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 (PICU)	Chase Farm Hospital Edgware General Hospital St Ann's Hospital	RRP16 RRP23 RRP46
Forensic inpatient/secure wards	Chase Farm Hospital	RRP16
Child and adolescent mental health wards	Edgware General Hospital	RRP23
Wards for older people with mental health problems	Edgware General Hospital Barnet General Hospital	RRP16 RRP01
Mental health crisis services and health-based places of safety	Chase Farm Hospital St Ann's Hospital Edgware Community Hospital	RRP16 RRP46 RRP23
Community based 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

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 services safe?	**Requires improvement** 
Are services effective?	**Requires improvement** 
Are services caring?	**Good** 
Are services responsive?	**Good** 
Are services well-led?	**Good** 

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.

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Summary of findings

Overall summary

Our rating for the trust stayed the same. We rated it as requires improvement because:

- Of the 12 separate mental health and community health services managed by the trust that we have rated, four are now rated as requires improvement: acute wards for adults of working age and psychiatric intensive care units, mental health crisis services and health-based places of safety, community based services for adults of working age, and specialist eating disorder services.
- Ratings for two of the five overall ratings for key questions (safe and effective) remain as requires improvement.
- Following the inspection in December 2015, the trust implemented a comprehensive improvement plan. At this inspection in September 2017, it had made many improvements, but in a few areas this had not been fully implemented or embedded. We also found some new areas for improvement.
- Staff found it hard to keep patients safe and protect their privacy and dignity because some of the trust's buildings were old and did not provide a good environment for patient care. Some patients at St Ann's hospital were required to sleep in dormitory rooms. Patients who needed access to seclusion rooms sometimes had to be moved through public areas and had to use bathrooms that contained potential ligature anchor points. The trust had improved many ward environments since the last inspection and had proposals to rebuild St Ann's hospital, but it needed to continue work to improve all environments.
- Staff in three of the core services did not always complete and update risk assessments in sufficient detail to ensure they managed risks to patients and themselves. Staff in the acute wards for adults of working age and psychiatric intensive care units did not complete physical health checks for patients following rapid tranquilisation.
- The trust still needed to embed improvements in physical health monitoring and planning especially in community services for adults with mental health needs. Staff did not always ensure, in partnership with GPs, that patients had received physical health monitoring. Staff in wards for older people with mental health problems did not complete diabetes plan care for patients that required them.
  - Staff did not always receive regular formal supervision. In some teams managers did not record when staff completed formal supervision or what had been discussed.
  - Patients could not always access advice and support from teams. Ten percent of calls made to the trust's hub telephone service did not get answered.
- The trust needed to ensure its management systems identified and addressed all areas of risks. The trust had not identified some areas of concern so they could be addressed in a timely manner. In addition, managers on some acute wards were recently appointed. They needed to ensure improvements were made and embedded in all wards.

However,

- Of the 12 separate mental health and community health services managed by the trust, two are now rated as outstanding: forensic inpatient/secure wards and community based mental health services for older people. This is a significant achievement.
- Six of the services are now rated as good: child and adolescent mental health wards, wards for older people with mental health problems, specialist community mental health services for children and young people, community health inpatient services, community health services for adults, and community health service for children, young people and families.
- The trust is rated as good for three of the five overall ratings for key questions (caring, responsive and well led).
  - Whilst the trust is still rated as requires improvement it is now close to achieving a rating of good in the future.
  - We carried out a full review of the trusts leadership and governance processes and found the trust was well-led and had made many improvements since

Summary of findings

our last comprehensive inspection. It had embedded its divisional management structure and improved its assurance processes, which had helped it deliver many of the required improvements to services.

- Despite the significant financial challenges faced by the trust and the ongoing cost improvement plans, leaders in the trust planned resources to ensure this had as little impact as possible on the care patients received.
- Most staff felt proud to work for the trust and were committed to ensuring they delivered good care for patients. Most staff supported patients with kindness, respect and support.
- Staff in the outstanding community based mental health services for older people and forensic/secure inpatient wards worked in partnership with patients and carers to plan care and develop services that were responsive to their needs. Staff had supported patients in the forensic/secure inpatient wards to deliver self-catering food.
- The trust leadership was open. The trust engaged well with staff and encouraged them to raise concerns when they had them. Many staff told us they found the trust a good place to work.
- The trust systems enabled staff to escalate risks. In most areas, senior leaders knew where areas of concern were and had plans to address these.

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 

Our rating for safe stayed the same. We rated it as **requires improvement** because:

- At our last comprehensive inspection in December 2015, we rated three of the eight mental health core services provided by the trust as requires improvement and one core service as inadequate for this key question. We rated one of the three community healthcare core services provided by the trust as requires improvement for this key question. This led us to rate the trust as requires improvement overall for this key question.
- Since the last comprehensive inspection in December 2015, we rated the specialist eating disorder services provided by the trust as requires improvement for this key question in September 2017. This mental health service in not a CQC core service.
- At this inspection in September 2017, we rated three of the eight mental health core services provided by the trust as requires improvement for this key question. We rated the one community healthcare service we inspected as requires improvement for this key question. This led us to rate the trust as requires improvement overall for this key question.
- At this inspection in September 2017, we found the following:
- Whilst the trust had taken steps to make seclusion rooms safer, the location, access through public areas and lack of ligature free en-suite bathroom facilities compromised patient's privacy and dignity. At St Ann's this will be addressed by the proposed hospital rebuild, but at Chase Farm further work was needed.
- Staff in the acute wards for adults of working age and psychiatric intensive care units did not keep all clinic rooms and medical equipment clean or regularly calibrated.
- Staff in the acute wards for adults of working age and psychiatric intensive care units, community-based mental health services for adults of working age and mental health crisis services and health-based places of safety did not complete and update risks assessments in sufficient detail for all patients.
- Staff in the acute wards for adults of working age and psychiatric intensive care units did not complete physical health checks for patients following rapid tranquilisation.

Summary of findings

- Health visiting staff in community children, young people and families service were not clear about the frequency of visits for children from targeted families.

However:

- The trust had made many improvements since the last inspection. For example, staff now followed procedures to keep them safe whilst working in the community, and staff now reported more safeguarding concerns.
- Staff identified and managed most environmental risks to patients. They kept most areas clean.
- Managers assessed staffing levels and made sure they were sufficient to keep patients safe. Most staff completed their mandatory training.
- Most staff knew which incidents they needed to report. Teams investigated incidents and made changes to improve services, but sometimes they did not share learning with all teams.

Are services effective?

Requires improvement 

Our rating for effective stayed the same. We rated it as **requires improvement** because:

- At our last inspection in December 2015, we rated three of the eight mental health core services provided by the trust as requires improvement. This led us to rate the trust as requires improvement overall for this key question.
- At this inspection in September 2017, we rated four of the eight mental health core services provided by the trust as requires improvement for this key question. This led us to rate the trust as requires improvement overall for this key question.
- At this inspection in September 2017, we found the following:
- Managers in acute wards for adults of working age and psychiatric intensive care units and mental health crisis services and health-based places of safety did not ensure all staff received regular formal supervision.
- The trust had not ensured staff in the wards for older people with mental health problems had sufficient training and knowledge to support patients with diabetes. Staff did not complete diabetes care plans in sufficient detail for these patients.
- Staff in the community-based mental health services for adults of working age did not complete and update person-centred and holistic care plans for all patients. They did not always record patients' physical health needs in care plans.

However:

Summary of findings

- Staff assessed most patients and developed plans, many of which were personalised and recovery-orientated. The trust had improved the support staff gave patients with their physical healthcare needs, but there was more to do in this area.
- Experienced staff from a range of professional backgrounds supported patients following best practice guidance. They completed clinical audits to assure themselves the care they provided was good.
- The trust showed a good level of adherence with the Mental Health Act.

Are services caring?

Good

Our rating for caring stayed the same. We rated it as **good** because:

- At our last inspection in December 2015, we rated seven of the eight mental health core services provided by the trust as good and one as outstanding. We rated the three community healthcare core services provided by the trust as good for this key question. This led us to rate the trust as good overall for this key question.
- Since the last comprehensive inspection in December 2015, we rated the specialist eating disorder services provided by the trust as good for this key question in September 2017. This mental health service in not a CQC core service.
- At this inspection in September 2017, we rated six of the eight mental health core services provided by the trust as good and two as outstanding for this key question. We rated the one community healthcare service we inspected as good for this key question. This led us to rate the trust as good overall for this key question.
- At this inspection in September 2017, we rated caring as good because:
- Most staff supported patients with kindness, compassion and respect. The maintained patients' privacy and dignity.
- Staff in many teams sought to involve patients in decisions about their care and the service.
- Staff in forensic inpatient/secure wards supported patients to give feedback. Patients described positive changes resulting from their input including the introduction of mobile phones, laptops and self-catering on the wards.
- Many staff sought to involve families and carers. Staff in community-based mental health services for older people provided carers with extensive support to help them cope with their caring responsibilities.

Summary of findings

Are services responsive to people's needs?

Good

Our rating for responsive improved. We rated it as **good** because:

- At our last inspection in December 2015, we rated two of the eight mental health core services provided by the trust as requires improvement. This led us to rate the trust as requires improvement overall for this key question.
- At this inspection in September 2017, we rated five of the eight mental health core services provided by the trust as good and two as outstanding for this key question. We rated the one community healthcare service we inspected as good for this key question. This led us to rate the trust as good overall for this key question.
- At this inspection in September 2017, we rated it as good because:
- Patients could access services. When services had waiting lists, staff monitored these to identify patients at risk. The trust managed access to beds and had reduced the number of moves patients made between wards.
- Where possible, the trust provided care in environments that promoted comfort, dignity and privacy.
- Staff took consideration of the needs of patients and put in place plans to support them. Staff established close links with local community organisations to provide patients with personalised support. Staff in the community based mental health services for older people had developed links with a local Greek care home in Enfield and had links with a local LGBT support charity in Barnet. The trust supported patients with their cultural, religious and spiritual needs.
- The trust responded to complaints, but needed to ensure that it did so promptly for all people that complained.

However:

- Staff in the mental health crisis services and health-based places of safety gave patients a wide time range for appointment and did not always communicate with patients when they were running late for an appointment.
- In mental health crisis services and health-based places of safety, the trust did not ensure that patients could contact services through the hub.
- Some of the trust's building were old and did not provide an environment that promoted comfort dignity and privacy. Some patients had to share dormitories. The trust had a plan to redevelop St Ann's hospital to improve the environment.

Summary of findings

- Some patients being supported by community mental health services were experiencing long waits of around a year to receive individual psychological therapies.

Are services well-led?

Good

Our rating for well-led improved. We rated it as **good** because:

- At our previous inspection in December 2015, we rated four of the eight mental health core services provided by the trust as requires improvement for this key question. This led us to rate the trust as requires improvement overall for this key question.
- Since the last comprehensive inspection in December 2015, we rated the specialist eating disorder services provided by the trust as good for this key question in September 2017. This mental health service in not a CQC core service.
- At this inspection in September 2017, we rated five of the eight mental health core services provided by the trust as good for this key question. We rated the one community healthcare service we inspected as good for this key question. We found the trust to be well-led in the review we conducted of the trust's leadership and management systems. This led us to rate the trust as good overall for this key question.
- At this inspection in September 2017, we found the following:
- Stable leadership was provided to the trust through the board and the executive leadership team who had an appropriate range of skills, knowledge and experience.
- Despite the significant financial challenges facing the trust and the ongoing cost improvement plans, appropriate clinical feedback was in place to ensure this did not compromise patient care.
- Risks were appropriately escalated and the board had an awareness of these challenges and how they were being mitigated. The IT infrastructure was not operating well but plans were in place to replace the IT support provider.
- The trust was working to ensure a good balance between providing assurance and promoting quality improvement. The first year of adopting a formal quality improvement methodology had gone well and was producing positive results.
- The trust had engaged with patients, carers, staff and stakeholders to develop the trust values. Staff appreciated the interactive training available to help them understand how to apply these values in their work.
- Staff were proud to work for the trust and found senior leaders approachable. The trust engaged well with staff and made good use of a range of communication approaches. Staff were

Summary of findings

encouraged to raise any concerns and the implementation of the Speak Up Guardian was going well. However, there were some pockets of low morale and bullying that needed to be addressed.

- The trust was fully committed to promoting equality, diversity and human rights. However, further work was needed to develop networks for staff and patients who were lesbian, gay, bi-sexual and transgender; had a physical disability or needed support with their emotional health.
- There were positive examples throughout the trust of engaging patients and carers. However, this could be promoted further for example by extending the number of peer workers and the use of volunteers.
- The trust had systems in place to receive feedback from surveys and complaints. However, they were continuing to miss their targets for responding to formal complaints in a timely manner.

However

- In a few teams which were community-based mental health services for adults of working age and mental health crisis services and health-based places of safety, the trust's governance system did not identify some areas of concern so they could be addressed in a timely manner. In addition managers on some acute wards were recently appointed and so improvements still needed to be completed or be embedded. This required ongoing monitoring through governance processes.

Summary of findings

Our inspection team

Our inspection team was led by:

Chair: Paul Devlin, Chair Lincolnshire Partnership NHS Foundation Trust

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

Acute wards for adults of working age and psychiatric intensive care units (PICU)

The team that inspected this service comprised four CQC inspectors, one inspection manager, five nurse specialist advisors who had a background in the mental health of working age adults, three Mental Health Act reviewers, two CQC pharmacist specialists and two experts by experience. A CQC expert by experience is a person who has personal experience of using, or supporting someone using mental health services.

Forensic inpatient/secure wards

The team that inspected this service comprised two inspectors, one inspection manager, one assistant inspector, one Mental Health Act reviewer, one pharmacist specialist, two specialist advisor forensic mental health nurses, one specialist advisor forensic psychologist and an expert by experience. A CQC expert by experience is a person who has personal experience of using, or supporting someone using mental health services.

Child and adolescent mental health wards

The team that inspected this service comprised two CQC inspectors, one specialist advisor who was a psychiatrist with a background in the mental health of children and adolescents, a nurse consultant specialist advisor who had a background in the mental health of children and adolescents and an expert by experience. A CQC expert by experience is a person who has personal experience of using, or supporting someone using mental health services. A Mental Health Act Reviewer and a pharmacist specialist also visited the service and contributed to the inspection.

Wards for older people with mental health problems

The team that inspected this service comprised a CQC inspector, one CQC inspection manager, one CQC assistant inspector, three specialist advisors with experience of working in services for older people, one Mental Health Act reviewer and an expert by experience. A CQC expert by experience is a person who has personal experience of using, or supporting someone using mental health services.

Mental health crisis services and health-based places of safety

The team that inspected this service comprised a CQC inspector, a CQC inspector manager, a CQC Mental Health Act reviewer, three specialist advisers which included two qualified nurses and a social worker and an Expert by Experience. A CQC expert by experience is a person who has personal experience of using, or supporting someone using mental health services.

Community based services for adults of working age

The team that inspected this service comprised a CQC inspection manager, three CQC inspectors, two CQC assistant inspectors, two nurses, two consultant psychiatrists, one senior occupational therapist, one social worker and one expert by experience. A CQC expert by experience is a person who has personal experience of using, or supporting someone using mental health services.

Community based mental health services for older people

The team that inspected this service comprised a CQC inspector, two other CQC inspectors, two nurse specialist advisors with a background working in older peoples' mental health services and an expert by experience. A CQC expert by experience is a person who has personal experience of using, or supporting someone using mental health services.

Specialist community mental health services for children and young people

The team that inspected this service comprised a CQC inspector, three specialist advisors, all of whom were nurses with a background working in child and adolescent

Summary of findings

mental health services, a consultant psychiatrist who is the CAMHS national professional advisor for the CQC and an expert by experience. A CQC expert by experience is a person who has personal experience of using, or supporting someone using mental health services.

Community health services for children, young people and families

The team that inspected this service comprised two CQC inspectors and a variety of specialists including a school nurse, a health visitor, a specialist paediatric nurse and an Expert by Experience. A CQC expert by experience is a person who has personal experience of using, or supporting someone using mental health services.

Well Led Review

The team that completed a well led review comprised a CQC head of inspection, a CQC inspection manager, a CQC inspector and two specialist advisors, which included a specialist in governance and the chair of an NHS trust.

Why we carried out this inspection

For this inspection we looked at all the mental health core services provided by the trust:

- Acute wards for adults of working age and psychiatric intensive care units (PICU)
- Forensic inpatient/secure wards
- Child and adolescent mental health wards
- Wards for older people with mental health problems
- Mental health crisis services and health-based places of safety
- Community based services for adults of working age
- Community based mental health services for older people
- Specialist community mental health services for children and young people

We also looked at the community health services for children, young people and families provided by the trust in Enfield. We did not inspect the other community health services provided by the trust, which we rated as good for all our key questions at our previous inspection in December 2015.

We undertook this inspection to find out whether Barnet, Enfield and Haringey mental health trust had made improvements. At our last inspection, which we undertook in December 2015, we rated the trust as **requires improvement** overall. We rated the trust as requires improvement for safe, effective, responsive and well-led. We rated the trust good for caring.

Following that inspection, we told the trust it must make the following improvements 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.

In addition, we recommended the following actions:

- 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.

When we last inspected the trust in December 2015, we rated the **acute wards for adults of working age and the psychiatric intensive care units** as **requires improvement** overall. We rated the core service as inadequate for safe, requires improvement for effective, good for caring, requires improvement for responsive and requires improvement for well-led.

Summary of findings

Following that inspection, we told the trust it must make the following improvements to the acute wards for adults of working age and the 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.
- 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.

In addition, we recommended the following actions:

- 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 PICU's.
- The trust should ensure that it reduces the number of times patients are transferred to other wards for nonclinical reasons and that each incident is documented.

Summary of findings

- 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 informing patients' how their spiritual and religious needs can be met.
- The trust should ensure they provide food of good choice and quality that meets patients' cultural and dietary needs at Edgware community hospital.

When we last inspected the trust in December 2015, we rated forensic inpatient/secure wards as **outstanding** overall. We rated the core service as good for safe, outstanding for effective, outstanding for caring, good for responsive and good for well-led.

Following that inspection, we recommended forensic inpatient/secure wards take the following actions:

- 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.

When we last inspected the trust in December 2015, we rated the child and adolescent mental health wards as **requires improvement** overall. We rated the core service as requires improvement for safe, requires improvement for effective, good for caring, good for responsive and requires improvement for well-led.

Following that inspection, we told the trust it must make the following improvements to the child and adolescent mental health wards:

- The provider 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 provider must ensure that all staff receive regular supervision and that this is recorded.
- The provider must ensure a permanent management team is in place in the longer term, which can provide effective leadership to make the necessary changes.

In addition, we recommended the following actions:

- 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.

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When we last inspected the trust in December 2015, we rated the **wards for older people with mental health problems** as **good** overall. We rated the core service as good for safe, good for effective, good for caring, good for responsive and good for well-led.

Following that inspection, we recommended that the wards for older people with mental health problems take the following actions:

- The trust should ensure the guidance on same gender care was followed on the Oaks to protect the safety and dignity of the patients.
- The trust should ensure all the wards for older people reach the target for mandatory training.
- 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 multidisciplinary 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.

When we last inspected the trust in December 2015, we rated the **community-based mental health services for adults of working age** as **requires improvement** overall. We rated the core service as requires improvement for safe, requires improvement for effective, good for caring, good for responsive and requires improvement for well-led.

Following that inspection, we told the trust it must make the following improvements to 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 trust's lone working policy and have access to a working mobile phone.
- 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.

In addition, we recommended the following actions:

- 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.

Summary of findings

- 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.

When we last inspected the trust in December 2015, we rated the **mental health crisis services and health-based places of safety** as **requires improvement** overall. We rated the core service as requires improvement for safe, good for effective, good for caring, requires improvement for responsive and requires improvement for well-led.

Following that inspection, we told the trust it must make the following improvements to the 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 patient's phone-calls 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.

In addition, we recommended the following actions:

- 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.
- 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.

Summary of findings

When we last inspected the trust in December 2015, we rated the **community-based mental health services for older people** as **good** overall. We rated the core service as good for safe, good for effective, good for caring, good for responsive and good for well-led.

Following that inspection, we recommended that the community-based mental health services for older people take the following actions:

- 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.

When we last inspected the trust in December 2015, we rated the **specialist community mental health services for children and young people** as **requires improvement** overall. We rated the core service as requires improvement for safe, good for effective, good for caring, requires improvement for responsive and good for well-led.

Following that inspection, we told the trust it must make the following improvements to the 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 make changes to the teams so that assessment to treatment times can be delivered in a timely manner.

In addition, we recommended the following actions:

- 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.

When we last inspected the trust in December 2015, we rated the **community health services for children, young people and families** as **good** overall. We rated the core service as requires improvement for safe, good for effective, good for caring, good for responsive and good for well-led.

Following that inspection, we told the trust it must make the following improvements to community health services for children, young people and families:

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

In addition, we recommended the following actions:

- 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.

Summary of findings

- The trust should ensure that staff working in the community services for children, young people and families have completed appraisals in line with the trust's target.
- The trust should create a child friendly environment at Cedar House.
- The trust should ensure in clinic environments that information is available for people on how to make a complaint.
- 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.

We issued the trust with **15** requirement notices.

These related to the following regulations under the Health and Social Care Act (Regulated Activities) Regulations 2014:

Regulation 9 Person-centred care

Regulation Dignity and respect

Regulation 12 Safe care and treatment

Regulation 15 Premises and equipment

Regulation 17 Good governance

Regulation 18 Staffing

How we carried out this inspection

To fully understand the experience of people who use services, 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 NHS Improvement, clinical commissioning groups, NHS England and Healthwatch.
- Sought feedback from patients and carers through holding two engagement events.
- Received information from patients, carers and other groups through our website.
- Collected and analysed feedback from 217 patients, carers and staff using comment cards.

During the announced inspection visit from the 25 – 29 September 2017 the inspection team:

- Visited 22 wards and the health-based place of safety
- Visited 31 other teams and clinics
- Spoke with 155 patients and 67 relatives and carers who were using the service
- Joined four service user meetings
- Interviewed 22 senior staff and board members
- Spoke with 37 ward and team managers and 322 other staff members
- Joined care professionals for 26 home visits and clinic appointments

Summary of findings

- Attended and observed 27 hand-over meetings and multi-disciplinary meetings
- Completed an observation of an older people's ward using the CQC short observation framework for inspection
- Observed a board meeting and a quality and safety committee meeting
- Conducted focus groups with borough clinical directors and with Non-Executive directors
- Conducted 22 other focus groups with staff from a range of professions and backgrounds
- Interviewed the trust's 'freedom to speak up' guardians
- Interviewed the trust's guardian of safer working
- Looked at 258 treatment records of patients
- Carried out a specific check of the medication management across a sample of wards and teams.
- Reviewed 118 prescription charts.
- Looked at a range of policies, procedures and other documents relating to the running of the service
- Reviewed the arrangements for managerial supervision of staff
- Requested and analysed further information from the trust to clarify what was found during the site visits

The inspection looked at the eight mental health core services provided by the trust, the community health services for children, young people and families provided by the trust in Enfield, and the whether the trust was well led. We did not inspect the other community health services provided by the trust in Enfield, which we rated as good for all our key questions at our previous inspection in December 2015.

Information about the provider

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

The trust also provides specialist services for children and adults from across the UK. These services include forensic / secure inpatient wards and services for patients with eating disorders.

The trust employs around 3000 staff.

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, and Edgware Community Hospital and Barnet Hospital in Barnet.

The trust provides psychiatric liaison services at Barnet Hospital and at the North Middlesex Hospital.

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

The trust was under considerable financial pressure. A pricing review had taken place, which confirmed the trust was being paid at least £6.3 million too little for the services provided.

The trust has seven locations registered with CQC. The trust has been inspected 27 times. Since the last comprehensive inspection in December 2015, CQC has conducted four inspections.

We inspected the mental health liaison service the trust provides at the North Middlesex hospital in September 2016. This inspection did not identify any areas in which the trust must improve.

We inspected the specialist eating disorder services located on Phoenix ward on three occasions. The first two inspections were focussed and followed up specific areas of concern. We conducted a comprehensive inspection of this service in September 2017. At this inspection, we rated the service as requires improvement. We rated it as requires improvement for safe, good for effective, good for caring, requires improvement for responsive and good for well-led. We told the trust it must make improvements in how staff managed environmental risks and how in how staff supported patients' privacy and dignity.

Summary of findings

What people who use the provider's services say

Trust-wide

- Overall, patients we spoke felt positive about the trust. Most felt staff treated them with kindness, compassion and respect.
- Most patients gave positive feedback regarding the service. Prior to the inspection, we placed comment card boxes throughout the trust. We received 216 responses. Of these, 181 gave feedback on the quality of the service: 98 recorded positive feedback, 36 negative feedback and 47 mixed feedback.
- The CQC community mental health survey, published in November 2017, found the trust scored about the same when compared to other organisations. One hundred and ninety-eight patients responded to this survey. They scored the trust about the same as other similar trusts for all questions apart from two, which they scored as worse than similar trusts: help finding support for financial advice or benefits; and information about getting support from others with experiences of the same mental health needs.
- The feedback we received in most of the service was largely positive. Patients and carers in the acute wards for adults of working age and psychiatric intensive care units (PICU) and mental health crisis services and health-based places of safety provided more mixed feedback.

Acute wards for adults of working age and psychiatric intensive care units (PICU)

- We received 51 comment cards from patients. Twenty were positive, 12 contained mixed feedback and 19 cards had negative feedback. Positive themes included staff being friendly and helpful. Areas for improvement were identified as aggression on the ward, not enough staff on shift and difficulty accessing hot drinks and fresh air due to staff being busy elsewhere.
- We spoke to 23 patients who were using the service. Feedback was mixed across the wards. Patients said some staff were very good and supportive while others were less supportive and that sometimes staff were too busy to talk or get hot drinks due to what was happening on the ward. Some patients mentioned aggression and noise on some of the wards but said that they could take themselves away from this if needed.

Forensic inpatient/secure wards

- Patients and carers were very positive about their experience of care and treatment in the inpatient forensic service. They told us they found staff to be caring, respectful, kind and professional, describing particular staff who had gone beyond the call of duty to support them. Patients told us they were at the centre of their care and actively involved in all aspects of their care and treatment, working with staff towards their recovery goals. Patients said their personal views were respected and they had developed positive relationships with most staff. Care plans reflected the service value of placing the patient at the centre of the service.
- Patients described how much they enjoyed attending the various activity programmes offered at the Kingswood Centre, and several told us that they had learned new skills giving them confidence to consider new careers. Patients commented on the effectiveness of the treatment they were receiving and availability of various therapies to support their recovery.
- Patients told us that the user forum was effective in bringing about improvements to the service, including recent introduction of mobile phones and self-catering on the wards.
- We received some mixed feedback from the comment cards, including positive and negative comments about staff attitude, de-escalation of challenging behaviour and response to issues raised.

Child and adolescent mental health wards

- Young people were very positive about the attitude and behaviour of staff. They told us that staff had the skills and knowledge to respond to the needs of young people.

Summary of findings

- Young people told us that they found the Beacon Centre comfortable and pleasant. A parent said staff involved them in decision making and gave them support when they needed it.

Wards for older people with mental health problems

- Patients we spoke with said they were happy with the care they received. They said staff were very friendly and very nice to them.
- Relatives also gave very positive feedback about ward staff. They said staff identified and understood the individual needs of the patients and engaged with them well. For example, staff chatted with them, made them laugh and took a genuine interest in them. Most relatives said staff helped patients with their personal care well and patients were well dressed and well presented. One relative said staff were very good at settling new patients to the ward and were always smiling and talking with patients. Several relatives said staff were brilliant and were happy with the care patients received. One relative of a patient on Somerset Villas said they would recommend the ward to others.
- Relatives said staff were friendly and approachable and shared relevant information with relatives.
- Two relatives said there could be some more stimuli for patients, like music and some different activities on The Oaks. One relative on The Oaks felt their relative could have more support in personal care and presentation and staff could communicate information better.

Mental health crisis services and health-based places of safety

- We received mixed feedback from patients and carers of patients. Of the 17 patients and six carers we spoke to, 12 patients and carers told us that the staff were caring and respectful.
- Some patients and carers felt the service needed to improve. They raised concerns with regards to staff shortages, lack of consistency in the quality of staff, some staff visiting for only ten minutes, and staff not turning up or cancelling appointments with no notice. Two patients said that they were discharged too quickly from the crisis service and therefore relapsed quickly into crisis again; they felt they did not have an effective discharge plan.
- Three patients and carers felt staff answering the phones at the hub were not suitable for the role and came across as uncaring. They also mentioned difficulties in getting through on the phone.

Community based services for adults of working age

- Most of the people we spoke with during the inspection, including those who attended the services we visited, people who we spoke with on the phone and feedback we received from comments cards, were positive about the services.
- Patients and carers told us that staff were empathic and listened to them and that they found the support that they received helpful.
- Some patients told us that there had been a lack of consistency when their care coordinators had left the team. Some patients at Haringey Complex Care Team told us that they were concerned about delays to their treatment but they were satisfied with the treatment itself.

Community based mental health services for older people

- The patients and carers we spoke with were very positive about their experience of using the service. We received positive feedback about the support that staff gave patients and carers and patients told us that staff had a good, positive attitude and were very polite.
- Patients felt involved in their care and had the opportunity to discuss their medication and treatments with staff. They told us that staff had given them information about their conditions, their medications and additional support that was available to them. Patients told us they were comfortable giving feedback about the service and knew how they would raise a complaint if they wanted to.
- Carers told us they felt involved in their loved ones care and staff were supportive and asked them how they were managing. Carers had copies of their loved ones' care plans and were given information about how to access support groups and charities.

Summary of findings

Specialist community mental health services for children and young people

- We spoke to two young people and 13 family members or carers. Most spoke highly and were positive about the service and its staff. They said staff were compassionate, caring and offered interventions that had made a difference to them.
- Some carers said the wait for assessment and treatment was too long. However, they praised the support staff care children and young people when they saw them. Most carers and young people told us the environment in which they had their clinical appointments was clean and comfortable.
- The majority of the 46 comments cards received from young people and their carers were positive about the service. All of them said they felt listened to and supported by staff.

Community health services for children, young people and families

- Parents told us they had confidence in the staff they saw and the advice they received. They were mostly very happy with the care they received. Parents commented that staff are friendly and helpful and they give you lots of support.
- The friends and family test for the service for the period showed an average of 91% of children young people and families would recommend the service.

Good practice

Acute wards for adults of working age and psychiatric intensive care units (PICU)

- The trust supported staff to consider opportunities for improvements and innovation, and this led to change. Suffolk ward was taking part a quality improvement project to reduce violence and aggression. The ward had won a bid at the trust's Dragon's Den, where staff could bid for money for small projects, to make a relaxation room with sensory equipment. Since the start of this project, the number of incidents had reduced from 22 in January 2017 to four in August 2017.
- The wards at Edgware Community hospital hosted a weekly 'coffee with the consultant' afternoon with patients. The consultant met with patients in the lounge and provided tea and cakes. Patients told us that they really enjoyed this opportunity to have an informal chat with their psychiatrist and that this helped break down barriers.
- The ward manager on Haringey assessment unit was co-producing a relapse prevention group with the patients on the ward.

Forensic inpatient/secure wards

- Patients were represented at all levels within the service. The service had a user forum, with a representative from each ward. The chair-person and vice-chair of the user forum (patients) attended board meetings, and clinical governance meetings representing patients' views. They described positive changes that had resulted as a result of their input including the introduction of mobile phones, laptops and self-catering on the wards.
- The forensic service employed twenty experts by experience in paid roles including patients on the wards, and some who had been discharged into the local community. They were involved in co-production and co-delivery of the recovery college courses, and also took part in training for staff and recruitment interviews.
- 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 had also reduced the number of one to one observations carried out. This had been developed on the basis of research evidence.
- The service was piloting positive handovers on the wards. They were also providing increased follow up for patients after discharge, and some training for external providers in relapse prevention. To support patients on discharge into the community, the service paid for gym membership in their local area for their

first year after discharge. They were also able to continue to participate in the community football team, which played in the West London forensic football league.

- Patients were offered work experience at the shop and café 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 a social enterprise refurbishing and selling on bicycles.
- The service had recently purchased equipment that screened for various drugs and medication in a non-intrusive way. Staff were receiving training in how to use this from the physical health team and said that wards will be using it from October 2017. This machine detected various types of drugs and was able to detect if patients had been in contact with drugs.

Child and adolescent mental health wards

- There were daily handovers at the morning and end of the day between the service manager, psychiatrist and ward manager.
- A quality improvement project was taking place in relation to improving the involvement of young people in planning their care and treatment.
- The service asked young people for their views of the service and had made changes in response to their feedback.

Wards for older people with mental health problems

- Two wards had a cat. Patients gave positive feedback about being able to interact and care for it.

Mental health crisis services and health-based places of safety

- Staff in the Haringey home treatment team had a mindfulness session before the start of their shift.
- The Haringey home treatment team staff had received training to use the Open Dialogue approach, which uses family therapy and social network building.

Community based services for adults of working age

- In Barnet and Haringey, the services provided interpreters in groups for Turkish and Farsi speaking patients. The Haringey Complex Care Team had an event with Farsi, Tamil and Turkish interpreters present to increase community access.
- The Early Intervention Service in Enfield had put on an event in conjunction with patients who used the service to explain what the service did and how it could help people who were new to the service and their family members.

Community based mental health services for older people

- The teams offered programmes of cognitive stimulation therapy, which helped improve outcomes for patients. Staff tailored these sessions to ensure they suited the needs of the group. At Haringey memory service, carers were invited to a maintenance therapy group so they could continue to practice cognitive stimulation therapy with their loved one at home in future.
- Staff worked with other organisations to ensure patients received the most appropriate care and treatment and to improve waiting times at community services.For example, staff worked closely with local GP practices to ensure they only made appropriate referrals to memory services. Staff had also worked with the organisation that provided head scans to reduce waiting times, meaning that patients received a diagnosis quicker and could start treatments to slow the progression of dementia sooner.
- Dementia service practitioners worked closely with local care homes to develop staff skills in caring for people living with dementia, reducing hospital admissions.
- Dementia navigators at Haringey memory service gave extensive support to carers and helped them to access carers' assessments. Staff also set up an enablement project to help find the activities that patients liked to do and then link them in with relevant local community groups.

Summary of findings

- Staff established close links with local community organisations to provide patients with personalised support. Staff had developed links with a local Greek care home in Enfield and had links with a local LGBT support charity in Barnet.

Specialist community mental health services for children and young people

- The trust had set up a peer mentoring group in Haringey. Members of the group shared their experiences of receiving support from CAMHS and their progress.

Community health services for children, young people and families

- The specialist children's team were using the 'voice of the child' (talking mat) to support young people to communicate. They had obtained funding to commission the development of a film to train more professionals to use the tool in their work with children who have special needs.

Areas for improvement

Action the provider MUST take to improve

Action the trust MUST take to improve acute wards for adults of working age and psychiatric intensive care units

- The trust must ensure that plans are progressed to ensure the location of seclusion rooms protect patients' privacy and dignity. This includes female patients being secluded on a male ward, patients being moved between wards to access the facilities, access to bathrooms that are suitably ligature free, and ensuring other patients on the ward cannot view into the seclusion room.
- The trust must ensure that the clinic rooms provide a safe environment for medicine storage and administration and medical equipment is clean. This includes ensuring all the medication fridges are within the correct temperature range and that the environments used for storage are kept clean.
- The trust must ensure staff complete patients' risk assessments with sufficient detail and update them following incidents and risk events.
- The trust must ensure that staff complete physical health checks for patients following rapid tranquilisation.
- The trust must ensure that all staff receive regular supervision and this is recorded and monitored.
- The trust must continue to support recently appointed ward managers especially at Chase Farm hospital to embed the improvements that still need to take place and use governance processes to continue to monitor the progress on the acute wards.

Action the provider MUST take to improve wards for older people with mental health problems

- The trust must ensure staff have sufficient training and knowledge to support patients with diabetes and that care plans are detailed and reflect requirements outlined in the trust policy.

Action the trust MUST take to improve community-based mental health services for adults of working age

- The trust must ensure that patient risk assessment and management is clearly documented, updated and understood by staff within the teams that provide community support for adults of working age within the trust. This includes ensuring that they meet with their care co-ordinator at the intervals agreed in their risk assessment.
- The trust must ensure that patient care plans are person-centred and holistic and that the staff update care plans as necessary. Where care plans are agreed with the patient, they must be followed or reviewed.
- The trust must ensure that information about physical health is recorded when needed in the patients' care plans. Where GPs are not responding to requests for

information about physical health needs this must be recorded in the patient's records and there must be systems in place to monitor and chase this information.

- The trust must ensure that governance systems identify services which are not performing well and where needed that the appropriate improvements are made. This is particularly in relation to Haringey community services.

Action the trust MUST take to improve mental health crisis services and health-based places of safety

- The trust must ensure that all staff receive regular supervision.
- The trust must ensure that the documentation of risk assessments on patient care records contain sufficient and up to date detail to reflect risks accurately.
- The trust must ensure that, prior to undertaking visits, staff know patient risks.
- The trust must ensure that staff communicate with patients when they are running late for an appointment.
- The trust must ensure that patients can contact the service through the hub.
- The trust must ensure that it effectively assesses, monitor and improves the quality and safety of the services provided. In Enfield, the trust did not have effective audit systems in place to identify areas for improvement. It did not support the team manager to provide effective leadership.

Action the provider MUST take to improve community children, young people and families service

- The trust must ensure health visiting staff are clear about frequency of visits for targeted children and these visits are recorded accurately.

Action the provider SHOULD take to improve

Action the provider SHOULD take to improve acute wards for adults of working age and psychiatric intensive care units

- The trust should ensure that there are sufficient numbers of mirrors available to help improve levels of observation in patient accessible areas in the garden of Fairlands ward. The trust should remove the rubbish and debris in the garden.
- The trust should ensure that outstanding maintenance issues are carried out on Sussex, Fairland's, Avon and Haringey assessment unit.
- The trust should ensure that the ligature risk assessment for Fairlands ward is updated and accurately identifies the ligatures and how they will be managed. The trust should ensure that staff on Avon ward manage the ligature risks in the shared bathroom.
- The trust should ensure that restraints are always carried out using the correct techniques and are recorded correctly.
- The trust should ensure that all fire exits are kept clear at all times
- The trust should repair the CCTV system on Fairlands ward
- The trust should ensure that emergency bag checks are documented.
- The trust should ensure that physical health equipment is calibrated in line with trust guidelines.
- The trust should ensure blanket restrictions are kept under review and only used in response to a current risk.
- The trust should ensure all staff on Avon ward make safeguarding referrals promptly.
- The trust should ensure that staff complete all mandatory training that is below the target on each ward.
- The trust should ensure that patients are involved in the development of their care plans. Staff should support patients to set clear recovery goals. The trust must ensure that patients are offered a copy of their care plans.
- The trust should ensure that staff on Sussex ward know how to complete the national early warning

scores properly in line with all the other acute wards, as these identify when patients' physical health is deteriorating and that where needed medical assistance is sought.

- The trust should ensure that staff assess the capacity to consent to treatment for all patients. The trust should ensure that patients' rights are explained to them.
- The trust should keep to a minimum patients returning from leave that need to be cared for on another ward.
- The trust should ensure that there are systems in place for staff to learn from incidents across the trust. The trust should review the template for team meetings to ensure that learning from incidents is always documented.
- The trust should ensure that patients can make a phone call in private on Suffolk and Sussex wards.
- The trust should develop plans so that all patients are accommodated in single bedrooms to ensure their privacy and dignity.
- The trust should ensure that wherever possible staff involvement with patients is caring and supports patient recovery.
- The trust should ensure that patients on Dorset ward have facilities to keep their belongings safe and secure.
- The trust should ensure that they review the quality and quantity of food and drink provided to patients at Edgware Community and Chase Farm hospitals.
- The trust should ensure that staff report and investigate incidents in accordance with timescales set out in trust policy.
- The trust should ensure that there are mechanisms in place for staff working on Dorset ward to discuss their concerns regarding the working environment on the ward.
- The trust should ensure the number of beds on Avon ward follow national guidelines for PICU's.
- The trust should ensure that expired medicines on Avon ward are disposed of.

Action the provider SHOULD take to improve the forensic inpatient/secure wards

- The trust should review the location of the de-escalation room on Cardamom Ward, and its impact on the privacy and dignity of patients using this room.
- The trust should review the policy on Sage Ward for having all patient visits at the service supervised, to ensure that this is not a blanket restriction.
- The trust should review the system of recording seclusion records in four different formats, creating a burden on staff, and making it difficult to assess whether a patient was supported appropriately.
- The trust should ensure that patients' risk assessments on Devon Ward are updated after incidents or other changes, in addition to recording changes in the progress notes. This is to ensure that all staff can access the most up to date risk information for patients promptly.

Action the provider SHOULD take to improve child and adolescent mental health wards

- The trust should improve clinical governance arrangements in order to identify risks in relation to the quality and completeness of supervision notes.
- The trust should review the template for team meetings to ensure that learning from incidents is always documented.
- The trust should ensure that young people are always been informed of their rights after a second opinion doctor had authorised their treatment.

Action the provider SHOULD take to improve wards for older people with mental health problems

- The trust should ensure staff on Ken Porter Ward complete risk assessment documentation in full and review these regularly.
- The trust should ensure staff on The Oaks complete nutrition and hydration forms accurately.
- The trust should ensure staff calibrate blood glucose machines in line with trust policy.
- The trust should ensure the electronic record system functions at a speed that doesn't impact negatively on staff responsibilities.

Summary of findings

Action the trust SHOULD take to improve community-based mental health services for adults of working age

- The trust should ensure that all staff, including staff seconded to the trust and locum staff have access to regular individual supervision.
- The trust should ensure that where there are high levels of locum staff, that the number of changes in care co-ordinators is monitored to limit the impact on consistency of care.
- The trust should ensure that where learning from incidents takes place following an investigation, that there are processes in place to ensure that any necessary action is taken and monitored through governance processes.
- The trust should continue to improve waiting times for patients to access individual psychological therapies and review service provision where needed.
- The trust should ensure that all staff have a sufficient understanding of the relevance of the Mental Capacity Act and its scope in community mental health services for adults of working age.
- The trust should continue to work to support staff affected by bullying.
- The trust should ensure that staff and patients are engaged in changes to services that happen within the trust and that they are given sufficient information about this.
- The trust should ensure that team managers have a way of monitoring non-mandatory training and are aware of the additional training that members of their teams have so they can judge what further training may be needed.
- The trust should ensure that where patients are entitled to support under section 117 of the Mental Health Act that this is recorded clearly in their clinical notes.

Action the provider SHOULD take to improve mental health crisis services and health-based places of safety

- The trust should ensure that staff in the Enfield home treatment team demonstrate empathy towards patients or carers that complain.
- The trust should ensure that staff in the Enfield and Haringey home treatment teams are clear in their communications with patients regarding appointment times.
- The trust should ensure that the clinic room in the Enfield home treatment team is kept clean and tidy.
- The trust should ensure that staff involve patients in their care plans and that they are holistic and recovery focussed.
- The trust should ensure that staff understand the Mental Capacity Act and are confident to use it.
- The trust should ensure staff monitor and document patients' physical health needs.
- The trust should ensure that staff monitor and track safeguarding alerts that had been raised by staff or where patients have safeguarding alerts raised in regards to them.
- The trust should ensure there are systems in place such as team or business meetings, for all staff working in the health-based place of safety to cascade information and learning.
- The trust should ensure that staff in the health based place of safety are able to access a governance dashboard with their performance against key performance indicators.
- The trust should ensure that data gathered by staff, for example, how patients are transported to the service and how long they wait to be seen by an AMHP is collated and shared with the staff team and other stakeholders to monitor and drive improvement.
- The trust should ensure that all staff complete mandatory training.

Action the provider SHOULD take to improve specialist community mental health services for children and young people

- The trust should ensure that all members of staff in the Barnet CAMHS have access to alarms to call for support if needed.

Summary of findings

- The trust should ensure that physical health monitoring equipment is well-maintained and calibrated in line with trust policies. The trust should also ensure that the content of first aid kits and pads for defibrillators, if these are going to be used, are in date and fit for purpose.
- The trust should ensure that physical monitoring of patients is conducted in a way that does not compromise their privacy and dignity.
- The trust should ensure that there are cleaning rotas in place for toys and equipment to minimize the risks of infection control.
- The trust should ensure that children and young people's access to assessment and treatment continues to be monitored and that referral to treatment times are monitored by the board.
- The trust should respond to complaints in a timely manner.

Action the provider SHOULD take to improve community-based mental health services for older people

- The trust should implement a governance system for sharing information and learning across the community older adult services in different boroughs.
- The trust should continue its work to improve the completion of physical health checks by GPs for patients using Haringey older adult CMHT.

Action the provider SHOULD take to improve community children, young people and families service

- The trust should ensure that staff record patient care consistently.
- The trust should ensure there is visibility from the chief executive team.
- The trust should ensure that staff are consulted about the proposed changes linked to the trusts estates strategy for working remotely.

Barnet, Enfield and Haringey Mental Health NHS Trust

Detailed findings

Mental Health Act responsibilities

- The trust had clear structures and procedures for monitoring the administration of the Mental Health Act 1983 (MHA).It reviewed mental health policies every three years. The trust board had oversight of the day-to-day use of the MHA through the Mental Health Law Committee. The Mental Health Law Committee met quarterly. It considered changes to policies and reviewed statistical reports of MHA activity.
- The mental health law department conducted monthly audits into compliance, for example, the recording of assessments of capacity to consent to treatment, and annual audits, for example, MHA activity and the provision of approved mental health professional reports. The trust also completed an annual MHA equalities report.
- The trust monitored MHA activity using the MHA electronic management system developed by the head of mental health law. This system provided data on all aspects of the use of the MHA and sent weekly emails to wards and responsible clinicians providing an update on MHA activities that needed to take place.
- A yearly report was completed by the head of mental health law and presented to the Mental Health Law Committee.
- The mental health law team provided support on each inpatient site. Mental Health Act offices were based in Enfield, Barnet, Haringey and in the forensic services. Mental Health Act administration teams were managed by the head of mental health law. The director of nursing managed the head of mental health law.
- From October 2016 to September 2017, CQC conducted 19 visits to review the implementation of the MHA. CQC made actions with regards to the recording of capacity on 10 occasions, staff explanation of rights on seven occasions and care plans on 10 occasions. Following these reviews, the trust developed action plans to address any actions for improvement.
- MHA training did not form part of the mandatory training within the trust. Training in the MHA was delivered every two months and staff could access this as needed.
- The trust maintained regular contact with external stakeholders via the local Inter-Agency Mental Health Group, chaired by the director of nursing and attended by the police, London ambulance service, the local authorities and the clinical commissioning groups.
- Within all of the wards and teams 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.

Detailed findings

Mental Capacity Act and Deprivation of Liberty Safeguards

- The trust had an up to date policy on the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS).
- The trust had a MCA lead and also leads in different services to support staff as needed.
- The trust monitored adherence to the MCA through the Mental Health Law group, which provided a governance process. This looked at the results of audits and considered new methodology.
- The trust provided training in the MCA and DoLS as part of the safeguarding training that was mandatory for new all staff. There was also a module on the MCA included in the junior doctors training. The trust did not provide data on the number of staff that had completed training in the Mental Capacity Act.
- Staff knowledge and application of the MCA varied. Most staff applied the principles of the MCA, but some teams needed to embed staff understanding.
- Staff made DoLS applications when required and monitored the progress of applications to supervisory bodies. From 1 April 2016 to 31 March 2017, the trust made 69 applications to the local authority supervisory bodies.

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

Please see overall summary.

Our findings

Safe and clean environments

Safety of the ward layout

- Staff completed regular risk assessments of safety of the care environments.
- At our previous inspection of acute wards for adults of working age and psychiatric intensive care units in December 2015, we found that the wards had a number of blind spots in the ward corridors.This meant that it was difficult to observe these areas easily. At this inspection, we found that trust had fitted mirrors in the corridors. The bedroom corridor on the Haringey assessment unit had not yet been fitted with mirrors, but they had been ordered.
- At our previous inspection of acute wards for adults of working age and psychiatric intensive care units in December 2015, we found that the physical environment on Dorset ward was poor. At this inspection, we found that improvements had been made.
- Staff had conducted audits of ligature anchor points. Staff had identified most of these and put in plans to mitigate the risks associated with them. However, staff on Fairlands ward an acute ward for adults of working age had not accurately identified all potential ligature anchor points in the ligature risk assessment and put in place plans to mitigate them. Staff on Avon ward were not mitigating the ligature risks in a shared bathroom.
- Most wards provided a safe environment, however on Fairlands ward there was rubbish and debris in the garden which could present a potential risk to patients. The CCTV system on this ward was not working fully.
- The wards complied with the guidance on same gender care. There were a couple of wards where arrangements to improve the safety and privacy of patients of different genders could be improved such as the acute wards at Edgware community hospital where male patients had to be escorted through a female corridor to access the garden.
- Staff working on wards had easy access to alarms and patients had easy access to nurse call systems.
- At our previous inspection of community-based mental health services for adults of working age in December 2015, staff did not always have easy access to alarms. At this inspection, most interview rooms in community bases were fitted with alarms and there were staff on site to respond to alarms. Staff in the Barnet team in the specialist community mental health services for children and young people did not have access to alarms to call for support.
- At our previous inspection of acute wards for adults of working age and psychiatric intensive care units in December 2015, we found that the number of beds on Avon ward exceeded the number recommended in the national guidelines for PICUs. At this inspection, we found that the number of beds still exceed recommended number. The trust planned to move the ward to another location and reduce the number of PICU beds. This meant that the number of PICU beds that would then be provided would be in line with the recommendations contained in the national guidelines for PICUs.

Maintenance, cleanliness and infection control

- Most ward areas were clean, had good furnishings and were well-maintained. The trust scored better than the England average for cleanliness in the 2016 patient-led assessments of care environments. It achieved an average score of 99%.

Requires improvement

Are services safe?

- At our previous inspection of acute wards for adults of working age and psychiatric intensive care units in December 2015, we found that Fairlands ward and Avon ward were not clean. At this inspection in September 2017, these wards were clean.
- Staff adhered to infection control principles, including handwashing.
- At our previous inspection of community health services for children, young people and families in December 2015, the trust did not always ensure infection control and hand hygiene audits take place across the services. At this inspection, staff completed quarterly hand hygiene audits.
- Most cleaning records were up to date and demonstrated that the ward areas were cleaned regularly.
- The specialist community mental health services for children and young people did not have cleaning rotas in place for toys and equipment to minimize the risks of infection control.
- The acute wards for adults of working age and psychiatric intensive care units had outstanding maintenance issues that needed addressing on Sussex, Fairland's, Avon and Haringey assessment unit.

Seclusion room

- At our previous inspection of acute wards for adults of working age and psychiatric intensive care units in December 2015, we found that the seclusion rooms on the Chase Farm and St Ann's hospital site did not protect the patients' safety, privacy and dignity.Whilst the trust had taken steps to make these facilities safer, the location, the need to access through public areas and this lack of ligature free en-suite bathroom facilities compromised patient's privacy and dignity. At St Ann's hospital, this will be addressed by the proposed hospital rebuild, but at Chase Farm further work was needed.
- At our previous inspection of forensic/secure inpatient wards in December 2015, we noted that the toilet in the seclusion room on Devon Ward did not have a viewing panel and there were some ligature risks identified. This meant that staff observed patients in the room with them, which did not maintain patients' privacy and dignity.At this inspection, we found that the seclusion room facilities in Devon Ward provided sufficient observation.
- In the forensic inpatient/secure wards seclusion rooms allowed for clear observation and two way communication. Fennel, Cardamom and Blue Nile House wards did not have a dedicated seclusion room but had access to a ward close by, on the same level, if patients needed to be secluded.
- The location of the de-escalation room on Cardamom Ward impacted on the privacy and dignity of patients using this room.

Clinic room and equipment

- At our previous inspection of acute wards for adults of working age and psychiatric intensive care units in December 2015, we found that the clinic rooms were not a safe environment for the storage of medicines and the medical equipment was not clean. At this inspection, we found that the temperature of the medicine storage fridge on Avon ward was outside the recommended range and staff had not taken action. Also the temperature in the clinic room exceeded the recommended maximum temperatures.Staffhad not taken action to remedy this.The trust could not be assured that medicines had been kept at the optimum temperature and were still effective.
- Clinic rooms were fully equipped with accessible resuscitation equipment and emergency drugs that staff checked regularly.
- Staff in the specialist community mental health services for children and young people had not ensured that the contents of first aid kits and pads for defibrillators were in date and fit for purpose.
- At our previous inspection of community-based mental health services for adults of working age in December 2015, we found that Haringey teams did not have access to appropriate clinic rooms. At this inspection, the teams had access to clinic rooms.
- At our previous inspection of acute wards for adults of working age and psychiatric intensive care units in December 2015, we found that the medical emergency

equipment on Fairlands ward could not be easily reached in an emergency. At this inspection, medical equipment was located in the nurses' office, and staff could easily reach the equipment in an emergency.

- Staff in the acute wards for adults of working age, wards for older people with mental health problems and CAMHS services did not calibrate all physical health equipment in line with the trust's policy.

Safe Staffing

Nursing staff

- The trust had determined safe staffing levels by calculating the number and grade of members of the multidisciplinary team required using a systematic approach. The trust, led by the director of nursing, had completed a review of staffing levels and skill mix across wards and teams.
- In August 2017, the trust vacancy rate was 12.7%. It had a nursing vacancy rate of 16.6 %. The trust covered gaps in staffing through using bank and agency staff. When temporary staff were used, those staff received an induction.
- The trust had strategies to recruit more staff.In the last year, it had conducted ongoing recruitment programmes locally and internationally.
- Since our last inspection, the trust had improved staffing levels. At this inspection, we found the trust had sufficient staff to support patients safely in all teams and on all wards. Ward managers and team managers could adjust staffing levels daily to take account of case mix. When necessary, managers deployed agency and bank nursing staff to maintain safe staffing levels.
- The trust achieved safe staffing levels on most shifts. In August 2017, the trust reported daytime safer staffing average fill rates of 98% for registered nurses and 103% for care staff. It reported night-time safer staffing average fill rates of 99% for registered nurses and 104% for care staff.
- The trust used an e-rostering system to ensure sufficient staff on shifts.
- The trust was making significant use of temporary staff although the use of agency staffhad reduced and bank staff had increased. From 1 June 2016 to 31 May 2017, qualified staff from the trust's bank filled 13,036 shifts and care staff from the bank filled 11,900 shifts; qualified agency staff filled 6,281 shifts and agency care staff filled 131 shifts.
- At our previous inspection of acute wards for adults of working age and psychiatric intensive care units in December 2015, we found that there were a number of vacancies for permanent nursing staff on the wards. This had led to inconsistency in care and leave being cancelled for some patients. At this inspection, we found the trust had been proactive in recruiting permanent staff, which had improved the consistency of care for patients.
- At our previous inspection of acute wards for adults of working age and psychiatric intensive care units in December 2015, we found that there were a number of vacancies for ward managers and consultant psychiatrists. At this inspection, we found that the trust had been proactive in recruiting permanent managers and consultant psychiatrists for the ward.
- At our previous inspection of community-based mental health services for adults of working age in December 2015, we identified that the trust should ensure recruitment continues so that the majority of staff are permanent employees. At this inspection, there had been slight improvement across the three boroughs. The trust had taken action to address recruitment and staff development where they were able to. However, in Haringey East team, 24% of staff were locum and there was a 33% vacancy rate. This was leading to some patients experiencing changes in care co-ordinators and this needed to be monitored.
- At our previous inspection of community health services for children, young people and families in December 2015, the trust did not have sufficient staff to offer a full school nursing programme. At this inspection, there had been a cut in funding. This meant school nurse vacancies were no longer being filled.
- At our previous inspection of the child and adolescent mental health wards in December 2015, we found that the staffing of the service was not safe. We told the trust they must ensure that an effective strategy was in place for filling the high number of vacancies and to retain staff. There were now no vacancies for nursing staff.

Requires improvement

Are services safe?

- At our previous inspection of community health services for children, young people and families in December 2015, the trust did not have sufficient health visitors in post to deliver the 'healthy child programme'. At this inspection, the service was delivered in line with commissioning requirements. Two of the five elements of the programme were targeted to those families where there had been identified safeguarding or parental concerns. We recognised that the trust was prioritising the safety of children and families in delivering this work.
- Some staff on the wards for older people with mental health problems had worked over the specified number of maximum hours in a week.

Medical staff

- The trust had ensured that wards and teams had adequate medical cover day and night. The trust had on-call arrangements in place, which it reviewed on an ongoing basis.
- In August 2017, the trust had a medical vacancy rate of 9.3%.
- The trust supported medical staff to complete revalidation.

Mandatory training

- The trust had improved the number of staff completing mandatory training. At our previous inspection in December 2015, the trust did not ensure staff completed mandatory training. At this inspection, the trust had improved the number of staff completing mandatory training. It had set itself a target for 90% of staff to be compliant with individual mandatory training requirements. In August 2017, 87.4% of staff complied with individual mandatory training requirements.
- At our previous inspection in December 2015, some staff found it hard to book training. At this inspection, most staff told us they could book training.
- At our previous inspection of acute wards for adults of working age and psychiatric intensive care units in December 2015, staff working in Haringey had not met the trust's targets for the completion of mandatory training. At this inspection, the overall levels of training had improved. However, there were low completion rates of some mandatory training across all the wards, including some courses like basic life support and break-away which were essential to the safety of the patients. The majority of staff had not achieved the trust's target of 90% completion of mandatory training.
- At our previous inspection of acute wards for adults of working age and psychiatric intensive care units in December 2015, we found that there were delays in staff completing their refresher training in their prevention and management violence and aggression. At this inspection, we found that the completion rate for this course was 87%.
- At our previous inspection of forensic/secure inpatient wards in December 2015, the mandatory training for staff on Juniper ward was low at 73%, and across the forensic inpatient wards staff training was low in particular areas including safeguarding and breakaway training. At this inspection, staff received appropriate training in mandatory areas.
- At our previous inspection of the child and adolescent mental health wards in December 2015, staff did not complete mandatory training in line with trust targets. At this inspection, staff completed mandatory training in line with trust targets.
- At our previous inspection of wards for older people with mental health problems, the trust did not ensure staff completed mandatory training. At this inspection, most staff completed mandatory training.
- At our previous inspection of mental health crisis services and health-based places of safety in December 2015, not all staff had completed mandatory training. At this inspection, the number of staff completing mandatory training had improved and the average across the three teams was 73%. However, there was more to do. The completion of mandatory training varied between teams, was still below the trust target of 85% and the completion of some mandatory training courses was low.
- At our previous inspection of community-based mental health services for adults of working age in December 2015, some staff had not had access to mandatory training and team managers did not have accurate training records for staff. At this inspection, we found that most staff had access to mandatory training. Mandatory training information was available for team managers and senior managers.

Requires improvement

Are services safe?

- At our previous inspection of community health services for children, young people and families in December 2015, some staff had not completed mandatory training. At this inspection, most staff had completed mandatory training.

Assessing and managing risks to patients and staff

Assessment of patient risk

- Staff completed risk assessments using recognised tools for most patients. Since the last inspection, the services had made many improvements. At this inspection, we found some examples of risk assessments not being completed or updated in sufficient detail in the adults of working age and psychiatric intensive care units, mental health crisis services and health-based places of safety and community-based mental health services for adults of working age.
- At our previous inspection of acute wards for adults of working age and psychiatric intensive care units in December 2015, we found that staff working on the acute wards at Chase Farm hospital did not always update patients' risk assessments after incidents. At this inspection, we found that whilst this had improved there were still examples of staff not updating risk assessments after significant incidents.
- At our previous inspection of mental health crisis services and health-based places of safety in December 2015, the documented risk management plans lacked sufficient detail and did not always clearly state how risks would be managed. Since then the trust had provided training for staff and audited the risk assessments. At this inspection, the Barnet home treatment team completed and updated risks assessments, but the Haringey and Enfield home treatment teams did not ensure they completed and updated assessments for all patients.
- At our previous inspection of mental health crisis services and health-based places of safety in December 2015, staff discussed patient risk in the planning meetings. They did not record these discussions consistently in the care records. At this inspection, we found that this was still the case. In Haringey, we attended the morning planning meeting and then looked at the care records for the patients staff had discussed. We found that the notes were not clear and did not reflect the change in patient risk adequately.
- At our previous inspection of community-based mental health services for adults of working age in December 2015, the trust did not ensure risk assessments were monitored and updated when needed. At this inspection, most teams had improved, but we had specific concerns about the assessment and management of risk in the Haringey West team.
- At the previous inspection of specialist community mental health services for children and young people in December 2015, we found staff did not always update risk assessments. At this inspection, we found that staff updated risk assessments.
- At the previous inspection of specialist community mental health services for children and young people in December 2015, we found that staff could not always access accurate information because individual risk assessments had not always been updated. At this inspection, we found this had improved. We saw that clinicians updated risk assessments when a patients' situation changed.
- Staff on Ken Porter ward in older people with mental health problems did not always complete risk assessment documentation in full and review these regularly.

Management of patient risk

- Staff in most wards and teams were aware of and dealt with most specific risk issues. They identified and responded to changing risks to, or posed by, patients. Some teams needed to improve some of their management of risks. However, staff on acute wards for adults of working age and psychiatric intensive care units did not ensure that all patients at risk of falls had access to relevant safety equipment.
- Prior to undertaking visits, staff in the mental health crisis services did not know all patient risks.
- At our previous inspection of mental health crisis services and health-based places of safety in December 2015, not all staff in Barnet received information on the most up-to-date risks of patients because staff had to leave part way during the morning handover in order to meet home visit appointments. At this inspection, we saw that the Barnet morning planning meeting was well structured and lasted an hour.

Requires improvement

Are services safe?

- The community children, young people and families did not ensure health visiting staff were clear about frequency of visits for targeted children recorded visits accurately. Staff did not always record patient care consistently.
- At our previous inspection of community-based mental health services for adults of working age in December 2015, staff did not always monitor patients on the waiting list to receive treatment from the team. At this inspection, most teams had small waiting lists that they monitored. Haringey West CSRT had a waiting list of 20 patients.
- Staff followed the policies and procedures for use of observation.
- Staff mostly applied blanket restrictions on patients' freedom only when justified. At our previous inspection of acute wards for adults of working age and psychiatric intensive care units in December 2015, we found staff on Dorset ward imposed inappropriate blanket restrictions, and staff on a number of wards locked doors without reason.At this inspection, we found that staff on Dorset ward only used restrictions when justified and based on risk. Staff on Suffolk ward and Sussex ward imposed a blanket restriction regarding hot drinks only being available to patients at set times. This had been put in place following a serious incident where staff had been scalded but had not been kept under review. Patients on Suffolk ward told us that they could not always get hot drinks when they requested them and on occasions, staff provided drinks late. Patients were unhappy with this and felt that it had led to conflict on the ward.
- At our previous inspection of forensic/secure inpatient wards in December 2015, we noted that some patients were being prevented from using the garden due to smoking issues. Since the implementation of the smoking ban, this was no longer a cause of concern for patients. Staff on Sage Ward in the forensic inpatient/ secure wards imposed a policy that all patient visits at the service were supervised regardless of individual risk.
- At our previous inspection in December 2015, we found that the trust had not ensured that the information given to informal patients regarding their personal liberty was legally accurate. At this inspection, we found that the information to informal patients was legally accurate.
- At the previous inspection in December 2015, we found across a number of services that not all staff followed the lone working policy. At this inspection the trust had developed good personal safety protocols, including lone working practices, and there was evidence that staff followed them.

Use of restrictive interventions

- From 1 June 2016 and 31 May 2017, the trust recorded 728 incidents of restraint on 401 service users. One hundred and ninety-three of these incidents involved the use of prone (face down) restraint. Staff administered rapid tranquilisation in 301 incidents. The trust recorded no incidents involving the use of mechanical restraint.
- The trust had a policy on the prevention and therapeutic management of violence and aggression (PMVA).
- The trust trained staff in the use of PMVA. In July 2017, 88% of eligible staff had completed this training. However, some staff on the acute wards for adults of working age were observed not safely restraining a patient or recording this accurately.
- At our previous inspection of acute wards for adults of working age and psychiatric intensive care units in December 2015, we found that staff did not complete appropriate health checks on patients who had been administered intramuscular rapid tranquilisation.At this inspection, we could not see records to assure us that staff had completed appropriate health checks on three out of six patients who had been administered intramuscular rapid tranquilisation.
- From 1 June 2016 and 31 May 2017, the trust recorded 366 uses of seclusions. It also recorded two incidents of long term segregation, which both occurred in forensic/ secure inpatient wards. The appropriate checks had taken place to ensure this took place in line with the Mental Health Act code of practice.
- Staff in the forensic inpatient wards recorded seclusion in four different formats, creating a burden on staff, and making it difficult to assess whether a patient was supported appropriately.

Safeguarding

Requires improvement

Are services safe?

- In the year from 1 April 2016 to 31 March 2017, the trust raised 498 safeguarding adult concerns and 199 safeguarding children concerns. This was a significant increase from the previous year when the trust raised 332 safeguarding adult concerns and 133 safeguarding children concerns.
- The trust had a safeguarding committee, which was chaired by the director of nursing.
- The trust had a lead for safeguarding and deputy leads for children's safeguarding and adult safeguarding.
- The trust participated in local safeguarding boards.
- Staff recorded on the trust's electronic incident reporting system to highlight when an incident may constitute a safeguarding alert.
- Staff received training in safeguarding. The trust had increased the number of staff that received the level three training in children's safeguarding. In September 2017, 80% of eligible staff had completed this training.
- In most teams, staff reported and managed safeguarding appropriately.
- Staff on Avon ward in the acute wards for adults of working age and psychiatric intensive care units did not make all safeguarding referrals promptly.
- Staff in the mental health crisis services and health-based places of safety did not monitor and track safeguarding alerts that had been raised by staff or where patients had safeguarding alerts raised in regards to them.
- As part of the government's prevent strategy, staff received training on identifying radicalisation and extremism.

Staff access to essential information

- Staff had most information they needed to deliver patient care available when they needed it.
- At the time of the inspection, the trust's IT system sometimes worked slowly. This meant that it could be hard for staff to access and save some information. The trust knew about this problem and a new IT supplier had been selected.
- At our previous inspection of mental health crisis services and health-based places of safety in December 2015, the Barnet team's boards appeared difficult to read. At this inspection, all the wipe boards were legible and staff updated them daily with the key risks.
- At our previous inspection of community health services for children, young people and families in December 2015, the trust did not ensure that all current patient clinical records are regularly maintained. At this inspection, we found staff still did not record some details of patient care consistently.

Medicines management

- Since the last inspection, the trust had made improvements in the management of medicines.
- At our previous inspection of acute wards for adults of working age and psychiatric intensive care units in December 2015, we found that there was not always a clear record of when medicines had been reconciled after the admission of a patient to a ward. Staff did not review 'as and when' medication regularly. At this inspection, we found that there had been improvements. Staff completed clear and comprehensive records of medicines reconciliation and reviewed 'as and when' medication.
- At our previous inspection of acute wards for adults of working age and psychiatric intensive care units in December 2015, we found that staff did not know the procedure to collect and dispose of illegal substances.At this inspection, we found that staff knew the correct procedure for dealing with illicit substances.
- At our previous inspection of mental health crisis services and health-based places of safety in December 2015, staff did not complete all medication records fully. At this inspection, the trust had improved its monitoring and auditing of medication errors and had put measures in place to ensure the safe management of medicines.
- At our previous inspection of community-based mental health services for adults of working age in December 2015, the trust did not ensure that there were safe systems for the storage and transportation of medicines,

medical waste and sharps. At this inspection, staff transported medicines in secure, lockable briefcases. Staff stored medicines in locked cupboards and locked fridges.

- At our previous inspection of community-based mental health services for adults of working age in December 2015, the teams did not systematically identify patients who were prescribed high dose anti-psychotic medication to ensure that they were receiving appropriate checks on their physical health. At this inspection, we found the teams had developed systems to identify patients who were prescribed high dose anti-psychotic medication.
- At our previous inspection of community-based mental health services for adults of working age in December 2015, staff did not take medicines administration records when visiting patients at home. At this inspection, staff took medicines administration records when visiting patients at home.
- Medicines including controlled drugs (CDs) were stored securely. Staff regularly checked the temperatures of most of the locations where medicines were stored. This provided assurance that medicines were at the correct temperatures to remain effective. However, on Avon ward the temperature of the clinical room and medicines fridge were outside of an appropriate range and this had not been addressed in a timely manner.
- All prescription charts were clearly written and included patient demographics and information about allergies. Where appropriate, documentation regarding legal authority to administer medicines to individual patients was readily available.
- The physical health of patients was generally monitored appropriately. For high risk medicines such as haloperidol injections, all patients had received an electrocardiogram reading. In addition, all patients on lithium and clozapine had received the appropriate blood tests.
- We saw that medicines reviews and changes were clearly recorded on the trust's electronic records system. We also saw patient involvement in decisions and information about medicines related risks. Pharmacists gave advice to both staff and patients to improve medicines optimisation.
- Staff could access all the medicines policies via the trust intranet. Clinical pharmacists provided a ward based service during normal working hours. Medicines optimisation pharmacy technicians conducted medicines reconciliation and recorded this activity on prescription charts and on the trust's electronic records system.
- During the inspection, some oxygen cylinders appeared empty even though they were full. We raised this with staff, and they took immediate action to rectify this.
- The trust had arrangements to ensure that medicines incidents were reported, recorded and investigated. Staff we spoke with knew how to report incidents involving medicines.

Track record on safety

- From 1 July 2016 and 30 June 2017, the trust reported 64 serious incidents in the eight mental health core services.

Reporting incidents and learning from when things go wrong

- The trust had an electronic incident reporting system. Staff knew what incidents to report and how to report them. Most staff reported the incidents that they should report, but the trust reported fewer incidents than similar trusts.
- From 1 April 2016 to 30 September 2016, the trust was slower than average to report patient safety incidents to the National Reporting and Learning system (NRLS). The trust submitted 50% of all incidents to the NRLS more than 30 days after the incident occurred, compared with 26 days across all NHS organisations.
- At our previous inspection of specialist community mental health services for children and young people in December 2015, we found that staff did not report all incidents and managers did not ensure that learning from incidents and complaints was shared across the service and the trust. At this inspection, we found that this had improved. All the members of staff we spoke with knew which incidents to report and how to report them.

Requires improvement

Are services safe?

- Staff at Edgware hospital in the acute wards for adults of working age and psychiatric intensive care units did not always report and investigate incidents in accordance with timescales set out in trust's policy.
- Across the services, staff made changes as a result of investigations and feedback.
- Staff received feedback from investigation of incidents in their borough. At our previous inspection in December 2015, staff did not always receive learning from across the trust. At this inspection, this had improved, but the trust still did not ensure that all learning was shared.
- At our previous inspection of acute wards for adults of working age and psychiatric intensive care units in December 2015, the trust had not ensured that there were systems in place for staff to learn from incidents across the trust. At this inspection, the trust had systems to share learning but staff did not always receive learning from elsewhere in the trust. The trust was aware of this and was looking at how to improve this. The teams discussed learning from local incidents in team meetings, but staff did not consistently record this in the minutes for the meetings.
- At our previous inspection of acute wards for adults of working age and psychiatric intensive care units in December 2015, we found that the trust did not review incidents of absconsion. The trust had not ensured that measures were being put in place to keep these to a minimum. At this inspection, we found that staff reviewed incidents of absconsion and had put measures in place to keep these to a minimum.
- At our previous inspection of forensic/secure inpatient wards in December 2015, we found that staff were not always aware of incidents that had happened in the trust outside of the forensic service. At this inspection, staff were able to tell us about incidents that had occurred across the trust, and the resulting learning. Staff carried out simulations of different situations on the ward, to ensure that they were prepared in the event of an emergency.
- At our previous inspection of mental health crisis services and health-based places of safety in December 2015, learning from incidents was not being shared in a systematic way across the three teams. At this inspection, most staff could still not tell us what incidents had happened at other teams and what the learning had been from those incidents.
- At our previous inspection of community-based mental health services for adults of working age in December 2015, staff working in the community support and recovery teams did not always have access to information about incidents across the service. At this inspection, we found this had improved, but in Haringey West team it was not clear that learning from incidents was embedded in team practice.
- The community older adult services did not ensure that learning and good practice was shared with other teams.

Duty of Candour

- We looked at five serious incidents to see how the trust applied duty of candour. We found in all cases that families and carers had been contacted and were given an explanation of what had happened and where appropriate an apology. They had also been asked to give their views on the incident. What was not clear from the record of the root cause analysis was whether they had contributed to deciding the terms of reference for the incident investigation, or when they raised concerns if these had been followed through.

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

Please see overall summary.

Our findings

Assessment of needs and planning of care

- Staff completed a comprehensive mental health assessment for most patients in a timely manner at, or soon after, admission.
- Staff assessed most patients' physical health needs in a timely manner after admission.
- At our previous inspection of acute wards for adults of working age and psychiatric intensive care units in December 2015, we found that staff did not use the national early warning scores (NEWS) properly. At this inspection, staff on all wards apart from Sussex ward used NEWS sheets properly.
- Staff in the wards for older people with mental health problems did not all have sufficient training and knowledge to support patients with diabetes. They did not always complete diabetes care plans that were detailed and reflect requirements outlined in the trust policy.
- Staff in the mental health crisis services and health-based places of safety did not ensure all patients had their physical health needs assessed.
- At our last inspection of the in December 2015, staff did not always develop personalised plans for all patients. At this inspection, staff produced personalised, holistic and recovery-oriented plans for most patients. We found some examples in which staff had not developed plans that took into account all of the patients identified risks.
- At our previous inspection of acute wards for adults of working age and psychiatric intensive care units in December 2015, staff did not always involve patients in producing their care plans, and they did not always produce plans that were recovery focused. At this inspection, we found staff at St Ann's and Edgware Community hospitals developed plans with patients that were recovery focused, but staff at Chase Farm hospital did not complete plans with patients that were recovery focused for all patients.
- Patients and staff worked together in the forensic/secure inpatient wards to produce clear and holistic care plans that reflected patient views. Care plans reflected the care delivered, and patients told us that they had contributed to their care planning.
- Staff in the mental health crisis services and health-based places of safety did not involve all patients in their care plans. They did not always develop plans that were holistic and recovery focussed.
- Staff in the community-based mental health services for adults of working age did not develop person-centred and holistic patient care plans for all patients and the care plans were not always updated as necessary.
- At the previous inspection of specialist community mental health services for children and young people in December 2015, we found that not all care plans were holistic and person centred. At this inspection, we found that this had improved. Staff had developed care plans that were personalised, holistic, and recovery-oriented based on the young persons' strengths or goals for 11 of the 15 patients whose care plans we reviewed and these were updated as needed.

Best practice in treatment and care

- Staff provided a range of care and treatment interventions suitable for the patient group. The interventions were those recommended by, and were delivered in line with, guidance from the National Institute for Health and Care Excellence.
- The forensic/secure inpatient wards delivered a high quality of care with attention to best practice and evidence from research. Examples of this included the

roll out of self-catering across the facility, the integration of zonal observation on wards, and piloting positive handovers. The service encouraged innovative practice and supported research by staff within the teams.

- In the forensic/secure wards, patients and staff had co-produced and co-delivered a recovery college programme starting in May 2017. This included workshops on a wide range of topics co-facilitated by experts by experience, such as hearing voices, basic life support, getting the best out of care programme approach meetings, creative writing, sleep hygiene, and returning to study. Experts by experience were recruited by a vocational manager, with a view to providing a user led rather than a professional led programme.
- Staff in the wards for older people with mental health problems did not always keep accurate records of when one to one sessions take place with patients.
- The trust had improved patient access to psychological therapies, but some patients in the community teams still had to wait long periods to access services.
- At our previous inspection of acute wards for adults of working age and psychiatric intensive care units in December 2015, we found that the trust had not ensured that patients had adequate psychology input especially at St Ann's and Edgware Community hospitals. At this inspection, we found that patients on the acute wards had access to psychology input.
- At our previous inspection of mental health crisis services and health-based places of safety in December 2015, we found that all three teams had limited access to a psychologist. For example, a psychologist was available for one day a week in Barnet. At this inspection, we found that all teams could refer a patient to a psychologist if needed. However, patients being supported by the community-based mental health services for adults of working age often faced a long wait to access psychological therapy services and the trust did not monitor waiting times for patients to access these services.
- The trust had improved the support it gave patients with their physical healthcare. Since our previous inspection, it had developed physical healthcare champions in teams. National early warning scores were used across inpatient services to identify patients who were physically deteriorating. However, the trust still needed to improve and ensure staff supported all patients with their physical healthcare needs.
- At our previous inspection of community-based mental health services for adults of working age in December 2015, staff did not support all patients to have physical health checks, and staff did not always know patients' significant physical health conditions and how to address these. At this inspection, we saw that there had been some improvement. Some care plans included physical health sections and staff wrote to GPs for information about patients' physical health needs and to share information with them before care programme approach (CPA) review meetings. However, staff in Enfield and Haringey did not consistently follow up when responses had not been received from GPs.
- At our previous inspection of mental health crisis services and health-based places of safety in December 2015, we found that 18 care records across the three sites did not document whether full physical health issues were routinely re-assessed and monitored as ongoing practice. At this inspection, we did not find physical health care plans or reviews for any of the patients in the Haringey and Enfield HTTs.
- Staff in Haringey older adult's service in the community-based mental health services for older people had undertaken work to ensure GPs completed physical health checks, but some patients had not yet had physical health checks.
- Staff assessed and met patients' needs for food and drink and for specialist nutrition and hydration, but staff on The Oaks in the wards for older people with mental health problems did not complete all nutrition and hydration forms accurately.
- Since our previous inspection in December 2015, the trust had implemented a no smoking policy. As part of this, staff supported patients to access smoking cessation schemes.
- Staff used recognised rating scales to assess and record severity and outcomes, for example, Health of the Nation Outcome Scales.

Requires improvement

Are services effective?

- Staff participated in clinical audit, benchmarking and quality improvement initiatives. In the 12 month prior to the inspection, the trust participated in 78 national and local audits.

Skilled staff to deliver care

- Most teams included or had access to the full range of specialists required to meet the needs of patients on the ward.
- At our previous inspection of wards for older people with mental health problems, Ken Porter ward did not have an occupational therapist. At this inspection, the ward had a full time occupational therapist and an activities coordinator.
- Staff were experienced and qualified, and they had the right skills and knowledge to meet the needs of the patient group.
- Managers provided new staff with appropriate inductions.
- At our previous inspection in December 2015, we found staff did not always receive regular supervision. At this inspection, we found that the trust had improved, but some staff did not receive regular formal supervision that was recorded.
- At our previous inspection of acute wards for adults of working age and psychiatric intensive care units in December 2015, we found that staff did not receive regular supervision that was recorded. During this inspection, across a number of core services, whilst systems had been introduced for supervisions to be recorded, managers did not ensure that all staff received regular supervision and recorded supervision when they received it.
- Most staff completed appraisals. At the time of the inspection in September 2017, 81% of staff had completed an appraisal. The process was not yet finished, and the trust was on course to meet its target of 90% of staff completing an appraisal. In the NHS staff survey 2016, 92% or the staff that responded said they had been appraised in the last 12 months, which was similar to the national average.
- At our previous inspection of community health services for children, young people and families in December 2015, managers did not ensure all staff completed appraisals. At this inspection, staff completed an annual appraisal.
- Most teams held effective meetings in which they shared information. Some team meetings in the child and adolescent mental health wards and mental health crisis services and health-based places of safety did not follow a template that ensured all learning from incidents was shared. Dorset ward on the acute wards for adults of working age and psychiatric intensive care units did not have effective mechanisms in place for staff discuss their concerns regarding the working environment.
- The trust offered staff the opportunity to attend specialist training to develop skills.
- At our previous inspection of community health services for children, young people and families in December 2015, the trust did not offer school nurses the opportunity to access specialist community public health nurse training. At this inspection, staff were supported and encouraged to undertake specialist training and had opportunities to further their clinical personal development and training.
- The trust supported managers to deal with poor staff performance promptly and effectively.

Multi-disciplinary and inter-agency team work

- Staff held regular and effective multidisciplinary meetings in most services.
- At our previous inspection of the child and adolescent mental health wards in December 2015, we found that multidisciplinary working was not always effective. At this inspection, we found that staff from different disciplines now communicated well with each other and had a shared understanding of how the team should deliver care and treatment.
- At our previous inspection of mental health crisis services and health-based places of safety in December 2015, we found that planning meetings were primarily consultant led with limited input from other

professionals. At this inspection, we found that these meetings varied between teams. Some meetings were still consultant led with limited input from other professionals.

- Staff shared information about patients at effective handover meetings within the team.
- Most wards and teams had effective working relationships with other teams in the trust and outside of the trust.
- In Barnet, community teams had reorganised. This had led to closer working with GPs.

Adherence to the MHA and the MHA Code of Practice

- The trust had clear structures and procedures for monitoring the administration of the Mental Health Act 1983 (MHA).It reviewed mental health policies every three years. The trust board had oversight of the day-to-day use of the MHA through the Mental Health Law Committee. The Mental Health Law Committee met quarterly. It considered changes to policies and reviewed statistical reports of MHA activity.
- The mental health law department conducted monthly audits into compliance, for example, the recording of assessments of capacity to consent to treatment, and annual audits, for example, MHA activity and the provision of approved mental health professional reports. The trust also completed an annual MHA equalities report.
- The trust monitored MHA activity using the MHA electronic management system developed by the head of mental health law. This system provided data on all aspects of the use of the MHA and sent weekly emails to wards and responsible clinicians providing an update on MHA activities that needed to take place.
- A yearly report was completed by the head of mental health law and presented to the Mental Health Law Committee.
- The mental health law team provided support on each inpatient site. Mental Health Act offices were based in Enfield, Barnet, Haringey and in the forensic services. Mental Health Act administration teams were managed by the head of mental health law. The director of nursing managed the head of mental health law.
- From October 2016 to September 2017, CQC conducted 19 visits to review the implementation of the MHA. CQC made actions with regards to the recording of capacity on 10 occasions, staff explanation of rights on seven occasions and care plans on 10 occasions. Following these reviews, the trust developed action plans to address any actions for improvement.
- MHA training did not form part of the mandatory training within the trust. Training in the MHA was delivered every two months and staff could access this as needed.
- The trust maintained regular contact with external stakeholders via the local Inter-Agency Mental Health Group, chaired by the director of nursing and attended by the police, London ambulance service, the local authorities and the clinical commissioning groups.
- Within all of the wards and teams 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.
- At this inspection, we found staff followed the MHA and its code of practice for most patients but needed to improve in some areas.
- At our previous inspection of acute wards for adults of working age and psychiatric intensive care units in December 2015, we found that the trust had not ensured that staff explained patients' rights under the Mental Health Act and did not check that patients understood their rights. When patients needed the support of an interpreter to have their rights read to them, staff did not always book an interpreter in a timely manner. At this inspection, we found that for patients at Chase Farm hospital, there were delays for a few patients having their rights explained to them. Staff did not always evidence in care records if they had explained to patients their rights.
- At our previous inspection of acute wards for adults of working age and psychiatric intensive care units in December 2015, we found that the trust had not ensured doctors provided clinical judgement details in

the patients' capacity to consent or treatment assessments. At this inspection, we reviewed 21 records and found that in 18 records doctors had provided a clinical judgement.

- Staff in the child and adolescent mental health wards did not always inform young people of their rights after a second opinion doctor had authorised their treatment.
- Staff in the community-based mental health services for adults of working age did not always record clearly in notes when patients were entitled to support under section 117 of the Mental Health Act.
- At our previous inspection of mental health crisis services and health-based places of safety in December 2015, staff in the health-based place of safety had not completed all the Section 136 paperwork fully, and staff did not always record that they had informed patients of their rights. At this inspection, we saw this had improved. Section 136 paperwork was fully completed and six of the eight patients whose records we reviewed noted that staff had explained patients their rights.

Good practice in applying the Mental Capacity Act

- The trust had an up to date policy on the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS).
- The trust had a MCA lead and also leads in different services to support staff as needed.
- The trust monitored adherence to the MCA through the Mental Health Law group, which provided a governance process. This looked at the results of audits and considered new methodology.
- The trust provided training in the MCA and DoLS as part of the safeguarding training, which was mandatory for new all staff. The trust also provided a module on the MCA as part of junior doctor training. The trust did not provide data on the number of staff that had completed training in the mental capacity act.
- Staff knowledge and application of the MCA varied. Most staff applied the principles of the MCA, but some teams needed to embed staff understanding.
- At our previous inspection in December 2015, the trust needed to review implementation of the Mental Capacity Act. At this inspection, the trust continued to have some areas in which staff knowledge of the MCA could be improved.
- At our previous inspection of forensic/secure inpatient wards in December 2015, we found that staff training in the Mental Capacity Act was not consistent, and this was not monitored to ensure that there were no gaps. At this inspection, training relating to the Mental Capacity Act was not mandatory across the trust, but it was now being provided as part of the induction training for all new staff.
- At our previous inspection of wards for older people with mental health problems, staff did not always record meetings to discuss best interest decisions. At this inspection, staff recorded meetings to discuss best interest decisions.
- Some staff in the community-based mental health services for adults of working age did not have a sufficient understanding of the relevance of the MCA and its scope.
- At our previous inspection of mental health crisis services and health-based places of safety in December 2015, nursing staff knowledge of the MCA was not embedded, and non-medical staff told us that only doctors carried out capacity assessments. At this inspection, staff in Haringey and Enfield HTTs said the doctor completed mental capacity assessment for patients. Not all staff felt confident applying the MCA.
- Staff in child and adolescent mental health services considered Gillick competence. This is a test in medical law to decide whether a child of 16 years or younger is competent to consent to medical examination or treatment without the need for parental permission or knowledge.
- At the previous inspection of specialist community mental health services for children and young people in December 2015, we found that staff did not always record consent to treatment in the care records. At this inspection, we found that this had improved. Out of 15 care records we looked at 11 had consent to treatment recorded in the notes.

Requires improvement

Are services effective?

- At our previous inspection of community health services for children, young people and families in December 2015, staff did not always follow the necessary process for obtaining consent prior to carrying out health checks. At this inspection, staff sought consent before undertaking care interventions.
- Staff made DoLS applications when required and monitored the progress of applications to supervisory bodies. From 1 April 2016 to 31 March 2017, the trust made 69 applications to the local authority supervisory bodies.

Good

Are services caring?

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

Summary of findings

Please see overalls summary.

Our findings

Kindness, dignity, respect and support

- Most staff supported patients with kindness, dignity, respect and support. In most interactions we observed during the inspection, staff were very caring towards patients.
- Most patients gave positive feedback regarding the service. Prior to the inspection, we placed comment card boxes throughout the trust. We received 216 responses. Of these, 181 gave feedback on the quality of the service: 98 recorded positive feedback, 36 negative feedback and 47 mixed feedback.
- In all the teams we visited in the community-based mental health services for older people, patients and carers were very positive about the support they received from staff. They told us that staff were very caring and the service they received exceeded their expectations. Staff respected and empowered patients and carers. Staff described colleagues as highly committed and caring. All staff spoke enthusiastically about their work.
- We received very positive feedback from patients and carers in the forensic / secure inpatient wards. They felt staff treated them with respect, kindness and compassion. Patients received care, treatment and support that met their individual needs. Patients and other people important to them were fully involved in all aspects of their care and worked in partnership with the staff team.
- At our previous inspection of acute wards for adults of working age and psychiatric intensive care units in December 2015, we found that the trust had not ensured that wherever possible staff involvement with patients was caring and supported patient recovery and was not merely task-focussed. At this inspection, we found that on the wards at St Ann's and Edgware Community hospital that staff interactions were positive and supported recovery. However, this was not the case on the wards at Chase Farm hospital.
- Some staff in the Enfield home treatment team in mental health crisis services and health-based places of safety did not demonstrate empathy towards patients or carers that complained.

Involvement in care

Involvement of patients

- Most staff involved patients in care planning and risk assessments.
- The forensic / secure wards undertook numerous initiatives to ensure that patients were engaged and involved in the care they received. This included a focus on collaborative risk assessments and patient-led care programme approach meetings, and a robust clinical governance process which included patients attending clinical governance meetings.
- Staff in the community-based mental health services for older people had a strong person centred-culture. Staff placed the views of patients and their carers at the centre of care planning and actively involved patients and carers in making decisions about their care and treatment. Staff enabled patients to lead their own care programme approach meetings where possible.
- At our previous inspection of wards for older people with mental health problems, staff on Ken Porter did not always discuss with patients, their families or an advocate how they wish to be supported whilst eating. At this inspection, staff assessed how patients wished to be supported whilst eating.
- At our previous inspection of mental health crisis services and health-based places of safety in December 2015, the care records did not all record the views of patients or show that patients were being actively involved in the decisions about their care. At this inspection, staff discussed care with patients but did not always record patients' views in records.

Good

Are services caring?

- At our previous inspection of mental health crisis services and health-based places of safety in December 2015, staff did not always document whether patients had received a copy of their plans. At this inspection, staff did not always share care plans with patients. Staff in the Haringey and Enfield HTTs did not record whether they gave patients a copy of their care plans. Staff in the Barnet HTT told us they left a copy of the care plan with patients.
- Staff ensured that patients could access advocacy services.
- At the previous inspection of specialist community mental health services for children and young people in December 2015, we found some staff did not know how young people could access the advocacy service. At this inspection, staff could tell us what advocacy support was available and how they signposted patients to it when necessary.
- The forensic / secure wards had recruited 20 experts by experience, ensuring that patients who had left the service were able to input into the current service.

The involvement of families and carers

- Staff in most teams informed and involved families and carers appropriately and provided them with support when needed.
- Staff in the community-based mental health services for older people provided carers with extensive support to help them cope with their caring responsibilities. The number of carers having carer assessments had increased because of staff interventions. Staff offered and supported peer support programmes where guest speakers gave presentations to carers and 'mini dementia sessions' in which local stakeholders provided advice and information about local community support. Carers had access to psychological therapies to support them to cope emotionally.

Good

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

Please see overall summary.

Our findings

Access and discharge

Access and waiting times

- The services had clear criteria for which patients would be offered a service and, if waiting lists were used, who could be placed on them.
- At our previous inspection of mental health crisis services and health-based places of safety in December 2015, staff told us that the local accident and emergency department would not accept individuals in need of a place of safety. At this inspection, a small number of young people had been admitted to the place of safety since January 2017. No children under 16 had been accepted to the service. This was clearly stated in the unit's operational policy and procedure.
- At our previous inspection of mental health crisis services and health-based places of safety in December 2015, the service would not accept patients who were intoxicated and required acute medical support. At this inspection, staff were trained to assess the impact of alcohol or substance misuse on the patients' mental health presentation, and it did not turn away patients who were intoxicated.
- The trust had set targets for time from referral to assessment and from assessment to treatment. The teams could see urgent referrals quickly and non-urgent referrals within an acceptable time.
- In the community-based mental health services for older people, all teams met the 13 week overall referral to treatment/diagnosis targets. There were no waiting lists for access to the older adult CMHTs. The memory services met the six week referral to assessment targets and most patients received a diagnosis on the day of their assessment.
- At our previous inspection of community-based mental health services for older people in December 2015, we found that the provider should review the arrangements for the provision of the Haringey memory service in order to reduce the length of time patients had to wait between assessment and diagnosis. At this inspection, 70% of patients using the Haringey memory service had received a diagnosis within four weeks of their referral.
- At our previous inspection of mental health crisis services and health-based places of safety in December 2015, some patients had to wait for extended time periods in the health-based places of safety. The average time spent by patients was just over seven hours. At this inspection, we found that some patients waited longer than necessary because of the delays in getting an approved mental health professional (AMHP) to assess them.
- At the previous inspection of specialist community mental health services for children and young people in December 2015, the trust had long assessment to treatment times for young people waiting to access some parts of the services. At this inspection, we found that this had improved. Investment in new staff and teams had improved waiting times.
- At the previous inspection of specialist community mental health services for children and young people in December 2015, the trust needed to improve monitoring of children and young people on the waiting list. At this inspection, staff monitored the waiting list to ensure they saw all children and young people as soon as possible.
- Not all patients could contact teams at all time. At our previous inspection of mental health crisis services and health-based places of safety in December 2015, patients told us they sometimes had long periods of trying to connect to staff through the 24 hour crisis lines.At this inspection, we found that this was still the case for some people.

Good

Are services responsive to people's needs?

- At our previous inspection of mental health crisis services and health-based places of safety in December 2015, not all staff knew the function of the hub. At this inspection, all staff could explain what the hub was and how it related to the delivery of the crisis service.
- In most teams, appointments usually ran on time and staff informed patients when they did not, but staff in some teams in mental health crisis services and health-based places of safety did not always communicate well.
- At our previous inspection of mental health crisis services and health-based places of safety in December 2015, staff did always communicate with people to tell them when they were likely to attend or gave patients non-specific times. At this inspection, the teams varied in how they communicated with patients. Staff in the Enfield and Haringey home treatment teams did not always communicate clearly with patients regarding appointment times.
- The teams tried to make follow-up contact with people who did not attend appointments.
- At our previous inspection of community-based mental health services for adults of working age in December 2015, staff did not follow the trust policy for patients who did not attend (DNA) appointments. At this inspection, we saw some improvement. The trust had refreshed its policy in relation to patients who did not attend appointments. Staff in most teams followed up patients who did not attend appointments by contacting them on the telephone, sending letters or reminders and leaving notes for home appointments.
- At the previous inspection of specialist community mental health services for children and young people in December 2015, we found that not all staff knew what steps to take if a young person did not attend their appointment. At this inspection, we found that all staff could tell us what steps to take.

Bed management

- All wards in the acute wards for adults of working age and psychiatric intensive care units had high bed occupancy levels. Fairlands ward had the highest bed occupancy rate between April 2016 and March 2017. It peaked in August 2017, when it reached 137%. Haringey assessment unit had the lowest bed occupancy (89%) during that time period. The length of stay ranged from zero to 347 days.
- At our previous inspection of acute wards for adults of working age and psychiatric intensive care units in December 2015, we found that the trust transferred patients to other wards for non-clinical reasons. At this inspection, we found that the trust had reduced the number of times patients were transferred. None of the patients we spoke to said they had been transferred from other wards.
- At our previous inspection of acute wards for adults of working age and psychiatric intensive care units in December 2015, we found patients returning from leave did not always have a bed available for them. This meant that they had to be transferred to another ward, which disrupted their care. At this inspection, we found that patients almost always had a bed available when they returned from leave.

Discharge and transfers of care

- The trust held regular bed management meetings. Wards worked with community teams to facilitate discharges.
- At our previous inspection of mental health crisis services and health-based places of safety in December 2015, teams often had delays in discharging patients due to delays in other teams taking referrals. At this inspection, staff said that discharging patients from the service was not an issue as there were strong communication channels with the acute and community mental health teams.

The facilities promote recovery, comfort, dignity and confidentiality

- Most patients had their own bedrooms and were not expected to sleep in bed bays or dormitories. Some wards on acute wards for adults of working age and psychiatric intensive care units, for example Fairlands, had dormitories. The trust had plans to redevelop St Ann's hospital.
- Patients could personalise bedrooms.

Good

Are services responsive to people's needs?

- Most patients had somewhere secure to store their possessions, but patients on Dorset ward in the acute wards for adults of working age and psychiatric intensive care units did not have accessible facilities to keep their belongings safe and secure.
- At our previous inspection of acute wards for adults of working age and psychiatric intensive care units in December 2015, staff did not always protect the privacy and dignity of patients. Patients could not close the observation windows on their bedroom doors. At this inspection, patients could close the observation windows on their bedroom doors.
- Patients could make a call in private on most wards. At our previous inspection of acute wards for adults of working age and psychiatric intensive care units in December 2015, we found that the trust had not ensured patients could make a phone call in private. At this inspection, we found patients could make a call in private on all wards except Suffolk and Sussex wards. However, most patients were now supported to have access to their personal mobile phone.
- Patients had access to outside space.
- At our previous inspection of mental health crisis services and health-based places of safety in December 2015, the health-based place of safety suite did not have any chairs. At this inspection, the unit at St Ann's hospital had closed and the unit at Chase Farm hospital had been refurbished. Each new room had an en suite bathroom and appropriate mattress and bedding.
- At our previous inspection of community health services for children, young people and families in December 2015, the environment at Cedar House was not child friendly. At this inspection, the environment had been redecorated with child appropriate themes to make it more appropriate for young people.
- The forensic / secure inpatient wards had a good range of facilities including quiet rooms and outdoor garden space with gym equipment provided.

Patients' engagement with the wider community

- To support patients on discharge into the community, the forensic / secure inpatient wards paid for gym membership in patient's local area for their first year after discharge. They could also continue to participate in the community football team and contribute to the recovery college.

Meeting the needs of all people who use the service

- The services made adjustments to support disabled patients.
- Patients had a choice of food to meet the dietary requirements of religious and ethnic groups.
- At our previous inspection of acute wards for adults of working age and psychiatric intensive care units in December 2015, we found that the trust had not provided a choice of food that was of good quality and met the cultural and dietary need of patients. At this inspection, we found that there were mixed views regarding the quality of the food at Edgware Community and Chase Farm hospitals. Patients at Edgware community hospital complained that the trust provided insufficient fruit and vegetables.
- Staff in the community-based mental health services for older people proactively considered how to meet the needs of lesbian, gay, bisexual and transgender (LGBT) patients. Following their first known LGBT patient referral, staff in Barnet older adult team met to discuss how the service would work to meet the needs of LGBT patients in future. This meeting included a discussion about how to identify and support people's partners or companions. Staff could refer LGBT patients to a local charity that provided an activity group for older adults.
- Staff supported patients to access to appropriate spiritual support. At our previous inspection of acute wards for adults of working age and psychiatric intensive care units in December 2015, we found that the trust had not ensured that staff supported patients to meet their spiritual and religious needs. At this inspection, we found that the service was meeting patients' religious and spiritual needs.
- Staff made information available for patients, including some leaflets in languages other than English.
- Staff could access interpreting services to support them communicating with patients.

Listening to and learning from concerns and complaints

Good

Are services responsive to people's needs?

- Patients knew how to complain or raise concerns. When patients complained or raised concerns, they received feedback. Eight complaints were randomly checked as part of the inspection. This found that the final responses were comprehensive and written in an appropriate manner. The main concerns found were that the trust was not meeting the 90% trust target 83%. Letters from MPs were managed via the informal complaints process and it had not been recognised that some of these were formal complaints.
- At our previous inspection of mental health crisis services and health-based places of safety in December 2015, the teams did not share information on learning from complaints in a systematic way with each other. At this inspection, the teams still did not ensure they shared information between them, so staff did not always learn lessons from complaints in other teams.
- At our previous inspection of community health services for children, young people and families in December 2015, the trust did not ensure that information was available for people on how to make a complaint in clinic environments. At this inspection, information on how to complain was available.

Good

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

Please see overall summary.

Our findings

Leadership

- The trust board consisted of the chair, chief executive, seven non-executive directors and five executive directors.There were no vacant posts.
- The chair had been in post for nine years and the chief executive for ten years. This had provided stable leadership for the trust. The chair was coming towards the end of his tenure and plans were being put into place for his succession. The current chair was able to stay on until these arrangements were in place.
- The non-executive directors had the appropriate range of skills, knowledge and experience. They all had experience as senior leaders in a range of organisations and brought skills such as finance and investment, strategic development, working in partnership and transforming services. There had been careful consideration to ensure the right skills were in place to support the ongoing work of the trust. A recently appointed non-executive director had brought with them estate transformation experience, which will support the redevelopment of St Ann's hospital.
- The non-executive directors were supported with their learning and development. Three of the non-executive directors had only joined shortly prior to the inspection and had gone through an induction process. This had included meeting each executive director on an individual basis and attending board development events provided by NHS Improvement. In addition, each person had an annual appraisal. There was an annual board development day and development workshops every two months.
- The senior leadership team consisted of a chief finance and investment officer, medical director, director of nursing, chief operating officer and executive director of workforce. Most of the leadership team had been in post at the previous inspection two years previously and had a good knowledge of the trust. The exception to this was the chief finance officer who had just joined the trust prior to the inspection. The chief executive was very mindful of where each person was in terms of their career progression and offered them development opportunities, which included additional learning and development and opportunities to carry out new roles within the trust or in wider stakeholder forums.
- We reviewed a random selection of five trust board members fit and proper person checks. This showed that all the necessary checks had been completed including disclosure barring checks which was appropriate for people meeting patients and having access to confidential information.
- The trust reviewed leadership capability and capacity on an ongoing basis for the senior executive leadership team and for the four service lines. Since the previous inspection the service line structures had bedded in. There were three service lines for each borough and one for specialist services. Four very experienced and capable clinical directors led each of the four service lines. The managerial and clinical support available to each senior executive and clinical director varied and was based on their areas of responsibility. They also had support from some central teams provided by the trust such as the workforce team.
- Interviews held with the trust leadership team demonstrated a very high level of awareness of the priorities and challenges facing the trust and how these were being addressed. People were able to speak with insight about the staff recruitment and retention challenges and the estate issues particularly at St Ann's. As well as describing the risks associated with this they were also aware of the plans in place.
- The trust board carried out a programme of board visits. For non-executive directors, there was a co-ordinated

programme of visits. They recorded their findings and issues that needed to be addressed, which was then fed back to the director of nursing to manage. For executive board members, the visits were less structured, and records showed that there was a significant variation in the numbers of these visits between different executive members. Most staff commented on the approachability of senior leaders in the trust, although a few said they were not visited regularly.

- Leadership development opportunities were available for staff at different levels of the organisation linked to their appraisals and person development plans. This included training for first line managers, middle managers and senior leadership development. Much of the leadership development for first line managers was provided internally. There was also access to some external leadership development opportunities. Whilst the numbers of staff attending each cohort of training appeared quite small, managers throughout the organisation were mostly positive about their access to these leadership development opportunities. There were also leadership and strategy away days for staff from across the trust twice a year.
- At our previous inspection in December 2015, the trust had interim staff in key senior posts in teams such as human resources and the patient experience team. At this inspection, the trust had increased the number of permanent staff in these roles. This provided consistency and ensured the implementation of keys areas of work.
- At our previous inspection of the child and adolescent mental health wards in December 2015, the ward did not have a permanent management team providing leadership. At this inspection, the ward had a permanent manager.
- At our previous inspection of mental health crisis services and health-based places of safety in December 2015, the trusts had not ensured that managers with the appropriate leadership skills were in place to make the improvements needed in the home treatment. At this inspection, we found that many improvements had been made. However, we found that, especially in the Enfield team, changes had not been made.

Vision and strategy

- The trust had developed a clear vision and set of values. The vision of the trust was reflected in their 'enablement strategy' which is summarised as helping people to 'live, love and do'. This was launched in 2015 after wide consultation including many external stakeholders over an 18 month period. The ambition of the organisation was to promote recovery, social inclusion and community integration to maximise resilience. Through work with other stakeholders a number of projects across the three boroughs had started to generate change and provide support to people with areas such as employment and access to sporting and social activities. An example of this was the further development of the family nurse partnership in Enfield to support harder to reach communities. At the time of the inspection, the trust was about to go out to tender for a range of enablement projects. It was recognised that there were challenges in the development of new initiatives as all stakeholders were facing financial difficulties.
- The values of 'compassion, respect, being positive and working together' had been developed in 2016 with more than 500 staff and patients. Training had also been provided for teams on how to put the values on to action. This training was experiential and had been well received. Staff had a good knowledge of the trust's values and how they applied these in the work of their teams. There was more to be done to fully embed the values in wider trust processes such as in recruitment.
- The trust also had an annual operational plan highlighting their main priorities for development and progress with achieving these. This was approved by the trust board. Discussions about meeting the needs of local communities took place through the service lines at a borough level. This had led to specific improvements. For example, in Barnet there had been closer working with GPs including access to a helpline for clinical advice when needed. Most ongoing consultation related to very specific issues such as the St Ann's redevelopment.
- The trust was very actively involved in the sustainability and transformation plans with staff attending a range of meetings and contributing information as needed. The chief executive was chairing the group looking at workforce issues which fitted in well with the trusts own operational plans. This was already bringing about

opportunities for working with other providers. For example, the trust was working across North East London to share procurement. The trust was also working with another mental health trust to look at the provision of female psychiatric intensive care beds and perinatal services.

Culture

- The overall culture of the trust was very patient centred and this was under-pinned by the promotion of the trust values. Staff were highly motivated by wanting to provide the best possible care for patients. Staff said they felt proud to work for the trust and were able to articulate the contribution made by themselves and their teams.
- Most staff we spoke to felt respected, supported and valued. There was lots of positive feedback from staff about the support they received from their line manager, team and trust. We heard some accounts of staff who described the support they had received after a serious incident where there had been a no-blame culture and they had been able to learn and improve their practice. We also heard about staff being supported with their own health problems or where they had carer responsibilities. Staff regularly described the culture of the trust as being open and honest and willing to recognise where the problems were.
- In the NHS Staff Survey 2016, the trust score for the percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months was 27%, which was worse than the national finding. The inspection found that there were some small pockets of staff who reported bullying and harassment and inter-racial conflict was described by some as a problem. The trust had done some specific work on this such as a more in-depth review in one borough and some initial training on bullying and harassment but there was more to do.
- The trust recognised that they had more to do in terms of their workforce race equality standard results from 2016. The trust performed below the national average with 71% of BME staff believing that the organisation provided equal opportunities for career progression or promotion compared to 78% nationally. Also the likelihood of BME staff entering a formal disciplinary process was five times greater than white staff. The trust had developed an action plan. They had consulted with the staff race equality network. This plan was approved through the work-force sub-committee of the quality and safety committee.The trust was taking a number of steps to improve the results of the WRES. Two new non-executive directors on the board were from a BME background. Other examples were that the trust was promoting the use of mediation as an alternative option before a formal disciplinary process is used. For all staff interviews above band 7, an external person to the recruiting team was present on the panel. The trust had also held a career development day which was available for all staff.
- The trust also wanted to develop further their staff and patient networks. The trust had a staff race equality network called Better Together. A diversity week was being celebrated at the trust during the week of the inspection. For lesbian, gay, bisexual and transgender staff there had been an initial conference, but a network had not yet been established. For staff with a disability, work to establish a network still had to take place.
- The trust provided a range of opportunities for staff to raise concerns. Most staff said that they felt able to raise concerns with their line manager without fear of retribution. Staff also knew about whistle-blowing and had access to a whistle-blowing line. There was also a hotline if staff wanted to leave messages for the chief executive.
- There had been positive progress with the development of the Freedom to Speak up Guardian (FSUG). Two people had been employed each for one day a week to carry out this role. The role had been launched in April 2017 and their contact details were widely publicised and staff knew who they were. They also spoke at a wide number of events, such as staff induction days, across the trust. They had attended a conference arranged by the national FSUG and linked with colleagues in other trusts performing the same role. The FSUG had a good understanding of their role and were able to work flexibly to meet the needs of staff contacting them.
- At our previous inspection in December 2015, we asked the trust to consider if whistle-blowers would benefit from being able to contact someone more independent when they wish to raise concerns. At this inspection, the trust appointment of FSUG had given staff an opportunity to raise concerns with someone more independent.

Good

Are services well-led?

- The trust also had 20 dignity and well-being advisors working across the trust. These were staff working in a range of roles who were available to support colleagues. They had been provided with some training on informal counselling.
- The average staff sickness rate was 4.3% although for qualified nurses this was 6%. The trust recognised that a high percentage of their nursing staff were approaching retirement. They had introduced the 'one more year' scheme to work with individual nurses to review their work to encourage them to stay on for another year if they wanted.
- Managers across the trust said they were able to address poor staff performance where needed and received guidance from the human resources team when required.
- Staff had access to an occupational health service which provided counselling services and access to assistance with physical health needs such as physiotherapy. The trust was finding it challenging to meet its target for staff having the flu vaccine. It was also recognised that more could be done to meet the emotional health needs of staff.
- The trust recognised staff success. There were awards for employee of the month and an annual awards ceremony with a number of different categories of awards. Most staff said that they did feel the trust valued staff although a few said it would be nice to be thanked more regularly by the senior team.

Governance

- The trust had robust governance structures in place. This meant that from ward to board there was a good understanding of the challenges facing the trust. These appeared on the board assurance framework and there was a description of the actions being taken, although in a few cases there was scope for how these are mitigated to be described in greater detail.
- The trust board had seven sub-committees which were audit, finance and investment, charitable funds, remuneration, mental health law and quality and safety. In addition a new committee had been added for improvement to oversee the progress of the trusts quality improvement programme. This committee was still in development and the terms of reference for the quality and safety committee and the improvement committee were being developed. It was hoped that this will achieve a good balance for the board between assurance and improvement.
- The papers for the board and the quality and safety committee contained clear summaries and appropriate detailed information. There was a clear annual work-plan to ensure all the areas were covered.
- The non-executive directors were clear about their areas of responsibility. They chaired the board sub-committees. They also attended each other's sub-committees so they understood the broader working of the trust. The executive directors had clearly defined areas of responsibility. The clinical directors had operational responsibility for their service lines. They were clear about issues which needed to be escalated to the executive team and other stakeholders when they arose.
- There was a framework in each service line with meetings in place to ensure essential information was shared. This meant that each ward and team had access to learning from incidents, complaints and patient feedback. Clinical directors said they met regularly with each other which enabled them to share good practice.
- Each service line had a quarterly deep dive meeting. This was chaired by the director of nursing and all the wards and team managers attended. This reviewed all the data for these services. Staff who attended these meetings fed back that whilst they recognised the importance of assurance they would have valued more time to discuss opportunities for improvements.
- Three of the service lines were based on boroughs. This helped to facilitate joint working with clinical commissioning groups and local authorities. There were a number of examples of how the trust was working closely with primary care, local authorities, acute trusts and the third sector to promote good patient care.
- At a ward and team level front line managers were also clear about their responsibilities and felt they were given sufficient autonomy and also support to perform their roles.
- At our previous inspection of community-based mental health services for adults of working age in December 2015, some teams did not have local risk registers, which

were up to date so risks could be escalated when needed. At this inspection, all teams had a local risk register as well as having input into the borough risk registers.

- The community-based mental health services for adults of working age and the mental health crisis services and health-based places of safety must ensure that it effectively assesses, monitor and improves the quality and safety of the services provided.
- Staff in the health-based places of safety could not access a governance dashboard with their performance against key performance indicators. They did not monitor all relevant information to drive improvement.
- The trust had clear structures and procedures for ensuring the implementation of the Mental Health Act and Mental Capacity Act reflected good practice. Despite the size of the trust, the mental health law team had a presence on each inpatient site. The director of nursing was the executive lead for mental health law and oversaw the work of the mental health law team. The use of both acts were monitored and reported to the Mental Health Law committee which reported to the trust board.

Management of risk, issues and performance

- The trust had clear risk management processes in place, with risks collated and reviewed at different levels of the organisation to ensure action plans were in place. These fed into the trust risk register which included the top risks, the assurance and action plans. These were reviewed by the quality and safety committee and the board. The current concerns identified by the latest core service inspections such as staff vacancies and IT infrastructure were reflected in the risk register and actions to address them were in place. For example a work-force sub-committee reported to the quality and safety committee so that progress was carefully monitored.
- The trust recognised the importance of having a strong programme of quality assurance. This included clinical audits, where the trust participated in the relevant national audits including those relating to the prescribing of medication. The clinical audits largely used data lifted from the patient record system but then more in depth audits were carried out to look at specific areas. In addition they used feedback from patient surveys to drive improvement, embedding learning from serious incidents and complaints and assuring compliance against NICE clinical guidelines. These were seen working well as part of the inspection and where needed improvements were being followed through and implemented. The key findings from this assurance work were fed back to wards and teams through their individual dashboard which they received once a quarter. This clearly identified areas where improvements were needed. Ward and team managers showed varying levels of confidence in understanding and using the data but this was progressing in a positive direction.
- The trust had a quality and performance report which collated data on a range of indicators and performance targets. The report showed the progress of the trust and comments were provided on the contents where needed. This was a helpful report. The only information which was missing was the CAMHS referral to treatment times rather than just referral to assessment. The trust confirmed that including this data in the report was already in progress. Areas of concern were then escalated to the board for discussion.
- The trust also carried out some thematic work. For example there had been an in-depth look at patients who were absent without leave. This report was presented to the quality and safety committee and pulled together learning from incidents across the trust.
- The emergency planning & business continuity plan was reviewed on an annual basis by the board. In the latest plan for 2016/17, the trust was compliant with most standards and plans were progressing to meet the rest.
- At the time of the inspection, the trust was under considerable financial pressure. In the last financial year from 2016-17 the trust had a planned £12 million deficit. For 2017-18 there were plans to reduce this to £4.5. A pricing review had taken place, which confirmed the trust was being paid at least £6.3 million too little for the services provided. The trust had an ongoing programme of cost improvements. These were reviewed by the service line clinical directors and also by the director of nursing and medical director to ensure they did not compromise patient care. At the time of the inspection

there was work taking place to reduce the number of sites where care was delivered and make savings in the costs of estates. This was having an impact on patients and staff but was recognised as a way to save money.

Information management

- At the time of the inspection the trust was experiencing difficulties with their IT infrastructure and this was impacting on the delivery of care. This was affecting the speed for staff trying to access information from IT systems. We also heard of many other practical difficulties such as systems not working for periods of time, printers not working and the challenges for staff working in the community who did not have access to mobile technology. The trust had agreed a contract with a new provider which includes solutions to all these challenges to commence in March 2018. The impact on services was on the board assurance framework and risk register and was being closely monitored.
- The non-executive directors felt confident about the quality of the data at a board level. They said it was reliable, accurate and timely. Staff in each service line had a good knowledge of services and could challenge data that did not look correct.
- The information provided at the board meetings provided a holistic overview of performance and covered clinical, operational and financial matters.
- Staff reported that they did at times find the reporting of information a burden especially when they could not see this being used to make changes.
- The trust reported on information governance breaches. One incident of a filing cabinet being thrown away that was discovered to contain some patient identifiable information was thoroughly investigated and recommendations made.

Engagement

- The trust had many examples of positive engagement with patients and carers. The trust board always included hearing from a patient or carers about their experience.
- Patients and carers were participants in a number of committees such as the quality and safety committee. In addition they had been actively involved in consultations about the trust enablement strategy, values and specific areas of work such as the St Ann's redevelopment. Patients were actively involved in the patient led assessments of the care environment.
- At our previous inspection in December 2015, the trust did not always engage patients and carers fully in the delivery of services. At this inspection, the level of involvement varied between teams. There were many examples of working with patients and carers. Examples included co-production work at the recovery college, support groups for patients and carers provided by the memory services and the active participation of young people in developments within CAMHS.
- The trust did not have a clearly defined structure for patient and carer engagement such as a central committee or patient engagement leads in each of the service lines. Whilst there was a lot of very positive engagement taking place, this meant that this may not be happening consistently and there was only limited staff time available to extend this work. For example, there were only eight peer support workers in the trust and although their input in the adult community mental health teams was highly valued there was scope to extend peer support workers much further as recognised by the trust.The same could be said about the use of volunteers, which could also be extended.
- The trust wide patient experience team supported the service lines with the management and analysis of complaints and patient survey results. An annual report from the patient experience team pulling together the main themes was reviewed by the quality and safety committee and the board.
- The trust sought feedback from patients and carers using a range of surveys. As well as the family and friends survey they also real time feedback, postcard surveys, specialist feedback for children and young people and social media. The numbers of returns and levels of satisfaction were monitored along with areas for improvement which were shared with the appropriate services.
- The trust worked hard to engage effectively with staff. Staff described how the trust intranet had improved and how good use was made of social media to communicate with staff. In addition there were other bulletins and 'trust matters' the trust magazine. The

chief executive had regular forums where staff could come and raise issues. Visits took place to services by members of the senior leadership team. Staff also said how much they appreciated social events such as the carol service last year. Staff working in the Enfield community services still mentioned that they did not feel as well engaged.

- Some staff in the community-based mental health services for adults and the community children, young people and families services did not feel the trust had engaged them in changes to services or that they were given sufficient information about changes to services.
- The trust had arrangements in place to work with staff including a joint staff committee with trade unions. Senior executive staff described the positive joint working.
- The trust carefully analysed and developed action plans for the trust as a whole and each of the service lines in response to the results of the staff survey.
- External stakeholders fed back about the trusts engagement and said they received open feedback about the performance and challenges faced by the trust.

Learning, continuous improvement and innovation

- The trust, in partnership with the Haelo Innovation and Improvement Centre at Salford Royal NHS Foundation Trust, had set up a quality improvement programme. This had extended across 15 teams in the trust. We saw that staff were working on a number of projects and that the quality improvement approach was well received by staff who were energised about the ideas they would be able to develop.
- The trust had three main areas of quality improvement priorities: improving patient safety, clinical effectiveness and improving patient and carer experience. Included in clinical effectiveness was the improvement of physical health for patients. At the time of the inspection, the appointment of physical health leads had taken place and they were coming into post.
- The trust also encouraged innovation through its 'dragons den' scheme, which had doubled in size over the last year. This had extended from just providing funding for projects to improve patient care to now accepting projects to improve staff well-being. For example, it had provided funding for teams to learn mindfulness or receive team coaching.
- The trust was rightly very proud of winning a national health service journal award for 'project future' based in Tottenham supporting young people who are disengaged, excluded and may be gang members. The service provides psychological, emotional and physical health support to young people. The trust was also highly commended for their Enfield based care home assessment team.
- The trust had also joined the NHS Quest programme which supports NHS trusts to use an improvement science methodology.
- The trust had a number of accredited services. This included the forensic service, the wards for older people, the ECT service, the psychiatric liaison teams, the Barnet and Enfield memory services, the eating disorder service and the supported employment scheme provided by the trust with the Twining's Enterprise Partnership. The CAMHS tier 4 inpatient service at the Beacon Centre was working towards accreditation.
- The North London Forensic Service had been successful in an application to the NHSE new care model programme board and had been selected to lead a new care model across the whole of North London for secure services. They were given a devolved budget for these services and will work in partnership with the providers to improve consistency, quality and patient experience.
- The medical director was the trust lead on learning from deaths. Since April 2017, the trust has had been a weekly mortality review meeting with the medical director and the members of the patient experience team. They reviewed each of the death notifications and decided which needed investigation. An investigation chair would be identified, usually a senior manager in the borough where the patient died but at times this would be passed to another borough. An audit had been done of this work but further learning from themes still needed to take place. The medical director was engaged with external stakeholders in developing guidance on reporting if deaths could have been avoided.

Good

Are services well-led?

- The trust provided opportunities for learning from serious incidents including deaths. There was an annual patient safety conference. There had also been three Berwick learning events looking at suicide, improving patients' physical health and patients who were absent without leave. These were well attended with around 100 clinicians joining the event.
- Three years ago the trust became a university teaching trust affiliated with Middlesex University which had led to closer working between clinicians and academics to improve mental health education and research. The medical director hoped to progress opportunities for research. At the time of the inspection, there was just one older adults consultant who had a joint appointment with University College London to carry out research.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care Mental health crisis services and health-based places of safety The trust had not ensured the care and treatment of patients was appropriate and met their needs and reflected their preferences. 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. Community-based mental health services for adults of working age The trust had not ensured that patients' care and treatment reflected their preferences. This was because some records in Haringey and Enfield did not have up to date care plans reflecting the service user voice and some of the care plans we looked at were not holistic and had a very narrow focus on clinician priority. This was also reflected in feedback from service users we spoke with. This meant that service user voice was not sufficiently embedded to ensure that preferences were taken into account. This was in breach of regulation 9(1)(2)(3)

Regulated activity	Regulation

This section is primarily information for the provider

Requirement notices

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

Diagnostic and screening procedures

Treatment of disease, disorder or injury

Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

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

The trust had not ensured that care and treatment was provided in a safe way for patients.

The trust had not ensured that the seclusion rooms across the three sites protected the patients' privacy and dignity. This was due to where the rooms were located.

The trust had not ensured staff completed risk assessments for all patients with sufficient detail and updated these following incidents.

The trust had not ensured that staff physical health checks for patients after they administered intramuscular rapid tranquillization.

Wards for older people with mental health problems

Staff supporting patients with diabetes had not received training in this area. Care plans were not detailed, did not indicate how and when to escalate concerns to a doctor and were not complied with in all cases.

Mental health crisis services and health-based places of safety

The trust had not ensured that care and treatment was provided in a safe way for patients.

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

This section is primarily information for the provider

Requirement notices

Staff did not always do all that was reasonably practicable to mitigate risks to patients and staff. The Enfield team did not ensure staff knew risks before they attended appointments with patients.

Community-based mental health services for adults of working age

The trust was not ensuring that care and treatment were provided in a safe way for service users because the service was not assessing the risks to health and safety of service users of receiving the care or treatment and doing all that is reasonably practicable to mitigate any risks.

This was because risk information was not being consistently updated to reflect current risk in care records in Haringey West CSRT. Where risk management plans were established, they were not being following including the frequency by which restricted patients needed to meet with their social supervisors.

Staff were not ensuring that all information about physical health needs including updates from GPs were included in electronic records and where GPs had not responded to requests for information and this had not been received, there were no consistent ways of chasing this up to ensure the teams had done all they could to mitigate risk due to physical health concerns and assure themselves they were aware of the current issues.

Community health services for children, young people and families

The trust had not ensured that health visitors visited and reviewed targeted families who may be at risk as regularly as needed and recorded these events.

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

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment Acute wards for adults of working age and psychiatric intensive care units The trust had not ensured the premises and equipment was appropriately secure, suitable and maintained. The trust had not ensured staff checked the temperature of the medicine fridge on Avon ward and took action when it was outside the recommended temperature range. This was a breach of Regulation 15 (1)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Mental health crisis services and health-based places of safety The trust had not established systems or process to effectively assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity. The trust did not support the team managers in Haringey and Enfield to provide effective leadership. Community-based mental health services for adults of working age The trust had not ensured that in the Haringey community services, the local management team were ensuring that they were assessing, monitoring and

This section is primarily information for the provider

Requirement notices

improving the quality and safety of services provided in carrying on the regulated activity and that they were not working actively within systems in place in the governance structures to mitigate risk to the health, welfare and safety of service users and others who may be at risk that arises from the carrying on of a regulated activity.

This was because staff in the Haringey West CSRT had not had regular supervision and team meetings, which had been happening, had not been consistently documented and recorded. The minutes did not reflect discussion about performance was taking place and that there was sufficient information about learning from incidents across the service, borough and trust. An incident review had recommended that these minutes were documented from June and this had not taken place. This meant that there was a risk that there were not sufficient safeguards in place to ensure that where there was learning from incidents, audits and complaints, that this was followed up by changes and improvements in practice.

Acute wards for adults of working age

The trust had not ensured that all the improvements identified at the previous inspection had been fully implemented and embedded. Recently appointed ward managers needed ongoing support to make these changes and the progress needed to be monitored using governance processes.

This was in breach of Regulation 17(1)(2)(a)

Regulated activity

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

Diagnostic and screening procedures

Treatment of disease, disorder or injury

Regulation

Regulation 18 HSCA (RA) Regulations 2014 Staffing
Acute wards for adults of working age and psychiatric intensive care units

This section is primarily information for the provider

Requirement notices

The trust had not ensured staff received appropriate supervision to enable them to carry out their duties they are employed to perform.

The trust had not ensured that staff had access to regular supervision and that a record of this was maintained.

Mental health crisis services and health-based places of safety

Staff must receive appropriate support as is necessary to enable them to carry out the duties they are employed to perform.

The trust had not ensured that all staff received regular supervision.

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