Barnet, Enfield and Haringey Mental Health NHS Trust

Inspection report

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Ratings

Overall trust quality rating	**Good**
Are services safe?	**Requires Improvement**
Are services effective?	**Good**
Are services caring?	**Good**
Are services responsive?	**Good**
Are services well-led?	**Good**

Our findings

Our reports

We plan our next inspections based on everything we know about services, including whether they appear to be getting better or worse. Each report explains the reason for the inspection.

This report describes our judgement of the quality of care provided by this trust. We based it on a combination of what we found when we inspected and other information available to us. It included information given to us from people who use the service, the public and other organisations.

We rated well-led (leadership) from our inspection of trust management, taking into account what we found about leadership in individual services. We rated other key questions by combining the service ratings and using our professional judgement.

Overall summary

What we found

Overall trust

We inspected Barnet, Enfield and Haringey Mental Health Trust as part of our continual checks on the safety and quality of healthcare services. We also inspected the well-led key question for the trust overall.

We inspected three of the mental health services provided by the trust. We completed full inspections of the trust's acute wards for adults of working age and psychiatric intensive care units (PICUs) and mental health crisis and health-based places of safety. We completed a focused inspection, which looked at the safe and well-led key questions, for community-based mental health services for adults of working age. We also inspected the community health services for children, young people and families that the trust provided in Enfield. We chose these core services as we knew there had been some challenges including serious incidents or there were requirement notices from the previous inspection and we wanted to see how the trust had responded and if high quality care and treatment was being delivered.

The trust provides the following mental health services, which we did not inspect this time:

- Child and adolescent mental health wards
- Forensic inpatient/secure wards (low secure)
- Long stay/rehabilitation mental health wards for working age adults
- Wards for older people with mental health problems
- Community-based mental health services for older adults
- Specialist community mental health services for children and young people
- Specialist eating disorder services

The trust also provides the following community health services, which we did not inspect this time:

- Adults

Our findings

- End of life care

Our overall rating of the trust stayed the same. We rated them as **good** because:

- We rated effective, caring, responsive and well-led as good, and safe as requires improvement.
- We rated three of the trust's services that we inspected as good and one as requires improvement.
- In rating the trust, we took into account the current ratings of the mental health and community health services we did not inspect this time.
- Overall, we found that whilst there had been progress since the previous inspection there was more to do. However, the trust leadership was aware of this and had plans to continue this work. They were focusing on improving the experience of patients accessing and using their services.
- The inspection took place at a time of complexity for the trust board. The trust had entered a partnership with Camden and Islington NHS Foundation Trust. The trusts now had the same skilled and experienced chair and chief executive and planned to have one shared executive director team by the end of June 2022. However, the board and other senior leaders needed the time to think through the implications including areas for opportunities and risks including potential conflict associated with the partnership with Camden and Islington NHS Foundation Trust. Also, executive directors whilst positive about the partnership were feeling understandably anxious about the impact of the changes on the trust and their individual roles and the support to them individually during the change needed to be kept under review.
- The inspection also took place at a time where there were concerns about a new COVID-19 variant and the potential impact on plans for the winter. The trust had worked hard to ensure patients continued to receive safe care during the COVID-19 pandemic. The trust had implemented infection, prevention and control procedures. They had changed models of working, such as offering some services remotely, to support people to continue to access services. The trust had also worked closely with other stakeholders and providers in the North Central London health and care system to meet the needs of patients, such as setting up crisis hubs so children and young people could access support without having to go to an emergency department. The trust had progressed with vaccinating staff and were commended for setting up a service to vaccinate people with a learning disability in a calm and supportive environment.
- The trust's estate had seen a major improvement with the opening of the new wards at St Ann's Hospital, the opening of Oak Partnership Ward in Southgate and the removal of all shared bedrooms, but many of the trust's other buildings were old. They often contained risks that made it harder for staff to manage them safely and did not offer therapeutic environments. The seclusion room on Trent Ward at Edgware Community Hospital did not, offer patients full privacy and one of the rooms used in the health-based place of safety contains environmental features which could potentially harm patients. Senior leaders acknowledged the need for further improvements to the trust's estate, and a strategic outline case for the rest of the trust estate to be modernised had been submitted with the support of the integrated care system and NHS London.
- The trust had a clear strategic plan to meet the needs of its local population, but further work was needed to ensure this was delivered. Since the last inspection, the trust had developed a new clinical strategy aligned to Camden and Islington NHS Foundation Trust. The divisional structures had been embedded since the last inspection, with local services being managed by geography. Divisional leaders were very enthusiastic and committed to improving services. Divisional objectives were also in place although these needed to be further developed and embedded to ensure transformation of community services took place as planned and were aligned to the care pathways being developed across North Central London in line with objectives of the Long Term Plan.

Our findings

- The trust was working in partnership with third sector providers to meet the needs of people. It had, as part of the transformation of community mental health services for example, awarded contracts to third sector providers so people could be supported with housing, employment and finances. The trust needs to progress with its plans to extend this further to ensure it meets the needs of communities and reduces inequalities.
- Organisational culture was improving. We heard about staff feeling more able to speak up when needed and improved connections between front line and senior leadership staff. The staff survey engagement rate had just improved from 44% last year to 54% this year. The external and independent Freedom to Speak Up Guardian arrangements were working effectively and staff awareness of this had improved. The four staff inclusion networks had been sustained and there had been developments especially for the Better Together network for Black and Asian minority ethnic staff. We also heard about the work to improve WRES, the in-depth listening exercises and the development with staff of a behavioural framework to focus on staff living the values of the trust. Many staff we spoke with also spoke positively about how Black History Month had been celebrated at the trust. However, more work was needed to embed this work, to ensure it was adequately resourced and that the progress with key actions was monitored. For example, the network leads needed enough time to carry out their roles. Also, whilst sixty-three percent of interview panels for posts at band seven or above now included a panel member from an ethnic minority background this needed to increase.
- The trust continued to focus on improving the quality of care it provided. Its 'Brilliant Basics' approach had progressed well since the last inspection. It was talked about by staff and improving services for patients. There had been a sustained reduction in restrictive practices in the trust's acute wards, particularly across the new wards, with improvement methodologies being rolled out. We also heard about the safety huddles taking place at every level.
- Quality improvement work had developed and started to embed since the last inspection. A team was in place to support the development of this approach, over 1000 staff had been trained and the trust was developing a quality improvement academy. We heard staff talking about how they had started to use the methodology and it was being used in a wider range of areas including patient access and flow. This work needed to be further extended and embedded.
- The trust had progressed work to support more people to participate in the development and running of its services. It now employed 45 peer support workers and planned to employ a further 30 people. There were also around 100 Experts by Experience on an involvement register and this grew by 5-10 people each month. They helped in a wide range of roles across the trust including work on the development of strategy and policy, recruitment, supporting service users and training staff. It was positive to hear that there were patient forums in three of the divisions and plans for the other two. Trust leaders told us that they hoped to develop this work more and embed it more in the work of the divisions. There was also scope to further extend the people participation to ensure people who use services are central to all the trust developments, for example, through ensuring people are trained in quality improvement methodologies so they can be part of teams progressing this work.
- The trust was in the process of improving its IT infrastructure and the information available to staff. Over the last two years, it had spent £5.8m on improving IT systems and hardware, and it was in the final stages of delivering a data warehouse. The digital strategy was going to the next board for approval. The trust recognised the need to ensure staff had access to live data to enable them to manage services effectively and hoped that the first versions of new dashboards would be available imminently.
- The trust had started work to improve its research and development and had become a member of University College London Partners. The development of research was not just to increase the number of research projects, but also to widen the scope of who completed research to other professionals including nursing, and ensure research involves service users and makes a contribution to improving the services they receive.

Our findings

- The trust had arrangements in place for staff to implement the Accessible Information Standard, which applies to people using services (and where appropriate carers and parents) who have information or communication needs relating to a disability, impairment or sensory loss, and its website had been recognised nationally as an example of good practice in accessibility. Staff working in services did not, however, always know what the standard was or how they would apply it in their work.

However:

- The trust continued to have pressures on its acute adult services. Although staff had worked hard to reduce inpatient lengths of stay and fewer adult patients had to be placed in services outside the local area, further work was still required. Many patients remained in the health-based place of safety for more than 24 hours, often waiting for a bed, and patients identified as requiring assessments in the community under the Mental Health Act were not always assessed promptly. Trust staff continued to work with stakeholders, such as the police and local authorities, and on quality improvement initiatives, but further improvements were still required.
- The Barnet crisis resolution and home treatment team had a team caseload of 60. The team was working to reduce the size of the caseload, but it remained too high.
- The recruitment and retention of staff remained a significant challenge for the trust. The trust had continued with work to review its staffing model, with a new nursing strategy and a focus of developing new career paths. However, vacancies remained. Some acute and PICU wards had high rates of unfilled staff shifts.
- The completion of mandatory training had improved overall and at the time of the inspection was 87%. However, Immediate Life Support (65%) training was still below the levels required, with particularly low completion in some services, having fallen behind due to the pandemic presenting challenges for face-to-face training. The failure to meet the target for this training was a risk to patient safety. There were plans for this to be addressed with additional capacity for face to face training arranged but this needed to be fully implemented.
- The trust did not always respond to complaints quickly. Whilst it was acknowledged that during the height of the pandemic responding to complaints was a lower priority, at the time of this inspection the completion of complaint responses within the agreed timescales was only 25%. A quality improvement project was in place to identify the reasons for this and make changes, but this needed to be implemented and target response times met.
- The trust continued to work to improve the timeliness and quality of its serious incident investigation, but further work was required to embed improvements. There was now a trust-wide group to support shared learning, improve the consistency of reports and to review the quality and effectiveness of recommendations and there was improved confidence in incident reporting and in the identification of when an investigation was needed. The trust had also introduced a new template for the completion of reports and hoped to involve service users and carers more in the process. Nevertheless, the five serious incident reports we reviewed still needed some improvements, such as by ensuring the most important findings are clear, and the timeliness of responses needed to improve. Although the average completion period for serious incident reports had reduced from 118 days, it was still 80 days. Whilst we heard how the trust shared learning from incidents, further work was needed to ensure a reduction in incidents with recurring themes across the trust.

How we carried out the inspection

Our inspection teams comprised of nine CQC inspectors, two CQC inspection managers, four specialist advisors and three experts by experience who contacted patients and carers on the telephone.

Our findings

The well-led review team comprised an executive reviewer who was Chair of an NHS mental health trust, two specialist advisors, a financial governance assessor from NHSE/I, two CQC inspectors, an inspection manager and a head of hospital inspection.

The core service inspections, gave short-notice to the services they were visiting to ensure the staff were available to be interviewed.

During our inspection of the four core services and the Well-led review, the inspection teams:

- reviewed records held by the CQC relating to each service
- visited five inpatient wards: Daisy and Tulip Wards at St Ann's Hospital, Devon and Suffolk Wards at Chase Farm Hospital, and Trent Ward at Edgware Community Hospital. We looked at the environment, medicines and observed interactions between staff and patients
- visited six community teams supporting people with mental health needs, including three crisis resolution and home treatment teams, one early intervention team and two locality teams supporting adults of a working age
- visited teams providing community health services for children and young people in Enfield, including team bases and two specialist schools
- visited the health-based place of safety
- spoke with 25 members of staff and conducted three focus groups during the well-led review
- spoke with 15 senior leaders during our inspections of services, including matrons, divisional directors, team managers and ward managers
- spoke with 107 other members of staff, including registered and non-registered nurses, doctors, occupational therapists, speech and language therapists, clinical psychologists, physiotherapists, dieticians, activities coordinators, peer support workers, pharmacists, graduate mental health workers, nursing associates, support worker and social workers.
- completed two focus groups with staff from across Enfield community health services
- interviewed 53 patients and 21 relatives of patients
- reviewed 82 patient care and treatment records
- observed six patient appointments and two home visits, with the patients' consent
- attended the morning daily planning meetings at all crisis resolution and home treatment team and four meetings at adult community teams, including a risk management meeting and caseload review
- attended meetings on all five wards, including two staff handover meetings, a quality safety meeting, a ward round, three 'Pride and Joy' multi-disciplinary meetings, and one bed management video call
- carried out a specific check of the medication management on the wards, including looking at 22 medicines administration records for patients
- looked at nine records of patients who had been administered rapid tranquilisation
- looked at a range of policies, procedures and other documents relating to the running of each service.

You can find further information about how we carry out our inspections on our website: www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

Our findings

What people who use the service say

During this inspection, we spoke with 53 patients and 21 relatives of patients

Patients that we spoke to supported by the community mental health teams were very positive about the service they were receiving. They said that the staff were caring and treated them with dignity and respect. Patients said that staff were easy to contact and that they received regular communications with their care co-ordinator over the phone or face to face. Several patients that we spoke to told us that they felt the service had saved their lives. Most patients we spoke to said they felt involved in their care and that they had a copy of their care plan. Patients knew who to contact out of hours and told us that they knew what their crisis plan was.

All parents of children supported by the Enfield community health teams we spoke with told us that staff treated them with compassion, kindness and dignity. Parents said staff were approachable, non-judgmental and were responsive to their needs in addition to their child's needs.

Most patients we spoke with on the wards said staff treated them well and behaved kindly and they felt safe, although sometimes they thought there were not enough staff to meet everyone's needs. Patients generally described the staff to us as nice, friendly and helpful. However, some patients said that some bank and agency staff could be less helpful with them, and some could be rude.

Patients spoke of a huge improvement in the accommodation provided in the new Haringey Wards at St Ann's Hospital.

Patients across all wards told us it often took some time for nursing staff to respond to their requests at the nurses' station. Some patients also described staff not getting their names right, and not coming when they called them.

Patients told us that staff supported them to understand and manage their own care condition. Most patients told us they knew their diagnosis, medications and what their rights were whilst in hospital. Patients confirmed that staff supported them with their physical health needs.

Most patients understood how to make a complaint about their care, including speaking with their named nurse, the ward manager, or asking for support from an advocate to make a formal complaint.

Family members/carers across the wards, gave mixed feedback about the service. Reporting some good support from staff, helping their relatives to recover, and some less helpful staff. Three family members thought they should have been given more information about their relative's care.

Use of resources

Not inspected as part of this inspection.

Combined quality and resource

Not inspected as part of this inspection.

Outstanding practice

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

Our findings

- Assistant psychologists had recently been recruited and were receiving training to roll out and embed trauma-informed care on the wards. On Tulip Ward, the psychologist had been piloting the Open Dialogue Model approach, a family and social network model, alongside the early intervention service.

Community health services for Children, young people and families

- Staff from the special school nursing service identified that there was a gap in health promotion within schools. They piloted a programme in one school, working collaboratively with the dietician and school staff to address increasing levels of obesity within children and young people.
- Staff from the Looked after children's service provided support to children seeking asylum, ensuring that they received access to necessary vaccines, such as tuberculosis and blood borne viruses, sexual health screening and support to access English speaking classes.
- The Community health services for Children, young people and families service had a charity, 'Little Sparks', that supported families and children, including those who have experienced a bereavement.

Areas for improvement

Action the trust MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the trust MUST take to improve:

We told the trust that it must take action to bring services into line with four legal requirements. This action related to three services.

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

- The trust must ensure that action is taken to protect the privacy and dignity of patients using the seclusion room on Trent Ward. Regulation 10 (2) (a)
- The trust must ensure that staff working on acute wards and PICUs that need immediate life support training complete it. Regulation 18 (1)
- The trust must continue to take action to address the high rates of unfilled staff shifts on acute and PICU wards, particularly on Devon, Trent and Daisy wards. Regulation 18 (1)

Mental health crisis and health-based places of safety

- The trust must ensure that that it continues to work effectively with partner organisations to ensure patients who require a Mental Health Act assessment are assessed without undue delay to ensure their safety and that of others. Regulation 12 (1)(2)(a)(b)(i)
- The trust must ensure it continues work to reduce the caseload size for the Barnet crisis resolution and home treatment team. Regulation 12 (1)(2)(b)
- The trust must continue its work to stop patients in the health-based place of safety from being held beyond the 24-hour Section 136 detention period with no legal framework for holding them. Regulation 13 (1)(2)(5)

Our findings

- The trust must ensure that all facilities used by patients in the health-based place of safety are safe, with an appropriate standard of fixtures and fittings. Regulation 12 (1) (2) (d)

Community-based mental health services for adults of working age

- The trust must ensure that that it continues to work effectively with partner organisations to ensure patients who require a Mental Health Act assessment are assessed without undue delay to ensure their safety and that of others. Regulation 12 (1)(2)(a)(b)(i)

Action the trust SHOULD take to improve:

Trust wide

- The trust should complete the recruitment of non-executive directors and improve the diversity of the board.
- The trust should ensure regular visits for all members of the board to services are resumed with opportunities for feedback and reflecting on what they find.
- The trust should ensure an ongoing programme of facilitated board sessions take place to enable the board to consider the implications, opportunities and potential conflicts and promote the future partnership working with Camden and Islington NHS Foundation Trust.
- The trust should ensure the objectives of the divisions are sufficiently embedded to enable the transformation of community services to take place as planned across the three boroughs and are aligned to the care pathways being developed across North Central London in line with the objectives of the Long Term Plan.
- The trust should ensure it completes further work to modernise the estate to create therapeutic environments for patients and support staff to provide high quality care and treatment.
- The trust should ensure there is an ongoing review the time resources needed by senior trust leaders to support the work across the integrated care system and the focus on population health.
- The trust should ensure it develops services to meet the needs of communities and address inequalities. These should have clear outcome measures so their impact can be evaluated.
- The trust should ensure it embeds its work on equality, diversity and inclusion to achieve an impact across the trust. Actions agreed in response to the workforce race equality standards should be monitored to ensure they are implemented – for example that recruitment panels for posts graded 7 and above include a representative from a minority ethnic background.
- The trust should ensure that staff inclusion network leads have sufficient time to carry out their roles.
- The trust should ensure that the work to meet its target on completed appraisals is completed.
- The trust should ensure all the mandatory training targets are met, especially those delivered by face to face training.
- The trust should ensure it undertakes further work to address staff recruitment and retention challenges – with an ongoing focus on 'hotspots'.
- The trust should ensure it undertakes further work to address its failure to meet target timescales in responding to complaints.
- The trust should ensure it undertakes further work to improve the timeliness and quality of its serious incident investigations and the associated reports.

Our findings

- The trust should ensure it undertakes further work to share the learning from incidents with the aim of reducing the number of incidents with recurring themes.
- The trust should ensure its annual accounts are submitted on time next year.
- The trust should ensure its digital strategy is approved and that there are clear plans for its implementation. Staff across the trust should be able to access live data to support them in carrying out their roles.
- The trust should ensure it undertakes further work to promote the participation of people who use services and carers in operational work across all the divisions of the trust. For example, people who use services should be active participants in quality improvement work.
- The trust should ensure it undertakes further work to progress its research and development to involve a wide range of professionals and people who use services. The research should contribute to improving the services people receive.

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

- The trust should continue to monitor staffing numbers across the wards, in consultation with staff teams, to ensure the safety of staff and patients.
- The trust should continue to work to address the high turnover of staff across the wards, and significant use of bank and agency staff.
- The trust should continue to monitor staff practice in recording post rapid tranquilisation physical health checks and consider simplifying the recording systems in place for this.
- The trust should ensure that relevant staff on all ward have training in administering rapid tranquilisation via the deltoid muscle (in the arm) for the dignity of patients and to reduce the need for prone restraint.
- The trust should continue to monitor staff practice in labelling all bottles of liquid medicines with the date that they are opened, and it should ensure that all staff are clear about the correct procedures to dispose of unused medicines.
- The trust should consider further work to address risks in the activities rooms on the new wards at St Ann's Hospital, and in patient areas on Trent Ward, to ensure the safety of patients.
- The trust should ensure that staff have training in supporting autistic patients and patients with learning disabilities.
- The trust should consider how to ensure that patients are able to use the safe boxes in their bedrooms, or an alternative way of protecting their valuables.
- The trust should continue work to address intense bed pressures and monitor rates of readmission due to earlier patient discharges.
- The trust should liaise with patients and staff on Suffolk and Devon wards to ensure a comfortable ambient temperature in all areas.
- The trust should ensure that occupational therapists are recruited to fill the vacancies on Devon PICU and Suffolk Ward.
- The trust should ensure that there are sufficient computers available for staff to use on each ward, particularly on Suffolk and Daisy wards to avoid delays in recording information.
- The trust should address concerns about the responsiveness of the maintenance team to repairs needed on the Edgware site (in Trent Ward).

Our findings

- The trust should consider action that can be taken to recruit permanent consultant psychiatrists to the Barnet wards, due to the impact on staff and patients' morale.

Mental health crisis and health-based places of safety

- The trust should ensure that it continue work to reduce staff vacancies in the crisis resolution and home treatment teams.
- The trust should ensure that work continues to ensure patients supported by the crisis resolution and home treatment teams can access psychological therapies.
- The trust should ensure that staff in the crisis resolution and home treatment teams understand and record accurately a patient's capacity to consent. Where a person lacks mental capacity to make an informed decision, or give consent, staff need to act in accordance with the requirements of the Mental Capacity Act 2005 and associated code of practice.
- The trust should ensure that where when staff in the crisis resolution and home treatment teams share patient information with family members that they have discussed and recorded the consent of the patient to do so.
- Managers in the crisis resolution and home treatment teams should ensure that yearly staff appraisals are conducted on time each year and that records are updated to show these conversations have taken place.
- The trust should ensure that staff in the health-based place of safety record the legal authority under which medicine is given to patients for the purpose of rapid tranquilisation.
- The trust should ensure that patients are informed of their legal status within the place of safety, including when the period of detention has expired.
- The trust should ensure that activities that are intrusive to patients' privacy, such as using closed-circuit television in the health-based place of safety, is only carried out when required, based on an assessment of risks.

Community-based mental health services for adults of working age

- The trust should ensure that staff community-based mental health services for adults of working age are trained in all mandatory training modules.
- The trust should ensure that staff in the Enfield North Community Mental Health Team are aware of and follow the lone working policy.
- The trust should ensure that there are processes in place to ensure alarms in buildings used by Community-based mental health services for adults of working age work.

Community health services for Children, young people and families

- The trust should ensure that risk assessments include risks within the home environment, when staff were completing home visits.
- The trust should continue with its recruitment campaign for permanent consultant paediatricians.

Is this organisation well-led?

Leadership

Our findings

At the time of this inspection there were significant changes taking place in the leadership of the trust with the development of partnership working with Camden and Islington NHS Foundation Trust (C&I). In April 2021 the chair of C&I was also appointed as the chair of Barnet, Enfield and Haringey Mental Health NHS Trust (BEH). In October 2021 the chief executive of BEH became the chief executive of both trusts. The chief operating officer of BEH took on the combined role of deputy chief executive. The trusts were planning to have one executive director team in place by the end of June 2022.

There had also been changes in the non-executive directors of the board since the last inspection. In November 2021, the trust board consisted of the chair, chief executive, six non-executive directors and seven executive directors. Two non-executive directors sat on the boards of both trusts. There were no plans to extend further the number of non-executives working across both boards.

The non-executive directors had the appropriate skills, knowledge and experience. They all had experience as senior leaders in organisations including the NHS, other public bodies and the private sector. Non-executive directors brought skills in finance and investment, strategic development, working in partnership and transforming services including estates transformation. There had been careful consideration to ensure the right skills were in place to support the ongoing work of the trust. The non-executive directors did not reflect the ethnic diversity of the areas covered by the trust. Senior leaders described this as unacceptable and were seeking to address this through the recruitment to current vacancies.

There were two vacancies for non-executive directors. The trust was also creating two vacancies for associate non-executive directors. Recruitment was underway to find applicants with clinical experience and with knowledge of system working and transformation. The trust secretary was preparing an induction process for when new directors joined the board. This included shadowing experienced non-executive directors on visits to the trusts' services. Members of the board participated in a programme of board workshops every two months. At each workshop board members looked at specific themes. For example, a workshop had been scheduled to look at child and adolescent mental health services and another scheduled to look at race equality.

The pandemic had presented challenges for the joint working of the executive and non-executive directors. Meetings had mostly taken place remotely and visits to services had not taken place routinely either in person or remotely for non-executive directors. There was an awareness that this needed to recover, and plans were being put into place for regular visits.

The aims of the strategic alliance with Camden and Islington were agreed in 2019. These were to improve quality through standardisation, share administrative functions, collaboration on staff recruitment and retention, create opportunities for shared appointments and sharing learning in improving information technology and data systems. Progress had been made in relation to shared appointments, such as the joint appointment of the chair and chief executive, and the development of aligned clinical strategies. However, the board and other senior leaders needed time to think through the implications including areas for opportunities and risks including potential conflict associated with the partnership with C&I. Whilst an initial facilitated board development day had taken place, and more dates arranged every six weeks, there needed to be a clear plan of how these sessions will be used to take forward this strategic work. There were plans for the two boards to meet in February 2022, but this also needed ongoing planning.

It was recognised that executive directors, whilst positive about the partnership, were also feeling understandably anxious about the impact of the changes on the trust and their individual roles. Whilst executive directors had bespoke

arrangements in place for their own development and specific coaching has been put in place to support the team during the development of our alliance, the support to them individually during the period of change needed to be considered and kept under review. Executive directors had all met, where applicable, with their fellow director at Camden and Islington and were working on areas of common interest.

The executive directors were well established. They consisted of the deputy chief executive and chief operating officer; chief finance and investment officer; medical director; director of nursing, quality and governance; chief information and performance officer; director of strategy, transformation and partnerships; and executive director of people and organisational development. The executive directors were clear on their portfolio's which were kept under review and they had deputy directors to give them capacity for their roles. The quality of the interviews during the well led assessment was varied with some presenting less clearly or not having the facts and figures easily to hand.

We reviewed a selection of trust board members' fit and proper person checks including checks for all those appointed since the last inspection. This showed that all the necessary checks had been completed. This information was kept up to date through annual declarations by board members.

The changes to local leadership which had commenced in 2019 were now embedded. Since the last inspection the five divisions had strengthened. These divisions comprised of a mental health division in each of the three boroughs, a division for community health services in Enfield and a division for specialist services. Each division had a managing director, clinical director and a head of nursing. Management arrangements were in place for all the directors offering management and clinical supervision. Divisional leadership teams were enthusiastic and committed to improving services. The directors felt the leadership arrangements in each division were working well and that there were healthy relationships between the divisions. Divisional leaders said they found the support they received from centralised functions within the trust, such as from the human resources department, pharmacy and information technology, were helpful. The collaboration between clinical and digital teams had led to improvements in patients' safety through the implementation of e-prescribing and improving communication with GPs.

The trust had strengthened or was working to strengthen some areas of leadership. For example, recruitment was underway for a director of corporate governance across both trusts and a chief of staff for public affairs. Since the last inspection the trust had further strengthened clinical leadership, for example by the appointment of a managing director of social work.

The trust's 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 challenges of staff recruitment and retention; meeting the needs of the local populations and the importance of partnership working.

The trust had a draft organisational development strategy which included leadership development. This was due to be approved by the board during the next few months. A leadership succession plan which included talent management and succession planning was being piloted in several divisions. All staff could be supported in their development through appraisals and online training. The trust ran an aspiring leaders programme of development for staff who were looking to move into management roles. There was a new managers forum which included an action learning set for peer support. There was also access to some external leadership development opportunities. The programme for developing senior managers focused on system leadership and was linked to a similar programme being run by C&I. Four doctors were participating in a leadership development programme funded by the Royal College of Psychiatrists. The trust had established action learning sets for clinical directors.

Vision and strategy

Our findings

The trust had developed a clear vision and set of values. The trust's vision was: "To support healthy lives and healthy communities through excellent integrated mental and community healthcare." The trust had summarised this in the motto of 'supporting healthy lives'. The values of 'compassion, respect, being positive and working together' had been developed in 2016 with more than 500 staff and patients. Staff had a good knowledge of the trust's values and how they applied these in the work of their teams. The trust provided training for middle managers that involved role-playing behaviours that are consistent with the trust's values.

The trust's strategy 'Fit for the Future' had been developed in 2019 in consultation with service users, carers, staff and other partners. The objectives were excellence for service users, empowerment for staff, innovation in services and partnerships with others. The trust created annual objectives for 2021-22 under each of these headings. This was refreshed in 2021 to ensure it reflected the changing healthcare landscape created by the impact of the pandemic, as well as the introduction of integrated care systems, complex health and social care needs and rising treatment costs. At a local level, strategic challenges included an increasingly diverse population, an aging population, differing social determinants of health, workforce shortages and a need to ensure staff felt they were treated fairly and included in decision making. The trust had developed outcomes for each of the strategic aims. These were supported by a set of annual trust objectives and success measures approved in May 2021 with a quarterly progress update to the board. Divisional objectives were also in place although these needed to be further developed and embedded to ensure transformation of community services took place as planned and were aligned across North Central London in line with the objectives of the Long Term Plan.

The brilliant basics programme consisted of ten workstreams which aimed to get basic care right across the trust. This had started at the time of the last inspection and was now well embedded in the trust and linked to quality improvement work. There was a recognition that there had been improvements in patients being informed of their rights under the Mental Health Act and there had been progress in reducing physical interventions and restrictive practices; but there was more to do in terms of improving patient safety, although the safety huddles were progressing well and ensuring learning from incidents.

The trust had also just completed its clinical strategy. This had been approved by the board. This was developed collaboratively with C&I which already had a clinical strategy in place. This offered the opportunity to look at care pathways across the two organisations. At the time of this inspection, we heard about how the two trusts were working together to manage the flow of adult patients with an acute mental illness across north-central London. Additional inpatient capacity was resulting in a gradual reduction in patients being admitted to services outside the area. The trust had also developed a nursing strategy to support the delivery of the trust strategy.

The trust had made improvements to its estate. The transformation of inpatient care at St Ann's Hospital, with the opening of Blossom Court, was very positive. This transformation had involved replacing four wards that had provided a poor environment for care and treatment. Staff and patients told us that the new wards provided nicer environments, and since the new wards had opened, there had been a reduced use of restraint and seclusion. The trust's work on this new facility was shortlisted for a national award in 2020 in the category of 'Mental Health Innovation of the Year'. In January 2021, the trust began work on developing the second phase of its modernisation at St Ann's that included refurbishments to other buildings, a new restaurant, a training suite and improvements to the site infrastructure. The elimination of shared bedrooms across the trust was affording patients improved privacy and dignity. A strategic outline case for the modernisation of the rest of the trust estate had been submitted with the support of the integrated care system and NHS London. The importance of this was recognised as there was a need for further estate improvements.

The trust had begun work on the transformation of its community mental health services. The aim of the programme was to support people to live with, or recover from, mental illness and offer support with other challenges such as debt,

relationship problems, housing, education or training. The trust will be working with general practitioners within targeted Primary Care Networks where there was the highest need. This programme was being delivered across the five boroughs of North Central London, including the neighbouring boroughs of Camden and Islington. It was supported by funding of £25 million over three years.

The trust was actively involved in provider collaboratives that had responsibility for commissioning specialist mental health services. The trust led a consortium of five NHS trusts in North London to form the North London Forensic Collaborative. The trust had delegated responsibilities to commission inpatient and community adult secure services in North London for the next three years from NHS England. The collaborative enabled decision making at a local level and was focusing on implementing a new specialist community forensic team model to ensure equality of access and provision across North London. The trust described how it managed the governance of both its commissioning and provider functions; and was able to demonstrate the separation of governance roles through the Provider Collaborative Commissioning Committee, which met quarterly under the chairmanship of a non-executive director. The trust was also part of a provider collaborative in North London for inpatient child and adolescent mental health services and for eating disorder services.

The trust had extended its involvement in the integrated care system with the chief executive leading the mental health program board. The chair and chief executive were members of the integrated care system steering committee. Other executive directors also joined meetings and workstreams where applicable. There had been positive examples of where the trust had worked closely with other providers during the pandemic to meet the needs of patients. This included the establishment of diversion hubs to keep people out of emergency departments; an all aged crisis helpline; and the opening of an additional step-down ward by Enfield community services to support people being discharged from local acute hospitals. The system work was also helping to identify unwarranted variations, for example it was leading to improved mental health support to patients at the North Middlesex Hospital.

We also heard how other professionals worked collaboratively with partners across the North Central London Integrated Care System. For example, the pharmacy department had a service level agreement with the Royal Free NHS Trust to promote good practice across both organisations. As part of this agreement, senior pharmacists from both trusts met each month.

The work within boroughs was led by members of the divisional leadership teams. Contracts had been awarded to third sector providers as part of the transformation of community mental health services, so people could be supported with housing, employment and finances. The trust was at an early stage in developing its work on population health. Public health analysis had identified the areas with the greatest local health inequalities. This diagnostic work will inform the development of services to meet the specific needs of people in communities, but more work was needed to develop these plans and services with partners including the third sector. The trust recognised the need to have a sound public engagement strategy to support its developing collaborative work going forward.

Culture

The trust had made improvements in its culture. We heard about staff feeling more able to speak up when needed and improved connections between front line and senior leadership staff. Improvements in staff engagement were reflected in the increased participation of staff in the NHS staff survey. This had grown from 44% in 2020 to 54% for the 2021 survey taking place at the time of the inspection.

The last staff survey reflected the improvements but also highlighted there was more to do. Bullying and harassment of staff was an area where the trust score was considerably worse than the national average. However, across the ten

themes of the staff survey, the figures for 2020 showed an improvement on the 2019 survey in nine of the categories. The trust also scored worse than the national average in categories of equality, diversity and inclusion, immediate managers, morale, safe environment – violence and safety culture. The trust's score for quality of care was higher than the national average. The scores for health and well-being, staff engagement and team working were about the same as the national average. Action plans to address the findings of the previous staff survey and workforce race equality standards (WRES) were reviewed by members of the board at meetings of the people committee.

The workforce race equality standard continued to show that black and minority ethnic staff were under-represented in senior roles and were more likely to enter formal disciplinary processes and the trust was working to address both these areas.

Between June 2020 and July 2021, 63% of appointments to posts at band 8a and above were to white employees. In response, all posts at band 8a and above were advertised internally first. All unsuccessful applicants were offered feedback and access to coaching. During the year before the inspection, 63% of interview panels for a post at band seven or above included a panel member from an ethnic minority background. On the whole, staff felt there had been an improvement in the representation of people from black and ethnic minority backgrounds at senior levels within the trust. Staff noted that nine of the fifteen divisional directors were from non-white backgrounds. However, some staff still felt that further work was needed.

The trust was embarking on an initiative to create a just culture with the organisation, using a model that had been introduced in other NHS trusts. As part of this initiative, the trust was seeking to move away from a punitive approach to staff subject to disciplinary procedures and to treat staff with respect. As part of the just culture initiative, and to addressed issues of inequality highlighted in the WRES, the trust had introduced a working group to review all disciplinary matters before a disciplinary hearing was arranged. The group included the deputy director for quality governance, a trade union representative and staff from the people department. This had led to fewer disciplinary hearings through matters being redirected to be addressed in supervision.

The Workforce Disability Equality Standard showed that people with long-term illnesses and disabilities were more likely to face harassment and abuse from patients, line managers, members of the public and colleagues. The Workforce Disability Equality Standard Report for 2021 showed that approximately 4.5% of the trusts' employees had a disability. The data showed that disabled people were more likely than non-disabled to be appointed to a role once they had been shortlisted.

The trust had four staff inclusion networks. The Better Together network for staff from black and minority ethnic backgrounds had gathered momentum and established a vice-chair in each of the divisions. Black History Month had become a focal point for some of its work, providing an opportunity for inspirational speakers to talk to staff and encourage people to talk about their experiences of racism and discrimination. The development of the Pride Network for lesbian, gay, bi-sexual and transgender employees, and the disability network had been slower. The women's network was an open network that campaigned on key themes such as support for maternity, support for carers, career development for women and menopause awareness. The leaders of the networks felt the trust's leadership was genuinely supportive of their work. They found the inclusion committee, chaired by the chief executive, to be very helpful in giving the networks strong voice within the trust. However more work was needed to embed the networks, to ensure they were adequately resourced and that the progress with key actions was monitored. For example, whilst an office, some administrative support and a small budget was available for the networks, the network leads needed enough time to carry out their roles.

Our findings

The trust had strengthened its Equality, Diversity and Inclusion Team to provide more expertise and resources to staff and managers. The trust had invested £2m in an inclusion programme, the equality, diversity inclusion team and mentorship. In October 2020, the trust began a programme of work with the Kings Fund, an organisation which aims to shape health and social care policy, and Brap, a charity that focused on equality, to develop a values-led culture of inclusion and empowerment. The trust had created an equality and inclusion action plan to implement the findings of this programme. This involved the creation of a new inclusion committee made up of patients, staff and the representatives of inclusion networks. This will be chaired by the chief executive and oversee the implementation of the action plan. The plan aimed to support just, fair and inclusive management practices and equip leaders with cultural knowledge to support inclusive and diverse approaches.

The trust had developed a joint Equality diversity and inclusion strategy with C&I for 2021-24. This was at final draft stage and awaiting final Board approval.

The Gender Pay Report showed that on 31 March 2021, 70% of people working in the trust were women. However, fewer than 33% of staff in senior bands were female. Female hourly pay was, on average, 6.35% lower than the male mean and 0.4% less than the male median value. The People and Culture Committee had noted that flexible working appeared to have negative consequences for career progression. They stated that more consideration was necessary to enable people to work in a manageable way and secure equal progression.

External and independent Freedom to Speak Up Guardian arrangements, launched in January 2021, were working effectively and staff awareness of this had improved. Guardians regularly visited services. If staff raised concerns about patient safety, guardians would escalate the matter immediately. The Freedom to Speak Up Guardian Service could be accessed 24 hours a day. The service reported directly to the board. In addition, the chief executive continued to have a hotline in place for staff to raise urgent concerns.

The Guardian of Safe Working Hours for doctors presented a quarterly report to the People and Culture Committee. The Guardian attended regular meetings with the junior doctors' forum and helped to resolve issues that were raised. For example, the Guardian supported junior doctors in their request for suitable rest facilities. This led to the trust procuring items for the facilities at St Ann's Hospital.

The recruitment and retention of staff remained a significant challenge for the trust. In July 2021, the overall vacancy rate for the trust was 10.4%, comprising of 367 whole time equivalent vacancies. This was slightly above the trust's target of 10%. Within this figure, the vacancy rate for registered nurses was 17.9%. The trust was recruiting staff to fill these vacancies. There were 59 nursing posts at the interview stage of recruitment and 132 posts had been offered to candidates and were awaiting a confirmed start date. This included the recruitment of 44 newly qualified nurses. The trust had introduced new initiatives to improve recruitment and retention rates. This included premium payments for working in child and adolescent mental health services, working with Capital Nursing to recruit international nurses, introducing new roles such as nurse practitioners and other new roles in partnership with third sector organisations. The vacancy rate for medical staff was 11.6%.

In September 2021, the overall sickness rate for the trust was 4.7%. Sickness rates were highest for healthcare assistants at 7% and nurses at 5.7%. Each division of the trust monitored sickness rates on a monthly basis. The management of long-term sickness was reviewed at sickness boards to ensure that managers were following the correct processes and that staff were supported. Business partners from the people department provided additional support and training to managers on how to manage sickness.

Our findings

In September 2021, the overall turnover rate for the trust was 17.9%. The turnover rate for allied health professionals was higher than the trust's average at 25.3%. The trust conducted exit interviews with staff to understand peoples' experiences of working for the trust and their reasons for leaving. The trust sought to promote the retention of staff through promoting career development, training opportunities and job rotation to enable staff to gain a greater breadth of experience.

In July 2021, the overall rate for compliance with mandatory training within the trust was 83.1%. Compliance with mandatory training was monitored through divisional performance management meetings. The trust noted that there had been a shortage of venues to accommodate face to face training. They were addressing this by using a vacant ward for this training. However, only 65% of staff had completed the immediate life support training. This was still below the levels required, with particularly low completion rates in some services, having fallen behind due to the pandemic presenting challenges for face to face training. The failure to meet the target for this training was a risk to patient safety. There were plans for this to be addressed with additional capacity for face to face, socially distanced training arranged. All staff who had not completed this training were booked to attend courses in the two months after the inspection. Compliance was being monitored through relevant governance structures.

There was a significant decrease in the number of appraisals being completed during the pandemic. In part this was due to staff moving across divisions as part of the business continuity plan. An online webform had been introduced to make it easier for staff to submit appraisals, although in June 2021, there was a backlog of forms that needed to be uploaded. In September 2021, the compliance rate for appraisals was 63%, well below the trust's target of 90%.

The trust was working to try and support staff well-being. Senior leaders spoke of their commitment to improving staff well-being and a full-time staff well-being lead had been appointed in Jan 2021 to further develop the well-being approach. They had promoted local and national well-being resources and refreshed information on the intranet. A calendar of well-being events had been set up. Staff were offered vitamin D tablets early on in pandemic. Trust has a 'here for you now' arrangement where staff have access to psychological support following a serious incident.

The trust had administered the first Covid-19 vaccine to 86% of staff. The trust had administered the second dose to 84% of staff. The trust recognised that some staff may have received the vaccine from other sources but did not have data on this.

The trust continued to recognise staff success. There was a popular annual awards ceremony with several different categories of awards. Also, celebrations in divisions. There had recently been an appreciation day for administrative staff who had often been overlooked in the past.

The trust was carrying out initiatives to maintain the morale of teams. This included communications with senior leaders; on-line learning events in the evening as well as during the day; on-line team away days; and team coffee mornings and social gatherings.

The trust was compliant with the requirements of the Accessible Information Standard 2016. This involved helping people who have difficulty accessing and understanding information and supporting them to communicate effectively. For example, the trust provided multi-language translation and easy-read literature was available whenever people asked for it. The trust's website has been recognised nationally as an example of good practice in accessibility. The trust achieved this through using 'read aloud' functions and simplifying the content to make it easier for people with visual

impairments to engage with the information. Staff had started to monitor requests for accessible information in order to identify trends. The trust's main clinical records system flagged when a patient may require Braille or large print communication. However, during our inspections of core services some staff could not explain how they would ensure patients received accessible information.

Governance

The trust board was organised well. They met six times a year.The board development sessions took place on the months in between. The board meeting was well chaired with good timekeeping and opportunities for members to raise issues and ask questions. Papers were clearly presented, and a summary sheet linked the paper to the trust objectives and the corporate risk register. There was an annual work-plan to ensure all the areas were covered. The chair was clear about the need for transparency and only putting items into the private part two of the meeting where appropriate.

There were six sub-committees of the board. The trust was in the process of changing the chairs for each committee. The sub-committees were audit, finance and investment, remuneration, mental health law, quality and safety, and people and culture. Minutes from these committees were received by the board in part two of the meeting. Summary reports were presented in part one of the meeting from each chair of a sub-committee.

The non-executive directors demonstrated a good understanding of how to undertake their roles. Non-executive directors chaired and attended other sub-committees, so they understood the broader working of the trust.

The trust carried out regular assessments of the effectiveness of the board to help identify areas for improvement. In June 2021, there was an independent review of the organisation's governance. This review was, overall, a positive assessment of the trust and noted that there had been a marked improvement in the depth and consistency of its performance and impact. However, the report also noted there were areas for improvement including an increased engagement, both internally and externally, to achieve a transformation of the organisation's culture. For example, the report stated that the trust's investment in diversity and inclusion work had not yet achieved the desired impact.

The trust was also reviewing its governance arrangements in collaboration with Camden and Islington. The trusts were seeking expressions of interest for a director of corporate governance. The chair was also planning to align the dates of board meetings with Camden and Islington and review the terms of reference for the board sub-committees to ensure adequate assurance and avoid unnecessary overlaps. An oversight committee reviewing the work of both trusts included non-executive directors of both trusts and reported to both boards.

The provider had robust arrangements for safeguarding adults and children. There were identified leads for child and adult safeguarding. The trust had refreshed its Safeguarding strategy in 2021. Safety reported to the quality and safety sub-committee. The trust participated in local safeguarding arrangements including attendance at local safeguarding boards, Prevent forums and the violence against women group. The adult and child safeguarding leads gave regular support to staff and teams. The safeguarding team disseminated any changes in policy to front line staff. The team had strengthened the role of safeguarding champions, members of staff that promoted safeguarding in teams, and expanded the network to include forensic teams. Staff training requirements were mapped to roles to ensure staff were trained to an appropriate level. At the time of the inspection, completion rates were higher than 85% of eligible staff for level 2, 3 and 4 training. Safeguarding process training had also been delivered to staff.

The trust had clear structures and procedures for ensuring that the implementation of the Mental Health Act and Mental Capacity Act reflected good practice. 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 was monitored and reported to the Mental Health Law committee, which reported to the trust board. The trust has used quality improvement initiatives to improve some areas of compliance with the Mental Health Act, such as ensuring staff informed patients of how the Mental Health Act applied to their circumstances and informed them of their rights to appeal. The trust has also carried out quality improvement initiatives to improve the quality of mental capacity assessments. However, the trust was still experiencing difficulties in the application of the Mental Health Act. For example, the average time taken to assess a patient under the Mental Health Act when a warrant was required to enter the person's home was four weeks. In addition, almost 40% of patients admitted to the health-based place of safety were held beyond the permitted period of detention due to difficulties in admitting patients to an inpatient bed. The trust was working with other agencies to address this. It held meetings every month with other agencies involved in admitting patients to hospital under the Mental Health Act, such as the police, ambulance service, local authority and the trust responsible for the emergency departments in the local areas. However, progress on these matters was proving difficult.

The patient experience team monitored and facilitated the investigation of complaints and provided reports to the quality and safety committee. In the two months from 1 June to 31 July 2021, the trust received 96 complaints, of which 26 were investigated through the formal complaints procedure. Of the 29 complaints closed in June and July 2021, one was fully upheld, thirteen were partially upheld, seven were not upheld and eight had been withdrawn. The quality and safety committee reviewed all the actions agreed following the closure of the complaints. The trust did not ensure that all complaints were responded to in a timely manner. Whilst it was acknowledged that during the height of the pandemic responding to complaints was a lower priority, at the time of this inspection the completion of complaint responses within the agreed timescales was only 25%. A quality improvement project was in place to identify the reasons for this and make changes, but this needed to be implemented and target response times met.

Management of risk, issues and performance

A review of operational performance and risk formed part of the agenda for each meeting of the trust board. Within this agenda item the trust reviewed reports from the finance and investment committee, the provider collaborative commissioning committee, the risk and audit committee, the integrated performance report and board assurance framework.

The trust updated its risk management strategy in January 2021. The aim of the strategy was to strengthen the trust's effective risk management framework that operated from a ward level to the board level. It included a risk escalation process and clarified the role and responsibilities for risk management.

The audit committee had responsibility for monitoring risk management systems. This included monitoring the progress of the board assurance framework, reviewing the work of external audits and monitoring performance risks such as delayed transfers of care and quality reviews of specific services.

The trust managed risk through a structure of risk registers. The corporate risk register included clinical, financial, governance and operational risks. In August 2021, there were 12 risks recorded on the corporate risk register. Four risks had recently been added. These risks related to potential delays in treatment within the child and adolescent mental health service, difficulties in arranging essential training for staff, lack of capacity to manage a backlog of inquests and risks of patients being placed outside the trust due to high demand for inpatient beds. Across the trust, managers kept registers of risks at a divisional and a service level. A total 271 risks were recorded as being open across the whole trust. These risks were formally reviewed by the operational risk management group that reported to the quality and safety committee.

Our findings

The Board Assurance Framework 2020-21 enabled the trust to identify and understand the principle risks to achieving its strategic objectives. The two areas of highest risk related to poor quality therapeutic environments due to the age of the buildings and limited access to capital investment funding and the risk that the trust will be unable to deliver its commitments to commissioners due to assumptions about underlying demand being incorrect. The framework also included details of the trust's analysis of the risks and actions required to mitigate areas of weakness.

The trust had developed an integrated performance report. There was a clear commentary within the report, using run charts so that trends could be seen. This formed part of the board papers and was reviewed in detail by the quality and safety committee.

The trust continued to have quarterly divisional integrated performance meetings chaired by the CEO. These identified the divisions with areas where support was needed. The trust had improved the identification of services where more support was needed.

The trust had worked effectively to address infection, prevention and control over the last two years in response to COVID-19. The successful system working with other stakeholders and providers to meet the needs of patients across the North Central London system during the pandemic had been very positive and it was hoped the collaborative working can be maintained. The progress made with vaccinating staff and offering a service to vaccinate people with a learning disability in a calm and supportive environment was good practice.

In September 2021, the trust introduced its winter pressure plan. The plan addressed a number of eventualities. The focus of the plan was to address out-of-area placements in anticipation of there being an increase in demand for inpatient beds during the winter months. Other key points of the plan included mutual aid arrangements with Camden and Islington and plans for reintroducing the command and control structure used during the Covid pandemic. The quality and safety committee had reviewed the learning from the previous year and was seeking to improve planning to ensure decisions could be made more quickly.

The trust's clinical audit and quality assurance programme provided a rolling programme of audits of performance and quality indicators. Audits within this programme were monitored by the clinical, audit and effectiveness group, a sub-group of the safe, effectiveness and experience group that reported directly to the quality and safety committee

During the year from 1 December 2020 to 30 November 2021, the trust recorded 6820 incidents on the NHS National Reporting and Learning System (NRLS) and 39 incidents on the Transfer of Strategic Executive Information System (StEIS). Of the incidents reported on NRLS, 80% were classified as either 'no harm' or 'low harm'.

Between April and July 2021, 19 serious incidents had been reported. This was an increase on the 11 incidents that had been reported in the same period during the previous year. Eleven serious incidents had been reported in June and July 2021 of which eight related to suspected suicide, one related to an unexpected death, one related to a homicide by a patient and one related to a fall from height.

The trust continued to work to improve the timeliness and quality of its serious incident investigation, but further work was required to embed improvements. There was now a trust-wide group to support shared learning, improve the consistency of reports and to review the quality and effectiveness of recommendations and there was improved confidence in incident reporting and in the identification of when an investigation was needed. The trust had also

introduced a new template for the completion of reports and hoped to involve service users and carers more in the process. Nevertheless, the five serious incident reports we reviewed still needed some improvements, such as by ensuring the most important findings were clear, and the timeliness of responses needed to improve. Although the average completion period for serious incident reports had reduced from 118 days, it was still 80 days.

The quality and safety committee reviewed learning from serious incidents. Reports of investigations into incidents were also reviewed at a divisional level by the serious incident review groups which reported to the trust-wide patient incident review group each month. Learning was communicated to staff through the shared learning bulletin. Examples of learning from incidents included the importance of teams having easy access to medical records when responsibility for care and treatment moved between services, increasing room searches when patients presented a known risk and the importance of increasing liaison with physical health leads. However, a delay in allocating investigations to suitably trained staff had meant there was a delay in the commencement of investigations. Staff who had been trained in the role had been reluctant to commit to undertaking investigations due to the amount of time it took away from their routine work. This matter had been escalated to the medical director and divisional leaders.

Safety huddles took place at every level of the organisation to discuss and learn from incidents. However, further work was needed to ensure a reduction in incidents with reoccurring themes across the trust.

The finance and investment committee provided a report to each meeting of the trust board. This included a monthly update on the trust's in-year financial position. The cost of out-of-area placements for the trust's, caused by bed pressures within the acute pathways for adults of working age has been reviewed by the committee along with the trust's action plan to address this. The committee recognised that achieving the trust's objective of eliminating out of area placements by March 2022 remained very challenging.

In 2020-21, the trust met all its statutory financial duties. These were: to break even on income and expenditure, keep capital expenditure within its capital resource limit, remain within the external financing limit and achieve a 3.5% return on investment. The trust's capital investments in 2020-21 amounted to £16.8m, including £8.3m for the redevelopment of St Ann's Hospital. The trust operating costs relating to patient care activities rose from £241m in 2019-20 to £315m in 2020-21. This increase was predominantly due to the trust becoming the lead provider for the North London Forensic Consortium, responsible for commissioning services forensic service from NHS and independent sector providers. The trust achieved a small operating surplus of £2m.

The trust's internal auditors had given the trust significant assurance about the operation of its internal controls. However, the external auditor had drawn to the trust's attention the delays in submitting the annual accounts over the past two years. The trust had commissioned an external review of the finance department.

Information Management

The trust had invested £5.8m over two years to improve technology and address cybersecurity risks. The pandemic had also accelerated the use of digital services across the trust. The trust had issued over 1000 laptop computers that had enabled staff to work in a more flexible and agile manner. The trust had significantly increased the number of digital consultations. This had led to improvements in access and productivity. The trust had also invested in improving network connections. The trust was planning further investment in systems and equipment.

Our findings

The trust was developing its data warehouse to enable easier access to management information from patients' records, and it was due to launch the first dashboards shortly after the inspection. A digital strategy was due to be presented for approval at the next meeting of the trust board. However, further work needed to enable live data to be available to staff teams to support them in managing their services.

The trust was participating in the North Central London Information Exchange. This arrangement enabled health care professionals to share information about patients, giving clinicians a better understanding of patients without the need for patients to explain their condition to different people.

The trust successfully completed the Data Security and Protection Toolkit for 2019-20 and had a data security improvement plan to ensure that any risks and weaknesses were monitored. During 2020-21, there were no serious governance incidents requiring investigation by the Information Commissioner's Office.

The compliance rate for mandatory training in information governance was 84%, below the trust's target of 95%. The trust had sent letters to staff who had not completed this training to remind them to do so.

The trust was working on initiatives to improve patients' experiences and enable staff to work more efficiently. The trust had begun to introduce applications to support patients to manage their conditions at home. For example, the trust supported patients to use an application to manage diabetes. The trust was working with C&I to facilitate patients access to their health records. The trust was also introducing speech recognition software to consultants.

Engagement

The trust launched a new Involvement and Engagement Strategy, and a new patient and carer survey, developed collaboratively with patients and carers. The aim of the strategy was to actively involve patients, their families and carers in shaping delivering and evaluating their care and the future direction of the trust. As part of this strategy, the trust had recruited a further 50 experts by experience bringing the total number of people on the involvement register to 100. The trust employed 45 peer support workers and had plans to employ a further 30. They helped in a wide range of roles across the trust including work on the development of strategy and policy, reviewing serious incidents, recruitment, supporting service users and training staff. Managers recognised that participation needed to be embedded in the work of the divisions. There were patient forums in three of the divisions and plans to develop these in the other two. The trust recognised there was scope to further extend participation to ensure people who use services are central to all the trust developments. For example, the trust needed to ensure that experts by experience were trained in quality improvement methodologies so they could be part of teams progressing this work.

During the pandemic, the patient experience team set up a well-being service to support patients who were asked to shield during that time. The aim of the service was to ensure patients knew about voluntary services in their borough that could help with food, social support, collecting medication and give advice. The trust also called over 2,500 patients to offer support which led to exceptionally positive feedback.

The patients' "Friends and Family Test" asks patients whether they would recommend the services they have used based on their experiences of care and treatment. The trust scored between 85% and 92% between May 2017 to February 2019. This rose to 94.7% of the 5,646 respondents in 2020-2021 saying they had a good or very good experience. Similarly, the trust's service user and carer survey showed an overall satisfaction rate of 89%, based on 5,879 responses.

Learning, continuous improvement and innovation

Our findings

Since our last inspection in 2019, the trust had embedded its quality improvement (QI) approach. This initiative was intended as being an integral part of the trust's approach to changing the culture of the organisation by empowering staff and patients identify and address areas for improvement. Although training through NHS England's Quality, Service Improvement and Redesign programme was postponed due to the pandemic, the trust had developed internal training courses attended by approximately 800 staff, ranging from basic awareness sessions to five-day redesign practitioner programmes. A team of staff was in place to support the creation of a QI Academy. The use of QI across the trust has been supported by a digital platform that enabled staff to plan, measure and report on their QI work.

In February 2020, the trust held a collaborative event with patients, commissioners and voluntary sector organisations to agree the trust's quality priorities for 2020-2021. The agreed workstreams were co-production between staff and patients, continuity of care, timely access to care and building a culture of continuous improvement.

For 2021-22, the trust aligned these workstreams to its strategic priorities, focusing on excellence for service users, empowerment of staff, innovation in services and partnerships with others. As part this of this programme, the trust aimed to introduce a new system of evidence-based care planning in 90% of community mental health services by the end of March 2022. The empowerment for staff programme will involve the creation of a forthcoming health and wellbeing strategy for staff. The trust aimed to achieve innovation in services by a further expansion of its QI programme. This will involve training a further 300 staff in QI foundations by March 2022, ensuring every new employee receives basic QI training as part of their induction, and to increase the number of QI projects by 20%. The trusts partnerships with others focused on the North Central London Mental Health Delivery Plan, as part of the transformation of community mental health services.

Quality improvement methodology was being used to address some of the critical challenges for the trust. For example, the trust was planning to use a QI approach to look at access and flow through services and managing increases in demand and acuity. This work needed to be further extended and embedded.

The trust was expanding its work on research and development. The trust had become a member of University College London Partners, a partnership of NHS providers and universities that worked together to improve population health through research, innovation and education. The trust aim was to both increase the number of research projects and widen the scope of staff who conduct research beyond just doctors to other professionals including nurses. At the time of the inspection, the number of research studies was relatively low (26 National Institute for Health Research portfolio studies and a patient identification centre for a further 15 studies). The trust provided details of some of the current and proposed studies. The studies were across mental health, dementia, other specialist services and public health including Covid-19. The successful completion of a project where pharmacists supported staff in care homes has resulted in the project being expanded. The future plans to develop research was not just to increase the number of research projects, but also to widen the scope of who completed research to other professionals including nursing, and ensure research involved service users and made a contribution to improving the services they receive. The trust's partner organisation C&I had a strong tradition of research and it was hoped the partnership working would support developments. The research and development department had a director (who has a clinical and academic background) and five other staff. A research group met monthly and there was a quarterly research and development meeting attended by clinical directors from the divisions to consider research proposals and agree which ones would go ahead. An annual report went to the board. The trust was also committed to ensuring research involved service users and contributed to improving the services they receive.

NHS trusts can take part in accreditation schemes that recognise services' compliance with standards of best practice. Accreditation usually lasted for a fixed time, after which the service must be reviewed. The trust has a number of services that have achieved accreditation:

Our findings

- Quality Network for Eating Disorders (QED): Eating Disorders Service – Iris Ward
- Electroconvulsive Therapy Accreditation Service (ECTAS)
- Psychiatric Liaison Accreditation Network (PLAN): North Middlesex University Hospital and Barnet Hospital
- Memory Services National Accreditation Programme (MSNAP): Barnet, Haringey and Enfield memory services
- Quality Network for Crisis Resolution Home Treatment Teams (QNCRHTT): Haringey Crisis resolution and home treatment team

The clinical mortality review group met every two weeks. The group was chaired by the medical director or their deputy. Members of this group reviewed the 72-hour reports for all patient deaths. Specific data on deaths from self-harm were also reviewed, showing an increase in such incidents in February and June 2021. The group also oversaw the action taken by the trust as a result of learning from mortality incidents. For example, after a suspected suicide on an acute mental health ward, the trust installed sensors and alarms at the top of doors to prevent them being used as a ligature anchor point.

The group had reviewed 62 deaths across the trust that had occurred between 1 June and 31 July 2021. The trust specifically monitored deaths of people with learning disabilities. There had been none during this period.

Key to tables

Ratings	Not rated	Inadequate	Requires improvement	Good	Outstanding
Rating change since last inspection	Same	Up one rating	Up two ratings	Down one rating	Down two ratings
Symbol *	➔➔	↑	↑↑	↓	↓↓

Month Year = Date last rating published

* Where there is no symbol showing how a rating has changed, it means either that:

- we have not inspected this aspect of the service before or
- we have not inspected it this time or
- changes to how we inspect make comparisons with a previous inspection unreliable.

Ratings for the whole trust

Safe	Effective	Caring	Responsive	Well-led	Overall
Requires Improvement ➔➔ Feb 2022	Good ➔➔ Feb 2022	Good ➔➔ Feb 2022	Good ➔➔ Feb 2022	Good ➔➔ Feb 2022	Good ➔➔ Feb 2022

The rating for well-led is based on our inspection at trust level, taking into account what we found in individual services. Ratings for other key questions are from combining ratings for services and using our professional judgement.

Ratings for a combined trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Mental health	Requires Improvement	Good	Good	Good	Good	Good
Community	Good	Good	Good	Good	Good	Good
Overall trust	Requires Improvement ➔➔ Feb 2022	Good ➔➔ Feb 2022	Good ➔➔ Feb 2022	Good ➔➔ Feb 2022	Good ➔➔ Feb 2022	Good ➔➔ Feb 2022

The rating for the well-led key question is based on our inspection at trust level, taking into account what we found in individual services. Ratings for other key questions take into account the ratings for different types of service. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Rating for mental health services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Acute wards for adults of working age and psychiatric intensive care units	Requires Improvement ➔➔ Feb 2022	Good ➔➔ Feb 2022	Good ➔➔ Feb 2022	Good ↑ Feb 2022	Good ➔➔ Feb 2022	Good ↑ Feb 2022
Wards for older people with mental health problems	Requires improvement Sep 2019	Good Sep 2019	Good Sep 2019	Good Sep 2019	Good Sep 2019	Good Sep 2019
Forensic inpatient or secure wards	Good Jan 2018	Outstanding Jan 2018	Outstanding Jan 2018	Outstanding Jan 2018	Outstanding Jan 2018	Outstanding Jan 2018
Community-based mental health services for older people	Good Jan 2018	Good Jan 2018	Outstanding Jan 2018	Outstanding Jan 2018	Good Jan 2018	Outstanding Jan 2018
Community-based mental health services of adults of working age	Requires Improvement ↑ Feb 2022	Good Sep 2019	Good Sep 2019	Good Sep 2019	Good ➔➔ Feb 2022	Good ➔➔ Feb 2022
Child and adolescent mental health wards	Good Jul 2021	Good Jul 2021	Good Jul 2021	Good Jan 2018	Good Jul 2021	Good Jul 2021
Mental health crisis services and health-based places of safety	Requires Improvement ➔➔ Feb 2022	Good ➔➔ Feb 2022	Good ➔➔ Feb 2022	Requires Improvement ➔➔ Feb 2022	Good ➔➔ Feb 2022	Requires Improvement ➔➔ Feb 2022
Specialist community mental health services for children and young people	Good Jan 2018	Good Jan 2018	Good Jan 2018	Good Jan 2018	Good Jan 2018	Good Jan 2018
Specialist eating disorders service	Good Sep 2019	Good Sep 2019	Good Sep 2019	Good Sep 2019	Good Sep 2019	Good Sep 2019
Overall	Requires Improvement	Good	Good	Good	Good	Good

Overall ratings for mental health services are from combining ratings for services. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Rating for community health services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community health services for children and young people	Good ↑ Feb 2022	Good →← Feb 2022	Good →← Feb 2022	Good →← Feb 2022	Good →← Feb 2022	Good →← Feb 2022
Community health services for adults	Good Mar 2016	Good Mar 2016	Good Mar 2016	Good Mar 2016	Good Mar 2016	Good Mar 2016
Community health inpatient services	Good Sep 2019	Good Sep 2019	Good Sep 2019	Good Sep 2019	Good Sep 2019	Good Sep 2019
Overall	Good	Good	Good	Good	Good	Good

Overall ratings for community health services are from combining ratings for services. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Mental health crisis services and health-based places of safety

Requires Improvement ➔➔

Is the service safe?

Requires Improvement ➔➔

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

Mental health crisis services

Safe and clean environments

All clinical premises where patients were seen were safe, clean and well maintained. Staff visited most patients at their homes or in community settings.

Staff completed and regularly updated thorough risk assessments of all areas and removed or reduced any risks they identified. Annual environmental risk assessments were completed for each of the care environments using a smartphone application. As the data was inputted and analysed instantly, staff could act on results immediately.

Staff saw patients at home or used trust premises to meet with patients. We observed some clinical premises where patients were seen. These were safe, clean, and fit for purpose.

Clinic rooms had the necessary equipment for patients to have physical examinations. Staff had access to equipment to measure patients' vital signs, which they could take to patients' homes. Staff made sure equipment was well maintained, clean and in working order. We checked some of the equipment used by staff, such as a blood pressure monitor and found it had been serviced and/or calibrated recently.

Staff completed monthly infection prevention and control audits for each of the care environments we visited. Staff described to us how they followed infection control guidelines. The trust provided staff with personal protective equipment to help prevent cross-infection. Staff followed the provider's infection prevention and control guidelines when travelling in cars together on appointments. Staff checked whether patients had COVID-19 symptoms before going to visit them. Green indicator tape had been applied to medical equipment to demonstrate that equipment was clean and ready for use.

Staff disposed of clinical waste safely. They put clinical waste in a bag and took it back to their base to dispose of it, when required. Staff disposed of sharps in yellow bins they took with them on visits.

Safe staffing

The service had enough staff, who received appropriate training to keep people safe from avoidable harm. The number of patients on the caseload of the Enfield and Haringey mental health crisis teams, and of individual members of staff, was not too high to prevent staff from giving each patient the time they needed. The Barnet team had a high caseload, which they were working to reduce.

The service had enough nursing and support staff to keep patients safe.

Mental health crisis services and health-based places of safety

Staff told us there were often challenges with staffing but there were always sufficient staff to be able to deliver the service safely.

Staff in all three teams felt that caseloads were more manageable than they had been previously, although the Barnet team still had a high caseload. Staff described how improved ways of working, including better joint working with other teams, had led to a smaller team caseload compared with a year ago. At the time of inspection, the Haringey team and the Enfield team had caseloads in the high 20's. The Barnet team had a caseload of 60 patients. The team was working with the community teams to reduce the caseload, but the caseload still remained too high. Most staff commented on the relatively low caseloads and, despite some staff vacancies, felt there were sufficient staff deployed to meet patients' needs.

Staff reported that changes to staffing arrangements at night had improved the service the team could offer. There had previously been two staff working across all three boroughs at night. More recently, the teams had been expanded so that there were two staff working in each borough at night. As a result, staff felt they could be more responsive to patients' needs at night.

The teams all had vacancies. As of October 2021, vacancy rates across the teams were: Haringey 18%; Enfield 14%; and Barnet 20%. All three teams were actively recruiting with plans in place to address recruiting challenges such as holding a recruiting day where people can come and apply in person.

Managers limited their use of bank and agency staff and requested staff familiar with the service. Managers made sure all bank and agency staff had a full induction and understood the service before starting their shift. The service had low rates of bank staff. The Enfield team used a pool of bank staff that had completed an induction with the team, and they had not used agency staff for four years.

Managers supported staff who needed time off for ill health. Levels of turnover and sickness varied across the teams. Between October 2020 and September 2021 turnover rates were: Haringey 19%; Enfield 6%; and Barnet 9.5%. Between October 2020 and September 2021 levels of sickness were: Haringey 8%; Enfield 0%; and Barnet 21%. Haringey implemented a policy of allowing staff to select preferred shifts, which led to a reduction in sickness and turnover rates.

The service had enough medical staff. Staff told us they could get support from a psychiatrist quickly when they needed to. Out of hours staff had access to medical support from the duty doctor and on-call consultant psychiatrist

Managers could use locums when they needed additional support or to cover staff sickness or absence. In Barnet the divisional clinical director was covering a consultant psychiatrist post. A locum psychiatrist was due to start the next week and cover while the service recruited for this position.

Mandatory training

Staff had completed and kept up to date with their mandatory training. Managers monitored mandatory training and alerted staff when they needed to update their training.

Staff were compliant with their mandatory training. Overall training compliance was 80% across the services in October 2021. All staff told us they had completed and kept up to date with their mandatory training or had dates booked to complete training.

Mental health crisis services and health-based places of safety

Assessing and managing risk to patients and staff

Staff assessed and managed risks to patients and themselves. They responded promptly to sudden deterioration in a patient's health, although some patients did not have assessments under the Mental Health Act completed promptly. Staff sometimes worked with patients and their families and carers to develop crisis plans, although we found some examples where these could be improved. Staff followed good personal safety protocols.

Assessment of patient risk

Staff completed risk assessments for each patient on admission, using the RAG (Red Amber Green) rating system, and reviewed this regularly, including after any incident.

The shift lead in each team screened referrals and allocated them for assessment. Staff discussed patient risks at daily morning planning meetings. Teams used a RAG system to prioritise patients based on risk. Red risk (high risk) patients were discussed everyday by the team and received at least one visit per day. Amber patients were considered lower risk and were usually visited every other day. Green risk patients were usually nearing discharge from the team or transfer to other services and were low risk. All new patients were initially given a red risk rating.

Staff carried out regular risk assessments, such as before they went to see a patient at home. They were very aware of the environments they were visiting. They assessed the risks before they left the office and again when they arrived at the patient's home.

We reviewed 18 patient care records across the three teams. We found a current risk assessment on all patient records we reviewed. Staff put in place plans to address identified risks.

Management of patient risk

Staff responded to changes in risk. We reviewed 18 patient records across the three teams, six from each team.

The recording of patient's crisis care plans varied, and some plans did not record patients views clearly. In the records we reviewed in the Barnet team, staff had developed and saved on the system crisis care plan that included the patients' views. In the records we reviewed in Enfield, three patients did not have a crisis care plan and the other three were generic and did not always contain patient views clearly. In Haringey, three patients did not have a crisis care plans. In addition, none of the care plans covered housing needs which often was a significant factor in their overall wellbeing. If housing needs are not addressed, this can raise the risk of a deterioration of the patients mental and physical health and can raise the likelihood of relapse.

There were delays across the Haringey, Enfield and Barnet in assessing patients under the Mental Health Act. Staff would make a referral to an approved mental health professionals (AHMPs) for an assessment, and they would escalate delays and support patients. However, the delays meant that patients were not being assessed and waiting to receive the right treatment for them.

Staff monitored risks to patients and developed plans to mitigate the risks. All three teams held a morning planning meeting, in which they discussed risks to patients and planned how to support them. We observed these meetings at all three teams and saw that staff took appropriate action to respond to risk, such as by increasing the frequency of visits. Staff recorded discussions on the team board. Risk were addressed by referring to the patient's assessment, care records and notes. The consultant and any other staff who had seen or interacted with the patient provided feedback and shared information.

Mental health crisis services and health-based places of safety

The Haringey team held a safety huddle each morning before the team planning meeting. This time was used to highlight particular risks to the team in terms of high-risk patients, incidents that had occurred since the day before and which patients should be visited in pairs. Staff recorded on the team whiteboard when patients should be visited in pairs or by staff of a specific gender.

Shift leaders handed over important information about patients to the night team when they came on duty. This verbal handover was supported by written information to ensure all key risks were handed over.

Staff had followed clear safety protocols. They assessed new patients in pairs. Some patients were always visited in pairs as the risks were considered too high for a single staff member. Males staff visited patients if the team identified risks to female staff. Staff in the Haringey and Enfield teams had lone working devices to use to summon help in an emergency when they were out of the office. In Barnet, the devices did not work properly. Managers had ordered new devices for staff. In the meantime, arrangements had been put in place to maintain staff safety. Staff all carried a mobile phone, and they informed the team base when they entered and left patients' homes.

Staff followed clear protocols when patients were not at home when staff visited them or did not attend appointments. Staff liaised with the police when they were concerned for the patient's safety.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Staff received training on how to recognise and report abuse, appropriate for their role. Staff kept up to date with their safeguarding training. Staff we spoke with understood how to protect patients from abuse.

All staff told us they had received training on how to recognise and report abuse. Staff knew how to recognise adults and children at risk of, or suffering, harm. They provided examples of when they had raised safeguarding concerns in respect of patients or their children. We observed staff identifying safeguarding concerns during the morning planning meetings. Staff knew who the trust leads for safeguarding adults and children were and how to contact them for advice.

Managers receive alerts for each safeguarding referral so they can keep track of them. The trust was supporting managers to attend Safeguarding Adult Manager training. This course aimed to support managers to develop skills in chairing safeguarding case conferences and safeguarding case conference reviews, so that the service can lead on safeguarding investigations.

Staff access to essential information

Staff working for the mental health crisis teams kept detailed records of patients' care and treatment. Records were clear, up-to-date and easily available to all staff providing care.

Patient notes were comprehensive and all staff could access them easily. Records were stored securely on an electronic patient record system.

Medicines management

The service used systems and processes to safely prescribe, administer, record and store medicines. Staff working for the mental health crisis teams regularly reviewed the effects of medications on each patient's mental and physical health.

Mental health crisis services and health-based places of safety

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines. Medicines were initially prescribed to patients daily, and then this would increase depending on how much support a patient would need and their other risk factors. Staff assessed new referrals and the staff have access to the Health Information Exchange though the electronic patient record system to check what other medicines the patient had been prescribed by other services. Staff reviewed patients medicine needs at least weekly. In Haringey, the team had a quality improvement initiative looking at how the pharmacy team could support patients to access their medicines faster, as this had been shown to help patients reach the point of discharge earlier.

Staff provided patients with information on their medicines, and patients could access advice from pharmacists by phone if needed.

We checked the arrangements for storing medicines. Medicines that staff were due to deliver to patients were kept in a locked cupboard. The team kept some injectable medicines that were prescribed to patients. Staff stored and managed medicines and prescribing documents in line with the provider's policy. We checked a number of medicines stored in the medicine cabinet in the Haringey team base. All medicines were within the expiry date. Staff kept records of the medicines that they delivered to patients.

Staff transported medicines in a locked bag. They took a small sharps bin with them to dispose of needles safely when they administered medicine by injection.

Staff observed patients for side effects of medicines and reported on these in the morning planning meeting.

Track record on safety

The three crisis resolution and home treatment teams had reported three serious incidents in the last year.

Between October 2020 and September 2021 there were three serious incidents reported across the three teams. In Barnet, there were two incidents: an unexpected death of a patient by suicide and an attempted suicide. The third incident, in Haringey, was the death of a patient by suspected suicide.

Reporting incidents and learning from when things go wrong

The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

Staff recognised incidents and knew when to report them. They gave us examples of incidents they had reported. Managers shared lessons learned from incidents with the whole team. Staff told us that incidents were discussed in safety huddles and clinical governance meetings. Staff told us about incidents that had occurred in the service and changes that had been implemented in response to lessons learned.

Incidents were investigated thoroughly and discussed at the team meetings. Patients and their families were involved in these investigations. Staff received feedback and from the investigation of these incidents, and support was offered and provided. Staff discussed the feedback and improvements to patient care at team meetings.

Staff understood the duty of candour. They were open and transparent, and they gave patients and families a full explanation if and when things went wrong. Staff said they apologised to patients and relatives when things went wrong.

Managers provided staff with a debrief after incidents.

There was evidence that changes had been made as a result of feedback. Following the unexpected death of a patient by suicide, for example, staff had updated the assessment checklist, and it now included prompts to include medication lists and next of kin contact numbers. In addition, the service had undertaken an urgent local review of the medication management policy.

Following another incident in which a patient died whilst staying at a crisis prevention house, the trust had revised the format used by crisis resolution home treatment team staff for discussions to ensure staff covered any risk issues and incidents of note.

Managers attended several weekly meetings. Managers attended clinical governance meetings with the governance facilitator, as well as with the head of nursing. The managers across the three services would also meet weekly to discuss serious incidents. Safety incidents were also discussed at team meetings.

Health-based places of safety

Safe and clean environments

Staff completed and regularly updated thorough risk assessments of all areas and removed or reduced any risks they identified. At the place of safety, all the facilities were clean and tidy. Staff cleaned and checked the rooms after each patient was discharged. Staff were sometimes required to support patients in a room in the place of safety that contained potential environmental risks.

All clinic rooms had the necessary equipment for patients to have thorough physical examinations. At the place of safety, there was a clinic room with an examination couch and other equipment for physical examinations.

Most areas were clean, well maintained, well-furnished and fit for purpose. At the place of safety, all rooms were of a good size with ensuite toilets and external windows providing natural light. However, one of the rooms had not been equipped with anti-ligature features. For example, doors and windows were not ligature free. The sink could be used as a ligature point and the smoke alarm was different to the alarms in the other two rooms. Also, this room could not be seen from the nurses' office. Staff explained that the service was only commissioned to provide accommodation for two patients at any time and, therefore, the third room was rarely used. They also said they mitigated risks by only placing low risk patients in this room and providing two-to-one observations of anyone using the room. Despite this, records showed that the room had been used 49 times between May and October 2021. The notes did not indicate that the patients were subject to close observations. By using a decommissioned area of the unit to accommodate patients, the service was increasing the risk of harm to patients.

Safe Staffing

Nursing staff

The service had enough nursing and support staff to keep patients safe.

At the place of safety, two registered nurses and two health care assistants were assigned to the service during the day and night shifts. They were supported by a team leader during the day and a site manager outside office hours. Staff felt this was sufficient to meet the needs of patients.

The service had low vacancy rates. The place of safety employed 15 staff. The service was recruiting new staff to cover two vacancies.

Medical staff

The service had enough medical staff. The place of safety had a specialty doctor assigned to the service. Out-of-hours cover was provided by the on-site duty doctor.

Assessment of patient risk

Staff completed risk assessments for each patient on admission / arrival, using a recognised tool, and reviewed this regularly, including after any incident.

At the place of safety, staff reviewed any information held on the electronic patient record as soon as they received a referral from the police. This enabled staff to complete an initial risk profile and provide information about the patient's risk history to the police if appropriate. When patients arrived at the ward, staff completed a comprehensive risk assessment.

Staff used a recognised risk assessment tool. When patients were admitted to the place of safety, staff completed a risk assessment on a standard form and recorded this on the electronic patient record.

Management of patient risk

Staff responded promptly to any sudden deterioration in a patient's health.

At the place of safety, staff asked the police to escort patients presenting any concerns about their physical health to an emergency department of a general hospital to receive medical clearance.

Use of restrictive interventions

Staff at the place of safety regularly used restrictive interventions. In October 2021, there had been 15 incidents involving restrictive interventions. This includes six instances of seclusion, five incidents involving violence, aggression or assault, two instances of restraint and two instances of rapid tranquilisation.

Staff at the place of safety made every attempt to avoid using restraint by using de-escalation techniques and restrained patients only when these failed and when necessary to keep the patient or others safe. For example, one record showed that staff had used "soft-words" and de-escalation techniques before restrictive interventions were used.

Staff at the place of safety understood the Mental Capacity Act definition of restraint and worked within it. Whenever staff restrained a patient, records indication that their action were a proportionate response to prevent harm to the patient. Staff record details of restraint including details of the circumstances leading to the restraint, the names of all staff involve, the type of restraint used and length of time the patient was restrained.

Staff at the place of safety mostly followed National Institute of Health and Care Excellence (NICE) guidance when using rapid tranquilisation. After staff administered rapid tranquilisation, they considered whether it was possible to observe the patient's vital signs. On the records we looked at, patients had either refused to have their vital signs observed or it

had not been possible due to their state of arousal. This was noted on patients' records. Staff also noted that patients were placed on one-to-one observations after receiving rapid tranquilisation and, when possible, respiration rates were recorded. However, on all four records we looked at that involved the patient receiving rapid tranquilisation, staff had not recorded the legal authority under which the medicine was given.

When a patient was placed in seclusion at the place of safety, staff kept clear records and followed best practice guidelines. We reviewed the records of four patients who had been secluded whilst staying at the place of safety. Staff recorded the reason for seclusion and observations every 15 minutes. Records showed that patients were seen by a doctor within one hour, reviewed by nurses every two hours and received medical reviews every four hours. The facilities at the place of safety met the requirements for seclusion rooms set out in national guidance.

Safeguarding

Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them. Staff at the place of safety, for example, talked to patients about whether they had children, whether the children were being looked after and discussed any arrangements for support from social services if necessary.

Staff access to essential information

Patient notes were comprehensive and all staff could access them easily. At the place of safety, staff recorded all their notes on the electronic patient record.

Medicines Management

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines. At the place of safety, staff stored standard medicines, such as a treatment for diabetes, in a locked cupboard in the clinic room. The service could access other medication from the adjacent wards if necessary.

Reporting incidents and learning from when things go wrong

Staff knew what incidents to report and how to report them.

Between May and October 2021, staff, on average, reported 29 incidents each month, ranging from 22 in September to 34 in July. The most common incident was a breach of the permitted period of detention. There were, on average, 19 breaches of the permitted period of detention each month, amounting to 39% of all admissions.

Staff reported serious incidents clearly and in line with trust policy. Staff recorded all incidents on the trust's electronic incident reporting system.

Managers debriefed and supported staff after any serious incident. At the place of safety, staff discussed incidents at reflective practice sessions.

Is the service effective?

Good 

Mental health crisis services and health-based places of safety

Our rating of effective stayed the same. We rated it as good because:

Mental health crisis services

Assessment of needs and planning of care

Staff carried out comprehensive assessments of patients' mental and physical health needs. They were very aware of the impact of social issues, such as housing, on patients' mental health, although this was not always recorded.

We reviewed 18 patient care record across the three CRHT teams. In Haringey and Enfield three patients within each service did not have a crisis care plan in place.

Staff did not always perform a full physical health assessment on patients. Of the 18 patient records we reviewed, for seven patients it was not clear whether staff had reviewed their physical health needs.

The teams completed audits on physical health monthly, and in most cases these showed that a physical health check was completed after the initial assessment of a patient.

Wellbeing clinics, which provided outpatient treatment and support for the patients, supported the teams and received referrals from them.

Staff formulated an initial care plan with patients when they were admitted into the service. Care plans were then brought to the next multi-disciplinary team meeting where a more comprehensive care plan was formulated. This was then be shared with the patient and their carers or family members. Staff regularly reviewed and updated care plans when patients' needs changed.

The Haringey crisis team implemented a quality improvement project to create a care plan that would involve the patient in its development and be in an accessible to read format. It included aspects of the patient's life and recovery. The other two services were adopting this care plan style in their own services.

Best practice in treatment and care

Staff referred patients to other services or professionals to meet their needs when appropriate. For example, staff referred patients with substance misuse problems to the dual diagnosis worker or local substance misuse service.

Staff ensured patients had support for their physical health needs, either from their GP or community services.

Staff supported patients to live healthier lives. For example, they referred them to smoking cessation services or their GP for support or provided nicotine replacement therapy. Staff in a morning planning meeting reported that smoking cessation was offered to a patient.

Staff used outcome measures to monitor the progress of patients. Staff in the Haringey team, for example, used a specific questionnaire, the clinical outcomes routine evaluation (CORE-10 screening measure), to measure outcomes for patients. Staff conducted the questionnaire near to the initial contact with the patient and again at discharge from the team. This gave a measure of the improvement the patient had made.

Mental health crisis services and health-based places of safety

Staff took part in clinical audits. Managers used results from audits to make improvements. For example, staff took part in clinical audits of risk assessments and care plans, physical health checks, medicines, serious incident action plans and environmental safety. Where gaps were identified these were addressed.

Staff took part in quality improvement initiatives. The Enfield team, for example implemented a quality improvement initiative to install a direct line to the crisis teams, so patients and carers could get through to the team directly. This was extended to become a 24-hour phone line. The doctors on the Enfield team had also carried out a quality improvement initiative in 2019 to ascertain how many inappropriate referrals were coming in and why. At the time of the inspection, they planned to repeat this audit to compare the outcomes. The Barnet team was part of an initiative to improve the completion of risk assessments.

Skilled staff to deliver care

The mental health crisis teams included or had access to a range of specialists required to meet the needs of patients under their care, although some teams only had limited access to clinical psychology support. Managers made sure that staff had the range of skills needed to provide high quality care. They supported staff with appraisals, supervision and opportunities to update and further develop their skills, although not all appraisals had been recorded on the trust's monitoring system. Managers provided an induction programme for new staff.

The mental health crisis teams included or had access to a range of specialists required to meet the needs of patients under their care. All staff told us they received an annual appraisal and regular monthly supervision. Supervision rates across the three teams for August 2021 to October 2021 had Haringey and Enfield at nearly 100% and Barnet 84%. Agency staff were also offered regular supervision. Supervision was completed each month unless the staff member was sick or on leave. Staff said they had opportunities for professional development and set development goals as part of the appraisal process.

Staff in the teams were able to refer patients to a clinical psychologist but access varied between the teams. The Haringey team did not have their own psychologist but referred patients to the community mental health locality team psychologist. The Enfield team had a part time clinical psychologist in the team. In Barnet, the acute care psychology lead oversaw the delivery of clinical psychology. There were four assistant psychologists, one for each ward and one for the home treatment team. They delivered low intensity psychological interventions to patients.

Staff we spoke with told us they had received an annual appraisal, although the data we reviewed suggested that progress was required to ensure all staff received an appraisal in the current year. At the time of the inspection, only two out of 26 members of staff in Haringey team had completed an appraisal. For Enfield 70% and for Barnet 60% of staff were up to date with appraisals.

Managers ensured staff had the right skills, qualifications and experience to meet the needs of the patients in their care, including bank and agency staff. Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge.

All teams held reflective practice group meetings, facilitated by a psychologist, that allowed staff to discuss their work experiences, although the frequency of these varied from team to team.

Some staff told us they had participated in additional training courses such as motivational interviewing. Some staff had begun in the team in a band 5 nurse development post and had quickly progressed to a band 6 post.

In the Enfield team, doctors delivered regular educational sessions to colleagues on a range of topics including the Mental Capacity Act, sleep hygiene and mental state examinations.

Staff were looking at additional ways to improve care. Trauma-informed care training was due to be rolled out to all staff. Trauma-informed care is an approach that takes into account any trauma the patient may have experienced, to protect patients from re-traumatization.

Managers provided an induction programme for new staff. In Enfield the bank staff undertook the same induction programme as permanent staff.

Managers made sure staff attended regular team meetings or shared information with those that could not attend. The teams had monthly team meetings scheduled. However, it was sometimes difficult for staff to attend due competing work priorities. Any urgent matters were discussed at the daily morning meeting. Since our previous inspection, the Haringey crisis team staff told us they implemented a daily afternoon team huddle for any staff that could attend. The staff would share information on risks so that all staff would be aware of this. The Barnet team held two separate monthly meetings, one for clinical governance issues and one for regular team matters.

The teams had introduced new roles to ensure they provided good support to patients. The Barnet team had, for example, employed a peer support worker. A peer support worker is someone that has lived experience of using services. The peer support worker attended all staff interviews to provide feedback on applicants. The other teams were actively recruiting peer support workers for their services.

Multi-disciplinary and interagency team work

Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. They had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.

Staff held regular multidisciplinary meetings to discuss patients and improve their care. We attended morning planning meetings with all three teams. These were attended by nurses, social workers, consultant psychiatrists, other medical staff and support staff.

The Enfield crisis team staff had strengthened working relationships within the team by undertaking regular team activities together.

All three teams met together periodically to share good practice.

All staff told us that teamwork was a real strength of the service. The different disciplines were very complimentary about each other's work and their contribution to the team.

Teams had effective working relationships with other teams in the organisation. Staff carried out joint reviews of patients involving other teams such as the early intervention team, perinatal team, learning disabilities team and the community mental health locality teams. Staff found these joint reviews helpful and said it helped facilitate the transfer of the care of the patient to more appropriate services when they were ready. Representatives from other trust services, such as community mental health teams, early intervention team and a dual diagnosis worker attended morning planning meetings virtually. This helped facilitate referrals between teams.

Mental health crisis services and health-based places of safety

Teams had good working relationships with external teams and organisations. They worked well with the locality teams who attended the daily planning meetings weekly.

The Enfield team met with the early intervention team and the enhanced treatment service weekly. The Enfield team had a good relationship with the Enfield carers association and hold monthly forums for carers with them.

The Barnet team met with the mental health crisis assessment service, which is based at Camden and Islington NHS Foundation Trust, on a frequent basis as needed, to discuss any specific service user issues. They met weekly with local authority approved mental health practitioners (AHMPs) and communicated daily with the ward discharge team about their plans to support patients discharging into their service. Staff would raise the issue of delays in completing Mental Health Act assessments with AHMPs and escalate their concerns around the raised risk this presented.

The teams had good contact with the perinatal teams and were able to access them quickly for support.

Adherence to the Mental Health Act and the Mental Health Act Code of Practice

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice.

Staff had access to support and advice on implementing the Mental Health Act and its Code of Practice. Staff knew who their Mental Health Act administrators were and when to ask them for support.

AHMPs sometimes attended the daily planning meetings and had twice weekly meetings with the Haringey crisis team. However, there were sometimes long delays in arranging Mental Health Act assessments. The crisis team managers reported the main reason for this was difficulties in obtaining a police officer to attend an assessment. The trust was aware of this issue, and there was a trust wide quality improvement project to look at ways to improve this.

Patients on section 117 leave were identified during daily planning meetings and on their patient care records.

Application of the Mental Capacity Act

Staff supported patients to make decisions on their care for themselves. Some staff did not always record clearly that they had assessed patients mental capacity.

There was a clear policy on the Mental Capacity Act (MCA) within the service.

Staff received training in the MCA. Although the systems showed that MCA training was not registering as complete for staff, the managers assured this had been completed but there was an error on the system preventing this from uploading.

Staff said they supported patients to make decisions on their care for themselves. Staff in Barnet crisis team discussed concerns regarding patients' capacity to consent in the morning planning meeting.

Staff considered but did not always record clearly that they had assessed a patient's capacity. In six out of the 18 records we checked, statements about the patient's lack of mental capacity to make decisions about their care were not supported by an assessment of their capacity. Where we found statements about a patient's lack of mental capacity, staff had not recorded any reference to best interest decision making in relation to receiving, for example, medication and input from the home treatment team.

Mental health crisis services and health-based places of safety

Staff audited how they applied the MCA and identified and acted when they needed to make changes to improve. Monthly audits were undertaken of patient risk assessments and care plans, this included whether a capacity assessment had been undertaken. Where the capacity assessment had not been undertaken or recorded, this was rectified after the audit and this issue resolved.

Health-based places of safety

Assessment of needs and planning of care

Staff completed a comprehensive mental health assessment of each patient.

At the place of safety, all patients were seen by a triage doctor within three hours of admission to assess whether the patient had a mental disorder and whether a further assessment for admission under the Mental Health Act 1983 was required.

Staff made sure that patients had a full physical health assessment and knew about any physical health problems. Staff at the place of safety completed a physical health check as part of the core assessment. Staff recorded patients' vital signs on a National Early Warning Score (NEWS) chart.

Best practice in treatment and care

Staff took part in clinical audits, benchmarking and quality improvement initiatives.

Staff considering a quality improvement initiative to reduce the number of patients being held at the place for more than 24 hours.

Skilled staff to deliver care

Managers made sure that staff had the range of skills needed to provide high quality care. They supported staff with appraisals, supervision and opportunities to update and further develop their skills.

Managers gave each new member of staff a full induction to the service before they started work. Staff at the place of safety said they spent time shadowing senior colleagues when they joined the service.

Managers supported staff through regular, constructive appraisals of their work. Staff at the place of safety said they had regular supervision with their manager, group supervision with their colleagues and an annual appraisal. All staff said they found these sessions helpful.

Managers made sure staff attended regular team meetings or gave information from those they could not attend. Staff at the place of safety had regular team meetings.

Multi-disciplinary and interagency team work

Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. They had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.

Mental health crisis services and health-based places of safety

Staff held regular multidisciplinary meetings to discuss patients and improve their care. Staff at the place of safety had monthly team meeting to review performance data on the service and discuss incidents and development.

Staff made sure they shared clear information about patients and any changes in their care, including during transfer of care. At the start of each shift, staff at the place of safety held a handover meeting to discuss patients held within the facility. Staff provided a discharge summary for the service that the patient was being discharged to.

Ward teams had effective working relationships with other teams in the organisation. Staff at the place of safety worked closely with bed managers, crisis teams, community mental health teams and acute admission wards.

Ward teams had effective working relationships with external teams and organisations. The team leader of the place of safety attended a monthly meeting with managers of other services involved in conveying patients to a place of safety. This included managers from the police, ambulance service, social services, approved mental health professionals and the emergency department of the local hospital.

Adherence to the Mental Health Act and the Mental Health Act Code of Practice

Staff in the health-based place of safety understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice.

Staff received and kept up-to-date with training on the Mental Health Act and the Mental Health Act Code of Practice and could describe the Code of Practice guiding principles. During our interviews, staff at the place of safety told us how important it was for staff within their team to have a good understanding of the Mental Health Act.

Staff had access to support and advice on implementing the Mental Health Act and its Code of Practice. Staff at the place of safety could access support on the Mental Health Act from the Mental Health Act office, approved mental health professionals and an on-call consultant psychiatrist.

Staff knew who their Mental Health Act administrators were and when to ask them for support. Mental Health Administrators were based on the same site as the place of safety. Staff could contact them whenever they needed to.

The service had clear, accessible, relevant and up-to-date policies and procedures that reflected all relevant legislation and the Mental Health Act Code of Practice. Staff could access policies and guidance through the trust's intranet.

Staff usually explained to each patient their rights under the Mental Health Act in a way that they could understand, repeated as necessary and recorded it clearly in the patient's notes each time. Staff consistently talked to patients about how the Mental Health Act applied to their situation when they arrived at the place of safety. However, we viewed three records of patients who were held at the place of safety for beyond the permitted period of detention. We did not find any evidence to show that staff informed the patient of the change in their status when the permitted period elapsed.

Application of the Mental Capacity Act

Staff in the health-based place of safety supported patients to make decisions on their care for themselves. They understood the trust policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly for patients who might have impaired mental capacity.

Mental health crisis services and health-based places of safety

Staff assessed and recorded capacity to consent clearly each time a patient needed to make an important decision. At the place of safety, staff attempted to assess the capacity of all patients when they were admitted. When staff were unable to assess capacity, for example due to the patient being unwilling to engage with staff, this was noted on the patient's record.

Is the service caring?

Good 

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

Mental health crisis services

Kindness, privacy, dignity, respect, compassion and support

Staff treated patients with compassion and kindness. They respected patients' privacy and dignity. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.

Patients and carers told us staff treated patients with compassion and kindness. They respected patients' privacy and dignity. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.

We spoke with 13 patients and carers across the three teams, and we observed staff speaking with patients over the telephone and when attending patients' homes for treatment. They were kind and respectful and explained the role of the team and the purpose of the appointments they were setting up.

Staff supported patients to understand and manage their own care treatment or condition. Staff gave patients help, emotional support and advice when they needed it. Patients said staff treated them well and behaved kindly. All 13 patients and carers we spoke said they felt involved in care planning, and staff were respectful and polite.

Where appropriate staff that were part of the multidisciplinary team supported patients transfer to community teams when there were long waiting times to access those service.

Involvement in care

Staff in the mental health crisis teams tried to involve patients in care planning and risk assessment and actively sought their feedback on the quality of care provided. Staff informed and involved families and carers but did not always record patients' consent to share information.

Involvement of patients

Patients told us staff involved patients in decisions about the service and gave them access to their care plans. Staff told us how they tried to involve patients in their care. We observed that staff gave patients a choice regarding the time of visits and appointments where possible, although this was usually within a two to three hour window.

Mental health crisis services and health-based places of safety

Patients told us staff made sure patients understood their care and treatment (and found ways to communicate with patients who had communication difficulties). Patients said that information was accessible to them and was explained to them by the staff.

Patients could give feedback on the service and their treatment and staff supported them to do this. Administration staff called patients and carers/relatives to get feedback about their experience of the crisis teams. Patients could access an online form to give feedback about their care.

Involvement of families and carers

Staff informed and involved families and carers, although they did not always record the consent of patients to share information.

Staff supported, informed and involved families or carers. In the 18 records we reviewed we found consistent evidence of proactive engagement with patients and family members.

However, in the majority of records in Haringey and Enfield there was no record of discussion with the patient about consent to share information with family members.

Staff considered the needs of relatives and carers and discussed these in the morning planning meetings we observed. Staff said they carried out carers assessments when appropriate and we observed this was discussed in the morning planning meeting.

Staff understood the importance of obtaining collateral information about patients from family members and friends.

Staff helped carers and families to give feedback on the service. Carers were contacted monthly for feedback via a carer survey. The Enfield team held a monthly carers event in partnership with the Enfield carers association which was an open forum where carers could discuss any issues and obtain information.

Health-based places of safety

Kindness, privacy, dignity, respect, compassion and support

Staff in the health-based place of safety treated patients with compassion and kindness. They respected patients' privacy and dignity.

Staff were discreet, respectful, and responsive when caring for patients. At the place of safety, staff talked about the importance of good patient care. They sought to achieve this through listening to, and engaging with, patients.

Staff gave patients help, emotional support and advice when they needed it. At the place of safety, staff spent time with patients, talking to them about how they feel. They offered patients encouragement and reassurance.

Staff directed patients to other services and supported them to access those services if they needed help. At the place of safety, staff referred patients to the crisis team or the community mental health team when they were not admitted to hospital.

Involvement of families and carers

Mental health crisis services and health-based places of safety

Staff informed and involved families and carers appropriately.

Staff supported, informed and involved families or carers. Staff at the place of safety contacted patients' families and involved them in decision making when this was possible and appropriate.

Is the service responsive?

Requires Improvement 

Our rating of responsive stayed the same. We rated it as requires improvement:

Mental health crisis services

Access and discharge

The mental health crisis service was available 24-hours a day and was easy to access – including through a dedicated crisis telephone line. The referral criteria for the mental health crisis teams did not exclude patients who would have benefitted from care. Staff assessed and treated people promptly. Staff followed up people who missed appointments.

The service met the target times for seeing patients from referral to assessment and assessment to treatment. Staff saw urgent referrals quickly.

The service had clear criteria to describe which patients they would offer services to. The Enfield team had worked with local GPs and liaison teams to highlight what an appropriate referral looked like. There were no waiting lists for the home treatment teams.

Staff saw patients referred urgently for a face to face assessment within four hours, and non-urgent referrals within 24 hours. The Haringey, Enfield and Barnet teams were regularly achieving the urgent four-hour target 100% of the time. The Haringey team was achieving the non-urgent 24-hour time target 98% of the time. The Enfield team was achieving this over 90% of the time, and the Barnet team were achieving this 80% of the time.

The mental health crisis service was available 24-hours a day and was easy to access, including through self-referral and a dedicated crisis telephone line. Staff assessed and treated people promptly. Staff followed up people who missed appointments. The team tried to contact people who did not attend appointments and offer support.

The team tried to engage with people who found it difficult, or were reluctant, to seek support from mental health services. Staff would do a joint visit with the care coordinator to try to engage with reluctant patients. Staff would also form a plan with community teams and involve families wherever possible to facilitate engagement.

Patients had some flexibility and choice in the appointment times available. Patients were given a timeframe for their appointment. If the appointment was cancelled by the service, the patient was usually made aware. If staff visited and the patient wasn't home, the staff would leave a note.

Social workers at the services support patients when they are referred or linked to other services such as the community teams and Citizens Advice Bureau. For example, social workers would send a letter to support a review of benefits on behalf of the patient.

Mental health crisis services and health-based places of safety

Facilities that promote comfort, dignity and privacy

The design, layout, and furnishings of treatment rooms supported patients' treatment, privacy and dignity.

The service had a full range of rooms and equipment to support treatment and care or could use rooms in other trust services. The home treatment teams supported patients in their homes, as well as in community settings such as GP practices.

Interview rooms in the service had sound proofing to protect privacy and confidentiality.

Patients' engagement with the wider community

Staff supported patients with activities outside the service, such as work, education and family relationships.

Staff connected patients to community teams and other agencies such as grief counselling services.

The teams supported patients who continued to work and could be flexible around appointment times, such as meeting outside of regular meeting hours.

The teams involved the families and carers of patients from their admission into the service. Staff did this by asking families and carers for further information about the patient, and involved them in future care plans for the patient. Staff sought patients consent to do this, although this was not always recorded.

Meeting the needs of all people who use the service

The service met the needs of all patients – including those with a protected characteristic. Staff helped patients with communication, advocacy and cultural and spiritual support.

The service provided information in a variety of accessible formats so the patients could understand more easily. For example, the service could provide information leaflets available in languages spoken by the patients and local community. Staff signposted patients/carers to relevant local third sector organisations for additional and longer-term support, for example to faith-based support groups, local crisis café and carers forums. The Barnet team, for example, was supporting a patient to access support from a Jewish community group and counselling service.

Staff discussed patients specific needs in daily morning planning meetings. Staff made sure patients could access information on treatment, local services, and how to complain.

Managers made sure staff and patients could get hold of language interpreters or British sign language interpreters when needed. In the morning planning meetings staff discussed the individual language needs of patients and how best to communicate with them including using a telephone interpreting service or booking an interpreter. The teams had a diverse caseload with several patients who needed an interpreter.

We asked several staff whether they were aware of the Accessible Information Standard (AIS), but they were not. The AIS sets out a specific, consistent approach to identifying, recording, flagging, sharing and meeting the information and communication support needs of patients. Staff said they could flag patients' individual communication needs via a pop up on the patient electronic records system, but they could not think of a time they had done this.

Listening to and learning from concerns and complaints

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and wider service.

Mental health crisis services and health-based places of safety

Patients, relatives and carers knew how to complain or raise concerns. Staff gave patients a welcome pack when they were first seen by the service. The welcome pack contained information about how to raise a concern or complaint.

We spoke with 13 patients about their experience of the service. Patients said they would know how to make a complaint if they needed to.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. Staff we spoke with understood the policy on complaints and knew how to handle them. Themes and outcomes from complaints were shared and reflected upon with staff.

Managers investigated complaints and identified themes. Managers shared feedback from complaints with staff and learning was used to improve the service. From October 2020 to September 2021, the services received four formal complaints, two regarding the Haringey team and two regarding the Barnet team. The two complaints in Barnet were regarding communication with the patients about their appointment time and discharge.

Managers spoke to patients to try and resolve the complaint informally initially. If the patient wanted to make a formal complaint, they would be put in contact with the patients experience team. Formal complaints were investigated by managers.

Health-based places of safety

Access and discharge

Staff in the health-based place of safety assessed and treated people promptly, but some patients who were waiting for inpatient beds remained in the place of safety longer than the permitted period of detention.

The service had clear criteria to describe which patients they would offer services to. The place of safety accepted referrals for patients aged 18 or over. Patients younger than 18 who required a place of safety were taken to the emergency department of local hospitals. The service did not accept patients when there were concerns about their physical health. The police took these patients to an emergency department for medical clearance before taking them to the place of safety.

Patients were frequently held in the place of safety for longer than the permitted period of detention. The trust did not always discharge patients from the place of safety within the 24-hour permitted period of detention. Between May and October 2021, 112 patients (38% of all patient admitted to the place of safety) were held in the place of safety for longer than the period of 24-hours allowed by the Mental Health Act. Staff explained that delays were caused by a lack of availability of inpatient beds.

Facilities that promote comfort, dignity and privacy

The service had a full range of rooms and equipment to support treatment and care.

The service provided large rooms for patients with ensuite facilities and natural light. However, the closed-circuit television (CCTV) used for monitoring patients in their bedrooms was always switched on, including when patients presented a low risk. This could compromise patient's privacy.

Meeting the needs of all people who use the service

Mental health crisis services and health-based places of safety

The service could support and make adjustments for disabled people and those with communication needs or other specific needs. At the place of safety, staff supported patients with cultural and spiritual activities. Staff provided clean towels for patients to use as prayer mats. Staff supported patients to access religious texts, such as the Bible and Quran, through the internet.

Is the service well-led?

Good 

Our rating of well-led stayed the same. We rated it as good because:

Mental health crisis services

Leadership

Leaders had the skills, knowledge and experience to perform their roles. They had a good understanding of the services they managed and were visible in the service and approachable for patients and staff.

Staff were very positive about the managers of all three teams.

Senior trust executives had visited the teams. The Enfield mental health managing director and head of nursing described a good relationship with the local authority. They were aware of the key risks and challenges and were open in sharing them.

Divisional directors were clear about issues affecting teams, and were working on plans to address the issues, such as implementing a quality improvement project looking at patients being held in a place of safety for longer than the permitted period of detention.

They were aiming to build a culture to support people to speak up and wanted to be visible for the teams.

Vision and strategy

Staff knew and understood the provider's vision and values and how they applied to the work of their team.

The trust's values were on display in the team offices. These were compassion, respect, being positive and working together. We observed staff behaving in line with the trust's values.

Patients said staff were caring, kind and polite and listened to what they had to say.

The trust reviewed and adapted its model of care to best meet the needs of patients. The trust had, for example, changed the model for the crisis prevention houses, with the aim of using them to prevent admissions and therefore manage access and flow. When assessed as being suitable, patients were admitted directly from the community to the crisis prevention house.

Mental health crisis services and health-based places of safety

Leaders had a strategic plan to improve the diversity of the team skill set. Divisional directors were looking at how best to do this. The trust was undergoing a transformation in terms of integrating social workers into the teams and strengthening the role that social workers had in the delivery of care. Each team have a peer support worker, who is someone that has lived experience of the service, and the Enfield and Barnet team were actively recruiting more peer support workers.

Culture

Staff felt respected, supported and valued. The staff we spoke to told us that they felt the trust promoted equality and diversity in daily work and provided opportunities for development and career progression. They could raise any concerns without fear.

All team managers were described as very supportive by their teams. Staff could also get day to day support from the shift lead.

Staff were passionate about their work and enjoyed working with their teams. They all described the teams as non-hierarchical said that they felt able to speak up.

There were networks in place to support staff. This included Black and Minority Ethnic (BAME) Better Together network, the women's network and the lesbian, gay, bisexual, transgender, questioning or queer network (LGBTQ+).

Staff did not necessarily know the name of the freedom to speak up guardian in the trust but knew about the service and said they could find out how to contact them if needed.

Governance

Our findings from the other key questions demonstrated that governance processes operated effectively at team level and that performance and risk were managed well.

Staff told us they attended regular clinical governance meetings at team level. Staff discussed learning from serious incidents and complaints at these meetings.

The service implemented improvements following serious incidents, such as stopping telephone assessments, as not seeing a patient face to face increased the risk to their safety. Managers of a service would assist in an investigation of incidents at another service, and the three team managers would meet regularly to discuss service issues and share information.

There were systems in place to ensure quality and safety. These included daily planning meetings to manage and discuss risk to patients, setting target times for the service and ensuring these were met.

Oversight of performance was maintained by regular clinical audits. The service used a smartphone application to complete audits which meant the data was inputted and analysed instantly so that staff could act on results immediately. Managers monitored staff wellbeing and performance through regular supervision.

The teams undertook other regular audits to provide assurance on the systems in place such as risk assessments, care plans, medicines, environmental safety and serious incident action plans. Where audits showed a drop in standards, this was identified and rectified.

Mental health crisis services and health-based places of safety

Management of risk, issues and performance

Teams had access to the information they needed to provide safe and effective care and used that information to good effect.

Service level risk registers were in place for Enfield and Barnet. Haringey did not provide a risk register. However, the Haringey team were aware of service risks and could apply mitigations, such as a new approach to recruiting staff involving a recruitment day so that potential staff could come in and apply in person. The risks for Enfield included the lack of working lone working devices in the team. This was being managed by recalling the non-working devices and using the in and out board to monitor staff.

The risk for Barnet was the recruiting challenges for the nursing, social worker and occupational therapy positions. This was being managed with ongoing recruitment, internal opportunities to be offered, a virtual recruitment day and the head of nursing to support borough wide recruitment.

Risk was managed well by the services. Risk was constantly discussed at daily planning meetings and was at the forefront of any patient discussions. Managers knew about delays in patient's being assessed under the Mental Act, and they were working to reduce the time assessments took. Leaders in the Barnet team were working to reduce the team caseload.

Serious incidents were investigated, shared with the team, and learning implemented through action plans.

Staff and service performance was managed well through regular supervision and clinical audits.

Information management

The electronic patient records system was effective for recording and updating risk, crisis plans, and physical wellbeing. Patient records were kept confidential.

Staff collected data about outcomes and performance and engaged actively in local and national quality improvement activities.

Staff had access to the equipment and information technology they needed to do their work. This included mobile phones, laptops and lone working devices for staff safety on home visits.

Managers had access to the information on their team's performance collected through clinical audits. This included information on completion of patient risk assessments, care plans and community physical health assessments.

Engagement

Managers engaged actively with other local health and social care providers to ensure that an integrated health and care system was commissioned and provided to meet the needs of the local population.

There were effective, multi-agency arrangements to agree and monitor the governance of the mental health crisis service.

Patients and carers were engaged through feedback forms and discharge surveys where they could share their feedback and how they felt about the service. Patients and carers were provided a welcome pack upon admission that explained how to feedback about the service and make a complaint if they wanted to. This also included a safeguarding safe line that patients could use to raise a concern.

Mental health crisis services and health-based places of safety

Carers could provide feedback about the service as well as receive information about resources and support for their role, through the trust's carers networks and forums. Patients and carers said in discharge surveys that they felt their needs were met by the service.

Learning, continuous improvement and innovation

Staff took part in quality improvement initiatives. For example, in Enfield the team had introduced a direct telephone number that patients could call to access the team more quickly. Patients had fed back that they found they were waiting on the line for long periods when they tried to call the team via the main hub. The initial pilot of the direct line worked well and was extended to cover 24 hours a day. Staff reported this had led to a reduction in the number of patients attending emergency departments.

The Barnet crisis team had implemented a quality improvement project aimed at improving the completion and quality of patient risk assessments and care plans, which had proved successful.

The teams participated in accreditation schemes. The Haringey service had achieved Home Treatment Accreditation Scheme (HTAS) accreditation. The Enfield and Barnet services were working towards HTAS accreditation and hoped to achieve it in 2022.

Each borough had a crisis prevention house where patients in crisis could stay for short periods. The management of the houses had recently been brought back into the trust. The crisis team screened all referrals into the houses and staff felt the houses were now being used more effectively. Crisis prevention house staff and the home treatment team communicated about patients regularly.

The trust was in the process of introducing and embedding trauma-informed care, which is an approach to trauma that takes into consideration any trauma the patient may have experienced so as not to re-traumatize the patient during care, across the acute wards and community teams, including the Barnet crisis service, in line with the NHS plan. The lead psychologist in Barnet had developed a trauma informed screening tool for use by services as well as a trauma informed group programme. The plan was to screen every new patient coming into the wards or teams.

The trust aimed to integrate the crisis resolution and home treatment teams into the bed management improvement initiative, by admitting patients from the community to the crisis prevention houses. This would help in avoiding an unnecessary admission to hospital.

Health-based places of safety

Leadership

Leaders had the skills, knowledge and experience to perform their roles. They had a good understanding of the services they managed and were visible in the service and approachable for patients and staff.

Registered nurses at the place of safety were all experienced nurses and had previously worked on acute admission wards and psychiatric intensive care units.

Staff at the place of safety said that senior managers visited the service more frequently. They knew the matrons and senior managers well. Staff said they had found the 'clinical Fridays' initiative helpful. This involved senior managers visiting the wards to offer support to staff.

Culture

Mental health crisis services and health-based places of safety

Staff felt respected, supported and valued. They said the trust promoted equality and diversity in daily work and provided opportunities for development and career progression. They could raise any concerns without fear.

Staff at the place of safety said that the trust was a good place to work. Staff from many different backgrounds said that the trust had supported their professional development. For example, one member of staff had begun work with the trust as a nursing assistant. The trust had supported them through their training and, having been an assistant ward manager, they were now a team leader. The trust had introduced a rotation scheme that enabled nurses to work in different areas of the trust in order to broaden their experience. Staff felt they were valued by their managers and felt that their contribution to the service was recognised. One member of staff commented that work at the place of safety could often be stressful, but that managers recognised this and provided support for staff. Staff said they would speak to a matron if they had any concerns.

Governance

Our findings from the other key questions demonstrated that governance processes operated effectively at team level and that performance and risk were managed well. However, the trust needed to take further work to reduce the time some patients remained in the health-based place of safety.

At the place of safety, staff held clinical governance meetings to review performance data relating to the service. The performance dashboard included data about the number of admissions, the discharge pathway, the number of breaches of the permitted time of detention, assessment times and incidents. Leaders had plans to try and reduce the amount of time people spent in the health-cased place of safety. This included a quality improvement project.

Management of risk, issues and performance

Staff had access to the information they needed to provide safe and effective care.

At the place of safety, staff produced a dashboard of key data for the service. The service held a review of clinical performance every six months to look at trends in performance such as the number of breaches of the permitted period of detention, the number of admissions and the number of admissions to the place of safety that led to patients being detained under the Mental Health Act.

Information management

Staff collected analysed data about outcomes and performance and engaged actively in local and national quality improvement activities.

Staff had been involved in quality improvements projects that aimed to improve access to inpatient beds.

Engagement

Managers engaged actively other local health and social care providers to ensure that an integrated health and care system was commissioned and provided to meet the needs of the local population.

The team leader at the place of safety met each month with managers from partner agencies including the police, ambulance service, emergency department and local authority. This meant that all the agencies involved in conveying patients to the place of safety had the opportunity to discuss and resolve any delays or difficulties they had experienced.

Mental health crisis services and health-based places of safety

Learning, continuous improvement and innovation

Staff at the place of safety talked about ideas for improving the service. This included putting televisions in patients' rooms, expanding the service, reducing the number of breaches of the permitted period of detention and reducing restrictive practices.

Community health services for children and young people

Good

Is the service safe?

Good

Our rating of safe improved. We rated it as good.

Mandatory training

The service provided mandatory training in key skills to all staff and made sure everyone had completed it.

Staff had completed 86% amount of their mandatory training within September 2021 against the trust target of 90%.

Clinical staff completed training on recognising and responding to children and young people with mental health needs, learning disabilities and autism. Mandatory training included subjects such as safeguarding adults level 1 and 2, safeguarding children level 1 and 2 and 3, equality and diversity, fire safety, moving and handling, information governance, infection control, and paediatric basic life support.

Managers monitored mandatory training through an electronic training record, and all staff were sent electronic reminders three months before their training was due to expire. Managers recognised that paediatric basic life support training was below the trust target at 65%, staff had reported that there was a problem with the booking system and managers were working to address this.

Safeguarding

Staff understood how to protect children, young people and their families from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it and followed appropriate policies and procedures.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. The service had a dedicated safeguarding team for children and young people. The team worked closely with third sector providers, schools, the police and local authority safeguarding teams. The safeguarding team worked in partnership in ensuring that children and young people were safeguarded. Members of staff attended multi-agency risk assessment conferences (MARAC), multiagency sexual exploitation groups (MASE), the multiagency safeguarding hub (MASH) and local authority safeguarding boards.

Staff told us that they knew how to make a safeguarding referral and could discuss any concerns with the safeguarding team. Staff had completed 97% of their safeguarding adults and children training for levels one to three. The safeguarding team also provided bi-monthly ‘light bite’ training topics to ensure that staff were updated with current safeguarding issues, such as domestic violence and modern slavery. Staff could also access online e-learning training for issues such as forced marriage.

Staff followed appropriate policies and procedures to safeguard children, young people and their families. Staff followed the policy for children who did not attend community appointments or children who were not brought by their parents or carers. Staff pro-actively followed up with children and their carers in attending appointments to ensure that their health needs were met.

Community health services for children and young people

Cleanliness, infection control and hygiene

The community health services for children and young people (CHSCYP) controlled infection risk well. Staff used equipment and control measures to protect children, young people, their families, themselves and others from infection. They kept equipment and the premises clean and an external cleaning company cleaned the premises daily.

Staff followed infection control principles including the use of personal protective equipment (PPE) and had received training in infection prevention and control. Staff were vaccinated against COVID-19.

The waiting room and consultation rooms were visibly clean, and furnishings were well-maintained. Staff ensured that equipment was cleaned after each use with antibacterial wipes, such as toys and weighing scales. Hand washing facilities and alcohol hand gel were available in the consultation rooms and we observed staff wash their hands in between therapy sessions.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff disposed of clinical waste safely using clinical waste bins.

The service had suitable facilities to meet the needs of children and young people's families. Staff had access to accessible consultation rooms, meeting rooms and a physiotherapy gym. Parents also had access to a baby changing room. Despite there being a shared reception area with adult services, none of the parents we spoke with had expressed any concerns about this.

The service had enough suitable equipment to help them to safely care for children and young people. Staff told us that there were no delays in obtaining equipment for children to use at home, such as toileting frames. A peer review completed in May 2021 showed that CHSCYP services had achieved 99% compliance in meeting the required standards for premises and equipment.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each child and young person and removed or minimised risks. Staff identified and quickly acted upon children and young people at risk of deterioration.

The service held a weekly multi-disciplinary team meeting, which staff from each CHSCYP service attended. Staff also attended from partner services, including the health visiting service, school nurses, the local authority and education. This ensured that key information was discussed to keep children and young people safe.

The electronic patient record system immediately alerted staff to any risks or concerns that they should be aware of, such as safeguarding concerns or allergies. Staff were also able to access the same record system that GPs used to ensure that key information was shared. Although risk was assessed for children, young people and families, staff did not always consider risks within the home environment when completing home visits, such as pets.

Staff followed the trust policy and procedures to keep safe whilst carrying out lone home visits. Staff from the youth offending service has access to panic alarms within the office environment and carried out joint home visits when necessary.

Community health services for children and young people

Staff shared key information to keep children, young people and their families safe when handing over their care to others. Staff from the looked after children service ensured that health information was shared with social workers for children and young people placed out of borough.

Staffing

The services had staff with the right qualifications, skills, training and experience to keep children, young people and their families safe from avoidable harm. However, the services had recognised that there was an increase in demand to provide care and treatment to children, young people and their families and recognised that this impacted the resources within the services.

Staff told us that that there needed to be more staff to meet the demands of each service. The trust was working with commissioners to address areas where resources did not meet current demands, for example an additional nurse post had recently been approved for the looked after children's service. This was in response to the increasing number of looked after children funded by the local authority.

The services had a low vacancy rate apart from the community paediatric service, which had a 62% vacancy rate. The trust had only taken on responsibility for this service in the last year. Managers ensured vacancies were covered with regular agency consultants who were fully inducted to the service before they started work. Managers told us that the vacancies were yet to be advertised due to waiting for the job description to be approved by the Royal College of Paediatricians.

Permanent staff held monthly clinical meetings with agency consultants to ensure clinical practice was discussed and shared, as not all agency consultants had a specialism in autism.

All staff we spoke with said that the services had a high retention of permanent staff with low turnover rates and low sickness rates for staff. The average sickness rate was 5.2% for August 2021.

Records

Staff kept detailed records of children and young people's care and treatment. Records were clear, up to date, stored securely and available to all staff providing care.

The CHSCYP services used an electronic patient record system. Staff told us that they sometimes had difficulty accessing the system remotely. This was identified on the risk register and staff told us that the trust's IT team had offered support to try and improve the connectivity.

We reviewed 12 records, and all the patient notes were comprehensive. Staff within CHSCYP services used the same patient record system as the CAMHS and health visitor service and were connected to the system used by GPs to ensure that pertinent information could be accessed.

Staff produced detailed assessments, including joint assessments with different services and goals to achieve. A detailed summary report was sent to the parent and young person after the initial session and a follow up letter was sent after every session thereafter. Staff ensured that copies were sent to the children or young person's GP.

Care plans were detailed, updated regularly and holistic to the child's needs. Staff created joint care plans with schools, such as contributed to education health care plans (EHCPS).

Community health services for children and young people

Staff created care plans to follow in the event of an emergency, such as a plan of actions for staff to take in the event of an allergic reaction. When children and young people transferred to a new team, their health record was also transferred to ensure that there were no delays in staff being able to access important information.

Medicines

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines.

Staff ensured that FP10 prescription pads were stored appropriately in a lockable cupboard.

Staff were responsible for providing immunisations to school age children in primary and secondary schools. This included administering the flu vaccine, Human papillomavirus (HPV) and the Covid-19 vaccine for 12 to 15-year olds. The service had procured extra staff from an external provider to help deliver the Covid-19 vaccine and managers ensured that they had completed their training and competency checks.

Staff managed medicines and prescribing documents in line with the provider's policy. Staff ensured that vaccines were stored in fridges and records showed that fridge temperatures were within the correct range. Staff ensured that vaccines were in date and transferred in cool bags, which were used to transport vaccines. Staff recorded the temperature of each bag when it was removed from the premises and when the vaccine was removed from the bag. If the bag was above the recommended temperature, staff escalated this to pharmacy. Staff completed regular audits for monitoring fridge temperatures and the temperature of cool bags to ensure that vaccines were being stored appropriately. Staff had noticed that the room temperature was higher than the recommended 25 degrees and had escalated this to senior managers. Plans were in place for air conditioning to be installed to address this.

Incidents

The services managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave children, young people and their families honest information and suitable support.

Staff raised concerns and reported incidents and near misses in line with trust policy. All staff we spoke with said that they knew what type of incident to report and how to report it on the electronic system. Staff told us that the main incidents that they reported were problems with IT. Managers told us that they are working to address these issues for staff.

Staff met to discuss the feedback and look at improvements to children and young people's care. Mangers told us that incidents and lessons learnt were discussed at monthly team meetings.

Senior managers reviewed and signed off incidents so that there was oversight of all current incidents, this was fed up into the trust quality governance service. Learning from incidents was shared in a monthly trust wide newsletter called a blue light bulletin.

Safeguarding leads attended a child death overview panel to analyse unexpected deaths that had occurred and if there was any learning that could be shared within the services from this.

Safety thermometer

Community health services for children and young people

The service used monitoring results well to improve safety. The service had no never events, which are serious incidents that are preventable, in the last year.

Managers had access to a dashboard with the key performance indicators for each of the CHSCYP services. This ensured that managers could analyse CHSCYP services performance data against the recommended trust targets to ensure that safe services are being delivered, for example analysing the percentage of children who have started treatment within eight weeks of a routine referral to a dietician.

Is the service effective?

Good 

Our rating of effective stayed the same. We rated it as good

Evidence-based care and treatment

The CHSCYP services provided care and treatment based on national guidance and evidenced-based practice but also developed their own best practice tools to meet the needs of children, young people and their families.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. All staff we spoke with said that they were aware of national guidance relevant to their area of expertise.

Staff delivered therapies based on evidenced based research. Physiotherapy staff were completing musculoskeletal (MSK) surveillance in line with national guidance. Specialist complex care nurses used a national framework to assess continuing healthcare needs for children and young people.

Staff from the speech and language service used evidenced based research to teach parents strategies for developing communication and play skills with their child. Staff used a parent interaction (PCI) model and a Hanen model to support children with autism.

We attended a therapy session and observed staff teaching strategies to improve their child's communication within their home environment, this was in line with evidenced based guidance.

Staff were innovative in their approach in thinking about how they can meet the holistic needs of children, young people and families. Staff within the physiotherapy department developed a bespoke Enfield determination of needs tool, to identify children and parents that required additional support.

Nutrition and hydration

Staff assessed, monitored and managed hydration and nutritional needs, where needed, for children and young people. Special feeding and hydration techniques were used when needed, such as enteral feeding tubes (this involves the use of a feeding tube placed into the gastrointestinal tract). The service made adjustments for children, young people and their families' religious, cultural and other needs.

Specialist support from staff such as paediatric dieticians, school nurses and speech and language therapists were available for children and young people who needed it. Dieticians were available to provide advice to parents and carers

about conditions, such as food allergies and tube feeding. School nurses worked closely with teachers and teaching assistants to ensure that care plans were in place for children who required this, such as a percutaneous endoscopic gastrostomy (PEG) feeding care plan and an anaphylaxis care plan. Speech and language therapists carried out dysphagia assessments and provided advice to parents to ensure that children and young people were eating and drinking safely.

The CHSCYP services dashboard showed that 100% of children that were referred for enteral feeding where seen within 10 working days. Dieticians were examining how they could improve the service for children and young people, such as introducing a weight management project within schools. They followed best practice guidance from the British Dietetics Association (BDA), such as information on how to do assessments over the phone during the pandemic.

Patient outcomes

Staff monitored the effectiveness of care and treatment by using recognised outcome measures. They used the findings to make improvements and achieved good outcomes for children and young people.

Managers used information from the audits to improve care and treatment. Audits included reviewing the do not attend (DNA) rates within each service, occupational therapy compliance with National clinical in excellence guidance and audits of telehealth intervention with speech and language therapies working with children in their early years.

Staff recorded outcomes for children and young people in order to improve the service. Physiotherapy staff completed cerebral palsy integrated pathway (CPIP) assessments to monitor the range of movement and function for a child and young person's mobility. Staff then set goals for children and young people to achieve, with equipment if necessary.

Occupational therapy staff and Speech and Language therapy staff set short term and long-term goals for children and young people to achieve in order to achieve good outcomes for their care and treatment. Staff used the Canadian occupational performance measure (COPM) to measure children's participation in everyday living. Within the last 12 months, staff collected data which had shown that 90% of children and young people had achieved their set goals.

Competent staff

The service made sure staff were competent for their roles. Managers appraised the work performance of staff annually and held supervision meetings with them to provide support and development.

Staff within CHSCYP services received regular supervision and an annual appraisal. As of October 2021, 96% of staff had received their annual appraisal. Staff we spoke with told us that they all received six weekly individual or group supervision.

Staff were had the right skills and knowledge to meet the needs of children, young people and their families. Specialist nursing staff were observed by managers to ensure that they were competent in performing their roles. Parents we spoke with told us that staff were very experienced.

Staff provided excellent training to parents, carers and external teams in order to meet the needs of children and young people. We observed a speech and language therapist deliver training on how to support and communicate with children who had a developmental language disorder to teachers and teaching assistants.

Staff within the speech and language therapy team delivered virtual training to the child and adolescent mental health service (CAMHS). Staff within the early year's speech and language therapy team also offered training to local nurseries to help staff identify children with autism.

Community health services for children and young people

Managers gave all new staff a full induction tailored to their role before they started work. All new staff completed a trust induction and local induction programme, which included mandatory and role specific training.

Staff were supported to undertake a range of additional training and education. Staff received training from external providers in order to develop their specialist skills and knowledge, for example, staff received ventilation training from a children's hospital in London. All staff spoke positively about the training opportunities offered by the trust and could further their clinical personal development (CPD). Staff told us that they could access leadership courses and mentorship training. Staff kept up to date with guidance and practice through reviewing topics and journals in their monthly team meetings.

Staff within the immunisation service were asked to deliver the Covid-19 vaccination programme for children aged between 12 to 15 years of age for six weeks starting September 2021. Managers had acquired additional bank nurses from an acute hospital to help deliver this programme and ensured that their competencies were signed off by a local university before they could administer vaccines.

Multidisciplinary working

Doctors, nurses, therapists and other healthcare professionals worked together as a team to benefit children, young people and their families. They supported each other to provide excellent care.

Staff held regular and effective multidisciplinary meetings to discuss children and young people and improve their care. Staff from each of the CHSCYP services attended weekly meetings, which were also attended by staff from the health visiting service and school nursing service who were employed by a different provider. This ensured that essential information was shared between all disciplines to benefit children, young people and their families, such as their physical and emotional needs. Staff told us that it would benefit the meeting further if a staff member attended from the Children and Adolescent mental health service (CAMHS) service. Managers planned to improve links with these services.

Staff had good links with other health care disciplines and with other agencies to care for children, young people and their families. Staff worked closely with safeguarding teams, children centres, nurseries, GPs, schools and acute hospitals. The looked after children's service had created a joint health protocol to ensure that health visitors and school nurses were invited to contribute to statutory health reviews for children and young people, including subsequent action plans.

Staff referred children and young people and their families to other services to meet their needs, such as referrals to a specialist autism service and referrals to Great Ormond Street Hospital.

Staff had a holistic approach in working together with different disciplines in order to meet the needs for children and young people and the electronic patient records showed evidence of strong MDT working. For example, we saw an education health care plan which had contributions from physiotherapists and speech and language therapists in addition to education needs to achieve joint goals for the child.

Health promotion

Staff gave children, young people and their families practical support and advice and implemented improvements to lead healthier lives. Staff from each service assessed each child and young person's health and provided support for any individual needs to live a healthier lifestyle. Parents told us that they received practical support and advice from staff in order to improve the health of their child.

Community health services for children and young people

Staff from the special school nursing service identified that there was a gap in health promotion within schools. They piloted a programme in one school, working collaboratively with the dietician and school staff to address increasing levels of obesity within children and young people.

Staff from the looked after children had produced a health questionnaire as they recognised that when a young person reaches 16 or 17 years old, they may choose or wish to dis-engage from the service. The aim of the health questionnaire was to assess the young person's holistic health needs, including a record of vaccinations, and produce a set of recommendations as to how the young person's health could be improved. Staff then asked the young person's consent as to whether they would like the full report to shared with their keyworker or just the recommendations. The questionnaire also listed local services that young people could access for advice, such as sexual health advice and drug and alcohol support.

Staff within the immunisation service created an HPV (human papilloma virus) video jointly with the local authority and an acute hospital. The aim of this was to promote and educate about the HPV vaccine for young people and parents.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported children, young people and their families to make informed decisions about their care and treatment.

Staff made sure children, young people and their families consented to treatment based on all the information available. We observed a therapy session and the therapist asked for the parent's consent before the start of the session with the child.

Staff obtained consent from children and young people and their parents when administering a vaccine. Staff we spoke with understood Gillick Competence and Fraser Guidelines and supported children who wished to make decisions about their treatment.

Staff clearly recorded consent in the children and young people's records. The service had introduced an electronic system for parents and young people, which enabled parents to book appointments and complete consent forms online.

Is the service caring?

Good 

Our rating of caring stayed the same. We rated it as good.

Compassionate care

Staff treated children, young people and their families with compassion and kindness, respected their privacy and dignity, and took account of their individual needs. We spoke with 13 parents, and all the parents told us that staff treated them and their children with kindness, respect and compassion.

Parents told us that staff went over and beyond to help parents improve the health of their child or young person and described staff as non-judgemental and empathetic. One parent told us that the dietician had been fantastic and listened to their views and this helped with their child's feeds at night.

Community health services for children and young people

Staff took time to interact with children, young people and their families in a respectful and considerate way. We observed staff providing lots of positive support and encouragement to a parent during a speech and language therapy session. Staff told us that they would observe a parent to identify their strengths and to give feedback as to how they could improve, such as strategies for developing communication skills with their child.

Staff told us that they would observe a parent to identify their strengths and to give feedback as to how they could improve, such as strategies for developing communication and play skills with their child. Parents told us that staff sought their consent before any care and treatment sessions and gave advice in a non-judgemental and empathetic manner.

The service had a charity called Little Sparks, which supported families and children, including those who have experienced a bereavement. Staff delivered 80 Easter eggs to children and young people known to the service during April 2021.

Emotional support

Staff provided emotional support to children, young people and their families to minimise their distress. They understood children and young people's personal, cultural and religious needs.

Staff gave children, young people and their families help, emotional support and advice when they needed it. All parents we spoke with said that staff were able to contact them in between appointments for advice and support. Staff signposted parents to other services to receive support, such as a parent autism support group.

Staff understood the emotional and social impact that a child or young person's care, treatment or condition had on their and their family's wellbeing. Staff from the complex nursing play and bereavement service provided additional support to siblings of children and young people, in recognising that they required additional support in dealing with a bereavement.

Understanding and involvement of patients and those close to them

Staff supported and involved children, young people and their families to understand their condition and make decisions about their care and treatment. They ensured a family centred approach. Parents told us that staff were experienced and professional in their approach.

Staff talked with children, young people and their families in a way they could understand, using communication aids where necessary. Staff within the speech and language therapy service provided training to parents and schools in using talking mats. Talking mats is a communication aid which allows children and young people to communicate using pictures.

Children, young people and their families could give positive feedback on the service and their treatment and staff supported them to do this. Staff had received 56 compliments from parents between April to September 2021.

Is the service responsive?

Good 

Community health services for children and young people

Our rating of responsive improved. We rated it as good

Service delivery to meet the needs of local people

The service was innovative in planning and providing care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Staff from all services had established excellent links within the community and other services to benefit the wellbeing of children, young people and families. Staff were part of a community recovery programme with other providers and worked in partnership with other trusts and staff had delivered therapy support to help children, young people and families. The speech and language service had created a speech and language communication hub, to offer training and support to schools to improve communication techniques with children and young people who required this. Occupational therapists had developed links with a local football team to support children and young people's integration in the community.

Staff were innovative and thoughtful as to how they could use their current resources to meet the changing needs of the local population by introducing quality improvement projects. Staff had created an autism diagnostic pilot project to work with paediatricians to try and get an earlier autism assessment for children and young people.

Staff were leading on a post-diagnostic project to look at the support that is offered to children with autism between the ages zero to six and seven to 12. Staff then shared their evidence in a programme of five sessions with the other boroughs in north London.

Staff within the physiotherapy department recognised that there was a need for a serial casting clinic within Enfield so were in the process of setting this up and training staff to deliver this.

Managers ensured that children, young people and their families who did not attend appointments were contacted. Staff had systems in place to follow up with families and young people who did not attend appointments. Managers had access to a dashboard which showed the did not attend rates for each service.

Managers recognised that there had been an increase in demand despite not having an increase in resources by carrying out audits on each service. Staff in some services, such as physiotherapy and had received at least a 45% increase in their caseloads and this was listed on the risk register and escalated to senior managers. Discussions were being held with commissioners as to the increase in demand and the impact on resources. Staff told us that they were carrying out safe care but felt an increase in demand to services.

Meeting people's individual needs

The service was very inclusive and took account of children, young people and their families' individual needs and preferences. Staff made reasonable adjustments to help children, young people and their families access services. They coordinated care with other services and providers.

Services were individually tailored to meet the needs of children, young people and their families. Managers had introduced a single point of access referral form, so that families and professionals only had to fill in one form to meet their needs. Managers shared this form with the Enfield's parent forum and GPs within Enfield. Staff met twice a month at child developmental meetings to discuss new referrals. This was chaired by the community paediatrician and was a collaborative meeting attended by each of the services within CCYFP service to decide which service was the most appropriate to meet the individual's needs.

Community health services for children and young people

Staff were exceptional in recognising the needs of children, young people and their families. Continuing healthcare nurses held an annual memory day for families of children that have passed away. They planted a tree of remembrance with families and asked them to attend every year. Staff within the physiotherapy department had created a project to identify children who were at risk of cerebral palsy.

Staff supported children and young people and families with holistic and up to date care plans. Care plans were detailed and had input from staff from different services to meet the needs of children and young people, such as physiotherapy, occupational therapy and complex care nurses. Staff worked closely with schools and other services to create joint health care plans. Parents told us that care plans and letters were shared with them after each session with staff.

Staff within the looked after children's service completed health assessments for children and young people. This was a health assessment looking at the holistic needs of the child including their immunisation history, oral health, play routines, sleep hygiene and information from their foster carers, social worker and health visitor. Staff reviewed health assessments twice a year for children under five and annually for children over the age of five. Staff had noticed that there had been an increase in demand to complete reviews for health assessments, but managers were working on increasing staffing provision to address this.

Staff supported children and young people who were transitioning to other services. The Early years speech and language therapy service created a transitional programme for children starting schools, 70 parents attended this programme out of 128.

Staff understood and applied the policy on meeting the information and communication needs of children and young people with a disability or sensory loss. Staff used different aids to meet the communication needs of children, young people and families. Staff from the speech and language therapy team had created a project called positive beginnings, which aimed to offer social connections and engagements with children aged between one to three years old with communication difficulties.

Managers made sure staff, children, young people and their families could get help from interpreters or signers when needed. Staff ensured that translators were present at meetings with parents and young people and children that could not speak English as their first language or used language line. We observed a speech and language therapy session where a translator was used to communicate with the parent. Staff from the Looked after children's service provided support to children seeking asylum from other countries, by ensuring that they received access to necessary vaccines, such as Tuberculosis and blood borne viruses, sexual health screening and support to access English speaking classes.

Access and flow

Most children and young people could access the service when they needed it and received the right care. Waiting times from referral to treatment for most services for children and young people were in line with trust targets. Children and young people had to wait longer than trust targets to access some services, such as the school age speech and language therapy service.

The CHSCYP services had acquired the community paediatrics service from October 2020 with a trajectory of 52 weeks for the first appointment to see a paediatrician. Staff had worked hard to reduce this waiting list and had reduced the backlog six months ahead of the predicted time. As of September 2021, the wait list had been reduced from 663 to 453 children and young people that were seen for a first appointment. This service had reduced the average wait time for a first appointment with a paediatrician from 44 weeks down to 22 weeks.

Community health services for children and young people

Managers monitored waiting times and made sure children, young people and their families could access services when needed. Managers had access to a dashboard which showed an overview of referral to treatment times for each service and if they were below the trust recommended targets. The current dashboard showed an upward trajectory to referral to appointment times, although these were still below the trust targets. For example, 45% of complex children and young people of school age were seen within six weeks by the speech and language therapy service. This was below the trust target of 80%.

Staff within the looked after children services, specialist school nursing services, complex healthcare nurses, immunisation services, school age speech and language therapists, noticed that there had been an increase in demand for services which impacted the referral to treatment times. Staff told us that they were able to prioritise parents, young people and children dependent on the urgency of their need. Staff within the immunisation team had acquired a backlog due to the closure of schools during the Covid-19 pandemic to deliver vaccines such as HPV and the flu vaccine. Despite this, staff had worked hard to clear the backlog.

Managers were trying to address the increase in demand by producing a business case to commissioners to review the resources of each service. For example, one specialist school had seen an increase its pupils from 70 to 400 children.

Staff supported children, young people and their families when they were referred or transferred between services. Staff ensured that essential health information was shared with other professionals. Staff also signposted parents and families to external services in order to meet their needs.

Learning from complaints and concerns

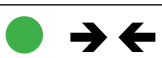
It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included children, young people and their families in the investigation of their complaint.

Parents could provide feedback about the care and treatment received at a parent experience forum. Parents were asked to complete a feedback form after using the service and comment on how the service could be improved. Staff also obtained feedback using an online evaluation system called tele-health.

Children, young people and their families knew how to complain or raise concerns. Parents told us that they were confident in knowing how to make a complaint if they needed to.

Staff knew how to acknowledge complaints and children, young people and their families received feedback from managers after the investigation into their complaint. The CHSCYP services had received one formal complaint in the last 12 months within the community paediatric services. This was investigated and learning was shared with staff at staff team meetings and the monthly clinical governance meeting.

Is the service well-led?

Good 

Our rating of well-led stayed the same. We rated it as good.

Community health services for children and young people

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

Local leaders had a good understanding of the services they managed. They could explain clearly how the teams were working to provide high quality care.

Most of the staff we spoke to said that there was positive morale within their teams and that they felt supported from managers, despite the pressures of the Covid-19 pandemic and the increase in demand on services. Staff spoke highly of their managers, stating that they were approachable and supportive.

Some staff told us that there could have been more support and guidance from senior managers at the start of the pandemic, however most staff told us that they felt supported overall by senior managers within the trust.

Staff told us that they were supported to developed into more senior leadership roles. One member of staff told us, for example, how they were supported by their manager to achieve a more senior position within the service.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

Managers worked collaboratively with the wider system to deliver services to children and young people. They worked closely with other providers in north London to deliver services to children and young people. This ensured that managers and staff received information as part of the wider system.

Staff were very passionate about providing a high-quality service to meet the individual needs of children and young people. Staff were innovative in thinking about how services could be improved to meet the needs of children young people and their families. They worked closely with partner organisations to help achieve this.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

Staff told us that they were proud to work within CHSCYP services and that there was a high retention rate because of this. Staff recognised that managers were doing their best to improve the resources for the services that required this to meet the increasing level of demand.

Staff informed us that they had received a pay bonus at the Christmas period and an extra day of annual leave during the covid-19 pandemic.

Staff we spoke with said that they valued and supported and supported to develop their career further and this was discussed as part of their annual appraisal.

Community health services for children and young people

Staff told us that they could access the Freedom to Speak up guardian to raise concerns and would feel confident to do so. Parents told us that they could speak to staff to discuss any concerns and staff were always approachable and responsive to their concerns.

Staff had access to support for their own physical and emotional health needs through an occupational health service. Staff could also access support through the employee assistance programme within the trust.

Governance, Management of risk, issues and performance

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service. Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events.

Senior leaders monitored the performance of the CHSCYP services at monthly clinical governance meetings. This included reviewing compliance with national guidelines, mandatory training and supervision rates, incidents, Infection prevention control issues, patient feedback (including complaints) and any innovative practice.

Overall performance of each individual CHSCYP service was discussed at the monthly operational management meetings, including a review of the performance dashboard. Actions were addressed in an ongoing action plan, which was updated after each meeting. As of October 2021, there were eight risks listed on the risk register for CHSCYP services. Risks included recruitment of doctors and an increase in the caseload for the physiotherapy; these were reviewed at the monthly clinical governance meetings.

There was a clear reporting structure where Information from the monthly clinical governance meeting was discussed in this meeting and was subsequently passed onto local staff meetings.

Managers were able to monitor the effectiveness of care and treatment of each service through local audits. Managers completed a monthly record audit for each service to look at care and treatment, physical health, communication and carers, risk, capacity and consent. Managers within the safeguarding team completed a multi-agency audit to assess how effective information sharing was between all providers working to safeguard children, young people and their families.

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were secure. Data or notifications were consistently submitted to external organisations as required. Remote IT access needed to improve for staff working in the community.

Managers were able to collect reliable data to be analysed using a performance dashboard of each service. This was used to compare against the trust targets and to understand themes and trends, such as whether a trajectory is moving up or down

Community health services for children and young people

Staff sometimes found it a challenge to use the IT systems, including when they were working remotely. Staff recognised that senior managers were working to address the issues with accessing IT systems, but there were still some improvements to be made. Staff told us that the most reported incidents on their incident reporting system were IT issues.

Learning, continuous improvement and innovation

All staff were dedicated and committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

Staff were innovative and thoughtful as to how they could improve services for children, young people and parents

Staff were completing a quality improvement project on integrating the services across the system to make one pathway for children with autism, learning disabilities and attention deficit disorder (ADHD). Staff worked with the local authority and commissioners to look at this pathway.

Staff had also created an autism diagnostic pilot project to work with paediatricians to try and get an earlier autism assessment for children and young people.

The trust produced blue light learning bulletins to ensure that learning from incidents were shared within the CHSCYP services.

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

Good ↑

Is the service safe?

Requires Improvement →←

Our rating of safe stayed the same. We rated it as requires improvement.

Safe and clean care environments

Wards were mostly safe, clean, and well equipped. Staff had identified potential risks to safety. Staff took steps to mitigate risk, although this often involved increased supervision of patients and restricting patients' access to some areas of the wards. Whilst most wards were well furnished, well maintained and fit for purpose, some wards were in a poor state of repair. There were delays in maintenance. The seclusion room on one ward did not maintain patients' privacy and dignity.

Safety of the ward layout

Staff completed and regularly updated thorough risk assessments of all ward areas and removed or reduced any risks they identified. Staff knew about potential ligature anchor points and mitigated the risks to keep patients safe. The trust had taken action as recommended, following the 2019 inspection, to ensure that staff were aware of all potential hazards on the wards. Each ward had an up-to-date environmental risk assessment and ligature risk assessment.

Significant improvements had been made to the ward environments, with new wards at St Ann's (including Daisy and Tulip wards that we visited) ensuring more privacy and space for patients. The windows had been replaced to make them ligature free on the Enfield wards.

Staff could observe patients in all the communal parts of the wards, with closed circuit television (CCTV) observable in the ward offices. Door top alarms had been fitted on patient bedroom doors on each ward, to prevent their use as a ligature anchor point. Staff told us that patients only used rooms which included potential risks, with staff supervision. However, this had an impact on their availability to support other patients. Some such rooms could potentially be made safe to enable more independent use by patients, such as the activities rooms on Daisy and Tulip wards, and female lounge on Trent Ward.

Wards complied with guidance and there was no mixed sex accommodation. Trent Ward was the only mixed gender ward inspected on this occasion with five 'swing' beds on a corridor, that could be used (collectively) for whichever gender was needed.

On most wards staff had easy access to alarms and patients had easy access to nurse call systems. Nurses carried personal alarms that were tested at the start of each shift. On each shift one staff member was allocated as the lead responder. However, the inbuilt alarm system for patients on Trent Ward did not cover all rooms. Staff told us that if a patient was at risk, they could be given a personal alarm to carry with them although, at the time of the inspection, no patients had individual alarms. An alarm sounded during our visit to Suffolk Ward. A nurse reported that it was a false alarm and switched it off, but later found out it was a genuine alarm, from a staff member needing assistance.

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

Maintenance, cleanliness and infection control

Ward areas were generally clean, well maintained, well-furnished and fit for purpose. On Suffolk Ward we observed that two bedrooms were dirty, however they were being cleaned on the day of the inspection. The new wards were in a very good state of repair, however, we found some maintenance issues on the other wards. Paint was peeling on the walls of Suffolk ward, and there was a broken window in the lounge (which had been made safe) on Trent Ward that had not been repaired for several weeks. Some new furniture had been ordered for Trent Ward in consultation with patients and staff. Staff followed infection control policy, including handwashing, and were able to describe in detail how they undertook precautions to reduce the risk of Covid-19 spreading on the wards.

Seclusion room

The new seclusion rooms at St Ann's Hospital allowed clear observation and two-way communication. These facilities met the requirements of statutory guidance. For example, there was a toilet and a clock. The rooms were also fitted with built-in, interactive electronic display units that patients could use to choose music, play games and produce artwork. The sites of the seclusion rooms allowed for patients' privacy as recommended at the inspection in 2019. There was one area in the new seclusion rooms which was difficult (but not impossible) to observe. However, there were action plans in place to address this issue, and it did not present a significant risk.

However, on Trent Ward, located on the Edgware Community Hospital site, the seclusion room was situated in a communal area, at the centre of the ward, on a male corridor, allowing little privacy or dignity to patients. The lines of sight through the vision panel into the seclusion room were significantly restricted, particularly to monitor a patient after rapid tranquilisation. We were particularly concerned to find an open eye hole into the shower and toilet room of this seclusion facility. The trust had plans to refurbish these seclusion rooms.

Clinic room and equipment

Clinic rooms were fully equipped, with accessible resuscitation equipment and emergency drugs that staff checked regularly.

Staff checked, maintained, and cleaned equipment. Records showed that equipment had been cleaned and calibrated to ensure accurate readings as recommended at the inspection in 2019.

On each ward, staff monitored the temperature of the clinic room and refrigerators for storing medicines to ensure that they were within a suitable range. On Tulip Ward staff had not taken action to report on a clinic room temperature of 26.5 degrees on three occasions within the last month, but they undertook to address this during the inspection.

Safe staffing

On most wards, the service had enough nursing and medical staff, who knew the patients. However, on some wards there were high levels of vacancies and turnover. When there were insufficient permanent staff to cover a shift, the service requested bank staff who were familiar with the ward. However, on three wards there had been a significant number of unfilled shifts, meaning that those wards had not had the minimum agreed level of staff required to ensure safety and quality of care. The Covid pandemic had disrupted the provision of face-to-face training causing some wards to be non-compliant with requirements for staff to complete training in immediate life support. This presented a risk to patients' safety. The trust was aware of this and was arranging extra training sessions to achieve compliance.

Nursing staff

Staff on some of the wards expressed some concerns about sufficient staffing numbers.

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

Despite actions to fill staff vacancies as required at the inspection in 2019, there remained significant staff vacancies on some wards. Staff vacancies were highest on Devon Ward at 25.2% and Trent Ward at 19.3%, whilst there were no vacancies on Tulip and Suffolk wards at the time of the inspection in October 2021. Similarly, staff turnover was highest on Devon and Trent wards at 19.2% and 16.5% with the highest use of bank (as and when) staff, respectively and lowest on Tulip and Suffolk wards at 6.2% and 7%. Rates of staff sickness ranged between 9.5% on Daisy Ward, and 5.3% on Trent Ward. Only Trent Ward had used agency staff in the last month.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants for each shift. They had undertaken a benchmarking exercise to review current nursing staffing numbers. However, it was concerning to note that on there had been 13 unfilled shifts on Devon and Daisy wards. This was largely due to late notice absence, or insufficient bank staff available to fill shifts. Managers told us that they limited their use of bank and agency staff as far as possible and requested staff familiar with the service. They made sure all bank and agency staff had a full induction and understood the service before starting their shift.

The ward managers could adjust staffing levels according to the needs of the patients and worked with other local ward managers to share staff with other wards when needed.

Most patients told us that they had regular one-to-one sessions with their named nurse, and that they rarely had their escorted leave or activities cancelled, even when the service was short staffed.

Staff expressed concerns about a recent reduction in staff numbers in terms of staff and patient safety (removing an extra staff member that had been added to shifts during the Covid-19 pandemic). They also had concerns about high staff turnover, and significant use of bank or agency staffing. Staff told us that the service had enough staff on each shift to carry out any physical interventions safely. However, staff on all wards, particularly Devon Ward, indicated that they did not always feel safe with the current staff numbers.

To address staff vacancies the trust had set up a retention group focussing on flexible working, professional development and wellbeing.

Medical staff

The service had enough daytime and night-time medical cover and a doctor available to go to the ward quickly in an emergency.

Managers could call locums when they needed additional medical cover. Managers made sure all locum staff had a full induction and understood the service before starting their shift. However, the trust was struggling to recruit permanent consultant psychiatrists to Daisy and Trent Wards, which was having an impact on staff and patient morale.

Most wards had cover from three doctors including a consultant psychiatrist, specialist registrar and junior doctor. However, on Trent Ward, at the time of the inspection, there was only a locum consultant and two junior doctors covering the ward.

Mandatory training

The mandatory training programme was comprehensive and met the needs of patients and staff. Managers monitored mandatory training and alerted staff when they needed to update their training. Staff had completed and kept up to

date with the majority of their mandatory training as recommended at the inspection in 2019, including infection control and fire safety training. However, due to the Covid-19 pandemic there were some gaps in face-to-face training provided. This particularly impacted on first aid, moving and handling, and prevention and management of violence and aggression (PMVA) training.

At the time of the inspection, the lowest rates of training in immediate life support were on Devon Ward at 27% and Trent Ward at 58%. Similarly, they had the lowest rates of basic life support training, at 79% and 70%. Most wards had staff compliance of over 80% in PMVA, except for Trent Ward which had 73% PMVA training, and which was also low for breakaway training at 77%.

Moving and handling training was lowest on Daisy and Tulip wards, with 17% and 21% staff trained respectively, and low on Devon and Suffolk Wards at 38% and 44% respectively. Trent Ward had 96% staff trained in moving and handling. Managers were aware of staff needing to undertake this training and had booked extra sessions for staff to attend.

Assessing and managing risk to patients and staff

Staff assessed and managed risks to patients and themselves well and followed best practice in anticipating, de-escalating and managing challenging behaviour. Staff used restraint and seclusion only after attempts at de-escalation had failed. The ward staff participated in the provider's restrictive interventions reduction programme. However, there were some gaps in recording essential information following rapid tranquilisation.

Assessment of patient risk

Staff completed risk assessments for each patient on admission, using a recognised tool, and reviewed this regularly, including after any incident. For example, the daily whiteboard meeting was well attended by the multidisciplinary team where each patient's risks were discussed including any physical health related risks and the risk assessment tool was updated in real time.

Staff knew about any risks to each patient and acted to prevent or reduce risks including physical health risks. For example, we observed thoughtful discussions about support for a patient with an eating disorder. This patient also had a detailed care plan which gave clear guidance on how staff should support them with eating and drinking and a food and fluid chart was in place to monitor intake.

We saw some evidence of patient involvement in risk assessment, including their views on how staff could support them to manage risks. For example, a patient had a risk assessment that included support for when they were distressed, including the use of 'soft words' to support them.

Management of patient risk

Staff knew about any risks to each patient and acted to prevent or reduce risks. Staff identified and responded to any changes in risks to, or posed by, patients.

Staff could observe patients in most areas of the wards and followed procedures to minimise risks where they could not easily observe patients.

Staff followed trust policies and procedures when they needed to search patients or their bedrooms to keep them safe from harm. Staff reported that police dogs visited the wards every couple of months to ensure that no illegal drugs were being stored on the wards.

All 27 patient records we looked at showed that their risk assessment had been updated following incidents. For example, one patient had a serious episode of self-harm and their risk assessment had been updated and personalised to their individual needs following the incident. However, not all risk assessments included evidence of patient involvement and one patient who was deemed to be at risk of falls did not have a falls risk assessment completed.

Staff discussed risk at handover meetings and in their 'pride and joy' meetings each day, with the multidisciplinary team. They told us that they worked with patients who had many physical health risks including diabetes, chronic obstructive pulmonary disease, ulcers, and heart conditions. They also completed regular physical health monitoring for patients on high dose antipsychotics.

Staff described how they managed the Covid-19 pandemic, including a recent outbreak on one ward, creating zones to restrict the transmission of the virus.

On Trent Ward (a mixed gender ward) there was a quality improvement project in place to ensure sexual safety. This included questionnaires for patients to fill out about their experience on the wards.

Use of restrictive interventions

Staff participated in the provider's restrictive interventions reduction programme, which met best practice standards. Levels of restrictive interventions had reduced since the previous inspection in 2019, particularly on the new wards. A clear rationale was recorded for all incidents of restraint, rapid tranquilisation, or seclusion. There was good evidence of using the SafeWards methodology as part of a quality improvement project to reduce restrictive practices on the wards including regular local and divisional safety huddles, use of soft words and de-escalation techniques and clear mutual expectations.

In the six months to October 2021, episodes of seclusion were highest on Devon Ward (a psychiatric intensive care unit) at 43, and lowest on Trent with 6 episodes. The number of patients restrained during this time was 72 on Devon Ward, and lowest on Daisy Ward, with 20 patients restrained. Of these, prone restraint was used 22 times on Devon Ward, 10 times on Suffolk ward, four times on Daisy, three times on Trent Ward and once on Tulip Ward. The trust was working to eliminate all use of prone restraint. On most wards staff had been trained in administering rapid tranquilisation by the deltoid muscle (in the arm) rather than the gluteal muscle. This training had not yet been undertaken by staff on Trent Ward.

In the six months to October 2021, Staff used intra-muscular rapid tranquilisation most on Devon Ward, where staff administered it on 29 occasions, and Suffolk Ward, where staff administered it on 27 occasions had 27 incidents of using rapid tranquilisation. Trent Ward was lowest with 11 cases. Staff told us that they made every attempt to avoid using restraint by using de-escalation techniques and restrained patients only when these failed and when necessary to keep the patient or others safe. Staff told us that they followed national guidance when using rapid tranquilisation.

Staff kept patients safe following the administration of intra-muscular rapid tranquilisation, but they did not always complete records fully. National guidance states that staff should monitor patients' pulse, blood pressure, respiration and oxygen saturation after rapid tranquilisation to ensure patients do not experience adverse side effects. At our last inspection in September 2020, we found that staff did not always record these physical health observations. At this inspection, we found that in many situations, patients did not allow staff to do this. When staff were unable to monitor patients' vital signs, they assigned a member of staff to provide one-to-one observations of the patient in order to reduce the risk of harm. However, the records did not always make this clear. A number of different recording systems were in use, which may have contributed to some gaps in records.

There had been no instances of long-term segregation in recent months. When a patient was placed in seclusion, staff kept clear records and followed best practice guidelines. Staff were clear about the processes to be followed for patients in seclusion.

On Daisy Ward staff were piloting the use of body worn cameras, and they spoke positively about their impact in terms of safety accountability.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Most staff had training on how to recognise and report abuse and they knew how to apply it. On some wards, the proportion of staff completing this training was below the mandatory level set by the trust. The service had plans to address this by providing additional training.

Staff received training on how to recognise and report abuse, appropriate for their role and kept up to date with their safeguarding training. Staff were generally up to date with their safeguarding training. With high compliance between 91% to 100% in safeguarding adults training at levels 2 and 3. However there were some gaps in safeguarding children training at level 3 at 60% on Trent Ward and 75% on Devon Ward. Managers were aware of these gaps and had plans in place to ensure that this training was completed without delay.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them. Staff followed clear procedures to keep children visiting patients on the ward safe. There was a visiting room outside of each ward for children to use, with a strict policy of no children entering the wards. Staff knew how to make a safeguarding referral and who to inform if they had concerns, and they gave examples of when they had done so.

The wards had a safeguarding lead who staff could discuss concerns with and staff we spoke with knew concerns needed to be reported to the local authority. For example, one patient who was at risk of financial exploitation was discussed and the local authority and police had both been informed and a safety plan was put in place for them.

Safeguarding was a standing item at the monthly quality and safety meetings attended by ward managers.

Staff access to essential information

Staff had easy access to clinical information and it was easy for them to maintain high quality clinical records both paper-based and electronic.

Patient notes were comprehensive and all staff could access them easily. Although the service used a combination of electronic and paper records, staff made sure they were up-to-date and complete. As recommended at the inspection in 2019, managers were fully competent in using the trust's electronic incident reporting system.

When patients transferred to a new team, there were no delays in staff accessing their records. Most patient records were stored on an electronic system which was easy to navigate and had alerts that popped up when you accessed individual case records. Records we looked included daily updates in the progress notes. Records were stored securely.

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

Medicines management

The service mostly used systems and processes to safely prescribe, administer, record and store medicines. Staff regularly reviewed the effects of medicines on each patient's mental and physical health. However, on some wards, there were concerns about labelling open bottles of liquid medicine and disposing of unused medication.

Staff mostly followed systems and processes when safely prescribing, administering, recording and storing medicines. However, we found a small number of open bottles of liquid medicines which were not labelled with an expiry date, or had exceeded the expiry date, on Tulip, Daisy, and Suffolk wards. We had reported on this issue at the inspection in 2019. On Suffolk Ward staff told us that they disposed of some liquid medicines by putting them down the sink and throwing unused tablets (rejected by a patient) in the general waste bins. We reported this to the ward pharmacist who undertook to address this issue without delay.

They reviewed patients' medicines regularly and provided specific advice to patients and carers about their medicines.

Staff followed current national practice to check patients had the correct medicines. The wards had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely.

Decision making processes were in place to ensure people's behaviour was not controlled by excessive and inappropriate use of medicines. Staff reviewed the effects of each patient's medication on their physical health according to NICE guidance.

When patients were on high dose antipsychotics, they had their physical health monitored closely. As recommended at the inspection in 2019, staff were carrying out medicine reconciliation for all patients.

Track record on safety

During the 12 months before the inspection, one inpatient had died of self-inflicted injuries using a ligature.

Reporting incidents and learning from when things go wrong

The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

Staff knew what incidents to report and how to report them and raised concerns and reported incidents and near misses in line with trust policy. The service had no never events on any wards. Staff we spoke with told us they would discuss any incidents of concern with the nurse in charge and thought the system was effective as incidents and learning were discussed in team meetings, including what could be done better in future.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong.

Staff learnt from when things went wrong and made changes. They shared recent examples, which included earlier follow up to ensure that there were no delays in obtaining patient's discharge summaries from other hospitals and closer auditing of physical health observations on patients at night.

Managers debriefed and supported staff after any serious incident. Managers investigated incidents thoroughly. Patients and their families were involved in these investigations. Managers shared learning about incidents with their staff and

across the trust. The monthly quality and safety meeting was attended by all ward managers, the therapy and physical health leads. This meeting discussed incidents that had happened across the trust and learning to be shared within their respective wards including any follow up actions or checks required. Learning was also shared using 'blue light bulletins', which detailed incidents and any learning from them.

Staff met to discuss the feedback and look at improvements to patient care. There was evidence that changes had been made as a result of feedback. For example, managers had introduced emergency scenarios simulation training on the wards, to ensure staff were confident of what to do in a medical emergency. There had also been a change to procedures followed when secluding patients to ensure that they were searched thoroughly before being placed in seclusion, for the safety of the patient and staff members.

Is the service effective?

Good 

Our rating of effective stayed the same. We rated it as good.

Assessment of needs and planning of care

Staff assessed the physical and mental health of all patients on or shortly after admission. They developed individual care plans which were reviewed regularly through multidisciplinary discussion and updated as needed. Care plans reflected patients' assessed needs, most were holistic, personalised and recovery-oriented.

Staff completed a comprehensive mental health assessment of each patient either on admission or soon after. Patients had their physical health assessed soon after admission and regularly reviewed during their time on the ward.

Staff developed a comprehensive care plan for each patient that met their mental and physical health needs and regularly reviewed and updated care plans when patients' needs changed in consultation with them. For example, one patient who self-harmed had their views about what helped when they were distressed incorporated into the self-harm care plan. An autistic patient had a clear, detailed and personalised care plan for restraint when they were in danger of hurting themself, which included their preferences about what helped, including sensory and environmental factors. Care plans included Covid-19 precautions, education, medicines, activities, independent living and crisis planning.

Staff identified patients' physical health needs and recorded them in their care plans. For example, a patient with an eating disorder had a detailed, person-centred care plan for management of this which included a dietary intake plan and how to maintain a balanced lifestyle.

All 27 records we looked at showed good physical health monitoring and physical health care planning. For example, one patient with co-morbid physical health issues had regular bloods taken to monitor their condition and had also been referred for a chest Xray. Staff had liaised with the GP for another patient who had raised levels of a particular hormone. One patient, who was refusing physical observations despite being in a high-risk group for a number of physical health conditions, was monitored closely by medical staff. Staff had discussed in detail with the patient the risks of their not complying with physical health monitoring and had assessed their mental capacity to make to these decisions. Additionally, this patient was referred to several specialist services for further investigations.

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

Best practice in treatment and care

Staff provided a range of treatment and care for patients based on national guidance and best practice. They ensured that patients had good access to physical healthcare and supported them to live healthier lives. Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, and quality improvement initiatives.

Staff provided a range of care and treatment suitable for the patients in the service and delivered care in line with best practice and national guidance. Staff identified patients' physical health needs and recorded them in their care plans and made sure patients had access to physical health care, including specialists as required. For example, they met patients' dietary needs, and assessed those needing specialist care for nutrition and hydration.

Staff helped patients live healthier lives by supporting them to take part in programmes, with regular healthy living groups and smoking cessation services offered. They had reduced the number of takeaway meals ordered by patients, to ensure healthier meal choices, restricting takeaways to one day each week.

Staff used recognised rating scales to assess and record the severity of patients' conditions and care and treatment outcomes including Health of the Nation Outcome Scores and National Early Warning Scores (NEWS2) which was regularly recorded in progress notes.

Staff used technology to support patients, including new interactive boards in the new seclusion rooms, enabling patients to play music of their choice and even undertake some art. The wards were also using an electronic observation tool to record physical health checks carried out on patients. They reported that following some teething issues this was now working well.

Staff took part in clinical audits, and quality improvement initiatives. Monthly audits were undertaken on each ward using an App, with different staff responsible for particular audits, and able to access these from their phones. Regular audits undertaken included safeguarding, environment, infection prevention and control, staff supervision, physical health, risk assessments and care plans. There were specific audits for monitoring recording of seclusion, restraints and rapid tranquilisation. Managers used results from audits to make improvements. For example, clinical Fridays had been introduced to focus on particular aspects of clinical practice on some wards. The frequency of staff supervision had been improved on some wards following gaps found in the supervision audits.

Staff told us about quality improvement initiatives on their wards including reducing restrictive practices, sexual safety initiatives, and improving recording of mental capacity assessments and reading patients their rights.

Assistant psychologists had recently been recruited and were receiving training to roll out and embed trauma-informed care on the wards. On Tulip Ward, the psychologist had been piloting the Open Dialogue Model approach, a family and social network model, alongside the early intervention service. So far, staff told us that this had been helpful in terms of patient and staff relationships.

Skilled staff to deliver care

The ward teams included or had access to the full range of specialists required to meet the needs of patients on the wards. Managers made sure they had staff with the range of skills needed to provide high quality care. They supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.

The service had access to a full range of specialists to meet the needs of the patients on the wards. Managers ensured staff had the right skills, qualifications and experience to meet the needs of the patients in their care, including bank and agency staff. Staff confirmed that managers gave each new member of staff a full induction to the service before they started work.

Managers supported staff through regular, constructive appraisals of their work. At the inspection in 2019, we recommended that there should be consistent supervision and support provided to staff across all wards. At the current inspection, staff told us that managers supported them and gave them regular and constructive clinical supervision of their work. We looked at records of supervision on each ward, and found they covered appropriate topics, with opportunities for staff to raise any concerns. The frequency of supervision varied a little between wards, with the highest compliance on Trent Ward, and the most gaps found on Devon Ward.

At the inspection in 2019, we recommended that all wards should hold regular staff team meetings. At the current inspection, we found that staff attended regular team meetings and had access to the minutes of those that they could not attend. Monthly clinical governance meetings were also held on each ward. Topics covered included staff wellbeing, incidents, audits, and training. Staff team meeting records confirmed feedback we received from staff about the challenges of insufficient staffing numbers to support patients safely on Devon Ward, and high acuity and turnover on Daisy Ward.

Staff told us that managers helped them identify any training needs they had or areas for development and encouraged them to develop their skills and knowledge. Staff told us about training they were undertaking including master degrees, leadership and apprenticeship courses. However, most staff had not undertaken any training in supporting autistic patients or patients with learning disabilities, although they had worked with these patients on the wards.

Multi-disciplinary and interagency team work

Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. Vacancies for psychologists and occupational therapists (OT) were covered by increasing the involvement of OT and psychology assistants in order to minimise the impact on patients. The ward teams had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.

Staff held regular multidisciplinary team (MDT) meetings to discuss patients and improve their care. Each ward had regular handover meetings between nursing staff and a daily 'whiteboard meeting' attended by the MDT. This meeting discussed patients and improved their care. At meetings we observed, staff gave clear information about patients and ensured any changes in their care was shared, both within the team, and with other teams external to the organisation. For example, one patient with an eating disorder had been referred to a dietitian for specialist assessment and support. Another patient who had a learning disability was referred to the specialist learning disability team for further support.

Ward teams had effective working relationships with other teams in the organisation and external teams and organisations. Attending MDT meetings, we found that staff used a bed management tool to identify tasks that needed to be completed. Discussion included the physical health status and needs of each patient. This including reviewing records of physical health checks and considering referrals to other specialist services. Each team had access to a physical health lead. In one case staff identified a patient who had a history of serious burns and pressure ulcers. The team has worked with an outreach physical health nurse, who arranged to change their dressings. The teams considered the risk of patients consuming illicit substances, but they did not yet have a dual diagnosis worker.

The service had access to a range of specialists to meet the needs of the patients on the ward. The MDTs on some wards including Tulip, Trent, and Daisy wards each had a peer support worker. Staff said that this was valuable to the team, providing an insight into assumptions they made. We had the opportunity to speak with one peer support worker who had been in post for one year. They told us that their role was new, and they had taken a lead in developing it. They undertook informal one-to-one sessions with patients to offer support and ran several groups including an art group, social activities and recovery group. They were also able to support patients to make a complaint and encouraged them to discuss concerns with the trust patient experience team.

All wards had access to a psychologist, however there was a vacancy for a ward psychologist on Daisy Ward. Assistant psychologists also provided support to patients on the wards, including one to one and group sessions, and contributing to formulation meetings. Most wards had reflective practice sessions for staff, but this was not in place on Daisy Ward and Trent Ward at the time of the inspection. On Suffolk Ward, staff had asked for more training on supporting patients with personality disorders. The psychologist provided a training session and talked about strategies, emphasising that every presentation was different. Tulip Ward has a reading group for staff, covering a different article each time, followed by a discussion on how to implement any identified improvements.

There was a vacancy for an occupational therapist on Suffolk Ward, but all wards had support from occupational therapy assistants.

Adherence to the Mental Health Act and the Mental Health Act Code of Practice

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and discharged these well. Managers made sure that staff could explain patients' rights to them.

Staff received and kept up to date with training on the Mental Health Act and the Mental Health Act Code of Practice and were familiar with the guiding principles. Staff told us that they had access to support and advice on implementing the Mental Health Act and its Code of Practice. They knew who their Mental Health Act administrators were and when to ask them for support.

The service had clear, accessible, relevant and up-to-date policies and procedures that reflected all relevant legislation and the Mental Health Act Code of Practice.

As recommended at the inspection in 2019, patients said that they could access an advocate promptly. They had easy access to information about independent mental health advocacy and patients who lacked capacity were automatically referred to the service. Information about the advocacy was posted in the ward, and this was also provided in the welcome brochure for each ward.

Staff explained to each patient their rights under the Mental Health Act in a way that they could understand. As recommended at the inspection in 2019, staff repeated patients' rights as necessary to ensure that they understood them, and they recorded this clearly in the patient's notes each time. Patient records we looked at showed staff were discussing patient rights with them on a regular basis. For example, for one patient, who was informal, staff had discussed regularly with them what this meant and recorded their agreement to stay and accept treatment. There was a quality improvement project across the wards to improve consistency in reading patients their rights and recording this, which had resulted in significant improvements in recent months.

Audits were undertaken to ensure that this was carried out consistently. Staff stored copies of patients' detention papers and associated records correctly and staff could access them when needed. Staff requested an opinion from a Second Opinion Appointed Doctor (SOAD) when they needed to.

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

Staff made sure patients could take section 17 leave (permission to leave the hospital) when this was agreed with the Responsible Clinician. Informal patients knew that they could leave the ward freely and the service displayed posters to tell them this. At the inspection in 2019, we noted that the trust should ensure that patients comply with the conditions of leave and take action to ensure the patient's safety if they do not. This appeared to be happening in most cases that we checked.

Good practice in applying the Mental Capacity Act

Staff supported patients to make decisions on their care for themselves. They understood the trust policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly for patients who might have impaired mental capacity.

Staff received and kept up to date with training in the Mental Capacity Act and had a good understanding of how this affected their work. There were no deprivations of liberty safeguards applications made in the last six months.

There was a clear policy on Mental Capacity Act and deprivation of liberty safeguards, which staff could describe and knew how to access. Staff told us that they knew where to get accurate advice on the Mental Capacity Act and deprivation of liberty safeguards.

Staff told us that they gave patients all possible support to make specific decisions for themselves before deciding a patient did not have the capacity to do so. They assessed and recorded capacity to consent clearly each time a patient needed to make an important decision.

When staff assessed patients as not having capacity, they made decisions in the best interest of patients and considered the patient's wishes, feelings, culture and history.

The wards carried out audits to monitor how well it followed the Mental Capacity Act with learning for staff when improvements were needed. As a result of a quality improvement project on the wards, the recording of patients' mental capacity and consent had improved in recent months.

Is the service caring?

Good 

Our rating of caring stayed the same. We rated it as good.

Kindness, privacy, dignity, respect, compassion and support

Most staff treated patients with compassion and kindness. They respected patients' privacy and dignity. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition. However, patients on some wards said they had a poor experience of temporary staff. On one ward, some patients said the culture was less friendly and more restrictive at night.

During the inspection we observed that staff were discreet, respectful, and responsive when caring for patients and gave patients help, emotional support and advice when they needed it. Staff and patients spoke of the huge improvement in the accommodation provided in the new Haringey Wards at St Ann's Hospital, with en suite facilities now available for all patients, promoting their privacy and dignity.

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

Most patients said staff treated them well and behaved kindly and they felt safe on the wards, although sometimes they thought there were not enough staff to meet everyone's needs. Patients generally described the staff to us as nice, friendly and helpful. However, some patients said that some bank and agency staff could be less helpful with them, and some could be rude. On Trent Ward patients described good support from staff during the day but a different culture on night shifts, which was more restrictive and less friendly. Patients across all wards told us it often took some time for nursing staff to respond to their requests at the nurses' station. Some patients also described staff not getting their names right, and not coming when they called them.

Staff encouraged patients to isolate due to Covid-19 precautions, providing them with an isolation box including access to an electronic tablet, games consoles and various other activities, with occupational therapists visiting to support them with any other activities as far as possible.

Staff supported patients to understand and manage their own care condition. One patient told us they had met with the doctor and they came up with a plan together about what might help them get better. Most patients told us they knew their diagnosis, medications and what their rights were whilst in hospital. Patients confirmed that staff supported them with their physical health needs. One patient described close support from staff while they were undergoing detoxification from an illegal drug, on arrival on the ward.

Progress notes indicated patients had regular access to their named nurse for one-to-one support sessions. In addition, staff had introduced an hour each day completely set aside for patient engagement time, which patients said was working well.

Patients confirmed that staff directed them to other services and supported them to access those services if they needed help. Staff we spoke with understood and spoke respectfully about the individual needs of each patient.

Most patients understood how to make a complaint about their care, including speaking with their named nurse, the ward manager, or asking for support from an advocate to make a formal complaint. Staff felt that they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients. Some patients noted that they sometimes had to deal with racism from other patients, and that staff supported them with this appropriately.

Staff followed policy to keep patient information confidential.

Involvement in care

Staff involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided. They ensured that patients had easy access to independent advocates.

Involvement of patients

Staff introduced patients to the ward and the services as part of their admission. Each patient received a welcome pack including information about the ward. On Daisy Ward, welcome packs included thick socks to wear on the ward and a selection of toiletries. It also included a list of mutual expectations between staff and patients.

Staff involved patients and gave them access to their care planning and risk assessments. Staff made sure patients understood their care and treatment and found ways to communicate with patients who had communication difficulties, for example, through the use of interpreters and easy-read care plans. Most patients we spoke with told us they understood their care and treatment but only a small number said that they had access to their care plans. However, records we looked at showed that care plans had been discussed with them and showed some evidence of their views and involvement.

Staff involved patients in decisions about the service, when appropriate. Their feedback was sought in regular community meetings on each ward, with items requested followed up. On each ward, there was a poster of 'You said, We did' including details of how requests had been met. For example, on Devon Ward, staff were working to meet patients' requests for more time in the garden and a gardening project, and to have more music on the ward. On Tulip Ward, staff had ordered a games console at the request of patients.

Patients could give feedback on the service and their treatment and staff supported them to do this. The ward collect feedback from patients using an electronic system. Managers told us that the biggest areas of feedback related to food portion size, and that the hospital is non-smoking.

Staff made sure patients could access advocacy services, and patients confirmed that they had been able to meet with advocates when they wished.

Involvement of families and carers

Staff usually informed and involved families and carers appropriately. However, the experiences of patients' families were mixed. Some patients' relatives gave positive feedback whilst others raised concerns about poor communication and a lack of involvement in the arrangements for patients' discharge. The Covid-19 pandemic had created restrictions on visits.

Patients across the ward told us that they were able to stay in touch with their friends and family and make phone calls in private. Staff attempted to support, inform and involve families or carers, and we observed staff discussing carer involvement during multi-disciplinary meetings. The records we reviewed showed members of the multidisciplinary team had regular contact with carers and relatives to keep them informed and updated about their relatives' care and treatment. For example, one patient's mother had regular discussions with the ward consultant about their care and treatment and this was documented in progress notes.

We spoke with four family members/carers across the wards, by telephone after the inspection. They gave mixed feedback about the service. One family member said that staff did a very good job, helping their relative to get back to themself, which was a major transformation. However, they noted that although other staff were respectful, one staff member was rude to them. One relative said that they had not been given any information about why their relative was on the ward, and their relative themself did not understand this.

A relative who visited a patient on one ward regularly, said that staff did not always answer the door for long periods of time, and that due to Covid-19 restrictions there was less interaction between staff and relatives. They expressed concerns about the safety of their relative due to being attacked by other patients on the ward on two occasions.

Another relative described poor communication from staff on a ward, with little notice of when the patient might be discharged, despite the relative having taken on the role of looking after the patients' children. This led to a patient having an unsuccessful discharge, with insufficient support, leading to them having to return to hospital.

Staff gave carers information on a local voluntary organisation to support them and undertake carer's assessments. There were no current support groups provided by the trust for carers across the wards.

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

Is the service responsive?

Good ↑

Our rating of responsive improved. We rated it as good.

Access and discharge

Staff managed the high demand for inpatient admissions well. The high demand for inpatient admissions meant that patients were admitted to hospitals outside the trust, although the number of these placements was falling. Patients were not moved between wards unless this was for their benefit. Patients' discharges were rarely delayed for other than clinical reasons.

Bed management

The trust continued to have high pressures on its acute care pathway for adults. Bed occupancy in October 2021 ranged between 82% on Devon Ward to 121% on Tulip Ward. Wards can have occupancy above 100% due to patients being on leave. Other than Devon Ward, all wards had over 100% bed occupancy. Managers regularly reviewed length of stay for patients to ensure they did not stay longer than they needed to. In October 2021, average length of stay for patients on the wards ranged from 29 days on Suffolk Ward, to 56 days on Tulip Ward. In June 2021, there had been a peak in the average length of stay for patients on Daisy ward, reaching 93 days. Managers from the community and inpatient teams met every week to discuss patients with a long length of stay, and the trust had held multi-agency discharge events to facilitate a reduction in long lengths of stay on its wards.

At the inspection in 2019 we required that trust to ensure there were sufficient beds to ensure that patients could be admitted to hospital in their local area without delays. Following the inspection, the trust reviewed the pathway for acute adult mental health, transferring back beds from another trust. Staff spoke of a recent bed crisis in August 2021, during which they had struggled to find enough beds for patients within the trust, needing to resort to private placements. This had led to escalation meetings with senior managers, and four bed management calls held daily to monitor the number of beds available and also to check on safe staffing on each ward. The home treatment team had increased their provision of support to patients discharged to bed and breakfast accommodation during this time.

At the time of the inspection, the service had relatively low and reducing out-of-area placements totalling nine in October 2021. This was a reduction from 28 out of area placements in June 2021, and 46 in December 2020. The trust had a reciprocal arrangement with Camden and Islington NHS foundation trust, in terms of sharing available beds. There were plans to reduce the bed numbers on Trent Ward from 21 to 18 beds to make the ward safer and more manageable for staff and patients. The trust was also considering the use of another ward as a step-down facility to assist with bed management.

Patients were moved between wards only when there were clear clinical reasons or it was in the best interest of the patient. Staff worked to avoid moving or discharging patients at night or very early in the morning, although there had been some exceptions due to infection control guidelines during the Covid-19 pandemic, to ensure patient safety.

The psychiatric intensive care unit (PICU) on Devon Ward was full at the time of our inspection, meaning if a PICU bed was needed, there would need to be an exchange with another patient from the PICU. Devon Ward had reduced from 14 to 12 beds since the previous inspection, with the creation of a new de-escalation and seclusion area. To manage demand for PICU beds, the unit was also providing some outreach work to other wards, to avoid patients needing to be admitted to a PICU bed. There was a plan to further develop this work across all three boroughs.

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

Managers and staff worked to make sure they did not discharge patients before they were ready despite significant bed pressures. Doctors told us that they had to be assertive in resisting pressures to create more bed spaces. However, several nurses across the wards reported that they had concerns about some patients being discharged too early, leading to a rise in readmissions.

Discharge and transfers of care

The service had reducing numbers of patients having delayed discharges in the past year. In June 2021, there was one delayed discharge on Trent and Suffolk Wards, two on Tulip Ward, and five on Daisy Ward. No delayed discharges were reported in October 2021.

There were five readmissions to Daisy Ward in October 2021, two on Trent and Suffolk wards, and one on Tulip and Devon Wards, totalling 11 readmissions across the wards. Readmissions had increased since June 2021 when there were five readmissions across the wards.

Managers monitored the number of patients having delayed discharges and readmissions. They were aware of the link between earlier discharges and an increase in readmissions and accepted that they had to make hard decisions when discharging patients.

Staff on all wards indicated that the discharge intervention teams had increased in size, including social workers, and a consultant psychiatrist available to facilitate discharge at weekends. Members of the discharge team attended weekly multi-disciplinary meetings on the wards. The trust provided a recovery house in each borough for patients needing extra support upon discharge.

Due to bed pressures, it was rare for patients' discharge to be delayed from the service, for reasons that were not clinical. Staff carefully planned patients' discharge and worked with care managers and coordinators to make sure this went well. Staff attempted to liaise with family members/carers prior to discharge. Following concerns raised staff, on Suffolk Ward told us that they recorded clearly when relevant on the patient record system "do not discharge until we have agreed with the family."

Staff carefully planned patients' discharge and worked with care managers and coordinators to make sure this went well. For example, one patient with young children had been referred to have a care coordinator and the team were liaising with children's services to support a safe discharge. Another patient, who was being evicted by their landlord, was referred to the housing department for support. We observed staff discussing discharge planning at daily whiteboard meetings, and the service used a live electronic system to update plans for discharge in real time. The service followed national standards for transfer and staff supported patients when they were referred or transferred between services.

Facilities that promote comfort, dignity and privacy

The design, layout, and furnishings of the wards supported patients' treatment, privacy and dignity. The trust had improved the environment by opening new wards and eliminating dormitory accommodation. Each patient had their own bedroom, most of which were fitted with an en-suite bathroom. There were quiet areas for privacy. The food was of good quality and patients could make hot drinks and snacks at any time. However, further improvements were needed at some hospitals to create a more therapeutic environment. Patients found it difficult to store personal belongings safely.

Each patient had their own bedroom, which they could personalise. However, although patients had been provided with safes in their rooms, none of those we spoke with knew how to use these, so they did not always have a secure place to store personal possessions. No patients had keys to their bedrooms, and therefore had to ask staff to lock and unlock their rooms when they went out. The trust had received complaints about the security of personal belongings and difficulties in using the safes. These concerns had been escalated to senior managers.

In our inspection in 2019, we raised concerns over sleeping accommodation that compromised patients' privacy and dignity. This included some shared bedrooms, and the lack of en-suite accommodation on some wards. Since then, considerable improvements had been made to the ward environments and patient accommodation, with newly built wards at St Ann's Hospital opening in August 2020. All bedrooms had en-suite shower and toilet facilities, and there were more communal and quiet rooms available to patients. These included an occupational therapy kitchen, outdoor gym equipment and a disabled access room. This had a direct impact on improving staff and patient morale on the wards, and a reduction of incidents of violence on the wards.

In September 2021, the trust confirmed that they had removed all their dormitories and shared bedrooms. Trent Ward remained without en-suite bedroom accommodation.

Staff used a full range of rooms and equipment to support treatment and care. The service had quiet areas and a room where patients could meet with visitors in private. However, on Suffolk Ward patients told us the ward was very cold, particularly in the nights, and early mornings. Patients also complained that the ward was cold on Daisy Ward at the time of the inspection. We observed that some rooms on these wards were very cold during the inspection.

Patients were unhappy with the ward environment on Suffolk Ward, which had little natural light, quite poor acoustics, and was very bare. Patients thought the ward needed to be repainted and brightened up.

Patients told us that they could make phone calls in private, and they were able to keep their mobile phones with them, providing they adhered to the ward policy on their use.

Each ward had access to an outside space that patients could access. On the acute wards, patients could make their own hot drinks and snacks and were not dependent on staff. There was mixed feedback about the meals provided on the ward.

A range of activities were available for patients on each ward. However, Devon PICU and Suffolk Ward patients complained about not having enough to do. The trust had sought to address this by increasing the involvement of occupational therapy assistants. At the time of the inspection, the pool table on Devon Ward was located in an office used by the doctors, limiting access by patients, but staff had plans to relocate this. There were also plans to have a sensory room on Devon Ward, where the previous seclusion room had been sited.

Sessions provided for patients on the ward included art and music groups, self-care, smoothie making, cooking, quizzes, light exercise, and walking groups. Each ward had a physical health instructor to support patients with using the gym equipment provided. There were also healthy living and recovery groups, as well as art and music therapy sessions. There were also facilities for basketball and football, pool, table tennis, outdoor gym equipment, and games consoles.

Patients' engagement with the wider community

Staff supported patients with activities outside the service, such as work, education and family relationships.

Staff made sure patients had access to opportunities for education and work, and supported patients. Several wards employed a peer support worker who had experience of being a patient in a similar setting. They acted as a role model and could be more approachable for some patients. Patients were encouraged to engage with the local recovery college, which had become online during the Covid-19 pandemic.

Staff helped patients to stay in contact with families and carers. All patients confirmed that staff supported them to maintain contact with friends and family and could facilitate visits on the ward.

Staff encouraged patients to develop and maintain relationships both in the service and the wider community. On Tulip Ward, the new lead occupational therapist had improved links to local community centres.

When needed, patients had activities of daily living assessments with an occupational therapist, to assess suitability for a community care package.

Meeting the needs of all people who use the service

The service tried to meet the needs of all patients – including those with a protected characteristic. Staff helped patients with communication, advocacy and cultural and spiritual support.

The service could support and make adjustments for disabled people and those with communication needs or other specific needs. There were wheelchair accessible rooms available on the new wards at St Ann's, but not all wards had wheelchair accessible facilities.

Staff gave examples of how they had supported transgender patients on the wards according to their preferences as far as possible. They also said that they were able to produce easy-read care plans for patients who might benefit from this format.

Staff made sure patients could access information on treatment, local services, their rights and how to complain.

The service had information leaflets available in languages spoken by the patients and local community. Managers made sure staff and patients could get help from interpreters or signers when needed. We observed interpreters supporting communication with patients on the ward during our inspection.

The service provided a variety of food to meet the dietary and cultural needs of individual patients. On Suffolk ward some patients said that there we not always enough Halal food.

Patients had access to spiritual, religious and cultural support. Each ward had a multifaith box and a quiet room available for patients to use for prayer/contemplation.

The wards had celebrated Black History Month, including art work, posters, and having a celebration meal arranged. This was described as a positive event by staff and patients.

Listening to and learning from concerns and complaints

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and wider service.

Patients, relatives and carers we spoke with knew how to complain or raise concerns. The wards clearly displayed information about how to raise a concern in patient areas, and in their welcome booklets.

Staff understood the policy on complaints and knew how to handle them. They knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint.

Managers investigated complaints and identified themes and ensured that staff protected patients who raised concerns or complaints from discrimination and harassment. Managers shared feedback from complaints with staff and learning was used to improve the service. For example, following a complaint about a missing phone, staff improved recording of all property brought in by patients on the ward. A complaint by a patient led staff to ensure that all patients received a debrief after restraint, and that this should be by a staff member who was not involved in the restraint when possible.

The service used compliments to learn, celebrate success and improve the quality of care. We observed compliments posted prominently on each ward.

Is the service well-led?

Good 

Our rating of well-led stayed the same. We rated it as good.

Leadership

Leaders had the skills, knowledge and experience to perform their roles. They had a good understanding of the services they managed and were visible in the service and approachable for patients and staff.

Staff reported strong support from the trust during the Covid-19 pandemic. They were very positive about their local ward management teams and described good opportunities for career development within the trust. We spoke with staff who were undertaking training as associate nurses (band 4) and were very positive about this opportunity. However, several staff told us that management should involve staff more in making decisions about changes to the wards.

Staff told us that senior leadership including the chief executive officer (CEO) had visited their wards. They were aware of the guardian service for reporting concerns at work, and also a CEO confidential hotline they could use to report concerns.

They were aware on action the trust was taking to improve their performance in workforce race equality, including the introduction of Black, Asian and minority ethnic group interview panels.

Staff said that they did receive recognition for good work, including shout outs on the trust intranet, and there were some local plans to introduce a staff member of the month award, nominated by patients.

The leadership were focussing strongly on recruitment to staff vacancies. This included open recruitment days for Barnet, Enfield and Haringey, increased attendance at career fairs undertaking some agency conversion to trust staff, and a training rotation programme to 'grow their own staff.'

Senior staff told us that they were aiming for visible and compassionate leadership, being present on each site as much as possible. The Barnet team had a divisional newsletter called The Barnet Bugle, and were introducing a Barnet stars programme to recognise staff achievements. They also planned to have a staff council, monthly open meeting with all staff, and a weekly check-in call with the wider trust management team and local authorities.

Vision and strategy

Staff knew and understood the trust's vision and values and how they applied to the work of their team.

The trust's vision was to support healthy lives and healthy communities through excellent integrated mental and community healthcare. The values were compassion, respect, being positive and working together. Strategic aims included excellence for service users, empowerment for staff, innovation in services and partnerships with others. Staff we spoke with were clear about the trust vision and values, and the outcomes they were working towards in line with the trust strategy.

Culture

Staff mostly felt respected, supported and valued, although some staff felt the trust could do more to improve staff morale. They said the trust promoted equality and diversity in daily work and provided opportunities for development and career progression. They could raise any concerns without fear.

Most staff were positive about the culture and morale on their wards, and the support they received from their teams. However, staff on all wards, particularly Devon and Trent Ward, were concerned about the number of staff available to support patients. Staff were particularly concerned about recent cuts in staff numbers, as the extra staffing during the Covid-19 pandemic ceased. Staff also expressed concerns about patients being discharged too early, leading to readmissions within a few weeks. Staff felt able to speak out, without fear of repercussions, but did not always think that management listened to them.

Some staff on Tulip and Daisy Wards told us that they felt demoralised, that the new wards did not have any facilities for staff to use on their breaks. Similarly, on Devon Ward there was no staff room allocated. Some felt this showed that the trust did not care about the staff. Another room on the wards had been converted for use as a staff room but this included closed circuit television recording.

Staff were positive about the introduction of peer support workers on the wards, and they felt that feedback from peer support workers was improving the way they interacted with patients.

Governance

Our findings from the other key questions demonstrated that governance processes generally operated effectively at team level and that performance and risk were managed well at a time of very high demand for the service.

At the inspection in 2020, we found that the trust should continue to ensure that robust systems and processes were in place to embed the positive changes made to the culture, leadership, quality and safety of Devon Ward. At the current inspection we found that there was strong leadership on this ward from a ward manager (who was also a matron) and three deputy managers. Staff described a supportive culture within the team but said that they were stretched due to staffing vacancies on the ward.

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

Each ward undertook regular audits of all core activities, and ward managers, matrons and other senior staff, such as the local head of nursing, monitored the results of these, to ensure that improvements were brought about where needed. Senior staff undertook night visits to the wards. Divisional quality and governance, and divisional management boards met once a month. Experts by experience (who had experience of using similar services) sat on the boards.

The trust had implemented a 'Brilliant basics' programme to focus on quality on each ward, including clinical Fridays, in which managers focused on clinical work.

In addition to whiteboard meetings, and daily handover meetings, there were regular team meetings and clinical governance meetings on each ward. The ward managers and matrons met regularly and there were interface meetings with other services. For example, Devon Ward had a regular interface meeting with forensic services.

Staff said that the trust had managed the Covid-19 pandemic effectively, including undertaking demographic risk assessments on all staff, with staff moved around accordingly. They also described a supportive infection control team.

Management of risk, issues and performance

Teams had access to the information they needed to provide safe and effective care and used that information to good effect. Staff recorded operational risks to the service and these were escalated appropriately.

Each borough held quality and safety meetings monthly, attended by the physical health lead, therapies lead, matron, all local ward managers, head of nursing and practice development lead. This meeting discussed Blue light bulletins including any learning or actions to be shared and disseminated. It was also used to update progress on any quality improvement projects.

Staff were proud of the reduction in incidents of violence and use of restrictive practices on their wards, which was evident from ongoing monitoring.

Staff on each ward, were aware of the main concerns on their local risk registers. For example, on Trent Ward these included the need for further redecoration, refurbishment and ligature reduction in patient rooms.

In Barnet, including Trent Ward, there was a particular risk due to insufficient permanent medical staffing, with difficulties recruiting and retaining staff.

Information management

Staff collected and analysed data about outcomes and performance and engaged actively in local and national quality improvement activities. However, on some wards there was a lack of computers that led to delays in recording information.

Staff took part in and were able to see the results of all relevant audits on their wards. Managers used this information to bring about improvements. They were involved in National quality improvements activities, such as implementing different parts of the SafeWards methodology on the wards to reduce restrictive practices as far as possible.

However, on Suffolk Ward and Daisy Ward, staff told us that there were often not enough computers available for staff to use, leading to delays in recording information.

Engagement

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

Managers engaged actively other local health and social care providers to ensure that an integrated health and care system was commissioned and provided to meet the needs of the local population.

Senior managers spoke of the work they were doing to consult and engage with their local communities. For example, in Barnet, a lead social worker had been appointed to the senior management team, with the aim of having a broader way of thinking, and building wider engagement with the local community. They had placed a bid to the inequalities board, for funding for a project to engage with young black men. In consultation with the psychiatric liaison team they were considering developing a three-bed unit to divert people from the emergency department at Barnet hospital.

They were also looking at ways of working with the voluntary sector and developing co-production work with local communities.

Learning, continuous improvement and innovation

The wards were actively working to make improvements. This was being achieved through participation in accreditation schemes and quality improvement projects.

Devon Ward was in the process of working towards accreditation with the National Association of Psychiatric Intensive Care Units (NAPICU) and staff had been involved in peer review of other services. Trent Ward was planning to apply for accreditation with the Royal College of Psychiatrist, following the completion of this accreditation by Shannon Ward.

There were a number of quality improvement projects underway at the time of our inspection. Staff were implementing SafeWards a methodology for reducing violence and restrictive practice on wards. On Daisy ward they were in the process of implementing mutual agreements between staff and patients. The wards aimed to further reduce violence and aggression by 50% by March 2022 (from Sept 2021).

Another quality improvement project was to improve the reading of Section 132 rights under the Mental Health Act. This included appointing a 132 champion to lead on this initiative, bringing about a significant improvement in the recording of rights being read.

The trust had introduced ‘Brilliant Basics’ an initiative to improve the basics of care, providing the right care, first time, every time. This was made up of a series of work streams to improve standards of care, including care planning, patient experience surveys, safeguarding, and physical health and medical devices.

Community-based mental health services of adults of working age

Good ➔➔

Is the service safe?

Requires Improvement ➔

Our rating of safe improved. We rated it as requires improvement.

Safe and clean environment

Most clinical premises where patients received care were safe, clean, well equipped, well furnished, well maintained and fit for purpose. Senior leaders at the trust were aware that some premises used by teams needed improvements, and they were working with partners to progress these changes.

Staff completed and regularly updated thorough risk assessments of all areas and removed or reduced any risks they identified. For example, the Enfield North Locality staff told us that the local authority would conduct routine fire risk assessments and would regularly carry out fire drills.

Most interview rooms had alarms and staff available to respond. At the Barnet South Locality Service there were wall alarms in the consultation rooms. At the Haringey Early Intervention Service (EIS) there were working portable alarms in all the rooms. However, at the Enfield North Locality Service the portable alarms in the consultation rooms were not working at the time of inspection. There was a risk that staff may be unable to request help and support when required. This was raised at the time of inspection and the trust had replaced the alarms the following day.

At the time of inspection, only the Enfield North Locality Team had a clinic room that was in use at the premises that we visited. This clinic room had the necessary equipment for patients to have thorough physical examinations. The clinic room was quite small and could not fit a bed inside, which meant that patients were unable to lie down to receive their injections. Staff told us that they would prefer a larger clinic room but had been unable to increase the size due to the building being listed. The Barnet South Locality Team and Haringey EIS both used clinic rooms in sites or buildings that were not visited by the inspection team. Both services were in the process of setting up clinic rooms in the same building where consultations took place.

Most areas were well-maintained, well-furnished and fit for purpose. However, staff in the Enfield North Locality Team told us that the team base in Silver Street had several issues. Staff told us that the building would often be too hot or cold and staff would have to use portable heaters to keep the rooms warm. Staff also told us that repairs would take a long time because the building was not owned by the trust. One of the rooms that we interviewed staff in also had damp present on the ceiling.

Clinical areas were clean. Staff made sure cleaning records were up to date and the premises were clean. Patients and carers said they found the premises to be well-maintained.

Staff followed infection control guidelines, including social distancing. Hand gel, face masks and disinfectant wipes were readily available for staff and visitors. Signage and posters were displayed, reinforcing infection control measures. Staff demonstrated good practice and use of personal protective equipment in all areas we inspected.

Staff made sure equipment was well-maintained, clean and in working order. In the Enfield North Locality Team, the fridge temperatures were recorded daily and the handheld defibrillator was checked on a weekly basis. The checks were recorded in a log which was fully completed at the time of inspection.

Safe staffing

The service had enough staff, who knew the patients and received basic training to keep them safe from avoidable harm. The number of patients on the caseload of the teams, and of individual members of staff, was not too high to prevent staff from giving each patient the time they needed. In the Haringey Early Intervention Service where caseloads were too high the staffing levels had been reviewed and additional staff approved which meant that caseloads were moving to an appropriate level.

The service had enough nursing and support staff to keep patients safe. The teams consisted of nurses, non-registered nurses, administrators, doctors, psychologists and occupational therapists. Patients said staff were available when they needed them, and they felt supported.

At the time of inspection, the Haringey EIS had a vacancy rate of 18%. These vacancies were in the process of being recruited to and the number of care co-ordinators had recently been increased. The Barnet South Locality Team had a vacancy rate of 9% and the Enfield North Locality Team had a vacancy rate of 7%. Staff told us that the teams that they worked in felt stable and supportive.

Staffing levels took account of the caseload numbers for each team, although some teams had higher caseloads than others. Managers assessed the size of the caseloads of individual staff regularly and helped staff manage the size of their caseloads. In the Haringey EIS, individual caseloads ranged between two and 21. Seven staff members had caseloads that was higher than the Royal College of Psychiatrists recommended maximum of 15 for staff working in the area of early intervention in psychosis. Staff should have smaller caseloads in EI teams due to the complexities and intensive support that patients receive. Staff numbers had recently been increased in the Haringey EIS as part of the transformation work. The team lead told us that caseloads had begun to decrease, and caseloads were trajected to be at 16 per care co-ordinator by January 2022.

Community teams used bank and agency staff appropriately to ensure patient safety. The service had cover arrangements in place for sickness, leave and vacant posts. Managers informed us that some of the vacancies had arisen when staff were promoted.

Managers made sure all bank and agency staff had a full induction and understood the service before starting their shift. Staff said the majority of bank and agency staff requested were familiar with the service.

Managers supported staff who needed time off for ill health. Staff told us that they had felt well supported during the Covid-19 pandemic. Staff were able to work from home when required and would regularly check in with their colleagues when working remotely.

Medical staff

The service had enough medical staff. Staff and patients said they could access support from a psychiatrist quickly when they needed to. The team leader at the Enfield North Locality Team was in the process of recruiting a locum staff grade doctor as the team had one vacancy. While the recruitment was ongoing the clinical director for the borough was working in the team two times a week. The team lead told us that the vacancy was delaying medical reviews and putting strain on the medical team.

Managers could use locums when they needed additional support or to cover staff sickness or absence. For example, a locum consultant had been in place for a year in the Enfield North Locality Team.

Managers made sure all locum staff had a full induction and understood the service.

Mandatory training

Most staff had completed and were up to date with their mandatory training. In the teams we visited training compliance ranged between 82% and 90%. However, there were modules across the teams that had a low level of compliance. For example, basic life support training compliance was at 40% and 65% in the Barnet South Locality Team and Enfield North Locality Team. Immediate life support training was also at 67% compliance at the time of our inspection. Managers in the teams told us that the availability of face to face training had reduced to the Covid-19 pandemic. At the time of inspection, the amount of face to face training was being increased.

The mandatory training programme was comprehensive and met the needs of patients and staff. Staff received training in care planning, risk assessing, infection prevention and control and safeguarding children and adults.

Managers monitored mandatory training and alerted staff when they needed to update their training.

Assessing and managing risk to patients and staff

Staff assessed and managed most risks to patients well. They responded to sudden deterioration in a patient's health, but patients requiring assessment under the Mental Health Act were not always assessed promptly. When necessary, staff worked with patients and their families and carers to develop crisis plans. Staff monitored patients on waiting lists to detect and respond to increases in level of risk. Arrangements were in place to support staff to work safely although in the Enfield North locality team staff did not consistently follow lone working procedures.

Assessment of patient risk

As part of the inspection we reviewed 16 care and treatment records across the three teams that we visited.

Staff completed risk assessments for each patient using the trust's risk assessment tool, and reviewed this regularly, including after any incident. The risk assessments contained information about individual risks to patients' physical and mental health, risk of harm to self and others, substance misuse history and compliance with medicines. Teams routinely audited the risk assessments used in their teams. The completeness of risk assessments was a key performance indicator for the teams and was reported centrally.

Staff regularly reviewed high-risk patients, for example in the Barnet South Locality Team, there was a weekly "red" zone meeting where higher risk patients would be discussed between the multi-disciplinary team (MDT). Patient care records would be updated during this meeting to evidence the discussion between the MDT members. Staff in the Haringey EIS used a digital board for high risk patients. Staff would add patients to the board who were complex or high risk. This allowed care co-ordinators to share risk with the MDT. There was also a slot in the weekly governance meeting to discuss complex cases. During the inspection we attended the complex case meeting. Staff contributed to the discussion and developed a plan that would provide the best outcome to the patient.

Staff could recognise when to develop and use crisis plans and advanced decisions according to patient need. We saw evidence of crisis plans in place for patients. Staff were reminded to update the crisis plans during MDT meetings. In the Enfield North Locality Team, for example, patients' crisis plans were reviewed during caseload reviews. Their relatives' knowledge of the crisis plan was also reviewed during this meeting. Nearly all patients we spoke to said that they were aware of their crisis plan and knew who to contact in a crisis.

Management of patient risk

Staff developed plans to manage most patient risks. Two out of the seven care records we reviewed in the Barnet South Locality Team had risks identified without a management plan in the person's care plan or crisis plan. For example, a patient was identified at risk of self-neglect in their risk assessment, but it was not clear how this risk was being managed as there was no reference to the management of the risk in their progress notes, care plan or crisis plan. This was raised at the time of inspection, and information on how the risk was managed was added to the care and treatment plan.

Staff identified and responded to sudden deterioration in a patient's health, but some patients that required assessments under the MHA were not assessed promptly. The teams held regular clinical meetings where staff discussed patients whose risks had changed or who were deemed high risk. For example, we observed a clinical meeting at the Haringey EIS, where staff discussed the need for a potential referral for a MHA assessment in response to a patient's mental health deterioration. Staff could also refer to the locality home treatment team for enhanced care in the community.

Patients identified as in need of an assessment under the Mental Health Act (MHA) were not always assessed promptly. Staff request that a patient is assessed under the MHA when they think that the patient is posing a risk to themselves or others. Assessments are mostly completed by approved mental health professionals (AMHPs) employed by local authorities and often require support from the Police. Delays in completing assessments mean that people may be at risk of harm. We identified that patients identified as in need of an assessment under the Mental Health Act (MHA) were not always assessed promptly at our previous inspection in July 2019, and the trust had taken action to address the problem. However, some assessments continued to be delayed for extended periods of time.

During the inspection, we reviewed records and identified that some patients had not been assessed five weeks after the assessment had been requested. The trust reported that between June 2021 and September 2021 there were 47 instances where a referral for a MHA assessment was accepted. Where a 135 warrant was not required, eight out of 13 MHA assessments were undertaken in four days or less. Section 135 of the MHA allows the police to enter homes so that a MHA assessment can be done. Where a 135 warrant was required, there was a significant wait for a MHA assessment. Of the 34 MHA assessments that required a section 135 warrant, only four patients had been assessed within 14 days. Twenty patients had not been assessed within 21 days. Staff that we spoke to told us that if they were concerned about a patient's safety they would escalate their concerns so that the assessment could be prioritised. Staff gave examples of MHA assessments occurring on the same day or the day after when required. Patients waiting for assessments also often received intensive support from the trust's crisis resolution and home treatment teams.

Since our inspection in July 2019, the trust has worked with stakeholders, including the Police and local authorities, to try and reduce the waiting times for MHA assessments. A multi-agency quality improvement (QI) project has been set up in March 2020 to try and reduce the delays. In Enfield, for example, the waiting times from police portal completion to first warrant execution had reduced from nine days to three days since the QI project had started. The Admission Pathway Monitoring Group had also developed a framework for the various stages of community MHA assessments, from referral through to admission, so it was clear what needed to be completed and when. The group also regularly

reviewed data on delays at all stages of the process, so it could identify problems and address them. The trust had also identified and escalated concerns that the changes in court booking systems had led to delays in obtaining 135 warrants. The Barnet Locality Team were also in the process of recruiting their own social workers and paying for their staff to complete AMHP training to try and reduce MHA waiting times.

Staff continually monitored patients on waiting lists for changes in their level of risk and responded when risk increased. Teams had robust systems in place to safely monitor waiting lists and to ensure patients knew who to contact in the event of a crisis.

In the Barnet South Locality Team and Haringey EIS, staff followed clear personal safety protocols, including for lone working. Staff we spoke with knew the trust protocols, which included a signing-out board and a requirement to call into the duty worker prior to the end of the day when lone working. However, in the Enfield North Locality Team some staff members were not clear on the lone working procedures within the team. There was not a consistent procedure in place to ensure that all staff were accounted for at the end of the day. There was a risk that staff could be unaccounted for following a visit. Staff told us that they would visit patients' homes in pairs if they were concerned about their safety. The Team Lead was already aware of this issue and had discussed adherence to the lone working policy at a recent team meeting.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Staff completion of mandatory training courses in adult and children safeguarding across the service ranged between 75% and 100%. All the staff we spoke with understood how to recognise and report abuse. All teams had effective liaison arrangements with the local authority to ensure adults and children were protected from harm. Staff held professionals' meetings to address immediate concerns. For example, staff in the Barnet South Locality Team had recently referred a patient for a multi-agency public protection arrangement (MAPPA). Multi-agency public protection arrangements (MAPPAs) assess and manage the risks posed by sexual and violent offenders.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. Safeguarding concerns reported by staff included financial, physical, sexual abuse and self-neglect. Staff knew who the trust safeguarding lead was.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff had access to the system that the local authority used so that staff could monitor the progress of safeguarding incidents. In Enfield, the trust had a section 75 agreement in place with the local authority. This meant that the trust acted as the delegated authority in managing safeguarding for the teams in Enfield. Local authority social workers worked as part of the team.

Staff access to essential information

Staff kept detailed records of patients' care and treatment. Records were clear, up to date and easily available to all staff providing care.

Staff used the trust's electronic database to record and store information. All staff, including agency staff, could easily access and use the database. Information about the patients' previous contact with trust services was readily available.

When patients transferred to a new team, there were no delays in staff accessing their records.

Medicines management

The service used systems and processes to safely prescribe, administer, record and store medicines. Staff regularly reviewed the effects of medications on each patient's mental and physical health.

Staff supported patients to understand their medicines and their side-effects. Leaflets were available for patients and carers about different medicines.

Staff reviewed the effects of each patient's medicines on their physical health according to National Institute for Health and Care Excellence (NICE) guidance. This included reviews of patients who were prescribed anti-psychotic medication or lithium. We saw letters to GPs from the doctors within the teams requesting reviews of physical healthcare and referrals to other specialists. The trust had recently employed physical health practitioners to look at working more closely with local GP practices. In the Haringey EIS the monitoring of high dose anti-psychotics was discussed at a recent team meeting. Staff were reminded that patients on high dose anti-psychotics should be monitored every three months, by having blood tests, vital signs checks and an echocardiogram (ECG). It was also agreed that the pharmacists would be asked to set up an audit for monitoring patients on high-dose anti-psychotics.

Staff monitored medicine fridge temperatures and recorded them daily.

Track record on safety

In the 12 months prior to the inspection, there had been three serious incident investigations reviewing the deaths of patients who had been supported by one of the three teams we visited.

Reporting incidents and learning from when things go wrong

The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

Staff knew which incidents to report and how to report them, including deaths in the community, safeguarding, and violence and aggression. Staff reported incidents via the trust's electronic incident reporting system.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation when things went wrong.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations. For example, in the Barnet South Locality Team the manager notified a patient's relative throughout an investigation.

Staff received feedback from investigations of incidents both internal and external to the service. This included discussions in team meetings and reflective practice. The trust circulated regular safety bulletins to all staff.

Staff met to discuss the feedback and look at improvements to patient care. Learning from incidents was a standing agenda item in clinical governance meetings. Learning from a serious incident was discussed in the October clinical governance meeting in the Barnet South Locality Team.

There was evidence that changes had been made as a result of feedback. For example, the Haringey EIS had recently introduced of system of ensuring there is one key person nominated in a patient's family to be contacted. This change came due to learning from a recent serious incident where there had not been consistent communication across a range of family members. Staff were also reminded about the importance of timely communication with patient GPs following any reviews by the EI team.

Staff were debriefed and received support after a serious incident. Staff were able to use the trust's counselling services as and when required.

Is the service well-led?

Good 

Our rating of well-led stayed the same. We rated it as good.

Leadership

Leaders had the skills, knowledge and experience to perform their roles. They had a good understanding of the services they managed and were visible in the service and approachable for patients and staff.

The senior managers led the service using appropriate skills and knowledge to perform their roles. The clinical director for Enfield provided clinical sessions in the Enfield Locality Teams. Team managers had worked within the trust for a number of years.

Senior managers and directors had a good understanding of the community services and ensured that patients received safe and effective care that was person-centred and of high quality.

Staff knew the senior staff team and they could approach them. Senior trust leaders attended the services periodically, although this had been affected by the Covid-19 pandemic. In response, the trust senior leadership held regular online calls. Staff told us that the online calls held by the leadership team were informative and kept them up to date with changes across the trust. The senior management team for the Barnet Locality Team held an open meeting once a month which all staff could attend.

The trust provided leadership development opportunities, including opportunities for staff below team manager level. For example, a member of staff from the Enfield North Locality Team was supported to do a senior leaders master's degree.

Vision and strategy

Staff knew and understood the provider's vision and values and how they applied to the work of their team.

Staff had the opportunity to contribute to discussions about the strategy of their service, especially where the service was changing. For example, in Enfield, the teams were in the process of being re-configured. Staff felt that they had been listened to during the change and the team lead was able to increase the provision of art therapists for the locality due to increased demand from patients.

Managers were aware of the budget available for their team and regularly reviewed it with senior managers. This ensured they were able to deliver good quality care to patients within the budget available. For example, the budget for the Haringey EIS had recently been increased. This allowed the number of care co-ordinators in the team to increase.

Culture

Staff felt respected, supported and valued. They said the trust promoted equality and diversity in daily work and provided opportunities for development and career progression. They could raise any concerns without fear.

Overall, staff across the community teams spoke positively about working for the trust. Staff felt supported by their managers. Staff participated in support groups that were provided on a regular basis. Staff were given welcome letters from the senior leadership team when starting at the trust.

Staff felt able to raise concerns without fear of retribution. Staff said they would feel comfortable in raising any concerns with their colleagues and managers. They felt their views and opinions would be listened to and acted on. Staff knew how to use the whistle-blowing process. Posters detailing who to contact if staff needed to speak up were on display in staff areas.

Managers dealt with poor staff performance when needed. For example, one team lead explained that they identified poor performance through supervision. Team leads set goals for performance to improve. Team leads could also send the employees on additional training if appropriate.

Teams worked well together and where there were difficulties managers dealt with them appropriately. Teams held regular away days to build rapport between team members.

Staff appraisals included conversations about career development and how it could be supported. Staff told us that they had good access to extra training courses for career and role development. For example, a nurse in the Haringey EIS had told us that they had recently received phlebotomy training and motivational interviewing training.

Most staff reported that the provider promoted equality and diversity in its day-to-day work and in providing opportunities for career progression. Staff told us that there were a lot of initiatives in place for Black, Asian and minority ethnic (BAME) staff, for example. A better together network to support BAME staff was in place at the trust.

Staff had access to support for their own physical and emotional health needs through an occupational health service. The Haringey EIS had recently set up a menopause social group to support and to educate the team about menopause. At the time of the inspection staff were considering of forming a similar group for patients.

The trust recognised staff success within the service, for example in the Barnet Locality Team there was a ‘Barnet Stars’ programme to recognise staff achievements.

Governance

Our findings from the other key questions demonstrated that governance processes operated effectively at team level and that performance and risk were managed well.

There was a clear framework of what must be discussed at a team level in team meetings to ensure that essential information, such as learning from incidents, was shared and discussed. For example, the Enfield North Locality Team had standing agenda items that included: audits, lessons learnt, safeguarding, policy notifications and mandatory training.

Staff had implemented recommendations from reviews of deaths, incidents, complaints and safeguarding alerts at the service level. For example, duty staff in the Barnet South Locality Team implemented the use of a spreadsheet to record any outstanding actions at the end of the shift to ensure they were followed up the next day. This was implemented following a recent death investigation which found that important information was not handed over. The management team would check the spreadsheet daily to ensure they were actioned as the use of the spreadsheet was still not consistent.

Staff undertook clinical audits. The audits were sufficient to provide assurance and staff acted on the results when needed. Staff would undertake peer reviews of other teams' work. In the Barnet locality, the team manager from another team would conduct a monthly peer review. This review would look at different areas each month such as physical health and dignity and respect. As part of this review the manager would speak to staff, patients and would review patient care and treatment records.

Staff understood arrangements for working with other teams, both within the provider and external, to meet the needs of the patients. For example, team members would routinely attend delayed transfer of care meetings. The purpose of these meetings was to try and remove barriers to people being discharged and transferred to other teams. These meetings were attended by staff from the inpatient wards, local authority and local commissioners. The Trust was also part of the MHA admission pathway monitoring group to try and reduce the time taken for MHA assessments. Leaders told us that the multi-agency approach was working well and the meetings were more structured around the data that was collected.

Management of risk, issues and performance

Teams had access to the information they needed to provide safe and effective care and used that information to good effect.

Staff maintained and had access to the risk register either at a team or directorate level. Staff could escalate concerns when required from a team level. For example, the Enfield Locality Team had a local risk register. The risks on the risk register matched the concerns that were shared by staff, such as the building not being owned by the trust so few changes could be made to the design and furnishings.

Senior and team managers had good oversight of the challenges within their teams and ensured plans were in place to ensure risk was mitigated.

Information management

Staff collected analysed data about outcomes and performance and engaged actively in local and national quality improvement activities. Connectivity to the internet was variable in some team offices.

The service used systems to collect data from teams that were not over-burdensome for frontline staff.

Most staff in the Barnet South Locality Team and Haringey EIS told us they had access to the equipment and information technology needed to do their work. The information technology infrastructure, including telephone system, worked well and helped improve the quality of care. Staff in the Enfield North Locality Team said there were often issues with the WiFi in the Silver Street location. Staff told us they would sometimes have to use their trust mobiles to hotspot with, these would also run out of data. Team leads told us how they had adapted the systems during the pandemic to ensure information was shared effectively. For example, telephone conferencing was used for meetings initially which was later replaced by online meetings.

Information governance systems included confidentially of patient records.

Team managers had access to information to support them with their management role. This included information on the performance of the service, staffing and patient care. Key performance indicators for each team was routinely monitored. Team managers would receive monthly ratings in relation to their key performance indicators.

Staff made notifications to external bodies as needed. For example, the teams would make safeguarding referrals to the local authority when required.

Engagement

Managers engaged actively other local health and social care providers to ensure that an integrated health and care system was commissioned and provided to meet the needs of the local population.

Staff, patients and carers had access to up to date information about the work of the provider and the services they used. For example, through the intranet and bulletins. There was a divisional newsletter for the Barnet borough called "The Barnet Bugle" which would update staff about changes in the trust.

Patients and carers had opportunities to give feedback on the service. Staff encouraged patients to complete questionnaires on the electronic feedback system. The trust collated feedback from patients, carers and staff and sent this to team managers. The trust had recently received the patient and carer survey results from October 2020 to September 2021. For the three teams we visited there were 161 responses from patients and carers, and 94% of patient and carers said that their experiences of the services were either good or very good.

Managers and staff had access to the feedback from patients, carers and staff and used it to make improvements. For example, the Haringey EIS was increasing the number of groups and activities for patients following feedback from patients and staff.

Directorate leaders engaged with external stakeholders, such as commissioners, GPs and voluntary organisations at consultation events. The trust had recently employed physical health practitioners to work closely alongside local GPs. Leaders also worked with the primary care network and helped provide update sessions to local GPs. The Clinical Lead for Barnet held a session to update local GPs on the Community Mental Health Transformation Programme and to discuss the Barnet Suicide Prevention Strategy. A local charity also attended the session to talk about the new crisis café that had opened in Barnet.

Learning, continuous improvement and innovation

Staff were given the time and support to consider opportunities for improvements and innovations and this led to changes.

Staff used quality improvement methods. Staff that we spoke to told us about quality improvement projects that were underway in their teams. For example, a quality improvement project was underway to improve the accessibility of the duty system, in response to a recent serious incident in the team. In the Haringey EIS a quality improvement project was being set up to improve the time between first diagnosis of psychosis and referral to the EIS.

Staff in the Haringey EIS continued to use open-dialogue approaches. Open-dialogue is an approach which is heavily informed by systematic thinking, as found in family therapy. The approach works to help the patient and their families feel heard, respected and validated. Staff felt that Open-dialogue had improved patient care and had led to richer conversations between MDT staff which led to more positive outcomes for patients.