North London Hospice

North London Hospice Day Care Service

Inspection report

North London Hospice
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Ratings

Overall rating for this service	Good ●

Is the service safe?	**Good** ●
Is the service effective?	**Good** ●
Is the service caring?	**Good** ●
Is the service responsive?	**Good** ●
Is the service well-led?	**Good** ●

Summary of findings

Overall summary

This inspection took place in 22, 23, 24 and 25 August 2016 and was announced. When we last visited the hospice on November 2013 we found the service met all the regulations we looked at.

North London Hospice Day Care Services provides a range of outpatient therapeutic and community based services for adults with life limiting illnesses and specialist palliative care needs who are residents of Barnet, Enfield and Haringey. At the time of the inspection there were 100 people using the outpatient services and 200 people were using the community service.

The hospice had a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People were supported to make choices about how their needs were met. People and relatives were involved in decisions about their care. Where people were unable to make decisions about their care best interests decisions were made on their behalf.

People were kept safe. Risks to people were identified and staff took action to reduce those risks. Staff were available and had the necessary training to meet people's needs. Staff responded to people's needs promptly.

There were systems in place to ensure that people consistently received their medicines safely, and as prescribed.

People were supported effectively with their health needs.

Care was planned and delivered in ways that enhanced people's safety and welfare according to their needs and preferences. Staff understood people's preferences, likes and dislikes regarding their care and support needs.

People who used the outpatients service were provided with a choice of food, and were supported to eat when this was needed. There was a strong emphasis on the importance of good nutrition and hydration and a commitment to providing people with what they wanted to eat and drink in a flexible manner.

People and their relatives told us that staff were caring, kind and compassionate. The hospice provided people with multi-professional and person centred care that helped to ensure their physical, emotional, psychological, spiritual and social needs were met.

People were treated with dignity and respect. People and relatives told us they consistently received care that met their individual needs.

There was an accessible complaints policy which the registered manager followed when complaints were made to ensure they were investigated and responded to appropriately.

People using the service, relatives and staff said the registered manager was approachable and supportive. Systems were in place to monitor the quality of the service and people and their relatives felt confident to express any concerns, so these could be addressed.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good ●

The service was safe. People received safe care both at the outpatients service and in their own home.

Staff followed the procedures that were in place to protect people from abuse.

The risks to people who used the service were as far as possible identified and managed appropriately

Staff were available in sufficient numbers and with the appropriate skills to meet people's needs.

Is the service effective?

Good ●

The service was effective. People were positive about the staff and felt they had the knowledge and skills necessary to support them properly.

People told us they enjoyed their meals. Staff were aware of any specific dietary needs that people had and ensured these were met.

People were involved in making decisions about their treatment and care needs. Safeguards were in place to help ensure that people who were unable to make decisions about their care had their human rights protected.

People's healthcare needs were monitored. People were referred to the palliative care consultant and other healthcare professionals as required so that their health care needs were met.

Is the service caring?

Good ●

The service was caring. People and their relatives spoke consistently about the caring and compassionate attitude of staff.

Staff were respectful of people's cultural and spiritual needs.

The service provided appropriate end of life care to ensure people experienced a comfortable and dignified death.

People told us they consistently received care that met their individual needs.

People and their representatives were supported to make informed decisions about people's care and support needs.

Is the service responsive?

Good ●

The service was responsive. Care plans were in place and gave detailed information about people's care and support needs and staff followed these.

Staff were knowledgeable about people's support needs, their interests and preferences in order to provide a personalised service.

People knew how to make a complaint as there was an appropriate complaints procedure in place.

Is the service well-led?

Good ●

The service was well-led. People and their relatives were consulted about how the provider could make improvements to the service.

Systems were in place to ensure the quality of the service people received was assessed and monitored.

The provider promoted an open and transparent culture in which good practice was identified and encouraged.

North London Hospice Day Care Service

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 22, 23, 24 and 25 August 2016 and was announced. We gave 48 hour's notice of the inspection due to the complexity of the service. The inspection team consisted of a lead inspector, a specialist professional advisor, another inspector and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of service.

Before our inspection, we asked the provider to complete a Provider Information Return (PIR). The PIR is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed the information we held about the service. We also received feedback from two external palliative care professionals, Enfield Healthwatch and one commissioning officer.

During the course of the inspection we spoke, either in person or on the telephone, with 15 people who used the service and two relatives. We also spoke with 20 members of staff and two volunteers. This included the chief executive, chair of board of trustees, registered manager, directors of patient services and quality and care, practice educator, associate director of community services and a psychologist. We spent time in the outpatients service, observing care and support. We joined two multi-disciplinary meetings and met with the outpatients and specialist community teams.

We looked at six people's care records and other records relating to the management of the hospice. This included nine staff recruitment records. We also looked at duty rosters, accident and incident reports, complaints, compliments and health and safety records.

Good ●

Is the service safe?

Our findings

People we spoke told us they felt safe. One person said, "'Yes it is safe here." Another person said, "I feel very safe here." One visitor told us, "The atmosphere makes me feel safe from the moment I walk in." Another visitor explained, "It is very nice here: professional, relaxed and welcoming."

Leaflets and posters about safeguarding and who to contact if people had concerns were available in the outpatients reception area and on a notice board. People knew their concerns would be listened to and action taken to maintain their safety.

Staff and volunteers knew how to recognise and respond to abuse and safeguarding issues. One member of staff told us, "If you have concerns about abuse you must report it straightaway." Staff had completed training on safeguarding people and the registered manager told us that further training was planned. They understood things that could be discriminatory while providing care to people such as racism or homophobia and gave us examples of how they valued and supported people's differences. Staff understood and delivered care that was person centred and knew that this was central to mitigating the risk of people being abused or exposed to harm.

Staff knew what to do if they needed to escalate concerns outside the organisation. Staff told us that they knew they could contact the police, the Care Quality Commission and the local authority safeguarding team.

People's risk assessment covered areas such as mobility, falls, communication, moving and handling, and behaviour that may challenge staff. These were scored as low, medium or high risk and indicated the action to take to manage the risks such as the number of staff needed to support the person. Where people were found to have specific risks these had been assessed and action to mitigate the risk had been recorded in their care plans. For example, one person was at risk of falls, and their care records showed that a referral had been made to the physiotherapist to support them with their mobility needs.

Staff were able to explain how they responded to actual and potential risks to people when providing them with care and support. Environmental and personal safety risk assessments were carried out which assessed risks to staff visiting people in their home's. These included risks to do with parking, street lighting, pets, space for equipment and other occupants.

The provider had assessed and put in place systems to manage corporate risks that may affect the continuation of the service. The provider had a business continuity plan and carried out exercises using different scenarios to establish whether the business continuity plan was robust. Policies and procedures had been put in place around the management of corporate risk. Corporate risks were reviewed by the quality, safety and risk committee so that the effectiveness of these plans and risk management processes was monitored.

The premises and equipment were appropriately maintained. Records showed that equipment was serviced and checked in line with the manufacturer's guidance to ensure that it was safe to use. Gas, electric and water services were maintained and checked to ensure that they were functioning appropriately and were safe to use. The records also confirmed that appropriate checks were carried out on fire alarms to ensure that they were in good working order. Systems were in place to ensure that equipment was safe to use and fit for purpose. A fire risk assessment was in place and staff were aware of the evacuation process and the procedure to follow in an emergency. People were cared for in a safe environment.

One person said, "There is enough staff at the day hospice," and another person who used both the outpatient and community service told us, "There were enough staff in every department. They are magnificent, friendly and helpful whilst giving out of this world treatment.' Another person commented, "There are sufficient staff here." Staff and volunteers told us, and we observed, that sufficient staff were available to meet the needs of people in both the outpatients and the community service.

People told us that staff had enough time to spend with them and meet their individual needs. People and relatives using the community support service told us that staff stayed with them often beyond the allocated time and made sure their needs were met. The staff rotas showed that consistent staffing levels were maintained. The registered manager had completed a scoping exercise around long terms conditions which has resulted in an increase of staffing. The registered manager told us they were in the process of recruiting staff and volunteers so that the service could expand the care and support it provided to people.

The provider's detailed recruitment procedures ensured that staff and volunteers were suitable to work with people who used the service. Staff records contained criminal records checks, two references and confirmation of the staff member's identity. Staff eligibility to work in the United Kingdom had been checked. A similar checking process and been carried out when recruiting volunteers. Checks had been completed to confirm that staff who had a nursing qualification were registered with the appropriate professional organisation. Staff that had been recently recruited to work at the service told us they had been through a detailed recruitment procedure that included an interview and the taking up of references.

The day hospice outpatients service does hold medicines and staff can administer medicines to people. None of these medicines had been administered. The registered manager explained that they had a system in place to record when these medicines were administered to people. Staff had been trained in the safe administration of medicines.

Nurses in the specialist community team explained that they do administer medicines to people in their own homes. They have arrangements with local pharmacist for obtaining medicines, including those that were administered to people at the end of their life. Nurses in the community team had completed medication training. Competency checks were carried out which ensured they administer medicines safely. The registered manager explained that the provider was introducing single nurse administration competencies within the community team. In addition the provider had developed a prescribing policy and guidelines that enabled nurses in the specialist community team to prescribe certain medicines. The specialist community nursing team would give advice to clinicians on what medicines. This would provide people in the community with prompt support to manage their conditions.

Good ●

Is the service effective?

Our findings

People who used both the outpatients' service and community care service confirmed that they received care and support from staff who had the knowledge and skills to meet their needs. One person said, "I was really impressed with their knowledge." Another person who was supported in the own home said, "The nurses really understand my needs and how to support me."

Staff and volunteers working in the outpatients and community team had access to the hospice's education team which provided internal and external training. Staff and volunteers told us that they had access to a wide range of training opportunities. The education team provided training on a wide range of aspects of end of life and palliative care, which included the Gold Standard Framework. This is a practical, evidence-based approach to delivering high quality care for all people nearing the end of life. Volunteers and staff undertook the induction together, which gave them a chance to meet and share ideas and experiences. The induction programme gave staff and volunteers a comprehensive introduction to working with people with palliative and end of life care needs.

Staff and volunteers had access to a comprehensive training programme that prepared them to work with people with palliative and end of life care needs. These included working with loss and bereavement, advanced care planning and pain management. Staff had training on meeting the emotional needs of people and how to support their cultural and religious beliefs and practices. Nurses had been given training so that they could maintain their nursing registration. Staff also were supported to complete train the trainers courses. This supported them to further develop their skills and share their knowledge with their other staff working in the hospice. Training records showed that training was up to date and refresher courses were planned to maintain their skills.

Staff told us that they received regular management and clinical supervision (one-to-one meetings with their manager or a clinical expert to discuss their skills and development needs). Records showed that supervision sessions were taking place regularly. Clinical supervision was available to all staff who worked in clinical an therapies areas, and social care services within the hospice. The registered manager explained that Schwartz rounds were being introduced to further support staff. Schwartz Rounds provide a structured forum where all staff come together regularly to discuss the emotional and social aspects of working in healthcare.

People who visited the day hospice said they were provided with a choice of meals. One person told us, "The food on offer here is good." Another person informed us that there were, "Lots choices on the menu, always something different." There was a four week menu that included a range of main meals as well as alternatives that people could request if they wished to. People told us that they were encouraged to request alternatives to the menu if they had specific preferences. Drinks were provided regularly, and people were seen to have access to water at all times.

People's nutritional needs were assessed and this highlighted if they needed to be referred to the dietician and speech and language therapist. Nutritional assessments identified if people had any specific nutritional requirements with regard to a special diet for medical reasons, dietary allergies and intolerances, or for cultural and religious reasons. The nutritional assessment was incorporated into people's individualised care plan. Where people were at the end of life their eating and drinking needs were assessed at regular intervals so they received care that met their changing needs.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

People told us that staff asked them for their consent before they supported them. People said they were able to make choices about some aspects of their care. People's comments were, "It is entirely up to me to undergo the treatment," and "The treatment was suggested and I agreed to it.' 'I can discuss anything." We observed staff asking people what they wanted in terms of their support. The registered manager and the staff we spoke with had a good understanding of the principles of the Mental Capacity Act 2005 (MCA). They told us they always presumed that people were able to make decisions about their day to day care. They said some of the people who used the service had been diagnosed as having dementia and they took extra care when communicating with them to involve them in making decisions.

Staff explained that if the person could not make certain decisions then they would have to decide what was in that person's "best interests" which would involve asking people close to the person as well as other professionals. Staff understood that people's capacity to make some decisions fluctuated depending on how they were feeling and how well they were. Staff had received training on the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS). Staff were able to describe people's rights and the process to follow if someone was identified as needing to be assessed under DoLS. Staff understood people's rights to make choices for themselves and also, where necessary, for staff to act in someone's best interests.

People were supported to receive good healthcare both from the hospice and other health and social care professionals. One relative explained that their family member's GP had referred their person to the Occupational Therapy at the hospice. This promoted their wellbeing and enabled them to remain as comfortable and pain free as possible. Staff recognised that people's healthcare needs could change and demonstrated awareness of how these could be reported and effectively acted upon. One person said, "The nurse and therapist at the hospice contact my GP and vice versa."

People had access to a range of palliative care professionals, including specialist palliative care doctors and nurses, physiotherapists, complementary therapists and counsellors. One person said, "The services definitely liaise. Everyone here seems au fait with my progress." Multidisciplinary team meetings (MDT) were held regularly for each of the services provided by the hospice. MDT's are meetings of professionals to discuss people individual's needs and how they could all contribute to meet these needs. We attended two MDT meetings (one focused on outpatients and another discussing the needs of people supported in the community). The MDT team consisted of a consultant (senior doctor), a clinical nurse specialist, a physiotherapist and their social worker. During the meetings an in depth discussion of each person's needs by the group of professionals took place, and a management plan for each person was drawn up based on consensus of opinion among the members of the MDT.

People had access to a range of complementary therapies, such as acupuncture, massage, reflexology, art therapy, relaxation and meditation. People and relatives told us these therapies helped with the management of symptoms. People's needs for alternative therapies were included in their care plans and staff spoken to understood that they were an essential part of the care provided by the hospice.

Good ●

Is the service caring?

Our findings

People told us that staff were kind and compassionate and caring. One person said, "We are treated with dignity and consideration." Another person said, "The staff are caring and it's amazing. It is peaceful. The staff are friendly but have a professional approach." One relative told us, "The staff are good at everything; they solve my problems. They are very caring and take time to have a chat." Another relative said, "It is a very human facility." We found that staff treated people with kindness, respect and compassion and consistently demonstrated a caring attitude.

The community service had a 24-hour contact line so that people and their relatives could always get support and advice regarding the needs. One person said, "Even when I cannot come, they phone me asking how I am doing." There was detailed information regarding the services and support available to people. Information was provided in the form of leaflets which were available at the reception. Another person said "Staff are kind and try to help." Staff treated people politely and with respect in their interactions and when supporting people.

Staff were aware of how to support people to express their preferences. One person told us, "The staff seem to know me well." Staff were able to describe how they supported people to make choices about what clothes to wear and we heard staff asking people where they wanted to spend time. We also saw that staff supported people to be as independent as possible, for example by encouraging a person to manage their personal care where they were able to do so.

Staff knew how to support people to express their views and be actively involved in making decisions about their care, as far as possible. One person said, "Oh, I do get the care I expect." Staff told us that people, or when applicable their representatives, were asked about people's preferences on admission to the hospice and that this was recorded in people's care plans. Two people who used the service confirmed that they were asked for this information.

Staff understood and responded sensitively to the needs of people and their relatives. This included supporting people to prepare advanced care plans and make their wishes about their end of life needs clear to their relatives and professionals. Care records showed that advanced care planning had been put in place where people were willing to discuss their needs. Staff understood that discussing with a person how they wished to be cared for at the end of their life was a sensitive matter. They told us that they would be led by the person who used the service in when and how much detail they would discuss this. One person told us, "At an initial meeting the staff asked what I hoped to get out of their services."

Staff were trained in advance communication skills enabling them to facilitate conversations. This helped to ensure that staff had the skills that enabled people to talk with them and share their worries. This training also gave staff the understanding and skills needed to have conversations with people about advanced care planning and end of life care.

People and their relatives had access to both psychological and bereavement counselling support. People told us that the counselling services were accessible and supported them to maintain their emotional well-being. People's need for counselling was established with them as part of the assessment of their needs. We spoke to staff who explained that they provided people with a range of psychological, counselling and psychotherapy support depending on their needs and wishes.

Care plans showed that people and their relatives had been consulted about how they wished to be supported. Relatives had been involved in decisions and received feedback about changes to people's care when this was appropriate. Care plans contained information about people's preferences regarding their care. People's likes and dislikes regarding food, interests and how they wanted to spend their time were also reflected in their care plans.

Staff treated people with respect and as individuals with different needs and preferences. One person told us, "This is a special place, very nice here: professional, relaxed and welcoming." Staff understood people's needs with regards to their disabilities, race, sexual orientation and gender and supported them in a caring way. Relatives had been asked about people's cultural and religious needs. Care records showed that staff supported people to practice their religion and attend community groups that reflected their cultural backgrounds.

There was a quiet room, which had religious books of different faiths such as the Quran and Bible. There was also a prayer mats. The registered manager told us that people from all faiths come and relax in the room for peace and meditations. Staff also had contacts with 17 religious leaders who came to the hospice and spoke with people as and when necessary, to provide spiritual support according to their faith.

Good ●

Is the service responsive?

Our findings

People and relatives told us that the hospice was very responsive to their needs. A person who used the service said, 'The staff are very helpful and make you feel comfortable." Another person said, "'Appointment times are made to suit my needs." The hospice had a 24-hour helpline that people and relatives could contact for advice. Staff told us they were aware of how to assess people's needs in a way that did not discriminate and they provided equal access to all people who used the service.

People received a comprehensive assessment of their needs when they were referred to the hospice. The detailed assessment and multi-disciplinary discussion ensured that staff making decisions about people's care and treatment had all the relevant information to ensure that the person received timely and effective care and support.

The hospice has started a cross sector collaboration to develop an 'End of Life' outcome based tool known as 'Outcome Star' working in collaboration with another hospice, an adult social care provider, and also with the London Association of Directors of Social Services and Macmillan Cancer Support. Outcome Stars are collaborative validated assessment tools that consider psychosocial and physical aspects of people. The registered manager explained that Outcome Stars were to be used to assess the needs of people who are receiving palliative and end of life care at the hospice.

Care records showed that comprehensive assessments had been carried out of people's needs on their referral to the outpatients and community team. These assessments were discussed at multidisciplinary team meetings so that the appropriate services were made available to people. Multidisciplinary team meetings meant that a full discussion took place with all the relevant professionals to ensure people's needs were met in a timely way. People received individualised assessments to ensure consistency and a thorough approach to meeting their specific needs.

The outpatient's therapy service provided a range of specialist medical and therapeutic services. When people attended they had access to health and social care professionals including doctors and nurses, therapies such as complementary therapy, occupational therapy, physiotherapy, family support team and pastoral care. People confirmed that they had been offered counselling and support and also that this had been extended to their relatives. One relative commented that, "They are very good with family. The human factor is there. There is meditation open to visitors and family. It was very relaxing when I attended. It is so nice here; I want to do some volunteering here." The Wellbeing and Therapy service is being expanded to be accessible to more people. This included additional investment in occupational therapy, social work and physiotherapy provision to develop and improve the service.

Clinical treatment interventions, such as blood transfusions, could be provided if appropriate. A relative said, "I think the service is great, they respond to any changes to my relative's needs." The service offered a range of support groups and activities. Their approach was to structure sessions around people's individual needs, whether this was receiving therapy, meeting other people or just relaxing in the garden.

The outpatient's therapy unit helped protect people from social isolation. In order to provide the opportunity for outpatients to meet and share experiences those attending a morning session stayed on for lunch and those attending in the afternoon came early so that they could have lunch together. We found that there was a very calm atmosphere and saw staff engaging with people in a friendly manner. Staff and people using the service also had some useful discussions, for example about the benefits of arts and crafts.

The service had systems in place to widen access for people who would not normally consider that hospice services could be for them. There were clinical leads on specific topics, for example, learning disability, dementia, transient population, sensory impairment and respiratory disease. The registered manager explained that they were working with another organisation to develop an' App' for end of life care and multi languages for individuals with limited communication and keyboard skills.

People were confident that if they made a complaint this would be listened to and the provider would take action to make sure that their concerns were addressed. One person told us, "I would go to the office to complain if needed." Another person, said, "'There are Yellow Forms for registering complaints, or I would talk directly to the staff, either the provider or the management." Copies of the complaints procedure were on display in the service. Staff told us that if anyone wished to make a complaint they would advise them to inform the manager about this, so the situation could be addressed promptly.

People and their relatives were confident they could raise any concerns they might have, however minor, and they would be addressed. People were able to give us examples of when they had made a complaint and confirmed they had been appropriately addressed. The complaint records showed that when issues had been raised these had been investigated and feedback given to the people concerned. Complaints were used as part of ongoing learning by the service and led to improvements being made to the care and support people received where necessary.

Good ●

Is the service well-led?

Our findings

People, their relatives and external professionals were positive about the care provided and the management of the hospice. People and relatives told us that a consultant will always come at short notice to explain care to both patients and relatives. One person said, "This is a special place." Another person told us, "Things really run smoothly here, that's due to the staff and management working together." One relative said, "Very impressive, there is a feeling of being supported from everyone here."

The hospice had a clear management structure and senior staff were clear about their roles and responsibilities. The mission and core values of the hospice provided staff with a clear direction of expected behaviours and conduct. These were reinforced throughout the induction, ongoing training programme and the support given to staff. Staff in all parts of the organisation understood their lines of responsibility and accountability for decisions about the management and direction of the hospice.

The chair of the board of trustees worked with the chief executive to address all governance matters as required. The chair of the board of trustees told us that they were committed to improving and spreading the service to more people while maintaining the quality of the service. The chief executive and executive team meet bimonthly with managers to exchange operational information and updates, review governance matters and brief the management team on meeting strategic objectives.

The provider had systems in place to monitor, evaluate and improve the care people received. People's views were sought regularly for each of the services that the hospice provided. Where these surveys showed that there was a need for improvement action plans were put in place and monitored by the clinical governance team, chief executive and the board of trustees. The provider had just conducted several patient and carer surveys as part of service development, and when concerns were raised these had been shared with board members and managers to make improvements to the services provided. People confirmed that they were asked about the quality of the service and had made comments about this. They told us they felt the provider took their views into account in order to improve the quality of the service.

The provider had an extensive and robust auditing program that was carried out at regular intervals throughout the year. Examples of these were, safeguarding, care planning, pressure area care, infection control and falls audits. Minutes of clinical governance meetings for various services and areas of work in the hospice showed that these audits were reviewed and where necessary improvements made to the service so that people continued to receive safe and good care.

Incidents and accidents were recorded and were reviewed by the registered manager. The provider took action to make sure that any risks identified were addressed. The provider's procedure to deal with incidents and accidents was available for staff to refer to when necessary, and records showed this had been followed for all incidents and accidents recorded.

The hospice worked with other organisations so that they maintained up-to-date practice and provided quality care to people. Staff provided advice and consultation to other providers of palliative care and end of life care. Staff told us that they were working on identifying the needs of those with long term conditions and moving forward with a process of co-design with people who used the service, staff, volunteers and external stakeholders (for example voluntary sector organisations and CCGs) to assist in planning future service developments for outpatients and therapies. The registered manager explained that they were currently working with the Enfield Local Authority commissioner to explore joint working for people with mental health, focusing on wellbeing approach and accessibility across different sites in the borough.