month review were targeted at the high risk patients.

However, most staff knew how to report incidents and there were changes taking place in response to the learning from incidents. The safeguarding arrangements provided support to staff to receive training and make alerts where needed. Medication was mainly well managed and provided support to patients and staff.

Are services effective?

Requires improvement

We rated effective as **requires improvement** for the following reasons:

In acute wards for adults of working age we found:

- Patients' care plans were not individualised or outcome and recovery focused and did not document patients' involvement with their care.
- All staff did not receive regular supervision.
- Most staff said they had not completed any MHA or MCA training. Staff's understanding of the MCA varied on the wards.
- Staff had not ensured that patients knew and understood their rights under the MHA. This was sometimes caused by delays with interpreters.
- The wards were not always accessing psychology input. There was no psychology available on Avon ward and some wards experienced a long waiting list.
- Staff on did not always score patients' MEWS charts which meant that physical health concerns may not always be raised or addressed.

In the child and adolescent mental health ward we found:

- Staff supervision records were very poor, and no nurse had a recorded supervision more than three times throughout 2015.
- Most of the young people on the ward were informal. The arrangements for their leave was agreed on an individual basis. However the sign on the ward entrance for informal patients did not accurately reflect their rights.
- Records of assessments of consent to treatment had been completed without any detail as to the rationale for the decision and there was no clear indication as to who had parental responsibility for the young person.

In the community based mental health services for adults of working age we found:

Summary of findings

- There were no systems in place to identify patients who were prescribed high dose anti-psychotics to ensure that the specific health checks these patients may require were undertaken.
- Staff referred patients to GPs for physical health checks. We found that staff did not follow up results with GPs. Teams had not developed links with the GP practices within their patch and did not always feedback to GPs the outcome of care programme approach reviews.

However, the trust was carrying out a range of audits to monitor and improve standards of care. Staff felt well supported and able to access a range of training to develop their skills. There were many good examples of multi-disciplinary team working and of teams working with external agencies to meet the needs of patients. The Mental Health Act was well managed within the trust.

Are services caring?

Good

We rated caring as **good** for the following reasons:

- Staff were enthusiastic, passionate and demonstrated a clear commitment to their work. Care was delivered by hard-working, caring and compassionate staff.
- People and where appropriate their carers, were usually involved in decisions about their care.
- Opportunities were available for people to be involved in decisions about their services and improvements were taking place when concerns were raised.
- Work was taking place to improve carer involvement and support.
- Advocacy services were available and patients were supported to access these services.

However, further work was needed to ensure that patients are involved in the planning of their care and this is recorded.

Are services responsive to people's needs?

Requires improvement

We rated responsive as **requires improvement** for the following reasons:

In acute wards for adults of working age we found:

- Patients' privacy and dignity were not promoted on the wards.
- Patients returning from leave might have to move to a new ward which would disrupt their continuity of care.
- At Edgware Community Hospital, many patients said the quality of food was poor and there was limited choice of food that did not address their cultural needs.
- The wards did not always inform patients' about how they could support their religious or spiritual needs.

Summary of findings

- Patients did not all have access to make a phone call in private.

In the mental health crisis services and health based places of safety we found:

- The home treatment teams had large numbers of patients who needed to be discharged to other teams.
- Some patients told us about their experiences waiting for long periods of time trying to connect to staff via the 24 hour crisis lines.
- Staff from the home treatment teams did not routinely communicate with people throughout the day to inform them about likely times of arrival to their homes.
- Patients in the places of safety had to wait extended periods of time to be assessed.

Specialist community mental health services for children and young people:

- The trust did not have a target waiting time from initial assessment to the start of treatment and waiting times for routine access to treatment after assessment varied. There was a four month wait for access to a family therapist and a six month wait for access to a psychiatrist. Whilst work to look at skill mix and caseload management had started, changes to improve access to some treatments had not yet taken place.
- Parents/carers and young people said they had not pro-actively received information about how long they would need to wait for treatment.
- Staff said they did not receive feedback from investigations, incidents and complaints as a staff group.

However, the trust was working with local commissioners and other stakeholders to make services more accessible and to inform people how to access services. The trust was working closely with the local community to understand and meet the diverse needs of the population. The trust was mainly responding to complaints in a timely manner and at a local level most teams were learning from complaints.

Are services well-led?

Requires improvement

We rated well led as **requires improvement** for the following reasons:

In acute wards for adults of working age we found:

- The lack of permanent ward managers and consistent medical input on two of the wards impacted the patients' continuity of care and stability of team leadership.

Child and adolescent mental health wards:

Summary of findings

- Stable long term management needed to be in place to ensure effective leadership to make all the necessary changes on the ward.
- Morale on the ward was low and nursing and medical staff said they felt the ward was frequently unsafe.
- It was acknowledged by senior management in the trust that the physical environment needed to be altered to provide a space more conducive to the delivery of high quality care for young people and more supportive of staff. The plans for these changes did not have a clear timescale for implementation.

Mental health crisis services and health based places of safety:

- The teams did not review and update their risk registers regularly.
- Key performance indictors did not provide the teams with clear information to monitor and review the performance of all aspects of the team.
- Whilst staff and managers knew that improvements were needed, staff with the appropriate leadership skills were not in place to make the necessary improvements.

Community based mental health services for adults of working age:

- Some managers and staff had little awareness of the information used to monitor performance and were not making improvements based on this data.
- Whilst staff had the ability to submit items to the risk register, some longstanding issues such as the risks associated with lone working and staffing had not been included in the local risk register.
- Managers were not always using their leadership skills to make improvements where needed.

Trust wide:

- Many key staff managing important support roles in the trust were either employed on an interim basis or were newly appointed. This meant that it was too early to be sure that the work would be sustained and successful.

However, the trust had a successful senior leadership team who were committed to improving services for patients. The trust had a clear vision and enablement strategy that was informing their work. Staff engagement was improving and morale was generally good across the services. The work of the trust was supported by good governance processes although some aspects of this were still quite new and had to bed in.

Summary of findings

Our inspection team

Our inspection team was led by:

Chair: Dr Paul Lelliott, Deputy Chief Inspector,lead for mental health

Team Leader: Jane Ray, head of inspection for mental health, learning disabilities and substance misuse, Care Quality Commission

The team of **88** people included:

19 CQC inspectors

5 trainee CQC inspectors

2 CQC assistant inspectors

1 planner

3 analysts

1 trainee analyst

7 Mental Health Act reviewers

7 allied health professionals

10 experts by experience who have personal experience of using or caring for someone who uses the type of services we were inspecting

16 nurses from a wide range of professional backgrounds

3 pharmacists

9 senior doctors

3 social workers

2 people with governance experience

Why we carried out this inspection

We inspected this core service as part of our ongoing comprehensive mental health inspection programme.

How we carried out this inspection

To get to the heart of the experience of people who use services' experience of care, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

Before the inspection visit the inspection team:

- Requested information from the trust and reviewed the information we received
- Asked a range of other organisations for information including the Trust Development Authority, NHS England, clinical commissioning groups, Healthwatch, Health Education England, Royal College of Psychiatrists, other professional bodies and user and carer groups
- Sought feedback from patients and carers through attending 4 user and carer groups and meetings.
- Received information from patients, carers and other groups through our website

During the announced inspection visit from the 30 November – 4 December 2015 the inspection team:

- Visited **56** wards, teams and clinics
- Spoke with **357** patients and **41** relatives and carers who were using the service
- Collected feedback from **181** patients, carers and staff using comment cards
- Joined **6** service user meetings
- Spoke with **52** ward and team managers and **498** staff members
- Attended **15** focus groups attended by **181** staff
- Interviewed **28** senior staff and board members
- Attended and observed **40** hand-over meetings and multi-disciplinary meetings

Summary of findings

- Joined care professionals for **44** home visits and clinic appointments
- Looked at **335** treatment records of patients
- Carried out a specific check of the medication management across a sample of wards and teams
- Looked at a range of policies, procedures and other documents relating to the running of the service
- Requested and analysed further information from the trust to clarify what was found during the site visits
- Observed a board meeting and a quality and safety committee meeting

The team inspecting the mental health services at the trust inspected the following core services:

- Acutes ward and the psychiatric intensive care unit
- Forensic inpatient wards including the high secure service
- Wards for older people with mental health problems
- Ward for children and adolescents with mental health problems
- Community based mental health services for adults of working age
- Mental health crisis services and health based places of safety
- Community based mental health services for older people
- Specialist community mental health services for children and young people

The team inspecting the community services at the trust inspected the following core services:

- Community health services for children, young people and families
- Community health services for adults
- Community inpatient services

We did not inspect substance misuse services or the specialist services including the eating disorder, liaison psychiatry, perinatal and increasing access to psychological therapies services.

There are no rehabilitation services. There are also no palliative care services and sexual health services have just transferred to another provider.

The team would like to thank all those who met and spoke with inspectors during the inspection and were open and balanced when sharing their experiences and perceptions of the quality of care and treatment at the trust.

Information about the provider

Barnet, Enfield and Haringey Mental Health NHS Trust provides services to a local population of around 1 million people. The trust supports adults, older people and children in the three boroughs. In Barnet and Haringey they just provide mental health services and in Enfield they provide mental health and community health services. They also provide specialist services for children and adults from across the UK.

The trust employs 2900 staff who provide inpatient and community care to approximately 155,000 people in the last year. The trust has 514 inpatient beds located on five main sites, St Ann's in Haringey (this is the trust HQ), Chase Farm Hospital and St Michael's in Enfield, Edgware Community Hospital and Barnet Hospital in Barnet. Psychiatric liaison services are provided at Barnet Hospital and were being piloted at the North Middlesex Hospital.

The services provided by the trust are organised into three borough based directorates and one specialist directorate and each had a clinical director and service managers.

The trust's foundation trust status was currently paused to allow a focus on the current financial challenges across the health economy. Management consultants appointed by five north central London commissioners and the trust concluded the trust was under-funded.

The trust has six locations registered with CQC. The trust has been inspected 23 times and at the time of the inspection there was an outstanding area of non-compliance at one location, Edgware General Hospital. This was followed up as part of the inspection.

Summary of findings

What people who use the provider's services say

Before the inspection took place we met with **4** different groups of patients, carers and other user representative groups as follows:

Enfield Mental Health Users Group

HAIL – Haringey carers group

Barnet Voice for Mental Health

Haringey Mind User Group

Through these groups we heard from patients and carers. We also received feedback from 2 independent mental health advocacy services and 3 Healthwatch who provided us with details of their enter and view visits.

During the inspection the teams spoke to 398 people using services or their relatives and carers, either in person or by phone. We received 181 completed comment cards of which 83 were positive, 54 negative and 44 mixed.

We also had received 73 individual comments from people through our website or by phone since January 2014 – October 2015.

Much of the feedback we received was very positive as follows:

- Kind staff, who are skilled, well managed and trained
- Access to talking therapies has improved – individual and group sessions and the quality is very good
- The womans drop in and care centre sessions are very helpful
- The support offered to help people find employment
- The development of psychiatric liaison services in A&E
- Better integration of care for people using Enfield community services
- Good help with physical health
- Team at Canning Crescent really helpful – value the 'walk and talk' group

Some of the challenges that we were told about were as follows:

- Lack of support for long term mental health conditions leads to relapses.
- Lack of support and consultation during and after discharge from hospital.
- High level of feedback about the lack of support in a crisis – patients told to call 999. At night there is only one AMHP on duty and the wait can be extremely long. Long waits in A&E. Carers struggling to support people while waiting for assessments. Crisis team not helpful.
- Home treatment teams - concerns with the support provided and also hard to explain problems to the contact centre staff when you call. Hard to get support in a timely manner, home visits are not on time.
- Access to an acute bed – having to go to private sector.
- Acute wards – stretched staff, lack of access to going outside or availability of snacks, ward noisy, lack of person centred care, some poor quality furnishings, no access to internet, not enough activities in the evenings and weekends and don't always follow the programme, under-current of violence on wards at times.
- Trust wide – website not up to date, lack of clarity about recording of compliments and complaints that are addressed at a ward level.
- Chase Farm site – poor signage on site and lack of lighting. Also poor food.
- Community recovery teams – long wait to see psychiatrist, lack of access to psychological therapies, lack of input from care co-ordinator, lack of cover if care co-ordinator off sick, lack of regular service user meetings poor contact between the psychiatrist and GP, lack of user involvement in care planning.
- Transition CAMHS to adult services – lack of timely support.
- Staff engagement – lack of interaction on some wards, looking at mobile phones, sitting with clip boards.
- Staff turnover is extremely high at all levels, especially within the management of the patient experience team.

Good practice

Acute wards for adults of working age and psychiatric intensive care units:

Summary of findings

- Thames ward's consultant hosted a weekly 'coffee with the consultant' afternoon with patients. The consultant met with patients in the lounge and provided tea and cakes. Patients could discuss anything apart from personal medical needs.
- The pharmacist on Thames ward hosted fortnightly medication awareness sessions with patients. This session was well organised and informative.
- Trent ward had won funding through the trust's 'Dragon's Den' competition to provide a 'safe space' room for patients on the ward. This was a large inflatable structure that patients could lie down on to relax with staff supervision. They could also use headphones to listen to music while in the room.
- The wards had a daily 'Jonah' meeting at 9am attended by staff from all disciplines. Staff used a task master to go into each patient and set out practical tasks such as managing patients' accommodation, reviewing medication or safeguarding alert. Managers allocated tasks to each staff to action and close off every day. Staff said they found these meetings essential to supporting patients and managing their discharge.

Forensic inpatient wards:

- The wards recorded and monitored restrictive practices such as seclusion and restraint. This included free text searches on electronic notes and incident reports to potentially pick up incidents of restraint which may not have been collected from incident reports alone. Information and data relating to restraint was gathered and reviewed by staff from the senior management team and shared through clinical governance meetings with ward staff to better understand the use of restrictive practices and work towards minimising them.
- There was excellent use of relational security to minimise the use of restraint and seclusion so that the levels were proportionately lower than other, similar services. The implementation of zonal observations on Sage ward had reduced the number of one to one observations carried out. This had been developed on the basis of research evidence.
- Patient-led care programme approach (CPA) meetings took place across some wards where people were involved in chairing their CPA meetings.
- A family intervention service provided support to family and those people important to patients who used services.
- Patients were offered work experience at the shop within the Kingswood Centre and the café in the main entrance of the medium secure unit. Patients had been successful in developing a bee keeping project and had won first prize at the Enfield farmers market for their honey. This was a successful enterprise which patients and staff took pride in.

Child and adolescent mental health wards:

- Young people were recently involved in the appointment of the new consultant and were on the interview panel.
- The involvement of a third sector provider to support the young people using a range of arts and therapies was a creative development aimed at engaging young people in their own recovery.

Wards for older people with mental health problems:

- On Silver Birches staff and relatives of patients worked together to raise additional funds for patients to use for special events and outings. Additionally, they arranged a 'Compassion in Care' award for a member of staff each month.
- Staff on Cornwall Villa had worked to develop a sensory garden for patients to use.

Community based mental health services for adults of working age:

- Some community teams had discharge co-ordinators and substance misuse workers as part of the team.
- The Haringey East and West CSRTs completed specific functional assessments for living skills. They used this to inform the provision of groups for patients. Staff had developed the 'walk and talk' group and 'build a bike programme' as a way of reaching out to people more effectively. The build a bike project was a progressive programme that combined building a bike with developing friendships and growing in confidence. The trust had nominated the programme for an award.

Mental health crisis services and health based places of safety:

- The trust worked with a local university to develop a two day training course in CRHT teams.

Summary of findings

- At Barnet, staff took part in monthly educational meetings where staff champions were nominated on a range of topics to lead teaching sessions with colleagues.
- Teams were participating in the CORE study, a National Institute of Health Research funded programme, in conjunction with University College London (UCL), that aimed to improve the standard of support offered to people using crisis resolution home treatment teams across England.

Specialist community mental health services for children and young people:

- The Haringey adolescent outreach team won the Health Service Journal Innovation in Mental Health award in November 2015. Young people's case studies were used to develop a theatre show for school assemblies and a film to address the issue of mental health and emotional wellbeing in schools. The project was run from September 2013 and was delivered in conjunction with a number of CAMHS partner agencies.

Community based mental health services for older people:

- Systems for continuous improvement in the Haringey and Enfield services were fully embedded and very effective in improving patient care and experience.

Community health services for children, young people and adults:

- The paediatric physiotherapy service had developed new innovated ideas to improve their practice. This included a screening clinic for under-fives with lower limb/gait concerns, a hypermobility group to help educate children and families and promote self-management and an information leaflet for doctors and health visitors on feet and lower limb development.

Community health services for adults:

- The GP integrated multi-disciplinary risk stratification meetings had led to effective multi-disciplinary work to meet the needs of patients with the most complex needs.
- The care home assessment team was providing effective support to people in care homes and helping to reduce acute hospital admissions and visits to accident and emergency departments.
- The diabetes team had developed 'living a healthy life': an education, monitoring and screening programme for adults with learning disabilities. This work was commended in the 2013 diabetes quality in care programme

Areas for improvement

Action the provider MUST take to improve

Trust wide:

- The trust must ensure that key senior posts in teams such as human resources and the patient experience team that support staff across the trust are filled with permanent staff to provide consistency and ensure the implementation of keys areas of work.

Acute wards for adults of working age and psychiatric intensive care units:

- The trust must ensure that the location of seclusion rooms are safe and protect patients' privacy and dignity. (This includes female patients being secluded on a male ward, transporting patients safely, staff being able to observe patients while in seclusion, sharing of bathroom facilities, other patients on the ward not being able to view into the seclusion room).
- The trust must ensure that the clinic rooms are providing a safe environment for medicine storage and administration, medical equipment is clean and on Downhills ward medical emergency equipment can be reached easily in an emergency.
- The trust must ensure patients' risk assessments are completed with sufficient detail and updated following incidents and risk events.
- The trust must ensure there are sufficient numbers of permanent staff working on the wards. This is to ensure consistency of care, avoid leave being cancelled and reduce the incidence of violence and aggressive behaviour especially on Downhills ward at St Ann's.
- The trust must ensure that there are sufficient numbers of mirrors available to help improve levels of observation in corridors on the wards.

Summary of findings

- The trust must ensure blanket restrictions are kept under review and only used in response to a current risk such as the locked doors throughout Dorset ward at Chase Farm.
- The trust must review incidents of absconding from inpatient wards, to identify the reasons and ensure measures are in place to keep this to a minimum.
- The trust must ensure that the use of rapid tranquillization is recognised so that appropriate health checks take place afterwards to maintain the safety of the patients.
- The trust must ensure that all staff receive regular supervision and this is recorded and monitored.
- The trust must ensure that staff know how to use the modified early warning scores properly as these identify when patients' physical health is deteriorating and that where needed medical assistance is sought.
- The trust must ensure that the wards protect patients' privacy and dignity by enabling patients to be able to close the observation windows on their bedroom doors.
- The trust must keep to a minimum patients returning from leave and needing to be cared for on another ward which disrupts their continuity of care.
- The trust must ensure they recruit permanent ward managers and consultant psychiatrists for the wards and that interim managers are appropriately supported and trained.

Child and adolescent mental health wards:

- The trust must ensure that an effective strategy is in place within an identified timeframe and which is subject to regular review, for filling the high number of vacancies and retaining staff.
- The trust must ensure that all staff receive regular supervision and that this is recorded.
- The trust must ensure a permanent management team is put into place to provide ongoing and consistent leadership.

Community based mental health services for adults of working age:

- The trust must ensure that all interview rooms are fitted with alarms or there are enough personal alarms for all members of staff.
- The trust must ensure there are safe systems for storage and transportation of medication, medical waste and sharps.
- The trust must ensure that staff carrying out trust business follow the trusts lone working policy and have access to a working mobile phone to maintain their safety.
- The trust must ensure there is a system to identify patients prescribed high-dose antipsychotic medication so that there can be checks to ensure their physical health is being monitored.
- Managers must develop and use their leadership skills to ensure the challenges facing the teams are escalated where needed and addressed.

Mental health crisis services and health based places of safety:

- The trust must ensure that lone-working policies are robust, and that they minimise risk to staff while carrying out home visits in the community.
- The trust must ensure that the documentation of risk assessments in patient care records is improved so that appropriate risk plans are recorded.
- The trust must ensure that patients accessing the home treatment teams receive a more responsive service. This includes patients phonecalls being answered in a timely manner, patients having a clearer knowledge of when their appointment will take place and being told if this is delayed.
- The trust must ensure that managers with the appropriate leadership skills are in place to make the improvements that are needed in the home treatment teams.

Specialist community mental health services for children and young people:

- The trust must ensure that staff report incidents and that learning from incidents and complaints is shared in an effective manner across teams and from other parts of the trust.
- The trust must ensure that the number of completed appraisals across all the teams meets the trusts target.
- The trust must make changes to the team so that assessment to treatment times can be delivered in a timely manner.

Community health services for children, young people and adults:

- The trust must ensure there are sufficient health visitors in post to deliver the 'healthy child programme'.

Summary of findings

Action the provider SHOULD take to improve

Trust wide:

- The trust should ensure that outstanding mandatory training is completed to reach the targets set by the trust.
- The trust should continue to work to improve the organisation of training, so that staff know what is available and can book this in a timely manner.
- The trust should review how effectively the use of the Mental Capacity Act is being applied across the trust.
- The trust should consider if whistle-blowers would benefit from being able to contact someone more independent when they wish to raise concerns.
- The trust should extend user and carer engagement by for example involving people in delivering staff training.

Acute wards for adults of working age and psychiatric intensive care units:

- The trust should improve the physical environment on Dorset ward.
- The trust should ensure all the wards are clean including Downhills ward at St Ann's and Avon ward at Edgware community hospital.
- The trust should ensure that all staff have their refresher training in the prevention and management violence and aggression in a timely manner.
- The trust should ensure that there is a clear record of when medicines have been reconciled after the admission of a patient to a ward. Patients who are taking 'as and when' medication should have this regularly reviewed.
- The trust should ensure that staff working in Haringey meet the trust's targets for the completion of mandatory training.
- The trust should ensure the number of beds on Avon ward follow national guidelines for PICUs.
- The trust should ensure that it reduces the number of times patients are transferred to other wards for non-clinical reasons and that each incident is documented.
- The trust should ensure that staff explain to patients their rights under the MHA, that patients understand their rights and these are repeated. Interpreters must be booked in a timely manner to ensure this is completed.
- The trust should ensure that all information given to informal patients regarding their personal liberty is legally accurate. The trust must also ensure that the MHA guidance available on the wards reflects the current code of practice.
- The trust should ensure that there are systems in place for staff to learn from incidents across the trust.
- The trust should ensure that all staff are aware of the procedures taken when collecting and disposing of illegal substances.
- The trust should ensure doctors provide clinical judgement details in patients' capacity to consent or treatment assessments and that these records are accurate and consistent.
- The trust should ensure that patient care records are recovery focused, include patient involvement and document patients' 1:1 time with their named nurse.
- The trust should ensure patients have access to adequate psychology input especially at St Ann's and Edgware community hospitals.
- The trust should ensure that wherever possible staff involvement with patients is caring and supports patient recovery and is not only task-focussed.
- The trust should ensure that patients can make a phone call in private.
- The trust should ensure they are meeting patients' spiritual and religious needs.
- The trust should ensure they provide food of good choice and quality that meets patients' cultural and dietary needs at Edgware community hospital.

Forensic inpatient wards:

- The trust should review how it records and monitors its training requirements relating to the Mental Health Act and Mental Capacity Act.
- The trust should review how trust wide incidents are communicated to staff so that broader learning can be disseminated.
- The trust should review how best practice in the forensic services was feeding into learning across the trust.
- The trust should review the restricted garden access on some wards and how garden access can be extended safely for patients.
- The trust should review the toilet facilities in the seclusion room on Devon ward so that patients' privacy and dignity is respected.

Summary of findings

Child and adolescent mental health wards:

- The trust should ensure staff complete the mandatory training in line with trust targets.
- The trust should continue to improve the effectiveness of the multi-disciplinary working on the ward.
- The trust should review the wording of the sign by the ward entrance to ensure the rights of informal patients are accurately reflected.
- The trust should review the recording of consent to treatment to ensure it reflects the rationale for decisions and for young people under the age of 16 the consideration of Gillick competency.
- The trust should review blanket restrictions on the ward for example the ward's policy of locking toilet and bedroom doors during the day.
- The trust should continue to offer ongoing staff support to improve morale throughout this process. This should include improvements to the physical environment.

Wards for older people with mental health problems:

- The trust should ensure it maintains the arrangements for same gender care on the Oaks to ensure patients safety and dignity.
- The trust should ensure that meetings to discuss best interest decisions are recorded so it is clear why decisions have been made for patients who have been assessed as lacking capacity to make the decision for themselves.
- The trust should review composition of the multi-disciplinary team on Ken Porter to ensure patients receive appropriate support to maintain and develop their independent living skills.
- The trust should review with each patient on Ken Porter and their family or advocate how they wish to be supported whilst eating. The review should include consideration of how the patient wishes to protect their clothes when they eat.

Community based mental health services for adults of working age:

- The trust should ensure a date is confirmed for the Haringey CSRTs to have access to an appropriate clinical treatment room.
- The trust should ensure that recruitment continues so the majority of staff are permanent employees in order to improve continuity of care for patients. This is a priority in Haringey.
- The trust should ensure that staff complete mandatory training.
- The trust should ensure risk assessments are monitored and updated when needed
- The trust should ensure that patients are supported to have physical health checks and that the team are aware of significant healthcare issues and how these are being addressed.
- The trust should ensure that patients are monitored while they are on the waiting list to receive treatment from the team, to provide support if they deteriorate.
- The trust should ensure that staff working in the CSRTs feel well informed about the learning from serious untoward incidents from other parts of the trust.
- The trust should ensure staff take medicines cards with them when visiting patients at home to ensure they administer the correct medication.
- The trust should ensure systems are in place to develop working relationships with GPs.
- The trust should ensure staff supervision is undertaken regularly across all teams.
- The trust should ensure that there are accurate training records in place for staff.
- The trust should ensure staff follow trust guidance and policy around patients who do not attend appointments.
- The trust should ensure the local team risk registers are kept up to date so risks can be escalated as needed.
- The trust should ensure that team managers make good use of information to support their management of the team.

Mental health crisis services and health based places of safety:

- The trust should review team staffing and caseloads to ensure the teams can meet the needs of patients.
- The trust should ensure staff teams continue to make progress towards meeting the trust target for mandatory training, especially in the Haringey home treatment team.
- The trust should ensure that staff receive training on, and understand the use of, the Mental Capacity Act and patient consent.

Summary of findings

- The trust should ensure that patients are involved in their care planning, and that care records document personalised and holistic patient needs.
- The trust should continue to audit medication charts to ensure these are completed correctly for all patients.
- The trust should ensure that learning from incidents is shared across the home treatment teams and other parts of the trust.
- The trust should ensure that staff from the home treatment teams monitor patient's physical health needs where needed after the initial assessment.
- The trust should review the multi-disciplinary team skill mix across the teams, particularly around access to psychologists and occupational therapists, to ensure that the range of interventions offered to patients meets the needs of the people who use the service.
- The trust should review the effectiveness and length of some of the team handover meetings to ensure key information around patient risks are disseminated appropriately across all staff.
- The trust should ensure that governance systems clearly collate information from incidents, complaints and audits which are accessible to staff across the teams.
- The trust should work with other agencies to ensure that where possible patients are taken to a place of safety by ambulance or other health transport.
- The trust should ensure it works with partner organisations to ensure that where possible patients are seen by an AMHP within three hours in the places of safety and that the length of time patients are waiting in the suite are reduced.
- The trust should ensure children admitted to the places of safety are always reviewed by appropriately qualified staff.

Specialist community mental health services for children and young people:

- The trust should ensure that young people on the waiting list for a service were monitored so that their care could be prioritized if needed.
- The trust should ensure that individual risk assessment records are kept updated so that staff can access accurate information when needed.
- The trust should ensure that when staff visit young people and their families in their homes that the lone worker policy is used.
- The trust should ensure that care plans are updated regularly and recorded in a young person's notes.
- The trust should ensure that all staff are accessing appropriate ongoing supervision in their role and that this is recorded.
- The provider should ensure consent to treatment is recorded.
- The provider should ensure consent to share information with parents/carers is recorded and followed where a young person is able to make this decision.
- The trust should ensure that all staff know what steps to take if a young person does not attend an appointment and that the data on this is accurately collected.
- The service should develop information about how the teams operate to give to young people and their relatives and carers.
- The provider should ensure all staff are aware of how young people can access the advocacy service available to them.
- The trust should ensure that managers of CAMHS develop and use their leadership skills to make changes to the service to ensure patient's needs are met.

Community based mental health services for older people:

- The provider should review the arrangements for the provision of the Haringey memory service in order to reduce the length of time patients have to wait between assessment and diagnosis.

Community health services for children, young people and adults:

- The trust should ensure that all current patient clinical records are all records are regularly maintained and updated when staff leave and that staff working remotely have access to a desk and internet services.
- The trust should ensure infection control and hand hygiene audits take place across the services.
- The trust should create a child friendly environment at Cedar House.
- Thye trust should ensure in clinic environments that information is available for people on how to make a complaint

Summary of findings

- The trust should ensure that staff complete mandatory training in line with the trusts targets, especially outliers such as the paediatric dietetic service.
- The trust should review school nursing staffing levels to ensure the full core service can be delivered to schools
- The trust should ensure that school nurses are offered the opportunity to access specialist community public health nurse training.
- The trust should continue to work with the trust that provides paediatricians to ensure there are enough staff available.
- The trust should ensure that all the immunisations levels are monitored to ensure the trust is reaching the necessary levels.
- The trust should ensure that it always follows the necessary process for obtaining consent prior to carrying out health checks.
- The trust should continue to take the necessary steps to maintain the reduced waiting times for paediatric occupational therapy input.
- The trust should ensure that staff working in the community services for children, young people and families have completed appraisals in line with the trusts target.

Community health inpatient services:

- The trust should ensure access into the unit was secure to prevent unwanted people entering the building.
- The trust should ensure staff continue to complete their mandatory training so they reach the trusts target.
- The trust should ensure a permanent manager is appointed to provide consistent on-going leadership at the Magnolia Unit.

Community health services for adults:

- The trust should continue to work towards recruiting more permanent staff, particularly in the district nursing teams to ensure there are sufficient staff to meet the needs of the patients.
- The trust should continue to encourage staff to complete their mandatory training in line with the targets set by the trust.
- The trust should continue to ensure staff have the right equipment and premises to carry out their work. This includes having access to consistently working mobile phones, an ability to complete patient notes and download them remotely and sufficient desks with access to computers when they are in the office.

Barnet, Enfield and Haringey Mental Health NHS Trust

Detailed findings

Mental Health Act responsibilities

We do not rate responsibilities under the Mental Health Act 1983. We use our findings as a determiner in reaching an overall judgement about the provider.

The trust's systems supported the appropriate implementation of the Mental Health Act and its code of practice. The application of the Act was overseen by the mental health law committee. This committee met quarterly to consider changes to policies and to review statistical reports of Mental Health Act activity. Legal advice was available from the head of Mental Health Act and administrative support from Mental Health Act administrators based at each hospital site.

Training on the Mental Health Act and the Mental Capacity Act was not mandatory. We were informed that take up for training sessions in relation to the Mental Health Act offered by the head of Mental Health Act was low, with 11 of the past 12 training sessions scheduled having been cancelled due to insufficient numbers attending.

During this inspection we completed eight Mental Health Act review visits pursuant of the CQC's duty under section 120 to keep under review the exercise of the powers and the discharge of the duties conferred or imposed by the Act so far as relating to the detention of patients.

Detention paperwork was filled in correctly, was up to date and was stored appropriately.

There was a good adherence to consent to treatment and capacity requirements overall. Copies of consent to treatment forms were attached to medication charts where applicable. However, on two wards where a Mental Health Act review visit was completed, we were unable to consistently evidence the completion of assessments of patient's capacity to consent to treatment, or a discussion about consent.

There was evidence that most people had their rights under the Mental Health Act explained to them. However on two of the wards where a Mental Health Act review visit was completed, we were unable locate consistent evidence that all patients had been informed of their rights on admission and were reminded regularly thereafter.

There were concerns in relation to the use of seclusion in Sussex ward and Finsbury ward. These related to the position of the seclusion facilities and the privacy and dignity of the secluded patients.

A majority of the care plans we reviewed were comprehensive and individualised. On four wards where a Mental Health Act review visit was completed, we found inconsistent evidence of patient involvement and the recording of patient's views in relation to their care and treatment in line with the code of practice.

Within all of the wards visited we found that people had access to Independent Mental Health Advocacy (IMHA) services and information on IMHA services was provided to patients. Patients and staff appeared clear on how to access IMHA services appropriately.

Two wards within the forensic services where Mental Health Act review visits were completed, Blue Nile ward and Juniper ward, were commended by the Mental Health Act reviewers for their overall compliance with the Mental Health Act code of practice guidance.

Detailed findings

Immediately prior to this inspection, we were notified that a consultant psychiatrist had been performing the functions of an approved clinician without the required accreditation. This had affected the legitimacy of actions completed under the Mental Health Act by this consultant psychiatrist for four patients. The trust had taken appropriate action to rectify this situation and informed all patients affected as appropriate.

Mental Capacity Act and Deprivation of Liberty Safeguards

The work on the Mental Capacity Act was overseen by the mental health law committee.

The trust had a comprehensive Mental Capacity Act (MCA) and deprivation of liberty safeguards (DoLS) policy. This included flowcharts and checklists to help guide staff. The trust also had 6 MCA champions.

Training on the MCA was not mandatory. This was arranged by the mental health law manager and in 2015-16 twenty six sessions had been arranged across the five sites. Training had also been provided through the medical academic programme. In addition training had been provided directly to individual teams tailored to their area of work. An external professional trainer had also been commissioned to provide some bespoke training for example to the CAMHS staff in November 2014.

For the first six months of 2015 there had been 39 applications made for an authorization of a DoLS. These were mainly for patients receiving care on mental health wards for older people.

Most staff we spoke with had a reasonable understanding of the Mental Capacity Act and knew where to seek advice if needed. There were some good examples of where staff had applied the MCA and recognised the need to hold best interest discussions.

In services for children and young people staff understanding of the Gillick competencies was good and they described how it would be applied.

The main area for improvement related to the recording of the assessments and best interest decisions. For example on some mental health wards for older people best interest discussions were not always clearly recorded so that there was clarity about how decisions had been reached. At the Beacon centre for young people the recording of consent to treatment did not explain the rationale for decisions.

Requires improvement

Are services safe?

By safe, we mean that people are protected from abuse* and avoidable harm

* People are protected from physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse

Summary of findings

Our findings

Safe and clean care environments

- The trust provided services from a very variable range of physical environments. There were five main inpatient sites, providing 514 beds. These were at Chase Farm hospital, St Ann's, Edgware community hospital, Barnet General hospital and St Michaels. Community services were provided from many sites across the three boroughs.

Detailed findings

- The trust had an estates strategy. This highlighted that there were lots of old buildings and challenging environments especially at St Ann's, however work to improve environments had taken place across the trust. An estates assessment indicated that 40% of the trusts premises were deemed unacceptable with major repairs or replacement needed soon and 42% were unsuitable. The estates strategy focuses on changes that are taking place as the models of care evolve.
- At the time of the inspection plans were progressing for the redevelopment of St Ann's. This would provide adult and eating disorder inpatient services within new purpose-built accommodation located within the retained estate at St. Ann's. Outline planning permission was granted in March 2015. A strategic outline case had been submitted to the NHS Trust Development Agency and this was waiting approval.
- The inspection team were most concerned about the physical environment at St Ann's and the impact on the safety and dignity of patients using these services. The reasons for the concerns was highlighted when looking at Downhills ward. On this acute ward the women, were occupying a very small space with mostly shared dormitories or bedrooms. The dining area was shared with another ward and could only be accessed at certain times. Access to the seclusion facilities required walking across a main public corridor and through a men's ward. The layout of the ward made observation very difficult. The ward was noisy, cramped and compromised peoples privacy and dignity. The patients were very unwell and the environment had a negative impact on their recovery. Similar concerns applied to other wards on the site and there was a need to address this as a matter of urgency.
- The safety of some environments could be improved. For example across a number of the acute mental health wards, the environments presented challenges in terms of being able to observe patients. Some wards would benefit from having more wall mounted mirrors to improve the ability to see along corridors. In the forensic wards there was some very good practice in terms of observing patients. For example Sage ward had introduced zonal observations and this had reduced the numbers of patients needing to be observed on a one to one basis.
- The trust had undertaken environmental risk assessments of ligature point risks in the mental health inpatient areas over the last year. A five year comprehensive plan to address ligature anchor points had been put into place with £2.6m of funds allocated for this work. Work had commenced to change sanitary ware and en-suite doors in high risk areas. Ligature reduction measures were also routinely built into any refurbishments. Staff were aware of risks from ligature anchor points and were mitigating these through identifying patients who were at greater risk of self-harm and needed higher levels of observation. Whilst details of the ligature reduction programme had been publicized Individual ward managers did not know when further ligature reduction work was taking place on their wards.
- Most of the wards in the trust were either single sex or had arrangements for patients of different genders to maintain their privacy and safety by having separated bedroom and bathroom accommodation. The exception to this was on the Oaks ward for older people with mental health problems at Chase Farm hospital. When a bedroom became vacant on the Oaks it could be filled by either a female or male patient. Although each patient had their own ensuite bathroom, the trust had not ensured there was as much gender separation as possible in relation to the sleeping areas. Managers had not grouped patients of the same sex together in rooms off one part of the corridor (for example, women towards one end of the corridor, men towards the other). Additionally, there was no female only day room. Patients using the Oaks were very vulnerable due to their age and mental health needs. Some patients were confused and many could not easily communicate their views and preferences. The trust addressed this during the week of the inspection but this needs to be maintained.
- Some services did not have access to clinical rooms that were appropriately located or provided sufficient space. An example of this was the clinic room shared by the Haringey recovery teams where the room was small and had no treatment couch. Whilst there were plans for this room to be replaced there was no clear date when this was happening.On Downhills ward at St Ann's the clinic room where the emergency equipment was stored was at the end of a corridor through two locked doors, which meant it was not easily accessible.

- Staff working in the mental health wards and some clinic areas needed to be able to call for staff assistance if needed. In most areas there were alarms readily available, either attached to the wall or carried by the staff member. At the Barnet and Haringey recovery teams staff said there were not enough alarms available for staff to access when meeting with patients.
- The inspection highlighted a number of other areas for ongoing improvements in terms of the physical environments. This included the Beacon centre, the inpatient mental health ward for children and young people and Cedar House where many of the community clinics for children took place. Both these services should have a more age appropriate environment.
- Equipment being used across the trust for a range of purposes including clinical examinations, emergency resuscitation and for moving and handling was all well maintained. Staff said that the contract with a company who maintained the equipment worked well and they were proactive in ensuring everything was regularly checked and maintained.
- The trust had an infection control lead. There were also governance processes in place to review policies and procedures and oversee audits to ensure standards were maintained. The inspection found that staff were following the infection control procedures. Infection control training was mandatory for all staff. Gloves, aprons, and other personal protective equipment were readily available to staff. The importance of all staff and visitors cleaning their hands was publicised and we observed people using hand gels and washing their hands. In the community inpatient service, the staff were providing care to one patient with MRSA in accordance with the trusts infection control procedures. The only area where hand-washing and infection control audits were not taking place was in community services for children, young people and families.
- Overall the trust scored better than the England average for all the patient led assessments of the care environment (PLACE) 2015. Most of the environments that were inspected were clean. However on Downhills ward at St Ann's and Avon ward at Chase Farm hospital it was observed that the environment could have been cleaner.

Safe staffing

- At the time of the inspection the trust, led by the director of nursing, was carrying out a review of staffing levels and skill mix across wards and teams. This had identified that the staffing levels on a number of wards was too low. A proposal had been discussed by the board and agreed in principle in March 2015. There remained an affordability issue which had been discussed with commissioners. The trust was progressing the rollout of the safe care model to help support inpatient ward staffing.
- The trust monitored safe staffing levels and 99% of the time these were being met or exceeded. However, whilst this was a positive achievement it was also recognised that in some wards these staffing levels were too low to meet the needs of patients. The Royal College of Nursing, when asked for feedback about the trust, had expressed concerns about staffing levels, especially in the district nursing services.
- In September 2015 the vacancy rate for the trust was 15%. This had risen steadily throughout the year, starting in April 2015 at 9%. In September 2015 the sickness rate for the trust was 4.4% and this had only varied slightly over the previous 6 months. It was noted that stress related absence had reduced and absence through injury had increased. The overall sickness rate was broadly in line with other trusts although as expected there were significant variations between teams. In September 2015 the turnover of staff was 16%, although again there were variations between teams and groups of staff.
- The trust was making significant use of bank and agency staff. Between May and July 2015, 11268 shifts had been filled by bank or agency staff. This clearly had an impact on the consistency of care. In November 2015 just prior to the inspection, the trust had established the 'temporary staffing bank', with the aim of recruiting more bank staff, meeting the need for staff to work in the services and reducing the use of agency staff. At the time of the inspection we heard from some managers that this was not yet running smoothly and staff with the appropriate skills were not always assigned to the correct shifts. It was however recognised that this service needed time to time to establish itself. The trust had also rationalised the nursing agency suppliers and from June 2015 they were working with 6 agencies. This

was ensuring that agency staff were in line with agreed standards and costs. The trust was also holding agency performance review meetings to monitor the working arrangements.

- The trust was using an e-rostering system. In May 2015 the trust e-rostering system was upgraded to version 10, which was web based and hopefully easier for staff to use. The trust had provided extra training to ensure staff were using the system and this had led to increased usage. In November 2015 a new module had been added to the e-rostering system to book temporary staff. A further 'safe care' module was due to be rolled out in January 2016 to enable real time rosters to be prepared that reflected the needs of the patients.
- The trust was working to recruit staff especially in hard to recruit areas. At the time of the inspection the trust was using a range of initiatives. This included arranging recruitment fairs where interested applicants can be interviewed on the same day, developing better links with local universities and meeting students who were graduating soon, improving the advertising of posts and using skype-type technology to interview people on-line. A proposal was also being developed for an international recruitment campaign including links with oversees universities. The trust was also using a programme that increased the speed and efficiency of the recruitment process with the aim of achieving a 12 week target from advertising to staff starting in post. The recruitment was starting to achieve results especially for district nurses and health visitors, although staff still needed to come into post. The feedback from managers across the trust was that recruitment was gradually improving.
- The inspection found that maintaining safe staffing levels across the trust was a continuous challenge and most of the services were struggling with ongoing recruitment and accessing enough temporary staffing to meet the needs of the patients. The trust was supportive about giving the managers the discretion to access enough staff to meet the clinical needs of the patients, but achieving this in practice was hard.
- Some services that were inspected raised particular concerns in terms of safe staffing. For example on the acute wards for working age adults, especially at St Ann's the shortages of permanent staff was impacting on the consistency of care, leading to patient leave being cancelled and contributing to an increased incidence of violence and aggression. At the Beacon centre a mental health ward for young people the high use of temporary staff and difficulties in filling shifts meant that leave was cancelled and young people did not all know who their named nurse was. At the time of the inspection the numbers of health visitors in post meant that the trust could not fully deliver the 'healthy child programme'. They delivered 3 of the 5 mandated contacts. The ante-natal contact and 8-12 month review were targeted at the high risk patients. This meant that safeguarding issues in this age group might not be identified and opportunities for health promotion would be missed. In the community mental health recovery teams, especially in Haringey, the staff vacancies meant that patients were experiencing changes in their care co-ordinators. The staff in the home treatment teams were struggling to meet the clinical needs of patients as the caseloads were too high. This meant that home visits were very brief and were often delayed or needed to be re-scheduled. There were also lots of specific examples of vacant staff posts in teams leading to patients having to wait for some specific clinical input. The trust was taking steps to mitigate the risks associated with safe staffing. For example the Beacon centre was not accepting out of hours admissions. Other teams were also prioritizing their input. However there was an impact on patients from the lack of permanent skilled and experienced staff in some services.
- Thoughout the trust there was sufficient medical cover to support people with their physical and mental health clinical needs. The only area of concern was in Haringey, where the wards and crisis and community mental health services were experiencing a lack of permanent consistent medical cover. During the inspection we heard that additional resources had been identified to support the medical revalidation process and this was up to date.
- The trust had just met its target of 85% for mandatory training. Prior to the inspection the completion of mandatory training had significanty improved with additional courses being provided. In November 2015 the trust reported an overall compliance rate of 86%. Some of the core skills subjects with the lowest compliance were - intermediate life support level 3, basic life support/ defibrillation adult & paediatric level, basic life support/defibrillation adult level 2, moving

and handling. The trust were working to improve compliance rates for a few mandatory areas. For example additional life support training had been arranged to meet the shortfall. There was more to do.

Assessing and managing risks to patients

- The trust had carried out a thematic review of 20% of the serious untoward incidents that had been reported in 2014-15. One of the key themes from this was the need to improve the quality of assessing risk for individual patients. This was also an ongoing area for improvement identified in the inspection. For example on the acute mental health wards and home treatment teams, whilst risk was discussed at team handover meetings it was found that recorded risk assessments were not always completed in sufficient detail or updated following an incident. Both these services were supporting patients who presented with a number of risks and there were also of temporary staff working in the teams. This meant that having accurate, accessible, clearly recorded risk assessments was a high priority. Other community teams for adults and children and young people needed to improve their recording of risk.
- The trust had safeguarding processes in place. The trust had a safeguarding team that incorporated a head of safeguarding people and leads for adult and children's safeguarding. In addition there was a safeguarding lead for CAMHS in Barnet and a safeguarding children`s lead within the Enfield community services. The trust had two trust wide safeguarding committees, adults and children. Both committees reported to the quality and safety committee on a quarterly basis. Each of the three local authorities had different arrangements for reporting safeguarding concerns, but these were clearly recorded in the procedures. The trust was represented on safeguarding boards in each borough. Services had safeguarding champions. There was a monthly safeguarding children and adults surgery where professionals across the organisation could discuss complex safeguarding issues, work collaboratively and be informed about new legislation. The trust aimed for an 85% compliance with safeguarding training. Compliance in October 2015 was adults level one: 85.3%; children level 1 & 2: 88.4%; children level 3: 75.9%. Managers and senior staff had received training on chairing safeguarding strategy meetings. The trust monitored numbers of safeguarding alerts. In 2014-15 there were 120 alerts in Barnet, 146 Enfield and 121 Haringey. The lead for safeguarding adults was responsible for analysing the safeguarding referrals and categorising into types of alerts and categories of safeguarding concerns. External stakeholders fed back that trust staff had improved in recognising and reporting safeguarding concerns. The exception to this was for health visitors where it was felt that staff vacancies was impacting on training and ability to identify safeguarding issues.
- The trust had a policy on the prevention and therapeutic management of violence and aggression (PMVA). There was also a separate seclusion policy. The policy on the prevention and therapeutic management of violence and aggression was in the process of being updated. A restrictive interventions reduction group has been established to develop policies and training.
- The policy makes it clear that restraint should only be used as a last resort. For the first six months of 2015, restraint had been used 218 times across 25 wards. Only six of these instances of restraint involved the patient being restrained in the prone position and three involved the administration of rapid tranquillization. The trust completed an audit of restraint in June 2015 and this showed that recording across the trust was generally poor and inconsistent. In specialist wards the time that the restraint commenced and ended was not recorded in all 12 cases. However, on the Barnet wards the time was recorded in all 23 cases. Recording of restraints was generally worst in Enfield and on the specialist wards, and slightly better in Haringey and Barnet. The inspection found that in forensic services there was good practice in terms of the service reviewing incidents of seclusion and restraint, discussing them in clinical governance meetings and looking at how restrictive practices could be minimized. The forensic services were also making really good use of relational security and the use of restraint and seclusion was proportionately lower than other similar services. The inspection also found that teams were working to improve the accuracy of the recording of incidents of restraint.
- In the first six months of 2015 there had been 183 incidents of the use of seclusion across 18 wards. Avon ward which was the psychiatric intensive care unit had 43 incidents of seclusion, which was as expected the highest number in the trust. We were concerned about

the use of seclusion for a number of reasons. Some seclusion rooms were not located near to the wards where patients needed to be secluded. For example at St Ann's female patients on Downhills ward would need to be taken across a public corridor and through a male ward which could compromise their safety and dignity. On Suffolk and Sussex wards at Chase Farm hospital the location of the seclusion rooms on the same corridor as other patient bedrooms could compromise the patients privacy. The trust had tried to mitigate this by providing screens but these were too low and patients could see over the top of them. The trust had completed audits of seclusion. These had highlighted the need to improve the recording of the 15 minute observations whilst the patient was in seclusion and also to ensure patients had a de-brief with staff after the period of seclusion. The inspection found that trust staff were working to improve the recording of staff observations, which demonstrated that patients had been observed and supported during their time in seclusion.

- Between the 1st April and the 30 September 2015, 109 patients had been absent without leave having absconded from a ward whilst in most cases detained under the Mental Health Act. The wards with the highest levels of patients absconding were Trent (15), Beacon Centre (11), Dorset (10) and Tamarind (10). The inspection found that these incidents of absconding had not been looked at in sufficient detail in order to make changes to services to improve the safety for patients. For example at Chase Farm hospital their had been 8 incidents where patients absconded from communal gardens and yet changes had not taken place in response to these incidents.
- The inspectors looked at whether there were examples of blanket restrictions in place that could impact on patients using the service and not reflect their needs. On Dorset ward which was an acute mental health service at Chase Farm there were doors locked throughout the ward and it was not clear if this was in response to the needs of the current patients. The same concern was raised at the Beacon centre for young people. It was also noted that the signage provided to tell informal patients that they can ask to leave the ward when they wished to do so was not always clear. For example outside the main entrance of Suffolk ward at Chase Farm there was a sign which said that patients needed the consent ot staff to leave the ward.
- The inspectors looked at the arrangements for lone working across the trust especially for staff working in community teams and going to patients homes. In some teams there were clear arrangements in place including phoning the office or a buddy and keeping a log of staff whereabouts in the office. There were also arrangements to keep in contact out of hours. In the home treatment teams, adult community mental health teams and to a lesser extent CAMHS teams where there were less home visits, the arrangements were not always robust and did not ensure staff whereabouts were known. The trust had a lone working policy, but this not reflect the different working practices of teams. Fortunately there had been no serious incidents but these processes needed to be reviewed to improve staff safety.
- There were safe and effective arrangements in place for medicines in almost all of the areas we inspected. Improvements had continued to take place since previous inspections. There were effective arrangements in place to order and supply medicines, so people did not experience delays in starting treatment, when they were discharged from the trust, or when they were receiving support from the home treatment teams. Arrangements were in place to obtain medicines and advice out of hours. Senior staff on each site had access to emergency drugs cupboards. There were easily accessible, tamper evident and in date emergency medicines and resuscitation equipment available, with evidence of regular checks. Prescription charts were completed fully, providing evidence that people were receiving their medicines safely and as prescribed. People were prescribed medicines for their physical health conditions, as well as for their mental health. When people were detained under the Mental Health Act, the appropriate legal authorities were in place for medicines to be administered.
- There were sufficient skilled pharmacy staff employed to provide services to all locations. There was a new post of deputy chief pharmacist, a medicines optimisation pharmacist and a clinical governance pharmacist. There was good clinical input by the pharmacy team, providing advice to staff and patients, and making clinical interventions with medicines to improve patient safety. There was a schedule of the minimum number of pharmacist visits to each area of the trust, which ranged from daily visits to weekly visits,

and at least weekly medicines top up services. There were now daily pharmacist visits and regular medicines audits of the three home treatment teams due to past issues with medicines. There was limited pharmacist input to the community clinics, with one visit per month, and we noted an issue in one community clinic regarding lack of stock control. The clozapine clinic provided a good service to people, with blood testing carried out and medicines supplied from the clinic at the same visit. Clinic staff told us that there were very occasional short delays in receiving medicines, affecting 2 or 3 people per month, due to changes being made to medicines which had already been pre-dispensed for people attending the clinic. This was due to the prescriber not notifying the pharmacy and clinic that a change had been made. We discussed this with the chief pharmacist during the inspection, and they told us they would look into it, however it was not a widespread issue considering the number of people who use the clinic.

- Medicines errors and incidents were reported quarterly. The trust had identified that it was under reporting medicines incidents and had been encouraging reporting. The levels of medicines incident reporting for Oct 2014-Mar 2015 was now in line with other similar trusts. There was learning from incidents via local learning events and medicines bulletins. Although medicines training was not mandatory, there was an ad hoc programme of medicines training for clinical staff, a medicines information pack for junior doctors, a medicines safety week, which took place in May 2015, and information about medicines on the trust intranet and laminated posters on the wards. Information about medicines was available to patients through the 'choice and medication' website, with a medicines information card supplied with all discharge medicines. Medicines information leaflets were available on the wards. In line with Department of Health IT strategy and its recommendations for safer, more effective care via e-prescribing, the trust was piloting the use of electronic prescribing and administration (EPMA) on one ward and one wellbeing clinic. The current version of the system does not identify whether medicines prescribed for detained patients had been legally authorised. The chief pharmacist told us that there were already plans for this to be addressed in the next version of the system. Trust clinical staff had direct log-in access to acute trust pathology systems, avoiding delays due to paper-based systems. Pharmacy staff had access to summary care records so were able to engage better with people about their medicines.
- There were three main areas for improvements. There was very little use of rapid tranquillisation, and no overuse during the week we inspected. However, on the acute mental health wards incident forms were not always completed following the use of rapid tranquilisation and the record of physical monitoring necessary for peoples safety after administration of rapid tranquilisation was not always available. The trust did not separately audit the use of rapid tranquilisation although it was considered when auditing the use of seclusion and restaint. Secondly there were temperature control issues in the medicines storage rooms at St Ann's hospital. This had already been identified by the trust, and the chief pharmacist told us that there was agreement for the installation of air cooling units in 2016. Finally in the Haringey community mental health recovery teams staff were not transporting medication to patients homes securely.

Track record on safety

- From June 2014 to June 2015 there were 63 serious incidents reported by the trust. There were no 'never events'. Of these serious incidents there were 11 outpatient suicides, 13 reported cases of grade 3 pressure ulcers, mostly in the community, and 4 cases of grade 4. There were 9 reported cases of unexplained death of community patients in receipt of care.
- The numbers of incidents being reported had fallen. The trust had a 46% reduction in the number of serious incidents reported for the first two quarters of 2015-16 compared to the same period last year. This was directly related to changes in national framework for incident classification. The trust were promoting the importance of reporting incidents.
- Thirty one incidents had been reported from April 2015 to September 2015. Of these 28 investigations were ongoing and 3 reports were overdue due to the complexity of the work.
- The NHS safety thermometer measures a monthly snapshot of four areas of harm including falls and pressure ulcers. There were no services where the levels of incidents reported were a particular concern.

Detailed findings

Reporting incidents and learning from when things go wrong

- External stakeholders said that the trust had developed a more open and honest relationship with the commissioners and was proactive in contacting lead commissioners to discuss serious incidents as they occur. The information was shared through the trust's patient safety team. They did however feel that more work was needed on suicide prevention.
- Staff were able to explain how they would report incidents and what would need to be reported.
- The trust has started to arrange learning events to embed learning from incidents. The event in September 2015 had attracted around 50 staff, of which more were senior staff. Staff in wards and teams did not refer to these events during the inspection and so their broader impact was not evident. Information about learning from incidents was shared in electronic information sent to staff in the 'trust quality news bulltin', but again very few staff mentioned this and the impact was low.
- Each directorate had a monthly clinical governance meetings which looked at incidents. There were also deep dive meetings which considered a range of data including incidents. Feedback on incidents and the learning was fed back to team meetings and this was effective. Staff in most services were able to talk about incidents which had happened in their service and the learning from these including changes in practice which had occurred. In the CAMHS teams staff did not know about incidents in different boroughs. In most wards and community teams, whilst staff could talk about incidents in their service, there was little knowledge of learning from other parts of the trust.
- The trust had completed a thematic review of the incidents for the period 1 April 2014 - 31 March 2015 which had identified themes which included, in order of frequency, communication and liaison, documentation and recording, team processes and systems, risk assessment and risk management, record keeping and communication with patients, carers or family. External stakeholders said the trust could improve further on the identification of themes and developing actions.
- The inspectors looked at 8 randomly selected root cause analysis reports from serious incidents and these were completed in a thorough manner. External stakeholders said quality of investigations had improved and that the trust needed to ensure the action plans reflected the recommendations and that there were appropriate timescales for actions to take place.

Duty of Candour

- The trust had a policy and procedure on duty of candour which explained its responsibilities to be open and honest with patients and carers. Training had taken place for managers across the trust and further training was planned for other staff members.
- The trust was auditing its compliance with the duty of candour. This included whether the affected people had been told about the incident, received an apology and been told about the investigation within 10 days of the incident being reported and whether they had received a copy of the investigation summary within 10 days of the report being signed off. For the first two quarters of 2015-16 the compliance for the initial contact for serious incidents was 94% and 69% for moderate incidents. The receipt of the investigation summaries was mostly taking longer than the target timescale.

Anticipation and planning of risk

- Teams and directorates had risk registers, which fed into the corporate risk register. These were mostly kept up to date and used to inform ongoing work. The progress of addressing issues placed on the risk registers was monitored by the performance improvement committee which reported to the trust wide quality and safety committee.
- Teams also had plans in place for how they would deal with situations such as severe weather.
- The trust had plans in place for what would happen in the event of a major incident and this information was available to staff across the trust.

Requires improvement

Are services effective?

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

Summary of findings

Our findings

Assessment of needs and planning of care

- Most of the areas we visited completed comprehensive assessments for the people they were supporting. The assessments varied dependent on the needs of the individuals. For example the assessments completed by the home treatment teams focused on the development of a crisis plan. For inpatient mental health services there was always a completed physical health assessment. For community children, young people and families they used the common assessment framework (CAF); a multi-agency tool used to identify the needs and to help support children with complex needs to access the necessary services.
- The trust carried out a monthly audit of electronically completed patient records. This identified records where all the necessary sections had not been completed. Feedback was provided to managers and individual members of staff so they could be supported to complete the records fully.
- The quality of the care planning varied between services and teams. In forensic services the care plans were a very high quality and covered patients' holistic needs such as social care needs, interests, needs relating to family and carer support. Care planning documentation clearly reflected patients' voice and involvement. There was a strong focus on recovery with some wards using the 'recovery star' approach to care planning, for example, Juniper and Blue Nile House wards. This was in contrast to the home treatment teams where care records were not fully holistic or recovery orientated across the three sites. For example, 18 out of 24 care records lacked information around social and occupational concerns, including housing, employment and financial issues.
- Most care plans were being regularly reviewed. The trust had a target that all patients must have the minimum of an annual review of their care package or a CPA review. In 2014-15 the trust achieved a result of 92% against a target of 85%. In most services, patients and their carers were involved in the care plan review meetings. There was good practice in the forensic services where there was a roll out of patient-led care programme approach meetings (CPA) on some of the wards and patients took a role in chairing their CPA meetings if they wished to. On Mint ward, the multi-disciplinary team ensured that patients and staff entered CPA meetings together so that patients were not intimidated by walking into a room 'of professionals'. These considerations were sensitive to the needs of the patient group and worked to increase involvement. There were many other examples of services aiming to involve patients in their reviews, for example at the Beacon centre a ward for young people. The Mental Health Act reviewers spoke to patients who were detained about their experiences of being involved in the development of their care plans and found a mixed response. It was recognised that this needed ongoing work especially on the acute mental health wards where the care plans were less personalised.
- Most patient records were on the trust electronic patient record system. Some records, especially for patients in the Enfield community services also included some paper documents. One of the trusts main areas of work was to provide staff with improved technology to support their roles. At the time of the inspection this was very much a work in progress and some community staff told us how they found it hard to update electronic patient records because they could not do this remotely. We also heard that some staff who were not based at a trust site had trouble accessing a hot desk to carry out this work. Staff also told us about mobile phones that were not working reliably. Senior staff acknowledged these difficulties and were in the process of reviewing contracts with their IT supplier and changing the telephone supplier and it was hoped this would lead to improvements in the service.

Best practice in treatment and care

Requires improvement

Are services effective?

- The trust had a wide range of measures in place agreed with commissioners, other stakeholders such as NHS England and in partnerships with social care with the aim of improving the outcomes of people who use their services. The commissioning for quality and innovation (CQUIN) framework had incentivised the trust to deliver improvement. A number of national and local targets were set. These included national CQUINs for improving physical healthcare and local ones about smoking cessation, prevention of alcohol misuse including alcohol screening, implementing a domestic violence policy, safe and timely discharges. Each directorate was monitoring their progress and this was reported to the quality and safety committee.
- The trust ensured it maintained the care it provided and the associated procedures in line with the latest guidance. Assurance around the monitoring of national institute for health and care excellence (NICE) guidance was by the trust quality and safety committee. When new guidance was issued this was distributed by the clinical effectiveness department and an analysis took place of changes that were needed to meet current best practice. Action plans were in place where needed.
- During the inspection we saw staff referring to NICE guidance and demonstrating a high awareness of how services were meeting the guidance. The inspectors found individual services updating their practice to reflect new guidance. Many of the mental health services had access to a range of psychological therapies in line with the guidance although there were areas where input was needed including the acute wards.
- The trust had a target in last years quality account of improving patients health by monitoring whether they received a physical health check in the community and during admission. This was achieved for 97% of patients and the inspection found these assessments had been completed. There was some good practice in terms of ensuring patients had their physical healthcare needs met. For example at Bay Tree House a ward for older people with mental health problems, staff had ensured patients were appropriately referred to specialists for diagnosis and treatment of their physical health needs. On all the wards for older people a record was kept of each patient's medical appointments and they were supported to attend hospitals and clinics. Ward managers had made sure that continuing care patients attended the dentist and optician. On the other hand in the community recovery teams and home treatment teams there were examples of patients having physical health needs but these not being followed through with the patients GP to support them to access physical health services. The acute mental health wards were using modified early warning scores to identify when a patients physical health was deteriorating. These were not always being used correctly and patients were not always being referred to the ward doctor when needed. The trust recognised that further work was needed to improve physical healthcare and this was carried forward as a quality improvement priority into 2015-16.
- The trust took part in the prescribing observatory for mental health (POMH-UK), a national audit-based quality improvement programme to improve prescribing practice in mental health. Three audits had been carried out in 2015, prescribing for patients with ADHD, bipolar disorder, and antipsychotic prescribing in people with learning disabilities. In the antipsychotic prescribing audit, the trust was performing lower than the national average for some indicators such as physical health and blood monitoring. In the national audit of schizophrenia, the trust was performing worse than average for 9 out of 18 indicators listed in this audit, including physical monitoring and interventions for elevated blood glucose levels. Where the results showed a need for improvement, action plans had been implemented.
- There was a trust high dose antipsychotic (HDA) policy in place. People prescribed HDA medicines were identified by the pharmacy team and prescribing had decreased by 59% compared to 2014, the reason for prescribing was justified in notes, and HDA monitoring forms were in place. There was also a prompt on people's electronic records when these medicines were prescribed to remind the prescriber to justify treatment, and to complete a monitoring form. The trusts latest audit in August 2015 showed that improvements were needed to ensure physical monitoring was carried out and recorded when people were prescribed HDA medicines.
- There were 2-monthly meetings of the medicines safety committee and the drugs and therapeutics committee (DTC). NICE guidance related to medicines, new drugs

and NHS England patient safety alerts were discussed at these meetings. There was good partnership working and good clinical commissioner attendance and involvement in the DTC meetings. There was prescribing guidance available to all staff on the trust intranet which was updated regularly. This contained guidance on the prescribing of unlicensed or off-licence use of medicines, and we saw this was being followed regarding justification, but no evidence in records of people being asked for their consent when these medicines were prescribed.

- The trust recognised that clinical audit was an essential part of improving quality.The effectiveness team led on clinical audit and patient safety. The clinical audits checked compliance with targets set by commissioners such as audits of physical health checks. They also checked compliance with internal procedures such as infection control and hand hygiene. They had also been developed to address areas of priority, for example the audits looking at the use of physical interventions such as restraint and seclusion. The clinical audit team in some cases carried out the audits themselves or supported and monitored audits carried out by others. They disseminated the results of these audits to relevant clinical groups; including through a recently introduced 'quality bulletin'. The results were also considered as part of the directorate 'deep-dive' meetings and key findings were included in performance dashboards and the 'heat maps' for clinical services. The clinical audit team also supported clinicians and clinical teams to undertake clinical audits that they themselves had identified as being a priority. The audit team ran a monthly competition with a prize for the best audit. The inspection team saw the results of audits being used in teams to reflect on and improve performance.

- An example of how audits were used was found in the community based mental health services for older people. There were monthly audits of safeguarding concerns and how they had been managed. Where concerns were identified action was taken to bring about improvements. All the teams took part in a trust wide quality assurance audit of care records every month. Eight to twelve patient care records were selected randomly. These were reviewed to measure compliance with specific key performance indicators such as whether smoking cessation had been offered to patients and that carers had been offered a carers assessment. Results from the audits were fed back to the teams to take action, where required, to improve performance. In community health services for adults, regular audits were taking place to monitor the prevention and care of patients with pressure ulcers. The results with action plans were presented at pressure care forums.

- The trust carried out a wide range of medicines related audits to assess how they were performing, and to identify areas for improvement, such as audits of controlled drugs, prescription chart gaps, medicines reconciliation, safe and secure handling of medicines, antibiotic prescribing and audits to check compliance with trust medicines policies such as medicines taken as and when required, high dose antipsychotic medicines and benzodiazepine/hypnotics. Older audits from 2014 had showed that improvements were needed. We saw that action plans had been put in place, and more recent audits from 2015 showed improvements had been made.

- In terms of measuring outcomes for individuals the trust was also using the paired health of the nation outcome scales to measure the health and social functioning of people with a severe mental illness and over time the patient outcomes. Services also used a wide range of other outcome measures dependent on the needs of the individual to see how patients were progressing. For example in the specialist community mental health services for children and young people staff used a range of outcome measures which included, but was not limited to, a goal based outcome record sheet, a session rating scale for under and over 13 year olds, the revised children's anxiety and depression scale, the children's global assessment scale and an ADHD assessment form for parent and child. There were posters on the wall in staff areas outlining different types of outcome measures and when to use them. There were records and scores from outcome measures and rating scales present in the young peoples' electronic records and paper files. The service in each borough was a member of the child outcomes research consortium (CORC). Staff supplied outcome measurement data to CORC who aggregated the data and provided an annual report of outcomes. In adult community health services, therapy teams used outcome measures that were based around individual patient led goals. Therapists completed assessments at

the beginning and end of interventions and treatment. Teams measured patient progress over the six-week period and a patient questionnaire was given to patients to complete to measure how effective they had found the treatment. These patient reported outcome measures (PROMS) were fed back to staff and discussed in supervisions. It was however acknowledged that in some services, the use of outcome measures needed further development.

Skilled staff to deliver care

- The trust provided a two day corporate induction for all staff. We heard from a range of staff that this training was very helpful. In addition staff received a local induction that supported them to understand their specific role in the services. We heard that in most areas this was very good.
- Staff talked positively about the clinical and leadership learning opportunities they could access. This was provided through a combination of internal and external training. The external training included attended conferences and other learning events. Courses were also accessed through the London leadership academy which facilitated a number of programmes. The trust had a number of educational links with the Middlesex university. An example of this was a training course for staff working in home treatment teams. Requests for accessing training went through a panel for approval.
- The trust was mindful of developing staff skills. For example quite a number of nurses working in community roles were having training to become nurse prescribers.
- At the time of the inspection the organisation of training and development needed to improve. Staff talked about not knowing what training they could access or being made aware of training very last minute. The trust recognised the need to improve in this area and was developing a 'map of learning and development'. This included core, specialist and enhanced development programmes. This brought together existing training as well as adding new courses in a more structured format.
- The trust expected all staff to have completed an annual appraisal. In October 2015 the trust had nearly reached its target of 85% of non-medical staff having received an in year appraisal. The trust scored in the top 20% of all mental health trusts in the 2014 NHS staff survey for questions relating to staff appraised in the last 12 months and having a well structured appraisal. The feedback from staff was that they had found the appraisals a useful process to identify their development needs. The community health services for children, young people and families had only completed 75% of appraisals and so needed to improve in this area.
- The trust complied with the medical revalidation statutory requirements. In 2014-15, 81% of the trust doctors had completed their appraisal.
- The trust had an expectation that staff will have access to regular clinical and managerial supervisions. Most staff we talked to said they were receiving clinical and managerial supervision. However there were services provided by the trust where regular supervision was not taking place. These were often areas where there was a higher use of temporary staff. For example the areas where staff were not receiving regular supervision were some acute mental health wards and the Beacon centre for young people. However in some community adult mental health teams and CAMHS teams there were also a few teams where the frequency of supervision needed to improve.
- The trust expected staff to have access to regular team meetings and we found that these were usually taking place and in most services there were also meetings providing opportunities for reflective pratice which was well received.
- We found examples of where managers were working to address staff performance issues. They felt supported by the human resources team with this work.

Multi-disciplinary and inter-agency team work

- Staff spoke favourably about internal multi-disciplinary work. The trust scored better than average in the NHS staff survey 2014 for questions relating to effective team working. We observed multi-disciplinary meetings and staff handovers. This reflected some good practice and we saw staff working well together in a respectful manner making the most of each others skills and experience. Meetings mostly took place with appropriate frequency and involved a detailed discussion of each patient's progression, behaviour and risks and displayed a good understanding of each patient's needs. At the Beacon centre for young people there had been a lot of changes in the staff team and the

ward was working towards achieving consistently effective team working. In the home treatment teams, some handover meetings were too long and did not involve all members of the team.

- We also saw many examples of how different teams in the trust worked together to support patients as they moved between services. This was particularly evident for patients who were moving from inpatient services to receiving support from community teams. We heard about how information was shared and staff from community teams attended meetings on the ward.
- Patients who were discharged from mental health inpatient services who were on a care programme approach were followed up within 7 days. The trust had performed above the average for mental health trusts in terms of meeting this target between October 2013 and June 2015.
- We heard from stakeholders that the trust faced ongoing challenges in working with GPs and sending them timely information to ensure they were informed about the current support being provided to the patient. The trust recognised that this was an ongoing area for improvement and had highlighted this as a quality improvement priority for 2015-16. The target was that by March 2016, 90% of the discharge communications would contain the specific information requested by GPs and assessment, review and discharge letters would be sent within 24 hours. For the first quarter of the year 2015-16 an audit of 80 records showed this was only achieved in 62% of the cases. Progress was being monitored by the trust wide quality and safety committee with the results of another audit due. Whilst the trust reported ongoing improvements were taking place, further work was still needed. This was confirmed in the inspection where the communication between the community based mental health recovery teams and GPs needed to improve, especially providing them with updates following care programme approach meetings. However, there was also some really good practice in community health services for adults such as district nursing services. Here for patients with complex needs there were GP integrated multi-disciplinary risk stratification meetings which led to effective work between all the professionals supporting the patient.
- The trust worked with three London local authorities, Barnet, Enfield and Haringey. The trust had restructured the management of its services on borough lines and this had been well received and was felt by stakeholders to be improving integrated working. A number of the community teams included council staff seconded to the trust. An example of the close working was the review of CAMHS in Haringey that was taking place at the time of the inspection. The trust worked closely with third sector partners, for example the home treatment teams supported patients in the recovery houses provided by Rethink.
- The trust had a mental health liaison and monitoring group, which involved the trust, police, London ambulance service, commissioners and local authorities linked to the crisis care concordat. This looked at how services could improve in each borough to support patients needing crisis care. Within the trust presentations had taken place on suicide prevention to a previous clinical quality review group. Recently there had been a tri-borough suicide prevention workshop including stakeholders. This was an area of ongoing work for the trust.

Adherance to the Mental Health Act and the Mental health Act Code of Practice

- The trust's systems supported the appropriate implementation of the Mental Health Act and its code of practice. The application of the Act was overseen by the mental health law committee. This committee met quarterly to consider changes to policies and to review statistical reports of Mental Health Act activity. Legal advice was available from the head of Mental Health Act and administrative support from Mental Health Act administrators based at each hospital site.
- Training on the Mental Health Act was not mandatory. Take up for training sessions in relation to the Mental Health Act offered by the head of Mental Health Act was low, with 11 of the past 12 training sessions scheduled having been cancelled due to insufficient numbers attending.
- During this inspection we completed eight Mental Health Act review visits pursuant of the CQC's duty under section 120 to keep under review the exercise of the powers and the discharge of the duties conferred or imposed by the Act so far as relating to the detention of patients.
- Detention paperwork was filled in correctly, was up to date and was stored appropriately.

Requires improvement

Are services effective?

- There was a good adherence to consent to treatment and capacity requirements overall. Copies of consent to treatment forms were attached to medication charts where applicable. However, on two wards where a Mental Health Act review visit was completed, we were unable to consistently evidence the completion of assessments of patient's capacity to consent to treatment, or a discussion about consent.
- Most people had their rights under the Mental Health Act explained to them. However on two of the wards where a Mental Health Act review visit was completed, we were unable locate consistent evidence that all patients had been informed of their rights on admission and were reminded regularly thereafter.
- There were concerns in relation to the use of seclusion in Sussex ward and Finsbury ward. These related to the position of the seclusion facilities and the privacy and dignity of the secluded patients.
- A majority of the care plans we reviewed were comprehensive and individualised. On four wards where a Mental Health Act review visit was completed, we found inconsistent evidence of patient involvement and the recording of patient's views in relation to their care and treatment in line with the code of practice.
- People had access to Independent Mental Health Advocacy (IMHA) services and information on IMHA services was provided to patients. Patients and staff appeared clear on how to access IMHA services appropriately.
- Two wards within the forensic services where Mental Health Act review visits were completed, Blue Nile ward and Juniper ward, were commended by the Mental Health Act reviewers for their overall compliance with the Mental Health Act code of practice guidance.
- Immediately prior to this inspection, we were notified that a consultant psychiatrist had been performing the functions of an approved clinician without the required accreditation. This had affected the legitimacy of actions completed under the Mental Health Act by this consultant psychiatrist for four patients. The trust had taken appropriate action to rectify this situation and informed all patients affected as appropriate.

Good practice in applying the Mental Capacity Act

- The work on the Mental Capacity Act was overseen by the mental health law committee.
- The trust had a comprehensive Mental Capacity Act (MCA) and deprivation of liberty safeguards (DoLS) policy. This included flowcharts and checklists to help guide staff. The trust also had 6 MCA champions.
- Training on the MCA was not mandatory. This was arranged by the mental health law manager and in 2015-16 twenty six sessions had been arranged across the five sites. Training had also been provided through the medical academic programme. In addition training had been provided directly to individual teams tailored to their area of work. An external professional trainer had also been commissioned to provide some bespoke training for example to the CAMHS staff in November 2014.
- For the first six months of 2015 there had been 39 applications made for an authorization of a DoLS. These were mainly for patients receiving care on mental health wards for older people.
- Most staff we spoke with had a reasonable understanding of the Mental Capacity Act and knew where to seek advice if needed. There were some good examples of where staff had applied the MCA and recognised the need to hold best interest discussions.
- In services for children and young people staff understanding of the Gillick competencies was good and they described how it would be applied.
- The main area for improvement related to the recording of the assessments and best interest decisions. For example on some mental health wards for older people best interest discussions were not always clearly recorded so that there was clarity about how decisions had been reached. At the Beacon centre for young people the recording of consent to treatment did not explain the rationale for decisions.

Good

Are services caring?

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

Summary of findings

Our findings

Kindness, dignity, respect and support

- The staff we spoke to across the trust were enthusiastic, passionate and demonstrated a clear commitment to their work. Care was delivered by hard working, caring and compassionate staff.
- We observed many examples of positive interactions between staff and patients throughout the inspection visit. For example in the forensic services staff had a very good understanding of the individual needs of their patients and spoke about patients with respect. In the community based mental health services for older people carers gave positive feedback for all three teams. They described staff as responsive, respectful and very caring. A carer reported that the Enfield memory service had been supportive and staff were kind, warm and welcoming. Carers from the same service felt that the education provided on dementia had been invaluable in helping them to cope with their relative's diagnosis.
- The trusts overall score for privacy, dignity and well-being in the patient led assessment of the care environment in 2014 was 89% which was above the average score across England of 87%. Prior to the inspection 86% of the respondents to the friends and family test said they were either 'likely' or 'extremely likely' to recommend the trust as a place to receive care, although there was a very low completion rate for this test (8% for mental health and 3% for Enfield community services in September 2015).
- The trust also carried out it's own patient survey and in September 2015, 94% of the 796 patients who completed the survey said they were treated with dignity. Also 92% of carers said they were satisfied out of the 136 people who completed the survey.
- The 181 comment cards and feedback from user groups showed that where there were negative comments these were found more in inpatient services. These generally indicated that they felt staff could be more supportive or helpful. During the inspection there were no specific examples of where poor care was observed, although it was noticed on the busy acute mental health inpatient wards that staff communication with patients tended to be more task focused.

Involvement of people in the care they receive

- The trust performed similarly to other trusts in the Care Quality Commission community mental health patient experience survey 2014 for questions relating to whether people felt as involved as much as they wanted to be in agreeing what care they received. The trusts own patient survey in September 2015 found that 87% of the 796 respondents felt they received enough information about their care and treatment.
- Throughout the inspection there were many examples of patients and their carers being involved in assessments, care plan reviews and decisions about their care. In most cases patients and carers were invited to be part of meetings where their care was discussed. In forensic services some wards had rolled out patient-led CPA meetings where patients were able to plan in advance what they wanted to discuss and highlight in their CPAs and lead by chairing their own CPA meetings. This had very positive feedback. In forensic services patients were also involved in a collaborative risk assessment which had been rolled out across the service. Patients and staff had undertaken training to understand this process and patients were partners in determining and understanding the risk factors related to their needs and how these risks were to be managed. The trust also monitored as part of its annual quality account patient involvement in care planning and this was 96% in 2014-15. Although there was a lot of good practice, there were still patients who said they had not had a copy of their care plan or there was no record of their involvement in preparing the care plans. This was highlighted in some of the Mental Health Act review visits and is an area of ongoing work for the trust.

Good

Are services caring?

- On most wards there were regular community meetings taking place which enabled patients to have some involvement in the services they were receiving. For example on the acute mental health wards at Chase Farm patients were able to give feedback on the services they received at weekly community meetings that took place on each of the wards. A range of issues were discussed including patient leave and therapeutic activities. Staff were respectful of patient views and responded positively to patients' concerns, providing practical solutions where possible. Community meeting minutes from each of the wards over a period of several months showed that staff had responded to patients' concerns.
- Advocacy services were available across the trust. Advocates visited the wards regularly. Information was available on the wards and teams about access to advocacy services. Staff mostly knew about the advocacy services and were supporting patients to access these services
- Most of the inpatient areas we visited had arrangements in place to introduce patients arriving on the ward in a thoughtful manner that enabled them to be shown around. We saw different examples of information being given to patients and their relatives and carers to introduce them to the service. Information was also available or being developed for the community services. For example the home treatment teams had produced packs for carers with information leaflets and contact telephone numbers of the crisis teams.

Requires improvement

Are services responsive to people's needs?

By responsive, we mean that services are organised so that they meet people's needs.

Summary of findings

Our findings

Service planning

- Stakeholders said that the trust worked with clinical commissioning groups, local authorities, people who use services, acute trusts, GP's and other local providers to understand the needs of the people in the three boroughs where local mental health and community services were provided. The trust also provided specialist services where patients came from across the London and other parts of the country to receive care.
- In April 2015, the trust reorganised their services to a borough based structure and specialist services line.This enabled them to focus on meeting the needs of local people. This revised structure was positively received by external stakeholders, patients and staff within the trust. There are regular meetings at a borough and trust wide level to plan and develop services.

Access and discharge

- Overall the trust was working to make the access and discharge arrangements work as well as possible. Where there were challenges, such as waiting lists for services, they were in discussions with commissioners to find solutions. There were variations between services about how well these arrangements were working in practice.
- In the mental health services, the trust had a higher than planned inpatient length of stay. Ken Porter ward at Barnet had the longest length of inpatient stay with an average stay of over 300 days, although this ward is a continuing care and in some cases care for life ward where the majority of patients would be expected to stay for an extended time.
- There were a total of 87 delayed discharges reported by the trust in the six months prior to the inspection. The Oaks and Silver Birches which were wards for older people with mental health problems had 42 and 33 delayed discharges respectively. There were also a few delayed discharges on the acute mental health wards. The trust was supporting patients with their discharge plans and these delays were often caused by factors such as availability of accommodation and the complex needs of the patients.
- There were a total of 227 readmissions within 90 days mainly on the acute mental health wards. At Chase Farm the readmissions were Dorset 62, Sussex 27 and Suffolk 20. In Haringey the Haringey assessment ward had 43. In Barnet Trent ward had 20 readmissions.

Access to mental health services in an emergency:

Home treatment teams:

- The trust provided home treatment crisis support 24 hours a day, seven days a week. Between 8am and 10pm this was provided by the borough based teams, whilst at night one joint team covered the three boroughs.
- Patients could access information and advice through phoning the team. During the day, administrative and clinical staff in the trust's 'hub' answered calls to the team. At night phone calls to the hub were responded to by the night team. Patients on team caseloads could also call the teams directly. Patients told us they sometimes had long periods of trying to connect to staff through the 24 hour crisis lines.
- Staff in the hub screened and triaged referrals to decide which team was the most appropriate to respond to a referral. When staff decided that a person should be assessed by the home treatment team the referral was passed to the respective borough team.
- The teams accepted referrals from community mental health teams, local GPs, inpatient wards as well as from psychiatric liaison services based in local acute trusts. Teams also accepted self-referrals and referrals from carers. Many referrals were received via the 'hub', although at the time of the inspection, it was not acting as a single point of access as the teams also received some direct referrals. The hub had been set up in January 2015. Not all staff we spoke with were clear about the function of the hub.

Requires improvement

Are services responsive to people's needs?

- Two qualified nursing staff were allocated by each team to complete initial referrals. The trust had agreed a target with local commissioners to respond to all patient referrals from GPs within four hours. The teams were meeting this target. For example, the Haringey team had responded to 95% of referrals within four hours. All new non-GP referrals that were accepted by the teams had a target to be assessed by staff within a 24 hour period. Staff we spoke with told us that the pressure of responding to the four hour target, given their resources, was hard. Staff did not have a system for prioritising referrals depending on the risk presented.
- The teams supported patients in recovery house houses located in each of the boroughs, which were managed by another provider. The recovery houses supported patients in a home environment who needed short term support whilst living in the community. They could also support patients being discharged from inpatient wards. At the time of inspection, most patients living in the recovery house were awaiting housing.
- At the time of inspection team caseloads for Barnet were 65 patients, 59 patients for Enfield, and 63 patients for Haringey. Of these patients a number were rated as presenting a green risk, 18 patients in Barnet, 16 in Enfield and 18 in Haringey. Staff told us this meant that these patients could be ready to be supported by other teams or discharged. The teams often had delays in discharging patients due to delays in other teams taking referrals.
- The teams operated with an open access referral system and provided services which did not include diagnosis as an exclusion criterion. This represented good practice and adhered to national guidelines. People were accepted by the home treatment teams based on appropriate clinical need, their risk level, and their geographical location.
- Where possible, staff tried to offer patients flexibility in the times of appointments. The teams provided a service from 8 am until 10pm. This meant staff could visit people at a range of times. However, the teams did not always communicate with people to tell them when they were likely to attend and or were non-specific in times. For example, telling patients they would attend in the morning. This meant that patients were not clear about when staff would be visiting them.

Psychiatric liaison services:

- These emergency services were available at the accident and emergency departments at Barnet hospital and the North Middlesex hospital. These services were not inspected.

Health based places of safety:

- There were two health based places of safety, at Chase Farm and St Ann's. In the six months prior to the inspection the trust's places of safety had been used 261 times. Fifty percent of patients had been discharged to the community, 23% of patients had been admitted to the trust under the Mental Health Act, 21% had been admitted as informal patients and 5% had been transferred to a different trust.
- Some patients had to wait for extended time periods in the places of safety. In September and October 2015, 100 patients used the trust's health based places of safety, 70 in the Chase Farm suite and 30 in the St Ann's suite. The average time spent by patients in the suites was just over seven hours. Twenty one patients spent longer than 12 hours in the Chase Farm suite, with four spending more than 24 hours. No patient was in the suite for more than 72 hours, with a patient who spent 46 hours in the suite spending the longest amount of time in the suite. Five patients spent longer than 12 hours in the St Ann's suite. No patients were in the suite for more than 24 hours.
- A doctor reviewed most patients promptly, although some patients had to wait a long time to see a doctor. Data produced for the London mental health partnership board in April 2015, covering the period June 2014 – February 2015, showed that for 28% of patients it was more than three hours before a doctor arrived to assess them. This was the second highest for London trusts.

Acute mental health care for working age adults:

- The inpatient wards were under great pressure although the trust had robust bed- management process to ensure inpatient beds were available where clinically needed and that they were used as effectively as possible. Each ward had a daily meeting attended by all the care professionals to consider each patient and look at the practical tasks that needed to be completed to support their discharge.

Requires improvement

Are services responsive to people's needs?

- The average bed occupancy on the acute wards for the six months prior to the inspection was 104%. This was highest on Finsbury ward in Haringey at 128%, Sussex ward at Chase Farm 109% and Downhills ward at Haringey at 107%.
- All admissions to the wards went through the crisis resolution home treatment team who first assessed patients. They tried to admit patients to services in the borough where they lived but if needed would use the services across the trust. The home treatment teams also supported patients when they were discharged.
- In the six months prior to the inspection 221 patients were placed outside of the trust in other NHS trusts or the independent sector. The trust also had at times opened a temporary ward on the Chase Farm hospital site, although this was closed at the time of the inspection.
- When patients went on overnight leave, this was done with the plan for them to return for a review and then discharged from the ward. They were informed that their bed may not be available for them. If a patient returned from leave and required a bed, staff would locate a bed for the patient, which may be on another ward or hospital within the trust. Before and during the inspection we heard from patients who said they found this very distressing and disruptive to their continuity of care.
- If male patients became acutely unwell on the wards, they could be assessed to be transferred to the psychiatric intensive care unit (PICU) ward located in the trust. Staff from the PICU ward also supported the acute ward staff on how to manage the patient on the ward. For female patients with a level of risk requiring a PICU, the commissioner was informed and a feale external PICU placement was identified.
- Staff and patients said patients were sometimes moved between wards for non-clinical reasons. The trust had worked to keep this as low as possible and were starting to monitor numbers. Whilst this was still an issue the numbers were low and this was less of a concern to patients than having access to a bed on the same ward when they returned from leave.

Access to other mental health inpatient services

Wards for older people with mental health problems:

- Patients were not moved between wards unless there was a clinical reason. Patients typically stayed on The Oaks for six to eight weeks for a period of assessment. The multi-disciplinary team planned for those patients who required a longer period of in-patient treatment and care to move to another older person's ward.
- Generally, new patients were admitted to the wards at an appropriate time of day which allowed staff to support them to get to know the ward and settle in.
- On The Oaks and Silver Birches there were a small number of patients who were clinically ready for discharge. Typically, these patients could not return to where they were living pre-admission and they were awaiting suitable alternative accommodation. We saw minutes of regular meetings that trust staff held with the relevant local authority to expedite the safe discharge of such patients. Staff felt that these arrangements were effective in ensuring patients were discharged as soon as possible.

Child and adolescent mental health wards:

- The ward was commissioned by NHS England who were told on a daily basis if a bed was available. Many referrals needed to be considered quickly however the ward did not currently accept any out-of-hours emergency admissions. Referrals were discussed in handover meetings and urgent cases sometimes required managers' meetings to be convened at short notice. There were frequent planned admissions. Young people were able to come to the ward for an assessment with a consultant and one of the nursing team.
- Discharge was not usually felt to be very problematic by ward staff. CAMHs community teams all came to care programme approach meetings. However sometimes social care arrangements, especially access to accommodation, could slow discharge.

Forensic inpatient wards:

- The service had a weekly meeting where referrals into the service were discussed and monitored, as well as the need to transfer patients between wards.

Requires improvement

Are services responsive to people's needs?

- The service had access to a rehabilitation low secure unit which was in the local community and run in partnership between the trust and the independent sector. This helped to facilitate a rehabilitation pathway for patients in the secure wards.
- There was a small team within the North London Forensic Service which monitored and reviewed all external placements nationally which were provided to patients who were in the services' catchment area. For example, placements in women's learning disability forensic services where the service was not available within the North London Forensic Service. These placements were reviewed a minimum of annually but more if necessary. This meant that the service had a good understanding of the needs of patients in the North London area regardless of where the services were being delivered.
- There was one learning disability ward within the service and the consultant on the ward linked with the community learning disability consultants. The pathway for patients within this ward was, wherever possible, to move from medium secure setting into the community.
- Between 1 January 2015 – 30 June 2015 there were eight delayed discharges. These were mainly due to funding and accommodation issues. However, during our inspection we were told that there was now only one patient whose discharge was delayed.

Access to other community mental health services:

Community based mental health services for adults of working age:

- The trust had established a hub, a central point where GPs could seek advice about patients in primary care from one of the assessment service consultant psychiatrists.
- The majority of referrals to the assessment services came from GPs, patients, carers and other professionals involved in patients' care. The assessment service triaged urgent referrals and forwarded them to the crisis team. They referred non-urgent referrals to the most appropriate community team for follow up. Some managers and staff commented that this process meant that patients had to repeat their stories at each stage to a different professional.
- Patients discharged from services within the last two years could re-refer themselves directly to the service if their circumstances changed.
- Community services did not have target times in place with regards to referral to treatment times. CSRT teams aimed to review referrals within 72 hours of receipt. Managers allocated referrals to staff. CSRTs offered most new referrals an initial appointment within two weeks of referrals being received.
- At each of the CSRTs there were waiting lists for psychology input. The trust had set a target time of 18 weeks from referral to treatment time. Each team we visited had a waiting list for psychological therapies. In each team, there was a wait of two to three months for a psychology assessment and then an additional two to three month wait for treatment to commence. Based on this information some teams may not have been achieving the 18-week target. However, data showing the actual referral to treatment time for psychological therapy was not available.
- Staff responded appropriately when patients phoned in. Where care co-ordinators were not Staff tried to be flexible with appointment times where possible. Appointments ran on time. Staff informed patients if appointments did not run on time. Patients told us that appointments were rarely cancelled and that staff always attended.

Community based mental health services for older people:

- The services were accessible and responded promptly to referrals. Referrals to the older people's community mental health teams came mainly from GPs. In Enfield and Haringey GPs and other referrers usually sent referrals via a single point of access where staff carried out an initial triage before sending the referral to the appropriate service. In Barnet there had been 1698 referrals to the team between January and October 2015. Ninety per cent of the referrals had come directly from GPs, 1% came from the in-patient wards and 8% came from other sources including the single point of access. In Barnet 30% of the referrals were for people who lived in a residential care home.
- When referrals came to the community teams they were reviewed by a staff member. In Haringey all new referrals were reviewed by a dedicated duty nurse who arranged urgent assessments and obtained more information

about routine referrals. Urgent referrals were prioritised and where possible they were seen and assessed within four hours. Urgent referrals out of hours were responded to by the crisis team.

- Non-urgent referrals were discussed at referral and allocation meetings within a week and, where appropriate, allocated to staff for assessment. The target time from the point of referral to the assessment of patients was 13 weeks. However, almost all patients were seen and assessed within two to four weeks. Delays were sometimes caused by patients going on holiday or appointment cancellations, but delays beyond 13 weeks were very rare. Some new referrals were signposted to other services such as out-patients or the improving access to therapies team if this would better meet their needs.
- Some new referrals were passed to the memory service for assessment. The Enfield and Haringey memory service received an average of 10 referrals every week. The Barnet memory service received an average of 25 referrals every week.
- In October 2015 in Barnet 15 patients had breached the six week referral to assessment target in the memory service. This had subsequently been reduced to five people who waited longer than six weeks.
- The referral to assessment target in Haringey was 13 weeks. This target was usually achieved. However, in order to meet the target staff had focussed on making sure the initial assessments took place quickly. This meant that the waiting time for patients between assessment and diagnosis had increased. There was currently a wait of about 21 weeks. The service was looking at the skill mix of the memory service in order to ensure that staff had the necessary skills to provide the service more effectively. Senior staff were due to meet with commissioners to discuss the overall provision of the memory service with a view to reducing waiting times and improving the pathway for people from referral to assessment and diagnosis.
- Sometimes there were delays in discharging patients from the service. Delays were usually caused by difficulty finding appropriate accommodation or placements for patients and delays in obtaining funding for identified placements. A lack of care home placements in Enfield and Haringey meant some patients needed to be placed further from their original homes and family support. In Enfield the team supported some patients who only required a visit to be given depot medication (medicine given by injection). Some local GPs provided the treatment to the patient in a primary care setting, but most did not.

Specialist community mental health services for children and young people:

- Referrals were received from GPs, schools, child health and the local authority. Services had systems in place to screen all incoming referrals daily for immediate risk and appropriateness for the service. Staff wrote back to the referrer with an explanation if the referral was not accepted and signposted to other appropriate services, if possible.
- Once a referral was accepted, administrative staff would set up an assessment appointment. The trust target for completing as assessment was within 13 weeks of the referral date. This target was met for over 94% of young people in October 2015. A service review report from September 2015 indicated that the mean waiting time for Haringey generic CAMHS was 71 days (about 10 weeks). This service review noted an improvement in waiting times since January 2015.
- The trust did not have a target waiting time from initial assessment to the start of treatment. Waiting times for routine access to treatment varied between each therapeutic discipline. There was a four month wait for access to a family therapist and a six month wait for access to a psychiatrist. Feedback from parents and carers was that the waiting list for appointments was too long. General feedback about the service was positive, but this was highlighted as a common concern. The teams did not have a formal system for regularly monitoring people on the waiting list to detect an increase in the level of risk. When waiting for therapy after a first assessment, staff gave young people verbal advice and a letter with contact numbers for the service. Staff said that if there was a deterioration in a young person's mental health and they become more unwell, staff could discuss this immediately with a psychiatrist and would be supported in taking the next steps to provide support to the young person.
- Due to the skill mix, staff were able to deliver a very therapy based model of care. This was highlighted as positive, but staff felt it also created an impact on the

waiting times for those accessing the service. Staff felt some cases were held longer than necessary and that introducing nursing care staff and new models would allow young people to access the service and be ready for discharge more quickly. The service review of Haringey CAMHS in September 2015 highlighted that average length of intervention for 2014/2015 in the generic team was 698 days. The average number of appointments was 12. This was double the average number of appointments and length of intervention outlined in the CAMHS benchmarking report from the NHS Benchmarking Network in 2013. The review needs to bring about changes that improves access to the service.

- Staff picked out urgent referrals immediately. Each borough had an adolescent outreach service for people aged 12-18 that would support people with more acute needs. The outreach services accepted self-referrals from young people as well as from GPs and generic CAMHS. All young people referred to this service received an appointment within two weeks. The key performance indicator report from October 2015 showed that the Haringey adolescent outreach service had seen 90% of people for an assessment within two weeks with an average wait of 12 days. If there was a more urgent need, staff would see the young person within 24 hours. These services received around 300 referrals per year in each borough.

Access to Enfield community services:

Adult community services:

- Referrals for district nurses, community matrons and the intermediate care team went through a single point of access. The single point of access had made joint working a lot easier, had helped to avoid duplication, improved communication and was clearer for the patient.
- Information from the community services dashboard showed district nurses and out of hour's nurses had 100% response to urgent referrals within four hours and 100% response to other referrals within 48 hours. The district nurse out of hours team covered Enfield and Barnet boroughs which was a large geographical area. They told us they were usually able to respond to a call within one hour. Sometimes this would be a telephone response. When in a person's home they did not answer the telephone and so in this situation there may be a short delay.
- District nurses told us told the trust had reviewed equipment delivery and a priority system was in place that involved triaging by managers. This had improved the effectiveness of equipment delivery. Equipment ordered in the afternoon was delivered in 24-hours but this did not include Sundays and bank holidays.
- Intermediate care teams caseloads fluctuated and the two teams worked together to meet the demand. Both teams were meeting their response times but had to work hard to do this. Responses times were four hours or 24-hour response for admission avoidance (according to patient need) and five working days for patients referred for rehabilitation. The service operated 9am to 5pm six days a week. On Sundays there was an on-call service which was predominantly telephone advice but patients could be seen as an emergency if there was an admission response crisis.
- The continence service met its target of seeing more than 75% of patients within three weeks of the initial referral in April, May, June, October, November and December 2014 but not in the other months up to March 2015. The reason for the patients not being seen in 2015 was due to a nurse on maternity leave and a recruitment process was underway to address this. Follow up appointments were based on patient need.
- Community therapy managers told us the team triaged patient referrals daily and contacted patients by telephone to discuss the referral. There were no occupational therapists in the community therapy teams because social services managed this service. If referral to occupational therapy was considered appropriate, the person may be advised to self-refer or the physiotherapist made the referral.
- Community physiotherapists achieved the target of seeing 90% urgent referrals within five working days in all but two months over this period. The target of seeing 90% routine referrals within eight weeks was only met in April and May 2014. In other months the response ranged from 81% to 87%. The musculo-skeletal physiotherapy target of 90% patients having their first appointment within 13 weeks was not met and ranged

Requires improvement

Are services responsive to people's needs?

from 44% to 75% over the 12-month period. Action was being taken to try to address this through consultation with commissioners, use of agency staff to cover maternity leave and new staff appointed to a vacancy.

- The community stroke rehabilitation service met its target of assessing 80% of patients within three working days in April, May and June 2014 and January February and March 2015. In the other months, it was 67%.
- The lymphoedema service was available for any patient of any age. The service level agreement was for palliative care patients to be seen within four to five working but they were usually seen in one to two days. The team saw babies at home and school age children in clinics during holiday time. The team arranged home visits with district nurses where patients could not come to the clinics.
- The stroke team told us referrals from the hyper-acute stroke unit (HASU) were seen within 24 hours and acute stroke unit (ASU) would be seen within three days. Referrals from GP's or self-referrals were seen in three to six weeks. There was no waiting list.
- The tissue viability nurses told us there was no waiting list for the service and patients could be seen within 24 hours if necessary but there was no weekend service.
- Waiting lists for speech and language therapy services was a pressing issue. A manager said the team was now fully staffed with 2.23 whole time equivalent staff. The clinical commissioning group were fully aware of the situation and were aware the waiting list had reduced with the use of agency staff but even with these staff in post patients still had to wait.

Community services for children, young people and families:

- Overall, children, young people and families received timely community health services. Waiting times for patients referred for treatment had improved. With a few exceptions, services met their performance targets and where there were waiting lists these were now being managed effectively.
- The health visiting service undertook 94% of new birth visits with in 10 to 14 days in 2014/2015 against the trust target of 95%. For the period April to October 2015, 95% of new births were visited with in 10 to 14 days.
- For the period April to October 2015, 44% of children referred to the clinical support service for occupational therapy (OT) had their initial assessment within 13 weeks against the trust target of 70%. This was an improvement on performance in the 12 months ending in March 2015 when 1% of children were seen within 13 weeks. The service were unable to manage the level of referrals received due to increased referrals and staffing capacity. This was included on the risk register. An improvement plan was implemented in June which included weekly monitoring, a directed daily team brief work allocation and one additional full time agency OT for one month. In July and August 2015, OT staff based in education were redirected to the routine waiting list and the package of care was refined. One new permanent OT commenced employment in August and locum staff continued to cover vacancies. The care pathway was redesigned and commenced in October 2015. By the end of November 2015 trust reported the service was stable and achieving it's assessment target.
- For the period April to September 2015, 85% of children referred to clinical support service for physiotherapy had their initial assessment within four weeks against the trust target of 75%. This was an improvement on performance in the 12 months ending in March 2015 when 67% of children were seen within four weeks.
- For the period April to September 2015, 98% of children referred to the physiotherapy neurodevelopmental service had their initial assessment within 13 weeks against the trust target of 95%. This was an improvement on performance in the 12 months ending in March 2015 when 89% of children were seen within four weeks.
- For the period April to September 2015, 100% of children referred to the speech and language early years drop in service had their initial assessment within 13 weeks against the trust target of 75%. This was an improvement on performance in the 12 months ending in March 2015 when 38% of children were seen within 13 weeks.
- The percentage of looked after children receiving immunisation between the period July to September 2015 was 83% which was lower than the previous quarter which was 86%. This was below the below the national uptake rate of 87%.

Community health inpatient services:

- Magnolia unit was a 29 bedded ward, with an annual occupancy rate of 86%. The expected length of stay on

the unit was up to two weeks. Discharge planning commenced on a patients admission to the unit, with patient goals being set and a provisional discharge date. Patient goals were reviewed weekly by the multi-disciplinary team.

- The manager told us that the unit's average length of stay had reduced from 24 days to 21 days.
- Staff told us there were clear criteria for the referrals of patients which meant that inappropriate referrals could be identified. Staff told us that the Magnolia Unit had flexible admission criteria depending on the patient's needs.
- Discharges could be arranged Monday to Sunday. If a person was due to be discharged to their home address the staff liaised closely with the local authority social services in assessing people's social care needs. A discharge summary would be sent to the patient's GP within 48 hours of discharge.

Accessibility of mental health services:

- Some patients and stakeholders including GPs still found the referral process for mental health services difficult to understand especially as some referrals went through the central hub and others went directly to the community teams. The trust had tried to make this information clear on their website. They had also delivered some training at GP surgeries to help raise awareness of services provided by the trust and how these can be accessed. This also included some refresher training on how to support patients with mental health problems most commonly encountered in primary care.
- The trust in September 2015 was following up 97% of patients discharged from mental health wards who were on a care programme approach within 5 days of their discharge.
- All of the community teams told us that they were proactive in trying to engage with patients who were reluctant to accept involvement from mental health services. Most services tried to offer flexible appointments and were aware of the need not to cancel urgent appointments and to be on time for appointments. This needed to be improved for the home treatment teams. The teams also followed up patients who did not arrive for their appointments.

The facilities promote recovery, comfort, dignity and confidentiality

- The trust provided services from a range of buildings some of which were in need of redevelopment. Most inpatient services had access to a range of facilities including quiet lounges, rooms for therapeutic activities and outside space. In some areas there had been considerable thought given to making the environment as pleasant and comfortable as possible. An example of this was the development of the sensory garden on Cornwall Villa a ward for older people with mental health problems at Chase Farm.
- The wards tried to afford patients with privacy and dignity. At St Ann's the size and layout of wards compromised patient privacy and dignity. Examples of this included the four bedded dormitories on Downhills and Finsbury ward. In these areas beds were separated by a curtain but this did not provide sufficient privacy, especially when patients were very distressed. These wards also shared a dining area and had access to this at specific times. This meant that the meals had to be eaten under timed conditions and also that the remaining communal space on the wards was small and cramped. The garden at the Haringey assessment unit was surrounded by a metal fence where members of the public could see patients as they walked past. The Beacon centre for children and young people was also waiting for improvements to the physical environment. Also at Cedar House where Enfield community services provided clinics for children, young people and families, the environment needed to be made more child friendly.
- Across the wards the observation panels on bedroom doors were compromising patient privacy. On some wards the viewing panels could not close, or could not be closed by the patient or had missing curtains. This meant that people passing the bedroom could see in. The arrangements for people to be able to lock their bedrooms were also mixed and not everyone was offered a key. Some wards provided a safe to help people store their personal possessions safely. On the psychiatric intensive care unit at Edgware community hospital we heard about personal possessions being

stolen. Across the acute mental health wards we found that several of the pay phones were broken. Patients were able to use the phone in the staff office, but this did not always provide them and the staff with privacy.

- Most of the patients were positive about the quality and variety of food. Overall the trust was performing 3.4% better than the national average for the provision of food in the patient led assessments of care environments in the 2015 survey. In the forensic services some patients are preparing meals for themselves. In the continuing care service, the Magnolia unit, they used red trays to identify patients who needed higher levels of support when eating their meals. The site where people were least satisfied with the food was at Edgware community hospital. Here patients said they did not like the choice of food and it did not meet their cultural needs. On the psychiatric intensive care unit we heard that patients were ordering lots of take-away food. On all wards hot drinks and snacks were available although arrangements for how these were accessed varied.
- Access to therapeutic activities were generally very good for people using inpatient services. For example on the forensic wards patients had access to the Kingswood Centre. This provided onsite activities and therapy space with a large garden area and a number of activities, both recreational and therapeutic, for example, with gardening areas, woodwork and arts and music therapy. This was within the medium secure parameter so patients were able to access this area. Patients were offered work experience at the shop within the Kingswood Centre and the café in the main entrance of the medium secure unit. Patients had been successful in developing a bee keeping project and had won first prize at the Enfield farmers market for their honey. This was a successful enterprise.
- On all of the wards for older people with mental health problems there were activities taking place. Patients enjoyed playing games, undertaking craft activities, exercising, enjoying music and dancing and participating in poetry and baking groups. Activities were timetabled throughout the week and patients told us they found what was on offer enjoyable and entertaining.
- At the Beacon centre for young people the trust had commissioned a third sector organisation that worked with mentally ill people using a range of arts and therapies, to become involved on the ward. An initial twelve week programme was underway. There was a good programme of activities on the ward including art, music and sports. Activities available to young people on the ward included: a current affairs group, an art therapy group, a young persons' forum, a poster design group, a shopping for cooking group, a cooking group, music therapy group, a pampering group and a walking group.
- Most structured activities took place during the week, but leisure activities were provided at weekends in most of the services.

Meeting the needs of all people who use the services

- The trust served a very diverse population across each of the areas it covered. The trust demonstrated a commitment in terms of meeting people's equality, diversity and human rights.
- The trust produced an annual equality and diversity report and this set out the evidence for how the trust met its commitment to deliver equal opportunities and tailored care to meet the needs of individual patients and staff.
- The trust had established an equality and diversity forum, Connections, chaired by the chief executive which aimed to positively impact on inclusion. Some of the initiatives that had come from this was the training on unconscious bias which had been delivered to senior staff who would then deliver the training in individual services. Also a workshop had taken place looking at improving healthcare to lesbian, gay, bisexual and transgender patients.
- Equality and diversity training was mandatory. In October 2015, 85% of staff had completed the training.
- Across the trust the inspectors found that most services had considered access for people with mobility issues, meeting peoples spiritual and cultural needs and providing information in accessible formats.

Listening to and learning from concerns and complaints

- Information on how to complain was provided on inpatient wards and in most community services. Complaint leaflets displayed a free translation phone

number for 22 languages. A separate complaints leaflet was being redesigned for people with a learning disability. Information for staff on how to handle complaints was displayed on staff boards. The trust website also had information on how to make a complaint. This was written in English and it was not clear how to access information in other formats.

- Complaints could be made by email, phone and post. The patient experience team (PET) dealt with complaints across the trust. Complaints were triaged and allocated to clinical leads for investigation. The person leading the investigation made contact with the complainant either by telephone or arranged a face-to-face meeting.
- Between January 2014 and October 2015, 246 complaints were received. Of these 31% (76) of those were upheld. Two complaints were referred to the ombudsmen and one relating to the Haringey home treatment team was partially upheld. An action plan was being prepared.
- Downhills ward had the highest number of complaints with 12 followed by Haringey assessment ward with 11.The Trust has reported 'clinical treatment' to be the most frequent cause of complaint, with staff attitude, communication, appointment delays and admission/ transfer arrangement within the top five.
- The trust produced a report every 6 months. The trust wide quality and safety committee received this report and reviewed themes from complaints. Complaints and the learning from them were discussed at team meetings and deep dive meetings. Staff were familiar with local complaints but less with the learning across the trust. External stakeholders said trust reports looking at complaints would benefit from more evidence of trend and theme analysis, learning for staff and actions taken to prevent recurrence. The Director of Nursing was leading a programme of 'values into action' during 2015/16. This will include a specific area of work to improve how complaints are handled.
- Informal complaints were dealt with locally, recorded in patient progress notes and should be followed up with a written response within 10 days. Formal complaints were acknowledged within 3 working days and the target was for 90% of them to be responded to in 25 days. In the last financial year 2014/15, 260 formal complaints were received, 97% were responded to within the target response time of 25 days. All complaints were signed off by the chief executive.
- Training on how to manage complaints was provided to staff during corporate induction. Further training on resolving complaints was provided to all staff. Specialist training was provided to staff at band 7 or above who were involved in investigating complaints. The staff member allocated to investigate a complaint was independent to the service involved.
- We reviewed seven complaint files and responses provided to complainants by the trust. Three of the responses were not prompt and fell outside of the trust's 25 working day response timeframe for various reasons such as complexity of the issues raised, and the complaint being sent to the wrong team. In two of these cases letters to keep the complainant informed of delays were not sent. Apologies for delays in responding to complainants were however included in final responses. In four of the cases there was no evidence of lessons learned from complaints. In all cases the response letter advised the complainant of how to contact the ombudsman service if they remained dissatisfied with the response.
- Information about how to send a compliment was displayed on posters, leaflets and on the trust website. There was no formal process for compliments to be reported to the patient experience team. This had been discussed in governance meetings and teams were encouraged to send a copy to the team. The Haringey older peoples community mental health team received the most compliments during the period April – September 2015.

Requires improvement

Are services well-led?

By well-led, we mean that the leadership, management and governance of the organisation assure the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

Summary of findings

Our findings

Vision values and strategy

- The trusts vision was 'to be the lead provider, co-ordinator and commissioner of integrated care services to improve the health and wellbeing of the people of north London and beyond'. The values were 'putting patients and carers first, showing kindness and compassion, being honest and open, creating a safe, friendly and caring environment, striving for excellence and supporting our staff'.
- The trusts strategic objectives were providing excellent services to patients, developing staff and being clinically and financially sustainable.
- The trusts clinical strategy is based around developing a programme of enablement for people using the services provided by the trust. The aim is for services to provide interventions that enhance and promote recovery, social inclusion and community integration. The trust says that it wants patients to 'live' – somewhere safe and secure to call home, 'love' – social contact, friends and relationships and 'do' – meaning activities supporting access to volunteering, study or employment.
- The trust quality priorities 2015-16 were as follows: patient safety – improving discharge communication with GPs, improve individual physical health through alcohol misuse screening and smoking cessation services. Patient experience – to enable young individuals through coping and self-care skills training and provide additional support to those dealing with long term conditions. Clinical effectiveness – to evaluate a sample of enablement pilots through patient recorded outcome measures.
- Staff had a high awareness across the services of the trusts vision, objectives and clinical strategy of enablement. These were displayed throughout the trust. Staff were proud of the values of the trust and were able to explain how their work reflected these values.
- At the time of the inspection the trust for the first time had a financial deficit of £4.7m. Along with the clinical commissioning groups the trust commissioned a review of the trust's sustainability. The review said the trust was an efficient provider but also showed that in relative terms the funding from commissioners was low. The trust were working with commissioners and the Trust Development Authority on this.

Governance

- At the start of the inspection, there was a presentation from the trust to the inspection team. This highlighted the work of the trust that was a success, the challenges and the areas for improvement. These largely reflected the findings of the inspection and showed that the trust knew where work was needed.
- The trust governance structure operated on three levels. Firstly providing assurance through the quality and safety committee which reported to the board, secondly providing scrutiny through borough level clinical governance committees and finally monitoring delivery through deep dive meetings.
- The trust had a robust board assurance framework in place. This document identified the top areas of risk and the measures of progress for assurance. It included operational and strategic risk. The framework was colour coded to show how each area related back to the trusts objectives. This was updated on an ongoing basis so the information was current. The board assurance framework was supported by a quality and safety dashboard which collated key data each month. It visually presented where targets were or were not being met. These documents were discussed at board meetings.
- At the time of the inspection there were six committees that were sub-committees of the board. The quality and safety committee provided the board with assurance in

relation to the care delivered to patients. They received reports from a number of sub-committees reflecting staff, service user and carer experience, clinical effectiveness & compliance and patient safety & safeguarding. The meeting we attended received updates on areas of significant risk such as serious incidents and completion of mandatory training. The committee showed good insight into the challenges facing the trust and 'hot spots'. For example it recognised that the demand for mental health services in Haringey was placing great pressure on the inpatient and community services.

- The services provided by the trust had been organised since April 2015 into three borough based service lines and specialist services. The borough based structures were well received both within and external to the trust as they provided the opportunity to focus on the needs of local populations. The structure however, presented a challenge for clinical staff communicating across the trust and sharing learning across the same services in different boroughs. The borough based structures were also still relatively new and the governance arrangements were still bedding down. The configuration of committees in each borough were slightly different, although they all included operational management and clinical governance.
- The trust had deep dive reviews in each of the boroughs and specialist services for different care pathways. The meetings reviewed a range of information covering performance, serious incidents, complaints, audits and feedback from patients. They also reviewed the risk register for the service so that issues of concern could be escalated. The meetings enabled key staff to review how services were being delivered and develop action plans.
- The trust had a system of peer service reviews. These were like internal inspections and involved staff visiting other wards and checking the environment, interviewing patients and staff and looking at some patient records. The results were then collated. These were discussed at deep dive meetings. Very few staff mentioned the peer reviews and awareness of where the need for improvements had been identified was limited.
- The teams in the trust had weekly management meetings and monthly clinical governance meetings. In most areas these were taking place as planned. Staff were aware of and involved in these meetings.
- Shortly prior to the inspection a new tool had been introduced to ward managers and some other team managers. These were 'heatmaps' and brought together a range of information about the service including staff data like vacancies, sickness, completion of mandatory training. These identified where action needed to take place and managers were seen using these tools to inform their work. The plan was to extend this tool to other areas of the trust where they were not yet in place.
- All the teams had risk registers that fed into service line risk registers and then into the corporate risk register which was reflected in the integrated performance and quality and safety dashboard. Most of the team risk registers were up to date and concerns had been appropriately escalated.

Fit and proper persons test

- The trust was meeting the fit and proper persons requirement (FPPR) to comply with Regulation 5 of the Health and Social Care Act (Regulated Activities) Regulations 2014. This regulation ensures that directors of health service bodies are fit and proper persons to carry out this role.
- The trust policy set out the requirements to meet the FPPR and how the trust will comply with the regulations. The trust was complying with the FPPR and had a compliance checklist to ensure that personal records for all board members adhered to the Trust FPPR policy
- The trust had undertaken a review of the information they held for executive and non-executive director posts to ensure they were meeting this standard. We reviewed 13 personal files of all executive and non-executive directors working on the trust board. This included the Chairmen, six non-executive directors and six executive directors; the majority of whom had been in post prior to FPPR being introduced as part of regulations in 2014.
- The trust had also identified three other staff members who were not part of the trust board but reported directly to the trust board. Professional registration checks had been completed for all four executive

directors requiring a professional revalidation. These were the medicl director, executive director of nursing, quality and governance, the chief finance officer and the executive director of workforce.

- For each of the personal records the trust had checked work references, proof of identity, and employment history. The trust also completed a search of insolvency, criminal record checks and through the appointment process led by the Trust Development Authority had ensured that board members had the capacity and capability to lead.

Leadership and culture

- The senior executive team has been relatively stable. The chief executive had been in post since 2007, chief finance officer since 2010 and executive director of nursing quality and governance since 2012. More recently there was the medical director since 2013, director of executive director of patient services since 2014 and executive director of workforce in 2015. The senior executive team were very aware of the challenges facing the trust and were committed to putting these right and providing a high standard of care for patients using the services provided by the trust. Staff working for the trust recognised the leadership provided by the senior team, especially the chief executive. External stakeholders felt that the trust had become much more open and transparent and recognised its collaborative working. Some of the areas that the senior team needed to address were not fully under their control and required action from the wider health and social care system to resolve. An example of that was the redevelopment of St Ann's. In these cases the trust had clearly raised the issues with key external decision makers in order to progress these matters

- The chair joined the trust in 2008. There were seven non-executive directors, including the chair which consisted of people who had been in post for some years and of recent recruits. The non-executive directors had expertise and experience that was relevant to the leadership of a trust that provides mental health and community health services. The board was recruiting a seventh non-executive director. None of the existing members of the board were black or from a minority ethnic group. In recognition of this the chair was working with the Trust Development Authority mentoring programme with the aim of offering a six month secondment to someone from a black or a minority ethnic group. There was a board development programme which included board workshop meetings throughout the year to discuss the strategic direction on key issues' and an annual away day. All board members had completed annual appraisals and a personal development plan. The chair completed a 360 degree appraisal with input from all board members.

- The main leadership challenge for the trust was reflected in the numbers of new or interim managers providing important support roles or directly leading teams providing care. For example in the human resources team there were several interim and new managers supporting important work like staff recruitment and the development of the temporary staffing bank. There were similar interim and new staff in the patient experience team and the team overseeing clinical audits. This meant that whilst there were lots of good ideas for how the services could improve these were at an early stage and it was too early to judge whether these changes would be sustained and successful.

- At a ward and team level there were also areas where robust leadership was not yet in place. For example across the home treatment teams there was a need to ensure effective leadership was in place to provide consistently high care. For example in Haringey they needed consistent psychiatry input. In addition the team was very overloaded and the risk register had not been updated. Whilst managers knew that improvements were needed these were not being robustly implemented and this was impacting on the safety of the service being provided. At the Beacon Centre, the child and adolescent mental health ward an intervention team had started to make progress in addressing the problems of the unit with a newly appointed ward manager, but a stable management team was needed going forward. In the community based mental health services for adults, especially the recovery teams, there were a number of challenges some of which were not being escalated through the risk register and leadership was needed to address these areas for improvement.

- The senior team recognised the need to improve leadership throughout the organisation. In some areas this had not yet been achieved and this is why some

core services and the trust had a rating of requires improvement. The findings from the inspection suggest that there is confidence given the current senior leadership that these matters should be addressed going forward.

- The trust recognised that there was still more work to do to create a healthy culture in the organisation that promoted the safety and well being of staff. The NHS staff survey in 2014 showed that whilst engagement had improved and staff felt satisfied with the quality of work and patient care they were providing, they were in the worse 20% of all mental health trusts for staff feeling able to raise concerns about unsafe clinical practice, staff feeling the trust did not provide equal opportunities for career progression, staff experiencing harassment, bullying and abuse from patients or relatives and staff experiencing discrimination at work and a few other areas.
- The trust had developed a staff engagement strategy, rolled out under the banner of 'place to BEH'. The three strands were promoting engagement, well-being and excellence and innovation.
- A number of staff engagement activities had taken place. These included ongoing chief executive forums, executive director and board member visits and communication initiatives like the CEO blog. The trust had also promoted the 'raising concerns at work' policy, produced accessible guidance on whistle-blowing. The staff engagement strategy incorporated the development of a staff well-being forum, which was developing a number of initiatives to support staff such as leisure activities.
- The trust had annual staff commitment to excellence awards and had recently introduced monthly awards. These were well received.
- The trust monitored the numbers of staff from black, asian and minority ethnic groups (BAME). In September 2015 this was 52% of the staff and broadly reflected the data on the ethnic profile of the catchment population. Staff from BAME groups had the highest uptake of training. Staff from BAME backgrounds were represented across all pay bands including band 8 and above. The trust had equality objectives to support staff to to be empowered, engaged and supported.
- During the inspection, staff said how positive they felt about working for the trust. There were many examples of staff saying how they had moved from other providers and were pleased with the change. Staff morale was generally very positive, despite some very challenging areas of work. Most teams were working well together. They felt the trust was doing its best to meet the needs of patients. We heard that staff found senior staff, especially the chief executive very accessible and they felt able to raise concerns. We also heard that the current medical director had improved morale across the medical team. We were not told of any bullying.
- The trust had a whistle-blowing process. Staff knew about this process but most said they would feel comfortable raising any concerns with their line manager. In the last year the trust had received 17 whistle-blowing concerns and they had been individually investigated. The whistle-blowing concerns through a confidential phone number would ultimately end up with the executive director of nursing, quality and governance as the 'freedom to speak up guardian' or the chief executive and a more external person might be better.
- The trust supported staff to access a range of leadership development opportunities. This included the following: a clinical leadership programme – 14 clinical leaders (doctors, AHPs, nurses) completed the programme; a manager's passport – a suite of modules to provide tools and techniques for people managers including policies, governance, performance management – 80 attended so far; Excelerate – last programme in 2014/15 and new programme planned for January; Middlesex University PG cert in leadership and management – 11 graduated, 15 applied for the next cohort; London Leadership Academy programmes – Elizabeth Garrett Anderson, Mary Seacole, Edward Jenner – a small number of staff have been sponsored in the last year or so. Throughout the inspection we heard from staff about the leadership development they had received.

Engagement with the public and people who use services.

- The trust was actively seeking to increase the diversity and number of people engaged with involvement activities. The trust had a patient experience team with a manager allocated to each borough, specialist services and the Enfield community services. A patient

experience committee had been established and was developing an involvement strategy to promote the involvement of patients and carers. This had involved a number of stakeholder events.

- The trust had engaged with patients and carers previously for example in the preparation of the annual quality account and for the development of policies such as the complaints policy and undertaking patient led assessments of care environments.
- In addition to the patient surveys carried out by the Care Quality Commission, the trust had an ongoing programme of trust led patient and carer surveys and the results were shared across the orgainsation to improve services. The trust also had positive results from the friends and family survey but the uptake of this was low.
- Throughout the services, there were examples of feedback being sought from patients and carers through surveys and suggestion boxes. The feedback was displayed on 'you said, we did' boards across the services and there were examples of changes that had taken place. For example in the CAMHS teams this had led to young people being involved in re-designing a waiting room. Also on Ken Porter ward for older people with mental health problems, after feedback from patients, staff had made a recent change to how they served patient meals.
- In some services participation had been progressed further. For example in CAMHS there were young person participation groups. Information posters about these groups and how to join were displayed in public areas. These posters were clear and outlined the work young people became involved in around improving and developing the service. In forensic services there was a service-wide patient's forum which met monthly. This involved patient representatives from each ward. Patient representatives also attended ward clinical governance meetings and service wide clinical governance meetings. There was a patient representative on a variety of working groups which were established by the senior management within the service, for example, around smoking cessation and catering. This ensured that the patient voice was reflected through all levels of governance within the service. In some services, patients were also part of the staff recruitment interview panel
- The trust was working to improve carer involvement, for example ensuring the correct details for carers were recorded in patient records, encouraging the completion of carer assessments, providing relevant information for carers, developing carer support groups and assessing progress with carer involvement using the 'triangle of care' assessment. There were also future plans to introduce carers awareness training. Examples of this work were seen throughout the inspection. For example at each of the community based mental health teams for adults, staff identified carers as part of the patient's initial assessments and on-going reviews. Carers had the opportunity to undertake their own carer's assessment. Information about carer's groups and networks were available at each site. Carer's groups and networks were able to offer emotional support and practical advice on matters such as benefits. On Silver Birches a ward for older people with mental health problems there was an active carers group which worked in partnership with staff to enhance the quality of life of patients on the ward. For example carers and staff worked together to arrange fund-raising events and entertainment and activities for patients. In forensic services there was a service-wide carers' forum which was held monthly on a Saturday for family members to attend. There was also a family intervention service to provide support to families and carers.
- At the time of the inspection there were very few peer workers employed by the trust. This was in contrast to most other trusts supporting people with mental health problems. The trust was working with a third sector provider to develop opportunities for peer workers in the trust. There was also scope to improve the involvement of patients and carers in staff training.

Quality improvement, innovation and sustainability

- The trust had a close links with academic partners.They were members of University College London Partners and had ties with teaching, training, research and development at UCL and Middlesex Universities. In 2014 the Middlesex University awarded the trust with an affiliated university award, due to it's commitment to joint research and education programmes.The trust played an active part in the Department of Health 'join dementia research' project to increase the number of people participating in dementia research.

Requires improvement

Are services well-led?

- The trust had worked in partnership with the local authority and a social enterprise who had provided intensive placement support to facilitate people into employment. Also in Haringey the trust had worked with the Middlesex University, a local college and a third sector provider to develop a training courseto give people the skills to enter the workforce. These formed part of it's enablement programme.
- The trust had set aside an innovation fund of £100,000 which was available to all members of staff. Using a 'dragons den' approach staff presented their ideas for projects which could improve the quality of services to benefit patients, carers and staff. Staff were very positive about this idea. An example of a successful project was the sensory space that opened on Trent ward for adults with mental health problems at Edgware community hospital.
- The trust also participated in external peer review and service accreditation. This included the accreditation for inpatient mental health services for older people where one ward, the Oaks was working towards accreditation. Other accreditations included the memory services national accreditation programme where the Haringey and Enfield teams were accredited. The forensic inpatient services were also part of the forensic quality network. The two psychiatric liaison teams were accredited.The home treatment teams were working towards accreditation.
- At the time of the inspection the trust had decided that it was not possible to identify further cost improvements without this impacting negatively on patient care. The trust was in discussions with commissioners and the Trust Development Authority about funding moving forward.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care **Regulation 9 HSCA (RA) Regulations 2014 Person-centred care:** The trust had not ensured the care and treatment of patients was appropriate and met their needs and reflected their preferences. In acute wards for working age adults: On Dorset ward at Chase Farm blanket restrictions were in place with doors locked throughout the ward. In mental health crisis services: Patients being supported by the home treatment teams found it hard at times speak to staff on the phone, were not given clear appointment times and were not informed when staff were delayed. In specialist community mental health services for children and young people: Assessment to treatment times were very long for young people needing to access certain interventions and this was not meeting their individual needs. This was a breach of regulation 9(1)(2)(3)

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment** The trust had not ensured that care and treatment was provided in a safe way for patients. In acute wards for working age adults: The seclusion rooms across the three sites did not protect the patients safety, privacy and dignity. This was due to to where the rooms were located, being able to observe patients and other patients on the ward being able to see into the seclusion rooms. Patient risk assessments were not always completed with sufficient detail and had not been updated following incidents. The trust had not kept under review the details of patients absconding from inpatient wards to ensure measures were put into place to keep this to a minimum. The trust had not ensured that when rapid tranquillization was used that health checks took place afterwards to maintain the safety of the patients. Tools to monitor if a patients physical health was deteriorating were not being used properly and medical assistance requested when needed. In community based mental health services for adults of working age:

This section is primarily information for the provider

Requirement notices

The trust did not ensure there was a system to identify patients prescribed high-dose antipsychotic medication to monitor that they are having the appropriate physical health checks.

The trust did not ensure medication was stored, administered and transported in a safe manner at all times.

In mental health crisis services:

The trust had not ensured that the documentation of risk assessments on patient care records contain sufficient detail to reflect risks accurately.

This was a breach of Regulation 12 (1)(2)(a)(b)(d)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment **Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment**

The trust had not ensured the premises and equipment used by the patients was appropriately secure, suitable and maintained

In acute wards for working age adults:

Some clinic rooms at St Ann's were too warm for medication storage, the lighting was not working properly and on Downhills ward the emergency equipment was hard to access from the main ward area.

This section is primarily information for the provider

Requirement notices

At St Ann's regular fire drills were not taking place on Finsbury and Downhills wards.

Poor lines of sight in some ward corridors had not been mitigated with mirrors.

Not all staff at Edgware community hospital had access to personal alarms.

In community based mental health services for adults of working age:

Clinic environments used by staff did not have sufficient alarms to enable staff to call for assistance if needed.

Staff doing lone working did not always have phones that worked and were not always following lone working procedures.

This was a breach of Regulation 15 (1)(a)(c)

Regulated activity

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Treatment of disease, disorder or injury

Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance

Regulation 17 HSCA (RA) Regulations 2014 Good governance

The provider should assess, monitor and mitigate the risks associated with the health, safety and welfare of patients who may be at risk.

In specialist community mental health services for children and young people:

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **Regulation 18 HSCA (RA) Regulations 2014 Staffing** The trust had not ensured sufficient numbers of suitably qualified, competent, skilled and experienced staff being deployed and that they had the appropriate supervision and support to enable them to carry out their duties they are employed to perform. In acute wards for working age adults: The trust had not ensured there were sufficient numbers of permanent staff working on the wards to ensure consistency of care, avoid leave being cancelled and minimize the incidence of violence and aggression especially on Downhills ward. The trust had not ensured that staff had access to regular supervision and that a record of this was maintained. The trust had not ensured that permanent ward managers were in post across the wards and consistent medical input. In mental health crisis services: The lone-working policy was not robust across the teams, and meant that staff safety was being put at risk. The trust had not ensured that all incidents were reported and that learning from incidents and complaints was shared across the CAMHS teams. This was a breach of regulation 17(1)

This section is primarily information for the provider

Requirement notices

The trust had not ensured that managers were providing the leadership skills needed to improve the home treatment teams and ensure patient and staff safety and a responsive service.

In child and adolescent mental health wards:

There were not enough suitably qualified staff deployed in the child and adolescent mental health wards to meet the needs of all

young people effectively.

Staff were not receiving adequate supervision.

Whilst the intervention team that had been assembled to address the problems of the unit had made a good start, a stable management team with the appropriate leadership skills still had to provide a consistently safe service.

In community based mental health services for adults of working age:

The team managers were not always escalating issues of concern or ensuring that they used their leadership skills to improve the operation of the teams.

In community health services for children and young people:

The trust had not ensured there were sufficient numbers of permanent health visitors to deliver the 'healthy child programme'. Health visitors also had to manage very high caseloads.

This was a breach of regulation 18(1)(2)(a)

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect **Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect:** In acute wards of working age adults: The trust had not protected patients privacy and dignity by ensuring patients could close their observation windows on their bedroom doors. Many patients were returning from leave and were not able to return to their previous ward. This was disrupting their continuity of care and in some cases causing distress. This was a breach of regulation 10(1)