Good

Barnet, Enfield and Haringey Mental Health NHS Trust

Community-based mental health services for older people

Quality Report

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Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RRPXX	Trust Headquarters	Enfield Older People's Community Mental Health Team	EN2 8JL
		Enfield Memory Service	EN2 8JL
		Haringey Older People's Community Mental Health Team	N15 3TH
		Haringey Memory Service	N15 3TH
		Barnet Older People's Community Mental Health Team	**EN5 3DJ**
		Barnet Memory Service	**EN5 3DJ**

Summary of findings

This report describes our judgement of the quality of care provided within this core service by Barnet, Enfield and Haringey Mental Health NHS Trust. Where relevant we provide detail of each location or area of service visited.

Our judgement is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from people who use services, the public and other organisations.

Where applicable, we have reported on each core service provided by Barnet, Enfield and Haringey Mental Health NHS Trust and these are brought together to inform our overall judgement of Barnet, Enfield and Haringey Mental Health NHS Trust.

Summary of findings

Ratings

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

Overall rating for the service	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Good

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

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

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

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

Summary of findings

Contents

Summary of findings

Overall summary

We rated community-based mental health services for older people as **good** because:

Staff were providing a safe service, where staff were aware of the risks for individual patients, where medication was managed well and staff had a good understanding of safeguarding. The staff were mostly able to see patients in a timely manner and prioritised people who needed urgent support.

Staff were caring and showed kindness and respect to patients and their carers. There was evidence across the board of patient and carer involvement in all aspects of their own care.

The staff teams were skilled and had a good understanding of the needs of the patients and carers they were supporting. Practice was evidence based and there was good access to a wide range of interventions. Staff were well supported with access to training, supervision and other opportunities to reflect and learn.

The teams worked well with GPs, the local authorities and other local services and groups. This enabled patients and their carers to experience a more joined up service.

Teams were well led and continuous improvement was embedded in everyday practice

Summary of findings

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

Are services safe?

Good

We rated safe as good because:

- Arrangements for safeguarding were clear with good systems in place to monitor and follow up concerns.
- Staff had manageable caseloads and managers ensured that workload was evenly distributed across the teams.
- Staff learnt lessons from incidents and made improvements where necessary.
- Arrangements for lone working were in place to ensure staff safety
- Staff carried out individual risk assessments on patients and put plans in place to address identified risks.

Are services effective?

Good

We rated effective as good because:

- Care was provided by experienced and qualified staff including dementia care specialists, nurse prescribers and staff specifically trained to work with carers.
- There was good use of evidenced based practice with a wide range of interventions available according to identified need.
- The memory services provided effective post diagnostic interventions and support for both patients' and carers.
- The services worked well with other services and professionals such as GPs and the voluntary sector.
- Staff carried out comprehensive patient assessments.

Are services caring?

Good

We rated caring as good because:

- Staff treated patients and carers with kindness and compassion
- Patients and carers were involved in all aspects of their care and decisions about their treatment
- Patients and carers were positively encouraged to give feedback about the care they received and staff used this to make improvements to the service.

Are services responsive to people's needs?

Good

We rated responsive as good because:

- Referrals were prioritised and dealt with in a timely manner. There were good pathways in to the service and patients were promptly allocated to an appropriate staff member.

Summary of findings

- Services researched and responded to the needs of a diverse local population in order to better meet their needs
- Information on how to complain was clearly displayed in the services and staff knew how to handle complaints appropriately.
- The memory clinic patient areas were well sign posted and took account of the needs of people with cognitive impairment.

However, patients' in one memory service waited a long time between assessment and receiving a diagnosis. The service was working to improve the responsiveness of the service overall.

Are services well-led?

Good

We rated well-led as good because:

- The service embedded continuous improvement in everyday work.
- Strong governance and timely information on performance helped managers assess and monitor the quality of service provided and make improvements.
- Teams were well led and staff felt supported.
- Two of the memory services were accredited to the Memory Service National Accreditation Programme (MSNAP).
- Management systems ensured that staff received appropriate training and supervision.

Summary of findings

Information about the service

We inspected three community mental health teams for older people providing specialist assessment, diagnosis, treatment and support. The teams were situated in Enfield, Haringey and Barnet. Each team was made up of psychiatrists, community psychiatric nurses, occupational therapists, psychologists, staff specifically trained to work with carers (called Admiral nurses) and administrative staff.

The service was offered to adults aged 65 and over with progressive memory problems, such as dementia and functional mental health problems, such as depression and anxiety. The majority of patients seen by the teams had dementia.

The teams worked using a multi-disciplinary approach and there was full integration between the memory services and the community mental health teams.

The teams worked closely with social care, GP's and voluntary organisations to ensure everyone received a holistic, comprehensive plan of treatment and care. Patients were seen in their own home or in outpatient's clinics.

The older people's community teams and memory services had not been inspected before.

Our inspection team

The team consisted of an inspection manager, an inspector, a consultant psychiatrist, a community psychiatric nurse, an occupational therapist and an expert by experience.

Why we carried out this inspection

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

How we carried out this inspection

To fully understand the experience of people who use services, we always ask the following five questions of every service and provider:

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

Before the inspection visit, the inspection team:

- Requested information from the trust and reviewed the information we received
- Asked a range of other organisations for information including Monitor, NHS England, clinical commissioning groups, Health watch, Health Education England, Royal College of Psychiatrists, other professional bodies and user and carer groups
- Received information from patients, carers and other groups through our website

During the inspection visit, the inspection team:

- Visited three community teams and their integrated memory services.
- Spoke with 28 patients and 18 relatives and carers who were using the services.
- Spoke with six team managers and team leaders.

Summary of findings

- Spoke with 51 staff members including doctors, nurses, social workers, psychologists, occupational therapists and administrators.
- Attended and observed three hand-over meetings and multi-disciplinary meetings.
- Joined care professionals for 11 home visits and clinic appointments.
- Joined two service user meetings.
- Looked at 19 treatment records of patients.
- Looked at a range of policies, procedures and other documents relating to the running of the service.
- Had a tour of the premises at each location.
- Looked at information received on 6 comments cards from patients and carers.

What people who use the provider's services say

The patients that we spoke to were happy with the care they received and felt that they were involved with decisions about their treatment. They said staff were caring, respectful and treated them with warmth and compassion.

Carers generally spoke very positively about the service they received. They said that they were given information about diagnosis and offered dementia awareness sessions where relevant. They valued the support given by the Admiral nurses, who are specially trained to work with carers, and those staff trained as dementia specialists. Carers said that staff were polite, responsive and treated them with dignity and respect.

Comment cards provided common themes of positive feedback regarding staff attitudes.

Good practice

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

Areas for improvement

Action the provider SHOULD take to improve

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

Barnet, Enfield and Haringey Mental Health NHS Trust

Community-based mental health services for older people

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Enfield Older People's Community Mental Health Team	Trust Headquarters
Enfield Memory Service	Trust Headquarters
Haringey Older People's Community Mental Health Team	Trust Headquarters
Haringey Memory Service	Trust Headquarters
Barnet Older People's Community Mental Health Team	Trust Headquarters
Barnet Memory Service	Trust Headquarters

Mental Health Act responsibilities

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

- Mental Health Act was not part of the mandatory training for staff and compliance rates are not collected. Teams requested training when needed. Junior doctors received Mental Health Act training as part of their induction.
- At the time of the inspection, there were no patients subject to community treatment orders.

Detailed findings

Mental Capacity Act and Deprivation of Liberty Safeguards

- All staff had completed training in the Mental Capacity Act 2005 even though this was not mandatory in the trust. Social workers in the teams lead on Mental Capacity Act. Staff demonstrated a good understanding of the principles of the Act.

Good

Are services safe?

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

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

Our findings

Safe and clean environment

- All interview rooms in the older people's community services where patients and carers were seen were fitted with alarms so that staff could call for help if they needed it.
- Clinic rooms in all three borough services were well equipped. Staff had the equipment they needed to carry out physical health examinations. Equipment was serviced and calibrated to ensure it was fit for purpose. Equipment, such as portable blood pressure apparatus, was labelled with the date it had last been calibrated. Records showed that glucometers were checked every two weeks. In Haringey, staff said they checked the defibrillator every day to make sure it was working although no records were kept of this. The equipment was visibly clean but it was not labelled with the date of last cleaning.
- The clinic waiting areas and out-patients were visibly clean and well-maintained. A poster in the clinic rooms reminded staff of the safest way to wash their hands and minimise the risk of cross infection.

Safe staffing

- Enfield older people's community mental health team had six nurses and two occupational therapists who were care co-ordinators. Two of these staff were specialist dementia service practitioners. In addition, the team had two social workers and the deputy manager also carried a small caseload. The Haringey service had similar staff numbers. There were five nurses and two occupational therapists who acted as care co-ordinators. One of the occupational therapists was a specialist dementia service practitioner. In addition there were three social workers in the team. The service had input from a speech and language therapist three days a week. The team had two vacancies. One for a care co-ordinator and the other for a specialist dementia service practitioner. The Barnet older people's community mental health team had similar staffing levels including two specialist dementia services practitioners. The service had four consultants covering the community team and memory service. The Barnet older people's community mental health team had a vacancy for a care co-ordinator and a staff grade doctor. There was a vacancy for a team manager. The manager we met during the inspection had just become the interim team manager.
- Barnet memory service had one team leader, one nurse prescriber, one Admiral Nurse, one staff nurse, one part time psychologist, one part time occupational therapist, four sessions of psychiatrist input and one junior doctor. The team had been without a team leader for nine months until the current team leader joined the service eight weeks prior to the inspection. The Enfield service had similar staff numbers with the addition of two band four assistant mental health practioners. The Haringey memory service had similar staffing levels including a new post for a band five nurse. The team leader post was covered by an interim arrangement while recruitment was ongoing.
- The average caseload of staff in the older people's community mental health teams was 18-25. In Haringey, the average caseload per care co-ordinator was 22. In the Barnet team, caseloads were between 16 and 26 at the time of the inspection. Team managers reviewed the caseloads of staff to ensure they were fair and manageable. None of the teams had a waiting list of patients. Patients were allocated to a named staff member immediately after the referral was received by the team.
- Locum staff were used in services to cover vacancies while recruitment for permanent staff took place. Cover arrangements for sickness and leave ensured patient safety.
- All the teams had rapid access to a psychiatrist when required and often had the mobile phone numbers of the psychiatrists who were attached to their teams.
- Most staff in all services were up to date with mandatory training requirements. All staff had completed training in the Mental Capacity Act 2005 even though this was not mandatory in the trust. Records showed that where staff had not completed a particular training course a date had been booked for this.

Assessing and managing risk to patients and staff

- All three older people's community mental health teams had staff on 'duty' that received and triaged referrals to

Good

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ensure urgent referrals were followed up quickly. In Haringey, there was a dedicated duty worker whereas in the other two teams care co-ordinators took it in turns to cover duty. Named duty managers were available to support staff when needed.

- The teams used an electronic patient record system. This contained up to date risk assessments for patients that were reviewed every six months. If a change occurred or a new risk presented, the plan would be immediately reviewed and updated. The 19 records we looked at were comprehensive and holistic.
- In Haringey, when patients either did not attend or cancelled appointments, there was a robust system in place that supported staff to act quickly to establish whether the person was at risk.
- Performance information for all three teams showed that over 90% of patients using the older people's community mental health teams had a risk assessment completed and reviewed within the last 12 months.
- All of the teams had a lone working protocol and each staff member was buddied with another. The buddies communicated with each other about their visits and whereabouts during the day. This helped maintain the safety of staff. Staff usually visited patients at home in pairs if they were not known to the service.
- Staff had received training in safeguarding adults and children. They knew how to recognise possible abuse, understood which events should result in a safeguarding referral and knew how to make a referral. Staff in the Enfield team, and some staff in the other teams, had been trained to investigate safeguarding concerns. The team managers had been trained to chair safeguarding meetings. There was a multi-agency safeguarding hub in Enfield which investigated safeguarding concerns relate to older patients who were not allocated to the older people's team. Safeguarding concerns raised about patients allocated to the team were investigated by a team member unless it directly concerned other staff, in which case it was passed to the local authority team to avoid a conflict of interest. In Haringey, safeguarding investigations were led by the local authority. Staff knew the safeguarding lead for the trust who could provide advice when needed. Safeguarding practice forums were held in Enfield every month but it was often difficult for staff to attend. There was a trust led safeguarding surgery to discuss complex cases. Information on how to contact the local authority safeguarding teams was on display in staff offices. Teams monitored the progress of safeguarding investigations.
- There were regular pharmacy audits to ensure medicines were managed safely. In all three teams the temperature of the clinic room, where medicines were kept, was checked every day to make sure it was suitable for safe medicine storage. Staff carried injectable medicines in a lockable case when they took them to a patient's home for administration. The medicine charts that we reviewed showed that medicines were clearly prescribed, the site of administration of an injection was documented and a review dates had been set.

Track record on safety

- There were two serious incidents reported over the last 12 months for all the older people's mental health community teams.
- Staff were aware of their duties in relation to the duty of candour. For example, the Haringey older people's community mental health team told us about an incident where some personal details about a patient had been accidently shared with another patient. A full explanation and apology was given to the patient, who had been unaware of the disclosure.

Reporting incidents and learning from when things go wrong

- Managers were confident that staff knew how to report incidents and reported appropriately.
- Staff described incidents that had occurred in the teams recently. The incidents were investigated and lessons identified. Improvements were made to the services to reduce the risk of the same type of incident happening again. Lessons learned were shared with staff in clinical governance and team meetings. Minutes from clinical governance and team meetings confirmed that incidents were discussed.
- Learning from incidents in other services was shared via operational management, deep dive meetings and team meetings. Business and team meeting minutes confirmed learning from incidents in the older people's service and other services were discussed. These meetings supported the sharing of learning within each borough. However, there was a relative lack of mechanisms for sharing learning across boroughs. Staff

Good

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said this was more evident since the restructuring of services along borough boundaries in April 2015. Opportunities for sharing learning across older people's services in different boroughs had been reduced as a result.

- Staff were given support after incidents. This included support within the team and access to external sources of support such as counselling.

Are services effective?

Good

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

Our findings

Assessment of needs and planning of care

- We reviewed 19 care plans on the electronic records system, found that the patient assessments and care plans were up to date, and personalised. They reflected patients' views, were holistic and included evidence of ongoing physical health care.
- In some services, we were told that there are paper records running alongside the electronic record. However, all documentation was uploaded on to the system so that information was accessible to staff and up to date.
- All staff have been trained to use the electronic records system and they had good access to computers so that entries to records were made in a timely manner.

Best practice in treatment and care

- Staff told us that NICE guidance was available at the team bases and they were supported to follow best practice. A number of clinical audits were undertaken by clinical staff including rolling audits on lithium monitoring and use of anti-psychotic medication in dementia.
- Patients in all three boroughs had access to psychological therapies. Waiting times to see a psychologist varied but were generally between three to eight months. The minutes of the Barnet older people's community mental health team business meeting in October 2015 stated that the waiting time for psychology assessment was six months but those urgent referrals could be seen within 13 weeks. Haringey and Enfield operated waiting lists of up to three months. In Haringey, the psychology services balanced individual patient work, input into individual staff supervision and facilitating patient and staff groups.
- The teams ran a number of therapeutic and support groups for patients and carers. For example, the Haringey team had run a Haringey older people's enablement group (HOPE) over 10 weeks. The group had been facilitated by an occupational therapist and an assistant psychologist and provided support to a group of patients who had recently been discharged from the older people's day service. The group supported the recovery of patients during the initial post discharge period whilst patients re-established their own support systems and built confidence. There was good joint working with the Alzheimer's Society in all three teams and a variety of carers support groups were available which were run by the Admiral nurses. Barnet memory service had implemented a group for carers called START, which assisted carers with coping strategies. This group was psychology led and there was a long waiting list. The Admiral nurse told us that he was now trained to run this, which would help reduce the waiting list. In Enfield, an occupational therapist ran a carers group on dementia awareness.
- Staff used a variety of recognised rating scales and assessment tools when assessing patients for potential cognitive impairment. These included the Addenbrooke's Cognitive Examination and the Geriatric Depression Scale.
- All teams provided a cognitive stimulation therapy group, which provided post-diagnostic therapeutic interventions to patients with dementia.
- Younger patients with suspected cognitive impairment were referred to other specialist services for further investigation.
- Older people's community teams held formulation meetings every month. These were led by a psychologist. A staff member presented a complex patient to the multi-disciplinary team and the team discussed alternative ways of approaching and supporting the patient. The meeting used a risk formulation framework called 5Ps (problem, precipitating factors, perpetuating factors, protective factors and predisposing factors) to structure clinical judgements and propose action to facilitate change.
- Staff considered patients' physical health care needs. Information from the trust heat map which measured key performance indicators showed that 100% of patients using Enfield older people's community mental health team had received a physical health check in the last 12 months. Staff had completed nutritional assessments for all patients.
- Staff monitored patients who were prescribed lithium and anti-psychotic medication. For example, the Haringey older people's community mental health team kept a list of all patients who were prescribed lithium. The list was reviewed regularly and used to prompt GPs to check patients' blood lithium levels. Similarly the team kept a list of all patients with dementia who were prescribed anti-psychotic medication. The list was used to prompt GPs to review patients' medicines after 12

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weeks, in line with national guidance. Those patients prescribed anti-psychotic medication for functional illness had their medicines reviewed every three to six months dependent on their needs.

- Staff used health of the nation outcome scales (HoNOS) to measure outcomes for patients.
- Staff carried out audits as a way of assessing and monitoring practice. For example, there were monthly audits of safeguarding concerns and how they had been managed. Where concerns were identified action was taken to bring about improvements. All teams took part in a trust wide quality assurance audit every month. Eight to twelve patient care records were selected randomly every month. These were reviewed to measure compliance with specific key performance indicators and commissioning for quality and innovation targets. For example, the audit checked whether smoking cessation had been offered to patients and that carers had been offered a carers assessment. Results from the audits were fed back to the teams to take action, where required, to improve performance.
- The teams took part in a safety thermometer audit on one day per month. This involved recording all patients over 70 years of age who had suffered a fall, a urinary tract infection, had a pressure ulcer or deep vein thrombosis. The information was used to inform investment in and development of services.

Skilled staff to deliver care

- Teams were made up of a range of disciplines including nurses, occupational therapists, doctors, social workers, psychologists, psychology assistants, occupational therapy assistants and graduate mental health workers. Some care co-ordinators in each of the teams were trained specialist dementia service practitioners. Occupational therapists prescribed equipment that would support patients with everyday activities at home and encourage independence. A geriatrician provided input to the Haringey team one day a week.=
- The memory clinics employed specialist dementia nurses, called Admiral nurses, who gave expert practical and emotional care and support to family carers, as well as the person with dementia.
- Specialist dementia service practitioners provided support to carers and offered advice on how to manage challenging behaviours at home. They were also closely involved in discharge planning, reviewing medicines, carrying out cognitive assessments, developing care plans and providing teaching and support to staff and carers.
- Staff in all teams had completed an annual appraisal in the last 12 months. Most staff received regular supervision. The aim was to complete supervision at least 10 times per year. In the Enfield service staff had generally received supervision between three to five times in the last six months. In Barnet staff had received supervision between six and eight times in the first 10 months of 2015. All teams provided opportunities for reflective practice which allowed staff time to consider their work and discuss with others. In Enfield and Haringey occupational therapists received professional supervision from an occupational therapist, which was in line with guidance from the Royal College of Occupational Therapists. However, the occupational therapists in the Barnet team did not receive occupational therapy specific professional supervision. They received managerial supervision from the interim team manager.
- Staff had access to additional specialist training. For example, several staff had been trained to investigate safeguarding concerns and others had undertaken specialist courses in dementia care. Some staff were completing higher-level degrees and others had attended relevant conferences. Staff identified further training needs in annual appraisal and mid-year review meetings. These were linked to individual and team objectives.

Multi-disciplinary and inter-agency team work

- Specialist dementia service practitioners provided support to patients and staff in care homes. They provided advice to staff aimed at reducing the need for the patient to come to hospital or be admitted. A care home manager we spoke with was very positive about this service.
- In the Enfield older people's community mental health team care co-ordinators were assigned to a group of GP practices. They met with the group of practices every month. They provided information and advice to GPs on the referral and management of older patients and followed up patients that had been assessed by the team. In Haringey consultant psychiatrists from the team attended a local GP forum. Staff took part in monthly teleconferences about complex patients. These

Are services effective?

Good

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telephone meetings involved GPs, district nurses and community matrons. The different health professionals involved with the patient worked together to agree a cohesive care plan and consistent approach to care and treatment.

- The older people's community mental health teams worked closely with the older people's in-patient teams and staff from the teams regularly attended ward rounds. This helped community staff support patients effectively when they were discharged from the ward to the community team. The principal social worker in the Barnet older people's community mental health team spent one day a week on an older people's ward supporting the in-patient social worker to address delays in discharging patients.
- GPs were invited to all patient discharge planning meetings. They were not usually able to attend but sent written information to help inform the meeting. Staff wrote back promptly to GPs regarding the outcome of patient assessments.
- The older people's community mental health teams worked closely with local voluntary sector organisations. For example, some organisations were able to support patients after they were discharged from the teams. The team referred patients to an organisation that was able to help patients who owned their own homes. They offered befriending, assistance with shopping and a handy person service. This kind of support helped people live independently in their own homes.

Adherence to the MHA and the MHA Code of Practice

- The Mental Health Act was not part of the mandatory training for staff and compliance rates were not collected. Teams requested training when needed. Junior doctors received Mental Health Act training as part of their induction.
- At the time of the inspection, there were no patients subject to community treatment orders.

Good practice in applying the MCA

- Staff had completed training in the Mental Capacity Act 2005 (MCA).
- Staff said that the social workers and doctors in the teams led on the Mental Capacity Act and that they would only be involved if they knew the patient. The staff that we spoke to demonstrated a good understanding of the five principles of the Act.
- Staff were aware of the MCA policy and how they could access it.
- Mental capacity assessments were not carried out routinely. Where there was concern about a person's capacity assessments were carried out. These were clearly documented.

Good

Are services caring?

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

Our findings

Kindness, dignity, respect and support

- Carers gave positive feedback for all three teams. They described staff as responsive, respectful and very caring. A carer reported that the Enfield memory service had been supportive and staff were kind, warm and welcoming. Carers from the same service felt that the education provided on dementia had been invaluable in helping them to cope with their relative's diagnosis.
- We attended a carer's forum at Haringey memory service. The participants told us that they were very happy with the service. They felt supported and particularly welcomed the input they received from the Admiral nurse.
- We observed good interactions between staff and patients that were respectful, kind and compassionate.
- We attended a cognitive stimulation group in Enfield and saw staff interacting and engaging well with patients. They showed kindness and patience and were observed to be very responsive to individual needs. All the patients fed back that they had found the group to be excellent.
- Some staff in Haringey were described as excellent in terms of the support they gave. Other feedback included comments on how caring and polite staff were.
- Staff addressed patients' individual needs and documented them in care plans.

The involvement of people in the care they receive

- The memory services provided carers' support groups.
- Staff involved carers in discharging planning. Staff invited carers to patient discharge planning meetings and signposted them to other sources of help when this was appropriate, including for an assessment of their needs as a carer. Copies of the discharge care plan were sent to carers as well as patients.
- Patients had access to support from an independent mental health advocate and an independent mental capacity advocate.
- Patients and carers were encouraged to give feedback about their care and treatment via a survey. Surveys were given to patients after an assessment. Staff gave questionnaires to longer term patients every few months. Feedback from patients and carers was collated, analysed and provided in a report so that staff could use the information to make changes in the service where required. For example, in Enfield, feedback from surveys suggested that patients needed more information and explanation of medicines and their side effects. The team took action to address this. Patients and carers gave positive feedback about the information given by the memory services following a diagnosis of dementia. They described receiving information both verbally and in written format about the diagnosis and the help available. They felt that time was given to discuss their concerns and receive answers to any questions they had. There was also an opportunity to discuss any advance directives the person may want to put in place.
- Patient and carer surveys were also left in out-patient areas with a pen, where they could be filled in by patients and carers attending for an appointment and posted in boxes provided.
- The teams responded to feedback by highlighting what people had said in surveys and what staff had done to address the concerns raised. 'You said…We did…' boards were displayed in patient waiting areas reporting on the actions taken.
- Feedback from patient and carer surveys in Enfield and Haringey in the last six months showed that 90% of respondents were satisfied with the care they received. Patients reported being treated with dignity and respect, listened to and involved in decisions about their care and treatment. In Barnet, 100% of patients and carers who had responded to the survey in September 2015 were satisfied with their level of involvement in their care and treatment and the way their dignity and privacy had been respected by staff.

Are services responsive to people's needs?

Good

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

Our findings

Access and discharge

- The services were accessible and responded promptly to referrals. Referrals to the older people's community mental health teams came mainly from GPs. In Enfield and Haringey GPs and other referrers usually sent referrals via a single point of access where staff carried out an initial triage before sending the referral to the appropriate service. In Barnet there had been 1698 referrals to the team between January and October 2015. Ninety per cent of the referrals had come directly from GPs, 1% came from the in-patient wards and 8% came from other sources including the single point of access. In Barnet 30% of the referrals were for people who lived in a residential care home.
- When referrals came to the community teams they were reviewed by a staff member. In Haringey all new referrals were reviewed by a dedicated duty nurse who arranged urgent assessments and obtained more information about routine referrals. Urgent referrals were prioritised and where possible they were seen and assessed within four hours. Urgent referrals out of hours were responded to by the crisis team.
- Non-urgent referrals were discussed at referral and allocation meetings within a week and, where appropriate, allocated to staff for assessment. The target time from the point of referral to the assessment of patients was 13 weeks. However, almost all patients were seen and assessed within two to four weeks. Delays were sometimes caused by patients going on holiday or appointment cancellations, but delays beyond 13 weeks were very rare. Some new referrals were signposted to other services such as out-patients or the improving access to therapies team (IAPT) if this would better meet their needs.
- Some new referrals were passed to the memory service for assessment. The Enfield and Haringey Memory Service received an average of 10 referrals every week. The Barnet Memory service received an average of 25 referrals every week.
- Minutes from the Barnet older people's forum meeting in October 2015 stated that 15 patients had breached the six week referral to assessment target in the memory service. This had subsequently been reduced to five people who waited longer than six weeks.
- The assistant clinical director for Haringey confirmed that the referral to assessment target in Haringey was 13 weeks. This target was usually achieved. However, in order to meet the target staff had focussed on making sure the initial assessments took place quickly. This meant that the waiting time for patients between assessment and diagnosis had increased. There was currently a wait of about 21 weeks. The service was looking at the skill mix of the memory service in order to ensure that staff had the necessary skills to provide the service more effectively. Senior staff were due to meet with commissioners to discuss the overall provision of the memory service with a view to reducing waiting times and improving the pathway for people from referral to assessment and diagnosis.
- Patients were encouraged to move on from the community teams as they recovered. However, staff were flexible and responsive to individual needs. They recognised that some patients needed to be supported for extended periods to prevent relapse and admission to hospital.
- Sometimes there were delays in discharging patients from the service. Delays were usually caused by difficulty finding appropriate accommodation or placements for patients and delays in obtaining funding for identified placements. A lack of care home placements in Enfield and Haringey meant some patients needed to be placed further from their original homes and family support. In Enfield the team supported some patients who only required a visit to be given depot medication (medicine given by injection). Some local GPs provided the treatment to the patient in a primary care setting, but most did not.
- Team performance information showed that GPs and referrers were informed of the outcomes of all assessments carried out by the teams.
- Team representatives attended older people's service bed management meetings every week. The meetings discussed and reviewed any patients who was experiencing a delay in the transfer of their care and looked at how these could be facilitated in order to maintain a flow of patients into and out of the older people's services, both in-patient and in the community.

The facilities promote recovery, comfort, dignity and confidentiality

- Information leaflets on a range of relevant topics for patients and carers were displayed in patient waiting

Are services responsive to people's needs?

Good

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

areas. These supported people to make decisions about their care and treatment. Feedback from patient and carer surveys in Enfield in the last six months showed that 89% of respondents had been given enough information about their treatment, including their medicines. In Haringey, 94% of community team patients and carers and 99% of memory service patients and carers were satisfied with the information provided to them. In Barnet, 100% of patients and carers in September 2015 were satisfied with the information they were given by the team.

- Waiting areas were welcoming. They were bright and well-lit and the Enfield service had particularly good signage, including pictorial representations of the functions of different rooms in the service, which was helpful to people with cognitive impairment.

Meeting the needs of all people who use the service

- Twenty per cent of patients in the Haringey Memory Service diagnosed with dementia did not have English as a first language. The service had recognised this and produced a range of leaflets in Turkish and Greek, which were common local languages. The service had proposed an educational programme for carers whose first language was not English using information technology. The team had attempted to get funding for this from the trust's 'dragon's den' but had been unsuccessful.
- The Haringey memory service used the Rowland universal dementia assessment scale, a short cognitive screening instrument designed to minimise the effects of cultural learning and language diversity on the assessment of baseline cognitive performance. Staff felt this worked well and better met the needs of the diverse group of patients using the service.
- Information leaflets on a range of appropriate and relevant topics for patients and carers were displayed in patient areas of the services, including leaflets in Turkish on understanding dementia. In addition there was information on local voluntary sector organisations that could offer support such as an Asian carers support group and a drop-in for lesbian, gay, bi-sexual and transgender people.
- Staff knew the make up of the local population and considered the patients using the service were representative of the local population. Many staff in the teams were multi-lingual and spoke different local languages such as Greek and Gujarati. Staff could obtain an interpreter when they needed one and information could be translated into other languages on request.

Listening to and learning from concerns and complaints

- The services received very few complaints from patients and carers. Enfield and Haringey had received no complaints in the last six months. Barnet had received two formal and two informal complaints since April 2015. There were no open complaints for the service.
- Information leaflets explaining how to make a complaint were available in patient waiting areas. The telephone contact details for the patient experience team were also on display.
- There was a clear process for managing complaints. Complaints were referred to the patient experience team and allocated to manager to investigate. The director of nursing for the trust oversaw all complaint responses before they were sent out.
- All informal complaints were logged with the patient experience team so that any themes or trends could be identified and used to inform learning.
- Team managers provided examples of learning and service changes they had made in response to individual complaints.

Are services well-led?

Good

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

Our findings

Vision and values

- Staff understood the vision, values and aims of the trust. Trust goals were reflected in the objectives of individual staff which formed part of their annual appraisal. Individual objectives showed how staff would contribute to the delivery of trust goals and initiatives.
- Staff knew who senior managers in the trust were and said they were visible. One team manager mentioned that the chief executive's blog was a good way of keeping up to date with what was happening in the trust.

Good governance

- There were clear governance systems in place that helped embed continuous improvement in the services.
- Deep dive meetings took place once every three months. These involved all departmental heads in the particular borough and were chaired by the director of nursing or her deputy. This meeting looked at all aspects of service performance in detail including incidents and complaints. Mini deep dive meetings just for the older people's service took place every two months. In Enfield and Haringey these meetings fed back to operational management group meetings which were held monthly. In turn these meetings fed into clinical governance and team meetings which were also held monthly. These meetings supported the flow of information from frontline services up to middle management and the trust board and vice versa.
- In Barnet the quarterly deep dive meetings fed information into the older people's forum meeting that took place every month and was chaired by the assistant clinical director. The meeting involved team managers, consultants and senior staff in older people's services. Information on incidents, complaints, clinical issues and differences in outcomes and performance were discussed. Messages from this meeting were taken to the older people's community mental health team business meeting and shared with staff.
- Managers had access to key information on the performance of their teams. This included information in the heat maps for each team and feedback from patient and carer surveys. Monthly heat maps showed managers how their teams were performing in terms of the percentage of patients with care/treatment plans and crisis plans in place; the numbers of carers whose needs had been assessed; and the number of patients assigned a care co-ordinator as well as a range of other measures of performance. Team managers used this information to monitor performance and make improvements where needed.

Leadership, morale and staff engagement

- Over a 12-month period, sickness rates had been above 6% in Barnet and Haringey. Enfield levels of sickness were low at less than 1%.
- Morale across the teams was generally good. Staff reported that managers were supportive and effective in dealing with issues. Team members were motivated and reported to be dedicated to their work by fellow colleagues and users of the services.
- There were no reported cases of bullying or harassment in the any of the teams. Staff were aware of how to use the whistleblowing process.
- Team managers told us there were opportunities for leadership development in the trust. Several had completed or were completing leadership and management learning modules run in conjunction with a local university.
- Staff felt well supported. They were able to raise concerns with senior managers and were listened to.
- The Barnet memory service had a psychiatrist led staff group, which ran every Monday afternoon. Staff used this to reflect on complex cases.
- Managers were very positive about working for the trust and about working with their teams.
- The Barnet older people's team had had five different service managers in the last three years and this had affected continuity and morale. The team manager had been off sick for over a year. A team leader had recently taken over as interim manager of the team and the service manager had been in place since August 2015. However, the team continued to function well and staff were optimistic about the current management.
- Managers told us they explained to people when things went wrong. They supported staff to report incidents and mistakes. Staff told us the trust encouraged them to be open, transparent and admit mistakes when they were made.

Commitment to quality improvement and innovation

- All of the older people's community health teams had well developed systems to support the continuous

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improvement of the service. Managers used a continuous improvement tracker to monitor progress with action plans. This was particularly well embedded in the Enfield and Haringey teams.

- The consultants and psychologist described a plan to set up a clinical network for old age mental health across the three boroughs, involving a combination of clinical and service delivery issues, with continuous improvement being the overarching theme. There was trust support for this plan.
- The teams used a quality improvement methodology to provide a structure for identifying problems and sustainable solutions. All actions were aimed at reducing unnecessary activities that took staff away from patients and increasing the time available for patient care. Gaps in the service were identified and action plans put in place to address these. Staff met every week to inform the team of the progress being made with different improvement projects. The meetings were called 'kanban' meetings. The Enfield team had a 'kanban' board in the office, which showed staff how new ideas and solutions to problems were progressing or had been completed. Staff provided us with examples of improvements that had been made through this process. These included the development of better information leaflets and the provision of the cognitive stimulation therapy groups.
- Teams had used quality wheels based on what they considered the services did well and not so well in order to identify areas for improvement.
- Trends from patient and carer feedback were identified and used to improve the service. For example, staff in Haringey had made contact with transport and facilities managers after receiving feedback from patients and carers about their experience of delays in transport to appointments.
- In Haringey it had been noted that patients of Greek and Turkish origin were more likely to present as urgent referrals. A staff member had researched the matter and identified factors which may have prevented families from seeking help at an earlier stage, such as stigma, trying to care for people at home for longer and positive use of local support groups. The team was considering what further action they could take to improve the service provided to these communities.
- The Enfield and Haringey Memory Services had accreditation to the Memory Service National Accreditation Programme (MSNAP). The Haringey team was rated as excellent in February 2015. The MSNAP report included positive comments on the kindness and sensitivity of staff, the very comprehensive information pack given to patients and carers following diagnosis and the wide range of interventions on offer. The service ran Tom's club, which was an information, therapeutic and social support group for carers and people with dementia. Staff were described as skilled with good levels of communication. The Enfield team MSNAP report praised the work carried out with local GPs to improve relationships. Patient waiting areas were described as homely and comfortable and the proforma used to assess patients was described as high quality. Other comments remarked on the good interpersonal skills of staff and the inclusion of a music room with a music therapist in the service. The Barnet memory service was working towards accreditation, which it hoped to achieve in the next six months.