

Barnet, Enfield and Haringey Mental Health NHS Trust

Inspection report

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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.

This report is a summary of our inspection findings. You can find more detailed information about the service and what we found during our inspection in the related Evidence appendix.

Ratings

Overall rating for this trust

Good 

Are services safe?

Requires improvement 

Are services effective?

Good 

Are services caring?

Good 

Are services responsive?

Good 

Are services well-led?

Good 

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.

Summary of findings

Background to the trust

Barnet, Enfield and Haringey Mental Health NHS Trust provides services to a local population of around one million people. It had an annual income of £212 million in 2018/19, and it employs around 3,300 staff. Fifty-four per cent of the trust's staff are from Black and minority ethnic (BME) groups.

The trust provides mental health services for adults, older people and children in the boroughs of Barnet, Enfield and Haringey. In Enfield, it also provides community health services. In addition to these local services, the trust also provides specialist services for children and adults from across England. These services include forensic / secure inpatient wards and services for patients with eating disorders. The trust has 565 beds. In 2018/19, the trust provided care to more than 145,000 people in the community and 2800 in their wards.

The service provides the following core services:

Mental health core-services

- Acute wards for adults of working age and psychiatric intensive care units (PICUs)
- 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
- Mental health crisis and health-based places of safety
- Community-based mental health services for adults of working age
- Community-based mental health services for older adults
- Specialist community mental health services for children and young people
- Specialist eating disorder services

Community health core-services

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

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

The trust operates from eight registered locations including five main hospitals:

- Barnet General Hospital
- Chase Farm Hospital
- Edgware Community Hospital
- Magnolia Unit
- St Ann's Hospital

Summary of findings

CQC has inspected the trust 29 times since 2009. We conducted a comprehensive inspection of the trust in September 2017. At that inspection, we rated the trust as requires improvement overall. We rated it as requires improvement for two key questions (safe and effective) and good for three key questions (caring, responsive and well-led). At that inspection, we inspected all eight mental health core services that the trust provided, the specialist eating disorders service, as well as the community health services for children, young people and families in Enfield. We did not inspect the community inpatient services or community health services for adults, which had been previously rated as good. At that inspection, we rated two services as outstanding, five as good and four as requires improvement.

Since the last comprehensive inspection in September 2017, CQC has conducted one unannounced focused inspection, in March 2018. In this inspection, we reviewed Silver Birches, a ward for older people with mental health problems, and Magnolia Unit, a community inpatient service. This inspection identified areas for improvement.

Overall summary

Our rating of this trust improved since our last inspection. We rated it as Good  

What this trust does

Barnet, Enfield and Haringey Mental Health NHS Trust provides a range of community and inpatient mental health services for adults and children in three north London boroughs. In Enfield, it also provides community health services for adults and children.

In addition to these local services, the trust also provides specialist services for children and adults from across the UK. These services include forensic / secure inpatient wards, for which the trust acts as lead provider for north London, and services for patients with eating disorders.

Key questions and ratings

We inspect and regulate healthcare service providers in England.

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs, and well-led?

Where we have a legal duty to do so, we rate the quality of services against each key question as outstanding, good, requires improvement or inadequate.

Where necessary, we take action against service providers that break the regulations and help them to improve the quality of their services.

What we inspected and why

We plan our inspections based on everything we know about services, including whether they appear to be getting better or worse.

We inspected six core and specialist services as part of our ongoing checks on the safety and quality of healthcare services:

- Acute wards for adults of working age and psychiatric intensive care units
- Wards for older people with mental health problems
- Community-based mental health services for adults of working age

Summary of findings

- Mental health crisis and health-based places of safety
- Specialist eating disorder services
- Community inpatient services

Our comprehensive inspections of NHS trusts have shown a strong link between the quality of overall management of a trust and the quality of its services. For that reason, all trust inspections now include inspection of the well-led key question at the trust level. Our findings are in the section headed 'Is this organisation well-led'.

What we found

Overall trust

Our rating of the trust improved. We rated it as good because:

- We rated effective, caring, responsive and well-led as good. We rated safe as requires improvement. In rating the trust, we took account of the ratings of the six services inspected previously. After this inspection, nine of the trust services were rated good, two were requires improvement and two were rated outstanding.
- Since the last inspection, there had been a new chair and chief executive. One new non-executive director had joined the board. The director of nursing and chief operating officer were also recent appointments. The trust had an ambitious board, with a wide range of skills and experience. The board had tremendous energy and commitment and the new membership had provided an opportunity to review how they carried out their business and make changes.
- Although there was still more work to do, the trust had improved its services since our previous inspection, especially in its community services. Teams we had previously raised concerns about, such as the Haringey West locality team and the Enfield Crisis resolution and home treatment team, now provided safe and effective care. The trust had also addressed our concerns about its community health inpatient service and its specialist eating disorder service. Where further improvements were needed, the trust was approaching this with thoughtfulness and seeking external advice where needed. This gave confidence that the improvements would bring real benefits to patients and staff.
- The trust leadership team knew the main challenges facing the trust and had started to make plans to address them. The trust faced significant challenges in ensuring all adults of working age with an acute mental illness who would benefit from admission could access a local bed promptly. The trust was proactively trying to improve this situation. It planned to open a new ward in autumn 2019 and had also commissioned a review of its acute care pathway.
- The trust was working hard to improve the quality of the buildings in which it provided care to patients. This included the redevelopment of St Ann's hospital, which would replace outdated and inappropriate provision. Other wards had also been refurbished. An ongoing estates strategy was in development looking at the options for the redevelopment of the trust's other estate. Dormitories would be eliminated from the Haringey and Barnet sites by the end of 2020. Further work was needed to eliminate the few remaining shared bedrooms on the Chase Farm site. There was also ongoing work to improve the seclusion facilities and reduce ligatures.
- Staff assessed the physical and mental health of most patients on admission and developed plans to support patients manage risks. Staff in most teams worked together with patients to develop care plans reflected the assessed needs. Although some teams needed to improve, many staff develop personalised, holistic and recovery-oriented plans with people. Staff supported many patients safely in the community.
- The trust had begun work to ensure it provided good services in the future. It had developed a new strategy, 'fit for the future', collaboratively with patients, carers, staff and external stakeholders that reflected local and national health and care priorities. It was actively involved with other local health providers in the sustainability and transformation

Summary of findings

plans, and it was actively participating in the development of new models of care. It was, for example, leading the North London Forensic Service, which was developing a new care model across north London for secure services. It had agreed a strategic alliance with Camden and Islington NHS Foundation Trust to explore ways in which they could work more closely together.

- The trust was working to improve the staff culture but recognised there was more to do. The board members were open and transparent in their manner and reflected the values of the organisation. A programme of executive roadshows had enabled members of the executive team to meet over 500 staff. Multiple other forums provided opportunities to listen to staff. However, the staff survey showed that improvements needed; high numbers of staff continued to report experiencing bullying and harassment and violence and aggression. This said, the overall culture of the trust was very patient centred, and this was under-pinned by the promotion of the trust values. Staff we met cared deeply about delivering the best care possible for their patients.
- Since the last inspection, the trust had made significant progress in addressing its financial challenges. For 2018/19, the trust met its control total it had agreed with NHS Improvement.
- The trust was strengthening its leadership structures and governance arrangements. The trust had moved from having four to five divisions to enable the community services in Enfield to have more focused attention. A triumvirate leadership team was being put into place in each division. The governance structures and accountability frameworks were being reviewed across the trust to provide improved clarity and consistency. The quality governance processes were being refreshed to provide improved assurance
- The trust had begun work to use quality improvement (QI) in its work, which it recognised was integral to changing the culture of the trust and empowering staff and patients to identify and make improvements, but it had more work to do to emend this approach. The trust had prepared a QI strategy, was recruiting a small team to support the work and had plans to train more staff and embed the work in the divisions. Since the previous inspection progress had stalled, but work was underway to re-invigorate the work.

However:

- The trust needed to continue to review the governance systems to ensure that it always identified and addressed areas of concerns, shared learning between teams effectively and make sure important changes following incidents had been embedded. We found areas that required improvements that had not been identified and addressed in the wards of older people with mental health needs and the mental health crisis services.
- The trust continued to experience pressures on its services, which meant that acutely unwell mental health patients sometimes did not get promptly assessed and cared for in local high-quality services. It had to place many patients in external services that may be a long way from where they lived, and many patients experienced long waits in the trust's health-based place of safety. In addition, many patients were waiting too long to have a Mental Health Act assessment when this was felt to be clinically needed to maintain their own or other people's safety.
- The trust did not have enough permanent nursing and care staff, particularly on the acute inpatient wards, who knew the patients. This impacted on their ability to form the professional relationships needed to understand and support each patient consistently with their individual needs. This was leading to instances of violence and aggression that might have been managed better by permanent staff. The trust knew it needed to address its ongoing workforce challenges and had plans to support the recruitment and retention of staff. It monitored whether the wards achieved safe staffing levels and had completed a nursing skill mix review to assess its nursing requirements.
- The trust still needed to implement a system to automate the production of live business information. The trust had arrangements in place in the interim to generate accurate data and had made improvements in how this was presented, but the overall process was cumbersome.

Summary of findings

Are services safe?

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

- At this inspection, we rated safe as requires improvement in three of the six core and specialist services we inspected. We rated the community based mental health services for adults of working age as inadequate for safe. We rated safe as good in the other two core services. When these ratings were combined with the other existing ratings from previous inspections, four of the trust services were rated requires improvement, one was rated as inadequate and seven were rated good.
- The service did not have enough permanent nursing and care staff, particularly on the acute inpatient wards, who knew the patients. This impacted on their ability to form the professional relationships needed to understand and support each patient consistently with their individual needs. This was leading to instances of violence and aggression that might have been managed better by permanent staff. The trust knew it needed to address its ongoing workforce challenges and had plans to support the recruitment and retention of staff. It monitored whether the wards achieved safe staffing levels and had completed a nursing skill mix review to assess its nursing requirements.
- The trust had not ensured that teams shared lessons learnt with each other - especially with teams in different boroughs. In some areas, such as the mental health crisis services, the trust had also not ensured that important changes had been embedded following incidents. The trust had identified this as an area to improve and had plans in place to support staff to share lessons learnt more easily.
- Patients identified as in need of a Mental Health Act (MHA) assessment were not always assessed promptly and there were significant delays to MHA assessments. Delays in completing assessments could mean that people may be at risk of harm. Staff across all adult community mental health teams told us that MHA assessment delays was a significant issue for their team, and told us of incidents where patients' safety had been compromised whilst waiting for a MHA assessment. Despite the delays in MHA assessments being completed, the trust was working closely with other agencies, including the police and social services, to address these delays.
- Whilst the completion of mandatory training had improved, and was 89% overall, there were still some courses where further improvement was needed. This included training which needed to be delivered face to face. However, the trust was monitoring this closely through their 'brilliant basics' programme and were providing bespoke training to teams where needed.

However:

- The trust was working hard to improve the quality of the buildings in which it provided care to patients. This included the redevelopment of St Ann's hospital, which would replace outdated and inappropriate provision. Other wards had also been refurbished. An ongoing estates strategy was in development looking at the options for the redevelopment of the other trust estate. Dormitories would be eliminated from the Haringey and Barnet sites by the end of 2020. Further work was needed to eliminate the few remaining shared bedrooms on the Chase Farm site. There was also ongoing work to improve the seclusion facilities and reduce ligatures.
- The trust had continued to improve in how staff assessed and monitored risks to patients. Although some teams still needed to embed further improvements, most teams in the community-based mental health services for adults of working age and mental health crisis services assessed and managed most risks to patients well, enabling people to live safely in the community. There were still some teams where further improvements were needed. For example, on the wards for older people with mental health problems, staff did not always record patients' physical health observations accurately and had not completed physical health monitoring of patients' vital signs after every use of rapid tranquilisation. Staff in the Barnet mental health crisis services did not clearly record the risk management plans for patients when their risk level had changed.

Summary of findings

- 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 had easy access to clinical information and it was easy for them to maintain high quality clinical records – whether paper-based or electronic.
- The trust managed most patient safety incidents well. Staff recognised incidents and reported them appropriately. When things went wrong, staff apologised and gave patients honest information and suitable support. While there was ongoing work to improve the timeliness of incident investigations, the reports were completed to an appropriate standard.

Are services effective?

Our rating of effective improved. We rated it as good because:

- At this inspection, we rated effective as good in all six core and additional services we inspected. When these ratings were combined with the other existing ratings from previous inspections, 11 of the trust's services were rated good and one was rated outstanding.
- Staff assessed the physical and mental health of patients on admission. They developed individual care plans for most patients, which they reviewed regularly through multidisciplinary discussion and updated as needed. Staff in most teams developed care plans reflected the assessed needs and were mostly personalised, holistic and recovery-oriented. Some teams still needed to make some improvements in ensuring that staff developed individualised and holistic plans with patients in all cases.
- The trust continued to make improvements in the physical health care it offered patients with mental health needs. It had held trust-wide learning events and some adult community mental health teams had established clinics to support patients. Further work was required to ensure that the trust delivered good support to all patients with their physical health needs as there were still variations between teams. The trust had also sought to improve its links to primary care services. In Barnet, they had developed a GP link-working service, which ensured that every GP practice had direct access to a dedicated mental health professional.
- The trust provided a range of care and treatment interventions suitable for the patient groups and mostly consistent with national guidance on best practice. They ensured that patients had good access to physical healthcare and supported patients to live healthier lives. Staff in the Haringey community-based mental health services for adults of working age and mental health crisis teams had begun to use the Open dialogue model in some of their care, which plans care around the person and their social network.
- The trust recognised the importance of having a strong programme of quality assurance. This included clinical audits, where during the year 2018-19 the trust participated in 11 national clinical audits, two national confidential enquiries, 86 trust-wide audits and 11 local audits.
- The trust made sure staff were competent for their roles. The trust had systems in place to induct and deliver ongoing training to ensure staff had the range of skills needed to provide high quality care. They supported staff with appraisals and opportunities to update and further develop their skills.
- The trust ensured that staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and discharged these well.
- Staff supported patients to make decisions on their care for themselves. Most staff understood the provider's policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly for patients who might have impaired mental capacity.

However:

Summary of findings

- The trust had not made sure that all staff consistently received all the support they needed. At the time of the inspection, whilst most staff said they had access to supervision and reflective practice, the trust did not have a robust system to monitor the delivery of this, although plans were in place to acquire a system to provide this management information. Across the trust, we found some teams in which supervision rates needed to improve. We also found large variations in the quality of team meetings. Some teams did not complete regular and meaningful team meetings that covered all relevant topics. The trust had recently put in a framework for ward meetings, but this needed to embed.

Are services caring?

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

- At this inspection, we rated caring as good in all six core and specialist services we inspected. When these ratings were combined with the other existing ratings from previous inspections, 10 of the trust's services were rated good and two were rated outstanding.
- Across all services, 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. Whilst there were some exceptions, most staff cared about patients and supporting them well.
- 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.
- The trust promoted the involvement of patients. Since the last inspection, the trust had developed a patient engagement strategy. Staff in wards for older people with mental health problems had set up improvement meetings, involving a range of staff, patients and relatives/carers, to gather the views of people and improve the service.
- Staff informed and involved families and carers appropriately. They supported carers to complete a carers' assessment. They provided opportunities for carers to become better informed or participate in the service such as through carers groups. The community-based mental health services for adults of working age early intervention services facilitated a carer group each month, where staff provided support and information to carers and encouraged them to provide mutual support for each other.

Are services responsive?

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

- At this inspection, we rated responsive as good in four of the core and specialist services we inspected. We rated responsive as good in the other two core services. When these ratings were combined with the other existing ratings from previous inspections, nine of the trust's services were rated good, two were rated outstanding, and two were rated as requires improvement.
- Staff worked across teams to try and optimise the care pathway for patient. Staff from crisis and home treatment teams attended wards to help support patient discharges.
- Referral criteria for community mental health services for adults did not exclude patients who would have benefitted from care. Staff assessed and treated patients who required urgent care promptly. Staff followed up patients who missed appointments.
- The food on inpatient wards was generally of a good quality and patients could make hot drinks and snacks at any time.
- The services met the needs of all patients who used the service – including those with a protected characteristic. Staff helped patients with communication, advocacy, cultural and spiritual support.

Summary of findings

- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, which were shared with all staff. The trust still needed to improve the timeliness of its completion of complaint responses and incident investigations although these were ultimately completed to an acceptable standard.

However:

- The trust had not planned and provided services in a way that met the needs of local people with an acute mental illness. Some patients experienced long waits to access local services. A bed was not always available locally patients on the acute wards for adults of working age and psychiatric intensive care units (PICUs). This meant the trust placed patients in beds out of the area. During the period of the inspection, more than 20 patients were placed in out-of-area services. Patients staying in the health-based place of safety often experienced long waits, some for more than two days, to access a bed. The trust was working hard to improve its bed management. It had invested in its bed management team, it planned to open a new ward in Autumn 2019, and it had commissioned a review of its acute care pathway to see if any other improvements could be made.
- The design, layout, and furnishings of some wards did not support patients' treatment, privacy and dignity. Some patients had to sleep in dormitories. Most bedrooms did not have an en-suite bathroom. But the trust was redeveloping the wards at St Ann's hospital and had refurbished other wards, such as the specialist ward for eating disorders, to provide better ward environments. Dormitories would be eliminated from the Haringey and Barnet sites by the end of 2020. Further work was needed to eliminate the few remaining shared bedrooms on the Chase Farm site.
- In some adult community mental health teams there were long waits for specific types of individual psychological therapies. The trust had worked hard since our last inspection to reduce waiting times for psychological therapies through reviewing the service model, using locum psychologists and offering group interventions however, some patients continued to wait a long time for psychological interventions. Barnet had the highest waiting times, with some patients waiting up to 18-months for individual and specialist group psychological therapies. The trust was not always fully cited on the waiting times.

Are services well-led?

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

- Since the last inspection, there had been a new chair and chief executive. One new non-executive director had joined the board. The director of nursing and chief operating officer were also recent appointments. The trust had an ambitious board, with a wide range of skills and experience. The board had tremendous energy and commitment and the new membership had provided an opportunity to review how they carried out their business and make changes.
- The trust had responded positively to the previous inspection and worked to make the necessary improvements. For example, we saw progress in how individual services assessed risk and worked to promote the safety of patients. We were also delighted to see the new wards at St Ann's being built. The trust was also looking at options for future estate modernisation.
- The inspection took place when there was still considerable work to do, however the trust was approaching this with thoughtfulness, seeking external advice where needed and this gave confidence that the improvements would bring real benefits to patients and staff.
- The board was cited on the areas where improvements were needed, and changes were taking place to ensure the provision of high-quality care to their local communities. For example, they were aware of the significant challenges in accessing high quality care for patients with an acute mental illness. They were opening additional beds but had also commissioned a review to look at how capacity and quality of care could be improved going forward.

Summary of findings

- A trust strategy had been launched 'fit for the future'. This was developed collaboratively with patients, carers, staff and external stakeholders. It reflected local and national health and care priorities. There were four clear strategic aims that were being used to develop the business plans for the trust.
- The trust was working to improve the staff culture but recognised there was more to do. The board members were open and transparent in their manner and reflected the values of the organisation. A programme of executive roadshows had enabled members of the executive team to meet over 500 staff. Multiple other forums provided opportunities to listen to staff. The arrangements for staff to 'speak up' were working well. However, the staff survey results were described by the trust as disappointing. Whilst staff engagement scores were similar to other trusts, there were improvements needed in staff experiencing bullying and harassment and violence and aggression. It was recognised that there were services where staff morale was poor. Measures were being implemented to make improvements, but it was recognised that more time was needed to ensure these were embedded and individual staff had an improved experience.
- The trust had made significant progress in addressing its financial challenges. At the end of the financial year 2016/17 there was a deficit of £12.3m. For the current financial year, the trust had agreed a control total deficit of £5.5m. They recognised there were some risks in achieving this total but were monitoring these closely. They were working closely with commissioners and were developing a shared understanding of the costs of meeting the needs of the local population.
- The trust recognised the importance of working collaboratively to meet the needs of the population across north central London and had formed an alliance with the adjoining trust, Camden and Islington NHS Foundation Trust. This was at an early stage but will offer opportunities to develop care pathways for patients across the two geographical areas. For example, last year a female psychiatric intensive care unit was opened at St Pancras Hospital providing a service for both the trusts.
- The trust was continuing to promote the equalities of staff and patients with protected characteristics. An equality and diversity forum was chaired by the chief executive. It was also positive that the trust had appointed a BME chief executive and chair. There was progress with the workforce race equality standards although there was more to do. The proportion of BME staff being promoted to senior roles had improved although the proportion of BME staff entering formal disciplinary procedures had deteriorated. The trust had four staff networks which were supported by the trust but might need more resources to grow and embed.
- The trust was strengthening its leadership structures and governance arrangements. The trust had moved from having four to five divisions to enable the community services in Enfield to have more focused attention. A triumvirate leadership team was being put into place in each division. The governance structures and accountability frameworks were being reviewed across the trust to provide improved clarity and consistency. The quality governance processes were being refreshed to provide improved assurance. However, at the time of the inspection this was being put into place and so the improvements could not yet be seen operating in practice. During the interim period, the current systems were being maintained to provide ongoing assurance.
- The trust valued the importance of multi-disciplinary working and was strengthening leadership and involvement across the organisation. A lead for allied health professionals was coming into post shortly.
- The trust had made progress in the co-production work with people who use services and carers. The trust had produced a patient engagement strategy. Since late 2017 the provision of enablement services in the trust was awarded to a local charity. They had worked to embed peer roles within the trust and increase staff working in partnership with people using services. The trust had increased the number of peer workers from eight to 24 people. Peer service workers were part of the psychiatric liaison team at the North Middlesex Hospital. There were lots of examples of co-production work. However, further progress was needed to ensure this was embedded across all the divisions.

Summary of findings

- The trust was working to re-invigorate their programme of quality assurance and saw this as integral to the empowerment of staff and patients to make improvements and therefore the culture of the trust. A quality improvement strategy had been approved and an investment this year of £0.5m to employ some key staff and extend training. However, it was not clear if this would be an adequate investment to promote the necessary changes.

However:

- The trust still needed to implement a system to automate the production of live business information. The trust had arrangements in place in the interim to generate accurate data and had made improvements in how this was presented, but the overall process was cumbersome. The trust intended to select a system later in the year. The trust was also in the process of tendering for a system to monitor the completion of supervision and appraisals and at the time of the inspection this data was collected manually.
- The trust still needed to improve the timeliness of its completion of complaint responses and incident investigations although these were ultimately completed to an acceptable standard. Measures were in place to promote improvements and it was anticipated that the strengthened divisional structures would ensure closer monitoring of progress.

Ratings tables

The ratings tables show the ratings overall and for each key question, for each service and for the whole trust. They also show the current ratings for services or parts of them not inspected this time. We took all ratings into account in deciding overall ratings. Our decisions on overall ratings also took into account factors including the relative size of services and we used our professional judgement to reach fair and balanced ratings.

Outstanding practice

We found examples of outstanding practice in two services we inspected:

- Mental health crisis and health-based places of safety
- Wards for older people with mental health problems

For more information see the Outstanding practice section of this report.

Areas for improvement

We found areas for improvement including breaches of four regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 that the trust must put right: Regulation 9 Person-centred care; Regulation 12 Safe care and treatment; Regulation 13: Safeguarding service users from abuse and improper treatment; and Regulation 18 Staffing. There were seven things the trust must put right in relation to breaches of these four regulations. In addition, we found 58 things that the trust should improve to comply with a minor breach that did not justify regulatory action, to prevent breaching a legal requirement, or to improve service quality.

For more information see the areas for improvement section of this report.

Action we have taken

We issued requirement notices in respect of the four regulations that had been breached within four core services.

For more information on action we have taken, see the sections on Areas for improvement and Regulatory action.

Summary of findings

What happens next

We will check that the trust takes the necessary action to improve its services. We will continue to monitor the safety and quality of services through our continuing relationship with the trust and our regular inspections

Outstanding practice

Wards for older people with mental health problems

- The décor, furnishings and layout on Silver Birches had recently been upgraded following a successful bid to the trust's 'Dragons Den.' The trust had worked with an external company to provide a bespoke dementia friendly environment. Patients had been involved in making changes about the décor, including sensory areas and murals evoking a street with front doors for each bedroom, street lamps, trees, and a tea shop and American diner area for mealtimes.

Mental health crisis and health-based places of safety

- The crisis teams came together each quarter and formed the 'crisis collaboration'. This was a partnership with each crisis team to share best practice and offer informal training to support staff in areas their team performed well in.
- The clinical leadership in Haringey were involved in research in conjunction with a local London university. The research programme is Open Dialogue: Development and Evaluation of a Social Network Intervention for Severe Mental Illness (ODDESI). The programme examines if open dialogue offers good outcomes for patients.

Areas for improvement

Action the trust **MUST** take is necessary to comply with its legal obligations. Action a trust **SHOULD** take is to comply with a minor breach that did not justify regulatory action, 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 legal requirements. These seven actions relate to four core services.

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

- The trust must employ sufficient permanent staff on all wards to ensure that the service can provide safe, person-centred care. **Regulation 18 Staffing (1)**
- The trust must ensure there are sufficient beds to ensure that patients can be admitted to hospital in their local area without delays. **Regulation 9 Person-centred care (1)(a)(b)**

Wards for older people with mental health problems

- The trust must ensure that physical health monitoring of patients' vital signs is undertaken after every use of rapid tranquilisation, and that staff are clear about the frequency required as outlined in trust policy. **Regulation 12 Safe care and treatment (1)(2)(a)(b)**
- The trust must ensure that staff on Ken Porter Ward complete physical health observations for patients consistently, scoring results accurately, and seek medical advice when indicated. **Regulation 12 Safe care and treatment (1)(2)(a)(b)(c)**

Summary of findings

Community-based mental health services for adults of working age

- The trust must ensure that it works 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 Safe care and treatment (1)(2)(a)(b)(i)**

Mental health crisis and health-based places of safety

- 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 Safeguarding service users from abuse and improper treatment (1)(2)(5)**
- The trust must ensure that in Barnet crisis resolution home treatment team (CRHTT), staff hold effective team meetings, where information about learning from serious incidents, can be shared and discussed. Staff should ensure any actions because of serious incidents are shared with staff to improve patient safety. **Regulation 12 Safe care and treatment (1)(2)(a)(b)**

Action the trust SHOULD take to improve

We told the trust that it should take action to comply with a minor breach that did not justify regulatory action, to prevent breaching a legal requirement in future or to improve service quality. These are the 58 actions related to the whole trust and five core services.

Trust-wide

- The trust should continue to improve the programme of visits to services by the non-executive directors to ensure a varied cross section receive visits.
- The leadership team should continue to work towards improving the culture of the organisation as reflected in the staff survey. They should continue to support staff to feel safe in speaking out and address poor cultures in services where needed.
- The trust should continue to implement the work to deliver robust governance structures and accountability frameworks throughout the trust.
- The trust should continue to work to ensure all the mandatory training targets are met, especially those delivered by face to face training.
- The trust should implement a system to automate the production of live business information to ensure timely access of data to teams, divisions and the trust.
- The trust should continue to work to ensure complaints and serious incidents investigations are completed in a timely manner.
- The trust should ensure a system is in place to monitor the completion of supervisions and appraisals.
- The trust should keep the implementation of quality improvement under review to ensure there are adequate resources available.
- The trust should continue to support the growth of staff networks and ensure there is adequate staff time and resources available to promote this work.

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

- The trust should ensure that staff note potential hazards on the wards in environmental checks and that these are addressed straight away.

Summary of findings

- The trust should ensure that all ligature risks are included in the ligature risk assessment, including those that present a low risk.
- The trust should ensure that refurbishments of seclusion rooms at Chase Farm are completed to ensure the privacy and dignity of secluded patients.
- The trust should ensure that all equipment is calibrated to ensure accurate readings.
- The trust should ensure that rapid tranquilisation is used consistently across the hospital sites and that staff monitor the physical health of patients after rapid tranquilisation has been administered.
- The trust should ensure that medicines reconciliation is carried out for all patients.
- The trust should ensure that staff record the dates on which liquid medicines are opened.
- The trust should ensure that information about never events within the trust is shared with staff in all relevant services.
- The trust should ensure that all managers are fully competent in using the electronic incident reporting system.
- The trust should ensure the progress in the provision of supervision is consistent across all wards and that staff are sufficiently supported to carry out their duties.
- The trust should ensure that team meetings are held on all wards to enable staff to be aware of and contribute to discussions about assessing, monitoring and improving quality and safety,
- The trust should ensure that advocates visit patients promptly.
- The trust should ensure that staff explain to patients how the Mental Health Act applies to them when they are admitted and repeat this if the patient does not understand the information.
- 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.
- The trust should ensure that sleeping accommodation does not compromise patients' privacy and dignity.
- The trust should ensure that leadership is consistently provided on all wards and sufficient interim arrangements are put in place if wards are temporarily without a permanent ward manager.
- The trust should ensure that staff have completed training designated as being mandatory.

Wards for older people with mental health problems

- The trust should ensure that staff record formal medicines reconciliation records for patients on all wards.
- The trust should put in place action plans to remove shared bays on The Oaks and Silver Birches, so that patients have their own private bedrooms.
- The trust should review governance arrangements to ensure that learning and best practice is shared and embedded between all units for older age adults.
- The trust should review medical provision at The Oaks and Ken Porter Ward to ensure that there is sufficient access to doctors at all times.
- The trust should review procedures for admitting sub-acute working age adults on Ken Porter Ward, to ensure that this does not impact on other patients on the ward.
- The trust should ensure that medicine storage cabinets with the correct specification as stated in the trust's medicines management policy, are fitted on The Oaks and Silver Birches.

Summary of findings

- The trust should review the frequency of fire drills (with or without an alarm) to ensure that all staff, including those working at night, have regular practice in using procedures for protecting patients in the event of a fire.
- The trust should continue to work to improve the frequency of staff supervision across the wards.
- The trust should ensure that all staff are up to date with mandatory training.

Community-based mental health services for adults of working age

- The trust should review staffing levels in the Barnet West and South Locality Teams to ensure there are enough staff to safely and effectively deliver care and treatment to patients. The trust should continue its recruitment drive for permanent staff in the Barnet West Locality and Haringey North East Locality team to limit the impact on consistency of care.
- The trust should ensure that staff regularly update patients' risk assessments, including after a change in circumstance or an incident, to ensure safe management of risk.
- The trust should ensure that staff in Haringey and Barnet Early Intervention Services have manageable caseloads, in line with national recommendations.
- The trust should ensure staff develop and embed the necessary skills to support patients with their physical health care needs.
- The trust should ensure that staff in the Early Intervention Services proactively offer interventions to patients in line with national guidelines and quality standards, and ensure care plans reflect these interventions.
- The trust should continue to improve waiting times for patients to access psychological interventions, and ensure that patients are safely monitored whilst waiting for the interventions.
- The trust should ensure that all staff have a sufficient understanding of the relevance of the Mental Capacity Act and are able to identify patients who might have impaired capacity, and assess and record capacity assessments appropriately.
- The trust should ensure there are formal systems in place for teams to share information, such as learning from incidents and good practice across the three boroughs.

Mental health crisis and health-based places of safety

- The trust should ensure that the documentation of risk management plans on patient care records contains sufficient and up to date detail to reflect when a change in risk has occurred, particularly in Barnet CRHT.
- The trust should ensure staff complete stock checks of medicines that are kept onsite and then administered to patients in their homes, particularly in Barnet CRHT.
- The trust should continue to ensure staff communicate with patients when they are running late or need to cancel appointments.
- The trust should ensure staff complete care plans for patients and these are holistic, recovery-focused and personalised.
- The trust should ensure senior managers have oversight of serious incidents to ensure that staff adequately implement the actions from investigation reports.
- The trust should ensure that pertinent risks posed to the teams are included on their risk register to ensure managers have oversight of the risks within the services.

Community inpatient services

Summary of findings

- The trust should continue the work to ensure all staff complete mandatory training.
- The trust should ensure all staff follow infection control policies and procedures including use of personal protective equipment.
- The trust should ensure that medicine reconciliation is carried out for all patients admitted to the unit.
- The trust should ensure it continues to work to improve recruitment and retention within the service to address the high nursing staff vacancy rate on the unit.
- The trust should ensure it improves the quality and consistency of patient records to ensure records are clear, up-to-date, stored securely and easily available to all staff providing care.
- The trust should ensure that staff complete nutrition risk assessments fully and decisions around nutrition monitoring are clearly documented.
- The trust should support each patient to have an individual program, so they know when their therapy sessions are taking place.
- The trust should ensure that the unit's risk register is up to date and reflects the current risks to the service.
- The trust should ensure that the processes in place to gather patient feedback are used.

Is this organisation well-led?

Our comprehensive inspections of NHS trusts have shown a strong link between the quality of overall management of a trust and the quality of its services. For that reason, we look at the quality of leadership at every level. We also look at how well a trust manages the governance of its services – in other words, how well leaders continually improve the quality of services and safeguard high standards of care by creating an environment for excellence in clinical care to flourish.

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

- The trust had an ambitious board, with a wide range of skills and experience. Since the last inspection, there had been a new chair and chief executive. One new non-executive director had joined the board. The director of nursing and chief operating officer were also recent appointments. The board had tremendous energy and commitment and the new membership had provided an opportunity to review how they carried out their business and make changes.
- The trust had responded positively to the previous inspection and worked to make the necessary improvements. For example, we saw progress in how individual services assessed risk and worked to promote the safety of patients. We were also delighted to see the new wards at St Ann's being built. The trust was also looking at options for future estate modernisation.
- The inspection took place when there was still considerable work to do, however the trust was approaching this with thoughtfulness, seeking external advice where needed and this gave confidence that the improvements would bring real benefits to patients and staff.
- The board was cited on the areas where improvements were needed, and changes were taking place to ensure the provision of high-quality care to their local communities. For example, they were aware of the significant challenges in accessing high quality care for patients with an acute mental illness. They were opening additional beds but had also commissioned a review to look at how capacity and quality of care could be improved going forward.

Summary of findings

- A trust strategy had been launched 'fit for the future'. This was developed collaboratively with patients, carers, staff and external stakeholders. It reflected local and national health and care priorities. There were four clear strategic aims that were being used to develop the business plans for the trust.
- The trust was working to improve the staff culture but recognised there was more to do. The board were open and transparent in their manner and reflected the values of the organisation. A programme of executive roadshows had enabled members of the executive team to meet over 500 staff. Multiple other forums provided opportunities to listen to staff. The arrangements for staff to 'speak up' were working well. However, the staff survey results were described by the trust as disappointing. Whilst staff engagement scores were similar to other trusts, there were improvements needed in staff experiencing bullying and harassment and violence and aggression. It was recognised that there were services where staff morale was poor. Measures were being implemented to make improvements, but it was recognised that more time was needed to ensure these were embedded and individual staff had an improved experience.
- The trust had made significant progress in addressing its financial challenges. At the end of the financial year 2016/17 there was a deficit of £12.3m. For the current financial year, the trust had agreed a control total deficit of £5.5m. They recognised there were some risks in achieving this total but were monitoring these closely. They were working closely with commissioners and were developing a shared understanding of the costs of meeting the needs of the local population.
- The trust recognised the importance of working collaboratively to meet the needs of the population across north central London and had formed an alliance with the adjoining trust, Camden and Islington NHS Foundation Trust. This was at an early stage but will offer opportunities to develop care pathways for patients across the two geographical areas. For example, last year a female psychiatric intensive care unit was opened at St Pancras Hospital providing a service for both the trusts.
- The trust was continuing to promote the equalities of staff and patients with protected characteristics. An equality and diversity forum was chaired by the chief executive. It was also positive that the trust had appointed a BME chief executive and chair. There was progress with the workforce race equality standards although there was more to do. The proportion of BME staff being promoted to senior roles had improved although the proportion of BME staff entering formal disciplinary procedures had deteriorated. The trust had four staff networks which were supported by the trust but might need more resources to grow and embed.
- The trust was strengthening its leadership structures and governance arrangements. The trust had moved from having four to five divisions to enable the community services in Enfield to have more focused attention. A triumvirate leadership team was being put into place in each division. The governance structures and accountability frameworks were being reviewed across the trust to provide improved clarity and consistency. The quality governance processes were being refreshed to provide improved assurance. However, at the time of the inspection this was being put into place and so the improvements could not yet be seen operating in practice. During the interim period, the current systems were being maintained to provide ongoing assurance.
- The trust valued the importance of multi-disciplinary working and was strengthening leadership and involvement across the organisation. A lead for allied health professionals was coming into post shortly.
- The trust had made progress in the co-production work with people who use services and carers. The trust had produced a patient engagement strategy. Since late 2017 the provision of enablement services in the trust was awarded to a local charity. They had worked to embed peer roles within the trust and increase staff working in partnership with people using services. The trust had increased the number of peer workers from eight to 24 people. Peer service workers were part of the psychiatric liaison team at the North Middlesex Hospital. There were lots of examples of co-production work. However, further progress was needed to ensure this was embedded across all the divisions.

Summary of findings

- The trust was working to re-invigorate their programme of quality assurance and saw this as integral to the empowerment of staff and patients to make improvements and therefore the culture of the trust. A quality improvement strategy had been approved and an investment this year of £0.5m to employ some key staff and extend training. However, it was not clear if this would be an adequate investment to promote the necessary changes.

However:

- The trust still needed to implement a system to automate the production of live business information. The trust had arrangements in place in the interim to generate accurate data and had made improvements in how this was presented, but the overall process was cumbersome. The trust intended to select a system later in the year. The trust was also in the process of tendering for a system to monitor the completion of supervision and appraisals and at the time of the inspection this data was collected manually.
- The trust still needed to improve the timeliness of its completion of complaint responses and incident investigations although these were ultimately completed to an acceptable standard. Measures were in place to promote improvements and it was anticipated that the strengthened divisional structures would ensure closer monitoring of progress.

Ratings tables

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 →← Sept 2019	Good ↑ Sept 2019	Good →← Sept 2019	Good →← Sept 2019	Good →← Sept 2019	Good ↑ Sept 2019

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
Community	Requires improvement →← Sept 2019	Good →← Sept 2019	Good →← Sept 2019	Good →← Sept 2019	Good →← Sept 2019	Good →← Sept 2019
Mental health	Requires improvement →← Sept 2019	Good ↑ Sept 2019	Good →← Sept 2019	Good →← Sept 2019	Good →← Sept 2019	Good ↑ Sept 2019
Overall trust	Requires improvement →← Sept 2019	Good ↑ Sept 2019	Good →← Sept 2019	Good →← Sept 2019	Good →← Sept 2019	Good ↑ Sept 2019

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.

Ratings for community health services

	Safe	Effective	Caring	Responsive	Well-led	Overall
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 services for children and young people	Requires improvement Sept 2017	Good Sept 2017	Good Sept 2017	Good Sept 2017	Good Sept 2017	Good Sept 2017
Community health inpatient services	Good →← Sept 2019	Good →← Sept 2019	Good →← Sept 2019	Good →← Sept 2019	Good →← Sept 2019	Good →← Sept 2019
Overall*	Requires improvement →← Sept 2019	Good →← Sept 2019	Good →← Sept 2019	Good →← Sept 2019	Good →← Sept 2019	Good →← Sept 2019

*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.

Ratings 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 ↔ Sept 2019	Good ↑ Sept 2019	Good ↔ Sept 2019	Requires improvement ↓ Sept 2019	Good ↑ Sept 2019	Requires improvement ↔ Sept 2019
Forensic inpatient or secure wards	Good Sept 2017	Outstanding Sept 2017	Outstanding Sept 2017	Outstanding Sept 2017	Outstanding Sept 2017	Outstanding Sept 2017
Child and adolescent mental health wards	Good Sept 2017	Good Sept 2017	Good Sept 2017	Good Sept 2017	Good Sept 2017	Good Sept 2017
Wards for older people with mental health problems	Requires improvement ↓ Sept 2019	Good ↑ Sept 2019	Good ↔ Sept 2019	Good ↔ Sept 2019	Good ↔ Sept 2019	Good ↔ Sept 2019
Community-based mental health services for adults of working age	Inadequate ↓ Sept 2019	Good ↑ Sept 2019	Good ↔ Sept 2019	Good ↔ Sept 2019	Good ↑ Sept 2019	Good ↑ Sept 2019
Mental health crisis services and health-based places of safety	Requires improvement ↔ Sept 2019	Good ↑ Sept 2019	Good ↔ Sept 2019	Requires improvement ↔ Sept 2019	Good ↑ Sept 2019	Requires improvement ↔ Sept 2019
Specialist community mental health services for children and young people	Good Sept 2017	Good Sept 2017	Good Sept 2017	Good Sept 2017	Good Sept 2017	Good Sept 2017
Community-based mental health services for older people	Good Sept 2017	Good Sept 2017	Outstanding Sept 2017	Outstanding Sept 2017	Good Sept 2017	Outstanding Sept 2017
Specialist eating disorders service	Good ↑ Sept 2019	Good ↑ Sept 2019	Good ↔ Sept 2019	Good ↑ Sept 2019	Good ↔ Sept 2019	Good ↑ Sept 2019
Overall	Requires improvement ↔ Sept 2019	Good ↑ Sept 2019	Good ↔ Sept 2019	Good ↔ Sept 2019	Good ↔ Sept 2019	Good ↑ Sept 2019

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.

Community health inpatient services

Good   

Key facts and figures

Magnolia Unit is a 28 bedded inpatient unit that provides short-term community inpatient care at St Michaels primary care centre in Enfield. At the time of the inspection, there were 28 beds open to patients. There were 15 patients on the ward.

The purpose of the unit is to prevent acute hospital admissions, where possible, by rehabilitating patients in the community. The unit is also designed to be a 'step down' service from acute hospital. This is for patients who are well enough to be discharged from hospital but require further support before they are discharged back to residential care or their own homes. The service provides access to nurses, doctors, occupational therapy, and physiotherapy. Specialist nursing services from the community also attend to see patients. The service accepts patients who are aged 18 years and over and registered with a GP in the London Borough of Enfield.

We previously inspected the service in December 2015 and rated the service as Good. We also carried out a focused inspection in March 2018 in response to concerns raised about the service. We did not rate the service following the inspection; however, we told the trust about action they must take to improve the service and comply with legal requirements.

We carried out an unannounced inspection of this service on 20 June 2019.

During the inspection visit, the inspection team:

- Spoke with eight patients who were using the service and four relatives or carers.
- Spoke with 12 staff members; including nurses, healthcare assistants, allied health professionals and the unit GP.
- Reviewed eight patient records.

The trust had recently taken over the management of another community inpatient ward, Capetown Ward. This ward transferred to the trust on 1 April 2019 and was not reviewed as part of this inspection.

Summary of this service

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

- Service leads had acted to improve the service and address concerns identified during the last inspection. The service had processes in place to ensure meal times were managed effectively and patients received personalised care and treatment. Although staff vacancy rates remained high, the service had a recruitment plan in place to ensure there were enough staff to care for patients and keep them safe.
- Staff assessed risks to patients, understood how to protect patients from abuse, and managed safety well. The service managed safety incidents well and learned lessons from them. Staff collected safety information and used it to improve the service.
- Staff provided good care and treatment, gave patients enough to eat and drink, and gave them pain relief when they needed it. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients and supported them to make decisions about their care.

Community health inpatient services

- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their care and treatment. They provided emotional support to patients, families and carers.
- The service planned care to meet the needs of local people and took account of patients' individual needs. People could access the service when they needed it and did not have to wait too long for treatment.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. They understood and managed the priorities and issues the service faced. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. Leaders encouraged innovation and supported staff to identify opportunities for learning and improvement.

However:

- Although the service provided mandatory training in key skills to all staff, not all staff had completed it. The overall completion rate for nursing and care staff was 78%, although there were variations between individual courses. The managers were aware of where individual staff needed to complete this training and had plans in place for this to be completed.
- Procedures were in place to maintain standards of infection control. However, two staff were observed not to be following these correctly.
- Patient records were not always clear, up-to-date, stored securely and easily available to all staff providing care. The ward was still using a combination of electronic and paper records.
- Although management of patient meal-times had improved and arrangements were in place to ensure patients had access to food and drink, staff did not always clearly document decisions around nutrition monitoring. A few recorded nutritional risks assessments were not fully completed.
- Some of the risks we identified during the inspection, for example around patient records and medicines reconciliation, had not been identified by the service.
- The service had not collected any patient survey feedback since February 2019 and it was not clear when this would start again.

Is the service safe?

Good   

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

- 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 kept equipment and their work area visibly clean.
- The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them.
- Staff identified and quickly acted upon patients at risk of deterioration.
- The service used systems and processes to safely prescribe, administer, record and store medicines.
- The service 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.

Community health inpatient services

- The service used monitoring results well to improve safety. Staff collected safety information and shared it with staff, patients and the public.
- Although staff vacancy rates remained high, the service had a recruitment plan in place to address this and effective processes to ensure there were enough staff to care for patients and keep them safe.

However:

- Although the service provided mandatory training in key skills to all staff, not all staff had completed it. The overall completion rate for nursing and care staff was 78%, although there were variations between individual courses. The managers were aware of where individual staff needed to complete this training and had plans in place for this to be completed.
- Procedures were in place to maintain standards of infection control. However, two staff were observed not to be following these correctly.
- Patient records were not always clear, up-to-date, stored securely and easily available to all staff providing care. The ward was still using a combination of electronic and paper records.
- Although management of patient meal-times had improved and arrangements were in place to ensure patients had access to food and drink, staff did not always clearly document decisions around nutrition monitoring. A few nutritional risks assessment records were not fully completed.

Is the service effective?

Good  → ←

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

- The service provided care and treatment based on national guidance and evidence-based practice.
- Staff assessed and monitored patients regularly to see if they were in pain, and they gave pain relief in a timely way.
- Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.
- The service made sure staff were competent for their roles.
- All those responsible for delivering care worked together as a team to benefit patients. They supported each other to provide good care and communicated effectively with other agencies.
- Staff gave patients practical support and advice to lead healthier lives.
- Staff supported patients to make informed decisions about their care and treatment.

Is the service caring?

Good  → ←

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

- Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Community health inpatient services

- Staff provided emotional support to patients, families and carers to minimise their distress.
- Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

However:

- Patients did not always know when their therapy or other activity sessions were taking place during the day.

Is the service responsive?

Good   

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

- The service planned and provided 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.
- The service was inclusive and took account of patients' individual needs and preferences.
- People could access the service when they needed it and received the right care in a timely way.
- 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.

Is the service well-led?

Good   

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

- Leaders had the integrity, 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.
- The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. Leaders and staff understood and knew how to apply them and monitor progress.
- 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.
- 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. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.
- 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.
- Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

Community health inpatient services

- All staff were committed to continually learning and improving services. Leaders encouraged innovation and supported staff to identify opportunities for learning and improvement.

However:

- Some of the risks we identified during the inspection, for example around patient records and medicines reconciliation, had not been identified by the service and placed on their local risk register.
- The service had not collected any patient survey feedback since February 2019. It was not clear what plans were in place to re-instate this.

Areas for improvement

Action the provider **SHOULD** take to improve

- The trust should continue the work to ensure all staff complete mandatory training.
- The trust should ensure all staff follow infection control policies and procedures including use of personal protective equipment.
- The trust should ensure that medicine reconciliation is carried out for all patients admitted to the unit.
- The trust should ensure it continues to work to improve recruitment and retention within the service to address the high nursing staff vacancy rate on the unit.
- The trust should ensure it improves the quality and consistency of patient records to ensure records are clear, up-to-date, stored securely and easily available to all staff providing care.
- The trust should ensure that staff complete nutrition risk assessments fully and decisions around nutrition monitoring are clearly documented.
- The trust should support each patient to have an individual program, so they know when their therapy sessions are taking place.
- The trust should ensure that the unit's risk register is up to date and reflects the current risks to the service.
- The trust should ensure that the processes in place to gather patient feedback are used.

Mental health crisis services and health-based places of safety

Requires improvement   

Key facts and figures

The team that inspected the crisis service and health-based place of safety consisted of three CQC inspectors, one specialist advisor, with experience working in crisis service and a Mental Health Act reviewer.

Before the inspection, we reviewed information that we held about the trust and asked other organisations to share what they knew about the trust.

During the inspection visit, the inspection team:

- spoke with the managers of each home treatment team and of the health-based place of safety
- spoke with two service managers
- spoke with 28 staff members including consultant psychiatrists, clinical psychologists, nurses, social workers and support workers psychologists
- spoke with the clinical directors of Haringey and Barnet
- looked at the quality of the environment at each location
- reviewed 28 care and treatment records
- spoke with five patients via telephone and face to face
- reviewed 10 medicines administration charts
- observed four handover meetings and multidisciplinary team meetings

The crisis service and health-based place of safety is part of the mental health service delivered by Barnet, Enfield and Haringey NHS Trust.

The crisis resolution home treatment teams provide initial assessment and home treatment for adults who present with a mental health need that requires a specialist mental health service. Their primary function is to undertake a comprehensive assessment of needs, whilst providing a range of short-term treatment/therapies aimed at a quicker recovery for people who did not need long term care and treatment in an inpatient setting. The teams support people who were discharged from hospital. We inspected the teams in the three boroughs based at the Chase Farm Hospital, Edgware Community Hospital and St Ann's Hospital.

A health-based place of safety is a place where patients experiencing a significant deterioration in their mental health are taken for an assessment by a team of mental health professionals. The health-based place of safety is based at Chase Farm Hospital in Enfield.

The Metropolitan Police and British Transport Police have the powers to detain people under Section 136 and Section 135 of the Mental Health Act. People detained under Section 136 or 135 can be brought to a designated health-based place of safety by the police for a mental health assessment. People taken to a place of safety under these sections may be detained there for a period of up to 24 hours, for examination by a registered medical practitioner and interview by an approved mental health professional, and to plan for their ongoing treatment.

Barnet, Enfield and Haringey NHS Trust crisis services and health-based places of safety were last inspected in September 2017, when the overall rating for the service was Requires Improvement. Safe, Effective, Responsive and Well Led was rated as Requires Improvement, and Caring was rated as Good.

Mental health crisis services and health-based places of safety

Summary of this service

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

- Whilst we found that the service had addressed most of the issues that caused us to rate it as requires improvement following the September 2017 inspection, we found new areas that the trust needed to improve on.
- Patients often stayed in the health-based place of safety for longer than 24 hours which was contrary to the Mental Health Act Code of Practice. Between January 2019 and June 2019, 20 patients out of a total of 150 (13%) patients stayed for two days. A further three per cent of patients stayed for three days and one patient stayed for four days and one patient five days.
- The trust had not ensured that teams embedded required changes after incidents. Managers, particularly in Barnet crisis resolution home treatment team (CRHTT), did not always share lessons learned from incidents with the whole team which could impact on the safety of care provided to other patients.
- Staff in the Barnet CRHTT needed to further improve their patient records. They did not consistently update risk management plans for all patients when a change in risk had occurred. This meant the staff might not adequately manage these risks. Staff did not always develop holistic, recovery-oriented care plans informed by a comprehensive assessment and in collaboration with families and carers.
- Whilst the service used systems and processes to manage medicines, staff in Barnet CRHTT did not always follow trust policy to check patients had the correct medicines.

However:

- Staff worked hard to manage patients' and staff risk within the community. They met daily to continuously review patients' risk to themselves and others, and they managed most patients safely in their homes. Staff had created crisis plans with most patients.
- The services had enough staff, who received basic training to keep patients safe from avoidable harm. The number of patients on the caseload of the mental health crisis teams was not too high to prevent staff from giving each patient the time they needed. The service was staffed 24 hours a day, with night staff provided by the bed management team to ensure patients are responded to in an emergency. Staff followed good personal safety protocols whilst out in the community.
- The service was available 24-hours a day and was easy to access – including through a dedicated crisis telephone line. Staff accepted referrals rapidly from those patients that otherwise would be admitted to an inpatient bed.
- Staff working for the mental health crisis teams provided a range of care and treatment interventions that were informed by best practice guidance and suitable for the patient group. They ensured that patients had good access to physical healthcare.
- Staff from different disciplines worked together as a team to benefit patients. The teams had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation. The crisis teams came together each quarter and formed the 'crisis collaboration'. This was a partnership with each crisis team to share best practice and offer informal training to support staff in areas their team performed well in.
- Staff treated patients with dignity and respect. Staff enabled patients to give feedback on the service they received. Staff in Haringey CRHTT particularly involved patients in the running of the service through a co-production event held in February.

Mental health crisis services and health-based places of safety

- Staff involved patients' families and carers in their care where appropriate. In Enfield CRHTT staff facilitated a monthly carers support group for patients they supported going through a crisis.
- Leaders had the skills, knowledge and experience to perform their roles, were visible in the service and approachable for patients and staff. Consultant psychiatrists in Enfield and Haringey CRHTT provided strong clinical leadership to staff.
- Staff felt respected, supported and valued. They reported that the provider promoted equality and diversity in its day-to-day work and in providing opportunities for career progression. They felt able to raise concerns without fear of retribution. In Barnet CRHTT the culture had improved, and staff were beginning to embrace the changes to the service.
- Staff across the teams had taken up several quality improvement projects to improve the running of the crisis teams. These projects included, new co-produced welcome packs for patients, improving the referral process and a previous street triage pilot.

Is the service safe?

Requires improvement   

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

- The trust had not ensured that teams embedded required changes after incidents. Managers did not always share lessons learned with the whole team and the wider service. This was a particular concern in Barnet crisis resolution home treatment team (CRHTT). Staff did not learn lessons from an unexpected death that had occurred in 2018.
- Staff did not always respond promptly to sudden deterioration in a patient's health and did not always keep detailed records of patients' care and treatment. Staff in Barnet CRHTT did not clearly record the risk management plans for patients when their risk level had changed. Staff did not routinely update records clearly after the daily risk meetings.
- Whilst the service used systems and processes to safely prescribe, administer, record and store medicines, staff in Barnet CRHTT, did not always follow trust policy to check patients had the correct medicines. Staff did not complete a stock check of medicines nor sign medicines out when they visited patients' homes to administer medicines.

However:

- The services had enough staff, who received basic training to keep patients safe from avoidable harm. The number of patients on the caseload of the mental health crisis teams was not too high to prevent staff from giving each patient the time they needed. Staff in Haringey CRHTT had done some work to reduce the size of their caseload.
- Staff worked hard to manage patient risk within the community. Whilst we found some areas for improvement in regard to managing risk within some teams, on the whole staff managed patients' safety in their homes. Staff met daily to continuously review patients' risk to themselves and others.
- Staff created crisis plans with patients. Staff in Haringey CRHTT created a safety plan with patients to identify triggers and signs their mental health was deteriorating.
- All clinical premises where patients received care were safe, clean, well equipped, well furnished, well maintained and fit for purpose. The physical environment of the health-based places of safety met the requirements of the Mental Health Act Code of Practice.
- Staff followed good personal safety protocols. Staff had a robust lone working protocol when they visited patients in the community.

Mental health crisis services and health-based places of safety

- 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.

Is the service effective?

Good  

Our rating of effective improved. We rated it as good because:

- Staff assessed the mental health needs of all patients. Staff working for the mental health crisis teams provided a range of care and treatment interventions that were informed by best practice guidance and suitable for the patient group. They ensured that patients had good access to physical healthcare.
- Staff working for the mental health crisis teams used recognised rating scales to assess and record severity and outcomes. Staff used the Dialog scale to determine patients' satisfaction with their therapeutic treatments.
- The mental health crisis teams included or had access to the full range of specialists required to meet the needs of patients under their care. Managers supported staff with appraisals, supervision and training opportunities to update and further develop their skills. Staff in Haringey CRHTT had received specialist training in Open Dialogue to improve how they supported patients in their recovery.
- Staff from different disciplines worked together as a team to benefit patients. The teams had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation. The crisis teams came together each quarter and formed the 'crisis collaboration'. This was a partnership with each crisis team to share best practice and offer informal training to support staff in areas their team performed well in.
- Staff supported patients to make decisions on their care for themselves. They understood the provider's policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly for patients who might have impaired mental capacity.

However:

- Staff working for the mental health crisis teams did not always work with patients to develop individual care plans and updated them when needed. Care plans did not always reflect the assessed needs. Five out of 18 care plans we reviewed were not sufficiently personalised, holistic and recovery-oriented.
- Staff did not always attend regular team meetings to support them in their role. Staff had only just started to embed regular team meetings into the teams.

Is the service caring?

Good   

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

- Staff treated patients with compassion and kindness. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.
- Staff in the mental health crisis teams involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided. Staff in Haringey CRHTT had improved the induction programme for new staff and this was co-produced with patients.

Mental health crisis services and health-based places of safety

- Staff enabled patients to give feedback on the service they received. Staff in Haringey CRHTT particularly involved patients in the running of the service through a co-production event held in February.
- Staff involved patients' families and carers in their care where appropriate. In Enfield CRHTT staff facilitated a monthly carers support group for patients they supported going through a crisis.

Is the service responsive?

Requires improvement   

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

- Patients often stayed in the health-based place of safety for longer than 24 hours which was contrary to the Mental Health Act Code of Practice. Between January 2019 and June 2019, 20 patients out of a total of 150 (13%) patients stayed for two days. A further three per cent of patients stayed for three days and one patient stayed for four days and one patient five days.
- At the last inspection, we found that when staff were late for appointments, patients were not always informed of this. Whilst this had improved, we still found two incidences where staff had not informed a patient when they were late or cancelled the appointment.
- Staff did not always respond in time to contact patients when they were running late for an appointment or they had to cancel an appointment. This could cause stress for the patient.

However:

- The 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 patients promptly. Staff followed up patients when they did not answer their telephone or front door.
- The services met the needs of all patients who use the service – including those with a protected characteristic. Staff helped patients with communication, advocacy and cultural support.
- The service treated concerns and complaints seriously and investigated them. A patient from Haringey attended the team's office to present their feedback to them after they had complained.

Is the service well-led?

Good  

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

- Leaders had the skills, knowledge and experience to perform their roles, were visible in the service and approachable for patients and staff. Consultant psychiatrists in Enfield and Haringey CRHTT provided strong clinical leadership to staff.
- Staff knew and understood the provider's vision and values and how they were applied in the work of their team.
- Staff felt respected, supported and valued. They reported that the provider promoted equality and diversity in its day-to-day work and in providing opportunities for career progression. They felt able to raise concerns without fear of retribution.

Mental health crisis services and health-based places of safety

- Staff collected analysed data about outcomes and performance and engaged actively in local and national quality improvement activities. Staff across the teams had taken up several quality improvement projects to improve the running of the crisis teams. These projects included, new co-produced welcome packs for patients, improving the referral process and a previous street triage pilot.
- There were effective, multi-agency arrangements to agree and monitor the governance of the mental health crisis service and the health-based places of safety. Managers of the service worked actively with partner agencies (including the police, ambulance service, primary care and local acute medical services) to ensure that people in the area received help when they experienced a mental health crisis; regardless of the setting.

However:

- Although the teams had made improvements since the last inspection in September 2017, our inspection identified issues at the Barnet CRHTT which the governance processes had not clearly identified relating in particular to the management of risk. However, the trust had recognised that it would be helpful to change the model for this service to promote improvements.

Outstanding practice

- The crisis teams came together each quarter and formed the 'crisis collaboration'. This was a partnership with each crisis team to share best practice and offer informal training to support staff in areas their team performed well in.
- The clinical leadership in Haringey were involved in research in conjunction with a local London university. The research programme is Open Dialogue: Development and Evaluation of a Social Network Intervention for Severe Mental Illness (ODDESI). The programme examines if open dialogue offers good outcomes for patients.

Areas for improvement

Areas in which the trust **must** make improvements:

- 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. **Regulation 13 (1)(2)(5)**
- The trust must ensure that in Barnet crisis resolution home treatment team (CRHTT), staff hold effective team meetings, where information about learning from serious incidents, can be shared and discussed. Staff should ensure any actions because of serious incidents are shared with staff to improve patient safety. **Regulation 12 (1)(2)(a)(b)**

Areas in which the trust **should** make improvements:

- The trust should ensure that the documentation of risk management plans on patient care records contains sufficient and up to date detail to reflect when a change in risk has occurred, particularly in Barnet CRHT.
- The trust should ensure staff complete stock checks of medicines that are kept onsite and then administered to patients in their homes, particularly in Barnet CRHT.
- The trust should continue to ensure staff communicate with patients when they are running late or need to cancel appointments.
- The trust should ensure staff complete care plans for patients and these are holistic, recovery-focused and personalised.
- The trust should ensure senior managers have oversight of serious incidents to ensure that staff adequately implement the actions from investigation reports.

Mental health crisis services and health-based places of safety

- The trust should ensure that pertinent risks posed to the teams are included on their risk register to ensure managers have oversight of the risks within the services.

Wards for older people with mental health problems

Good   

Key facts and figures

The service comprises:

- The Oaks: a 21-bed mixed gender acute assessment ward for people over 65 with mental health problems such as depression and psychotic illnesses.
- Silver Birches: a 15-bed mixed gender dementia assessment ward for people over 65. Patients on this ward have a diagnosis of dementia, or suspected dementia.

The Oaks and Silver Birches are located on the Chase Farm hospital site.

- Ken Porter: a 27-bed mixed gender continuing care ward for people of any age on the Barnet General hospital site. The trust set up Ken Porter in 2012 when two continuing care services closed as part of the trust's transformation programme. This ward is currently also taking up to six working age adults assessed as sub-acute due to bed pressures on the acute wards in the trust.

The last comprehensive inspection of this service took place in September 2017. We rated the service as good overall. We rated safe as effective as requires improvement and safe, caring, responsive and well-led as good. We issued a requirement notice for one regulation:

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

We conducted an unannounced focussed inspection of Silver Birches in March 2018. We issued three requirement notices for two regulations:

Regulation 9 HSCA (RA) Regulations 2014 Person-centred care

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

The current inspection was announced due to the number of core services being inspected concurrently. This was in line with CQC guidance.

During the inspection visit, the inspection team:

- spoke with three ward managers and two service managers
- spoke with 30 members of staff including doctors, registered and non-registered nurses, student nurses, ward clerks, psychologists, physiotherapists, pharmacists, occupational therapists and technical instructors
- spoke with 20 patients
- spoke with four relatives
- observed a ward round, safety huddle, board meeting, and discharge meeting
- observed lunchtime on three wards
- conducted observations of staff-patient interactions (short observation framework of inspection) on three wards, and observed group activities
- reviewed 14 patient care records
- completed three tours of the ward areas

Wards for older people with mental health problems

- reviewed three clinic rooms
- reviewed 26 medication charts
- reviewed 12 staff supervision files
- reviewed physical health records

Following the inspection, we spoke with five relatives/carers of patients by telephone to gain their views about the service.

Summary of this service

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

- We found a number of improvements across the service since the previous CQC inspections in September 2017 and March 2018.
- As required following the inspection in September 2017, improvements had been made in the recording of risk assessments and risk management plans for patients, and these were reviewed regularly. There were also improvements in the calibration of blood glucose machines. Since the inspection in March 2018, as required, we found improvements in the recording of prescribed doses on medicine administration charts, staff handwashing prior to medicine administration, and storage and labelling of medicines to avoid errors.
- The ward environments were safe and clean. The ward environment on Silver Birches had been upgraded to a high standard, providing a dementia friendly environment. Staff assessed and managed risk well. They minimised the use of restrictive practices, and followed good practice with respect to safeguarding.
- As required following our inspection of this service in September 2017, staff had received training to support patients with diabetes and this was reflected in care plans. Systems had also been improved for staff to access patients' individual blood results without delay, and patient's individual needs (including pain management and continence, nutrition and hydration forms) were appropriately recorded, and reviewed regularly.
- Staff developed holistic, recovery-oriented care plans informed by a comprehensive assessment. They provided a range of treatments suitable to the needs of the patients and in line with national guidance about best practice. Staff engaged in clinical audit to evaluate the quality of care they provided.
- Since our inspection in March 2018 the provider had recruited a permanent consultant for Silver Birches providing effective medical leadership. The ward teams included or had access to the full range of specialists required to meet the needs of patients on the wards. The ward staff worked well together as a multi-disciplinary team and with those outside the ward who would have a role in providing aftercare. Managers ensured that staff received training, supervision and appraisal, although there was still work needed to improve the frequency of staff supervision.
- Staff understood and discharged their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005.
- Staff treated patients with compassion and kindness, respected their privacy and dignity and understood the individual needs of patients. They actively involved patients and families and carers in care decisions.
- The service managed beds well so that a bed was always available locally to a person who would benefit from admission and patients were discharged promptly once their condition warranted this.

Wards for older people with mental health problems

- Patients had access to a range of activities, and had opportunities to go out within the local community. Food provision on The Oaks and Silver Birches had been improved to meet the preferences of patients.
- The wards were well-led and the governance processes ensured that ward procedures ran smoothly. Since our September 2017 inspection the trust had ensured that the electronic record system functioned at a speed that did not impact negatively on staff responsibilities.

However:

- Staff did not always ensure that physical health monitoring of patients' vital signs was undertaken after every use of rapid tranquilisation, record physical health observations accurately for patients, and seek medical advice when indicated.
- Staff did not record formal medicines reconciliation records for patients and had not yet upgraded the medicines storage cabinets on The Oaks and Silver Birches to the correct specification in line with trust policy.
- The frequency of fire drills did not ensure that all staff, including those working at night, had regular practice in procedures for protecting patients in the event of a fire.
- A small number of patients on The Oaks and Silver Birches had to share bedrooms with another patient, which impacted on their privacy and dignity, although curtains were in place to try and mitigate this. None of the bedrooms on Silver Birches had en-suite toilet or shower facilities.
- The medical provision on The Oaks and Ken Porter Ward needed review to ensure that there was sufficient access to doctors at all times.
- Reviews were needed of separate governance arrangements for the Enfield wards, and Ken Porter Ward, to ensure that learning was shared, and arrangements for the admission of sub-acute patients on Ken Porter Ward due to trust bed pressures. The trust needed to continue to work to improve the frequency of staff supervision across the wards.

Is the service safe?

Requires improvement ● ↓

Our rating of safe went down. We rated it as requires improvement because:

- Staff did not always ensure that physical health monitoring of patients' vital signs was undertaken after every use of rapid tranquilisation, in line with trust policy.
- Staff on Ken Porter Ward did not always record physical health observations accurately for patients and seek medical advice when indicated.
- Staff did not record formal medicines reconciliation records for patients on all wards.
- Medicines storage cabinets in use on The Oaks and Silver Birches were not of the correct specification as stated in the trust's medicines management policy.
- Although fire safety checks were in place as required, the frequency of fire drills did not ensure that all staff, including those working at night, had regular practice in procedures for protecting patients in the event of a fire.
- The medical provision on The Oaks and Ken Porter Ward needed to be reviewed to ensure that there was sufficient access to doctors at all times. However, on Silver Birches a permanent consultant was now in place and supporting consistent care to be provided to patients.
- Some staff had not completed all mandatory training, although plans were in place to deliver this training.

Wards for older people with mental health problems

However:

- All wards were safe, clean, well equipped, and well maintained, with sufficient trained and skilled staff to support patients safely. Staff assessed and managed risks to patients and themselves well and followed best practice in anticipating and de-escalating challenging behaviour.
- Staff understood how to protect patients from abuse and/or exploitation and the service worked well with other agencies to do so. The wards had a good track record on safety. Staff recognised incidents and reported them appropriately. When things went wrong, staff apologised and gave patients honest information and suitable support.
- Since the inspection in September 2017 there were improvements in the recording of risk assessments and risk management plans for patients, and these were reviewed regularly.
- Since the inspection in March 2018 there were improvements in the recording of prescribed doses on medicine administration charts, staff handwashing procedures prior to medicine administration, and storage and labelling of medicines to avoid errors. There were also improvements in the calibration of blood glucose machines.

Is the service effective?

Good  

Our rating of effective improved. We rated it as good because:

- As required following our inspection of this service in September 2017 staff had received training and knowledge to support patients with diabetes and produced detailed care plans that reflected patients' needs as outlined in the trust policy.
- Since the inspection in September 2017 staff had improved the accuracy of completing nutrition and hydration forms, and were recording accurate records of when one to one sessions took place with patients.
- As required following our inspection in March 2018, there were robust systems in place in order for ward staff to access patients' individual blood results without delay, and patient's individual needs (including pain management and continence) were appropriately recorded, and planned for in care plans, and reviewed regularly.
- Staff assessed the physical and mental health of all patients on admission. Individual care plans were personalised, holistic and recovery-oriented, and reviewed regularly through multidisciplinary discussion.
- Staff provided a range of care and treatment interventions suitable for the patient group and consistent with national guidance on best practice. They ensured that patients had good access to physical healthcare and supported patients to live healthier lives.
- Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives.
- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005 and assessed and recorded capacity clearly for patients who might have impaired mental capacity.

However:

- The trust needed to continue to work to improve the frequency of staff supervision across the wards.

Wards for older people with mental health problems

Is the service caring?

Good   

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

- 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.
- 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.
- On The Oaks and Silver Birches ward improvement meetings had been set up, involving staff, patients and relatives/carers to bring about improvements to the service.
- Significant improvements had been made to the level of staff engagement with patients on The Oaks, with a number of initiatives in place to increase one-to-one time spent with patients.

Is the service responsive?

Good   

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

- Staff managed beds well. This meant that a bed was available when needed and that patients were not moved between wards unless this was for their benefit. Staff worked creatively to prevent delayed discharges.
- The décor, furnishings and layout on Silver Birches had recently been upgraded with an external company to provide a bespoke dementia friendly environment. This included sensory areas and murals evoking a street with front doors for each bedroom, street lamps, trees, and a tea shop and American diner area for patients to have their meals.
- The Oaks and Silver Birches reported recent improvements in the quality and choice of food provided for patients. Patients on all ward could make hot drinks and have snacks at any time.
- The wards met the needs of all people who used the service – including those with a protected characteristic. Staff helped patients with communication, advocacy and cultural and spiritual support.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results.

However:

- None of the bedrooms on Silver Birches had en-suite toilet or shower facilities.
- A small number of patients on The Oaks and Silver Birches had to share bedrooms with another patient, which impacted on their privacy and dignity although curtains could be drawn to mitigate this.

Is the service well-led?

Good   

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

Wards for older people with mental health problems

- Leaders had the skills, knowledge and experience to perform their roles, had a good understanding of the services they managed and were visible in the service and approachable for patients and staff.
- Staff knew and understood the provider's vision and values and how they were applied in the work of their team.
- Staff felt respected, supported and valued. They reported that the provider promoted equality and diversity in its day to day work and in providing opportunities for career progression. They felt able to raise concerns without fear of retribution.
- Ward teams had access to the information they needed to provide safe and effective care and used that information to good effect.
- Staff engaged actively in local and national quality improvement activities.
- Leaders in the trust understood the need to progress the elimination of shared bedrooms and were working to achieve this.
- Since our September 2017 inspection the trust had changed provider so that the electronic record system functioned at a speed that did not impact negatively on staff responsibilities.

However:

- Separate governance arrangements for The Oaks and Silver Birches under a different directorate to Ken Porter Ward, meant that learning and best practice was not always shared and embedded between all units for older age adults.
- In addition to continuing care and rehabilitation patients on Ken Porter Ward, staff were also providing beds for sub-acute working age adults due to trust acute bed pressures. This needed to be reviewed to ensure that it did not impact negatively on other patients' experience on the ward.

Outstanding practice

We found an example of outstanding practice in this service:

The décor, furnishings and layout on Silver Birches had recently been upgraded following a successful bid to the trust's 'Dragons Den.' The trust had worked with an external company to provide a bespoke dementia friendly environment. Patients had been involved in making changes about the décor, including sensory areas and murals evoking a street with front doors for each bedroom, street lamps, trees, and a tea shop and American diner area for mealtimes.

Areas for improvement

Action the provider **MUST** take to improve

- The trust must ensure that physical health monitoring of patients' vital signs is undertaken after every use of rapid tranquilisation, and that staff are clear about the frequency required as outlined in trust policy. **Regulation 12(1)(2)(a)(b)**
- The trust must ensure that staff on Ken Porter Ward complete physical health observations for patients consistently, scoring results accurately, and seek medical advice when indicated. **Regulation 12(1)(2)(a)(b)(c)**

Action the provider **SHOULD** take to improve

- The trust should ensure that staff record formal medicines reconciliation records for patients on all wards.
- The trust should put in place action plans to remove shared bays on The Oaks and Silver Birches, so that patients have their own private bedrooms.

Wards for older people with mental health problems

- The trust should review governance arrangements to ensure that learning and best practice is shared and embedded between all units for older age adults.
- The trust should review medical provision at The Oaks and Ken Porter Ward to ensure that there is sufficient access to doctors at all times.
- The trust should review procedures for admitting sub-acute working age adults on Ken Porter Ward, to ensure that this does not impact on other patients on the ward.
- The trust should ensure that medicine storage cabinets with the correct specification as stated in the trust's medicines management policy, are fitted on The Oaks and Silver Birches.
- The trust should review the frequency of fire drills (with or without an alarm) to ensure that all staff, including those working at night, have regular practice in using procedures for protecting patients in the event of a fire.
- The trust should continue to work to improve the frequency of staff supervision across the wards.

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

Requires improvement   

Key facts and figures

Acute inpatient wards were located across three sites; St Ann's Hospital, Chase Farm Hospital and Edgware Community Hospital. The psychiatric care intensive unit was located a Chase Farm Hospital. We inspected the following wards:

Chase Farm

- Devon Ward
- Dorset Ward
- Suffolk Ward
- Sussex Ward

Edgware Hospital

- Thames Ward
- Trent Ward

St Ann's Hospital

- Haringey Assessment Ward
- Fairlands (formerly Downhills) Ward
- Finsbury Ward

The service is registered with the Care Quality Commission to carry out these regulated activities:

- Treatment of disease, disorder or injury
- Assessment or medical treatment, for persons detained under the Mental Health Act 1983

This inspection was carried out during a comprehensive inspection of the trust during June 2019. The inspection was announced in advance.

The CQC previously inspected this service in September 2017. At this inspection, we found the service was not compliant with four regulations within the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These were:

- Regulation 12 Safe care and treatment
- Regulation 15 Premises and equipment
- Regulation 17 Good governance
- Regulation 18 Staffing

We told the trust that it must take action to address these matters

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

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

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

Before the inspection visit, we reviewed information that we held about the service and asked a range of other organisations for information.

During this inspection we:

- visited each ward and checked the quality and safety of the ward environment
- spoke with the ward manager on all nine wards, a service lead and a service manager
- observed how staff worked with patients
- spoke with 33 patients who were using the service
- spoke with 67 members of staff, including psychiatrists, doctors, nurses, and an occupational therapist
- attended and observed five multi-disciplinary meetings, a care programme approach meeting and a bed management meeting.
- checked 33 patient records including medicines records, risk assessments and care plans
- reviewed a range of policies, procedures and other documents relating to the operation of the service.

The inspection team comprised of two inspection managers, five inspectors, a Mental Health Act reviewer, a medicines inspector, five specialist advisors with professional backgrounds in acute mental health services and an expert by experience.

Summary of this service

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

- The service did not have enough permanent nursing staff who knew the patients. This impacted on their ability to form the professional relationships needed to understand and support each patient consistently with their individual needs. This was leading to instances of violence and aggression which might have been managed better by permanent staff. Some nurses had not completed mandatory training to keep patients safe from avoidable harm although plans were in place to deliver this training.
- The physical environment of some wards was not fit for purpose. Staff did not record all potential hazards during environmental checks. Some low-risk ligature anchor points were not recorded. Seclusion rooms did not ensure patients' privacy and dignity.
- A bed was not always available locally to a person who would benefit from admission. The service worked hard to manage access to beds, but local patients were frequently referred to other hospitals because the trust could not accommodate them. Although patients were discharged promptly once their condition and circumstances warranted this, most admissions lasted longer than the target of 28 days. This was because many patients had complex needs and, for some, there were difficulties in finding appropriate accommodation.

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

However:

- Staff assessed and managed patient risk well. They worked towards minimising the use of restrictive practices, managed medicines safely and followed good practice with respect to safeguarding
- Staff developed holistic, recovery-oriented care plans informed by a comprehensive assessment. They provided a range of treatments suitable to the needs of the patients and in line with national guidance about best practice. Staff engaged in clinical audit to evaluate the quality of care they provided.
- Staff understood and discharged their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, and understood the individual needs of patients. They actively involved patients and families and carers in care decisions.
- The ward teams included or had access to the full range of specialists required to meet the needs of patients on the wards. Managers ensured that these staff received training, supervision and appraisal. The ward staff worked well together as a multidisciplinary team and with those outside the ward who would have a role in providing aftercare.
- The service was well-led and the governance processes ensured that ward procedures ran smoothly.

Is the service safe?

Requires improvement   

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

- The service did not have enough permanent nursing staff who knew the patients. This impacted on their ability to form the professional relationships needed to understand and support each patient consistently with their individual needs. This was leading to instances of violence and aggression which might have been managed better by permanent staff. Some nurses had not completed mandatory training to keep patients safe from avoidable harm although plans were in place to deliver this training.
- The physical environment of some wards were not fit for purpose. Staff did not record all potential hazards during environmental checks. Some low-risk ligature anchor points were not recorded. Seclusion rooms did not ensure patients' privacy and dignity.
- Medical equipment was not always calibrated to ensure accurate readings. Staff did not always complete medicines reconciliation when patients were admitted. Staff did not always record the date on which liquid medicines were opened.

However:

- The ward staff participated in the provider's restrictive interventions reduction programme.
- 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 had easy access to clinical information and it was easy for them to maintain high quality clinical records – whether paper-based or electronic.
- Staff regularly reviewed the effects of medications on each patient's physical health.

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

- The wards had a good track record on safety. The service managed patient safety incidents well. Staff recognised incidents and mostly 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. However, a few managers did not fully understand how to use a new incident reporting system.

Is the service effective?

Good ● ↑

Our rating of effective improved. We rated it as good because:

- Staff assessed the physical and mental health of all patients on admission. They developed individual care plans, which they reviewed regularly through multidisciplinary discussion and updated as needed. Care plans reflected the assessed needs, were personalised, holistic and recovery-oriented.
- Staff provided a range of care and treatment interventions suitable for the patient group and consistent with national guidance on best practice. They ensured that patients had good access to physical healthcare and supported patients to live healthier lives.
- Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives.
- 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 a range of skills need to provide high quality care. They supported staff with appraisals and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.
- 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. The ward teams had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.
- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice. However, we did find that patients did not always have their rights explained to them. Also, on one occasion we found an advocate did not visit a patient in a timely manner. Staff did not ensure that patients always complied with the conditions of their leave.
- Staff supported patients to make decisions on their care for themselves. They understood the provider's policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly for patients who might have impaired mental capacity.

However:

- Managers did not consistently support staff to have regular supervision and the records showed a variation in the areas covered. However, the trust was investing in a new system to monitor the regular completion of supervision.
- On some wards, managers did not always ensure that effective team meetings took place that allowed staff to be involved in discussions about assessing, monitoring and improving quality and safety. However, a new accountability framework was being developed to ensure a consistent approach was taken at all team meetings.

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

Is the service caring?

Good ● → ←

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

- 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.
- 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.
- Staff informed and involved families and carers appropriately.

Is the service responsive?

Requires improvement ● ↓

Our rating of responsive went down. We rated it as requires improvement because:

- A bed was not always available locally to a person who would benefit from admission. The service worked hard to manage access to beds, but local patients were frequently referred to other hospitals because the trust could not accommodate them. Although patients were discharged promptly once their condition and circumstances warranted this, most admissions lasted longer than the target of 28 days. This was because many patients had complex needs and, for some, there were difficulties in finding appropriate accommodation.
- The design, layout, and furnishings of the wards did not always support patients' treatment, privacy and dignity. At Chase Farm Hospital, some patients slept in shared bedrooms. In these rooms, the patients' beds were divided by a curtain. At St Ann's, some patients shared dormitories with four beds, separated by curtains. Most bedrooms did not have an en-suite bathroom.

However:

- The food was of a good quality and patients could make hot drinks and snacks at any time.
- The service met the needs of all patients who used the service – including those with a protected characteristic. Staff helped patients with communication, advocacy and cultural and spiritual support.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and the wider service.

Is the service well-led?

Good ● → ←

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

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

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

- Staff knew and understood the provider's vision and values and how they were applied in the work of their team.
- Most staff felt respected, supported and valued. They reported that the provider promoted equality and diversity in its day-to-day work and in providing opportunities for career progression. They felt able to raise concerns without fear of retribution.
- Our findings from the other key questions demonstrated that governance processes operated effectively at ward level and that performance and risk were managed well.
- Ward teams had access to the information they needed to provide safe and effective care and used that information to good effect.
- Staff engaged actively in local and national quality improvement activities.
- The trust has plans to eliminate dormitories from the Haringey and Barnet sites by the end of 2020. Further work was needed to eliminate the few remaining areas on the Chase Farm site

However:

- The trust had not provided sufficient interim arrangements when one ward did not have a permanent ward manager

Areas for improvement

Action the provider **MUST** take to improve

- The trust must employ sufficient permanent staff on all wards to ensure that the service can provide safe, person-centred care. **Regulation 18(1)**
- The trust must ensure there are sufficient beds to ensure that patients can be admitted to hospital in their local area without delays. **Regulation 9(1)**

Action the provider **SHOULD** take to improve

- The trust should ensure that staff note potential hazards on the wards in environmental checks and that these are addressed straight away.
- The trust should ensure that all ligature risks are included in the ligature risk assessment, including those that present a low risk.
- The trust should ensure that refurbishments of seclusion rooms at Chase Farm are completed to ensure the privacy and dignity of secluded patients.
- The trust should ensure that all equipment is calibrated to ensure accurate readings.
- The trust should ensure that rapid tranquilisation is used consistently across the hospital sites and that staff monitor the physical health of patients after rapid tranquilisation has been administered.
- The trust should ensure that medicines reconciliation is carried out for all patients.
- The trust should ensure that staff record the dates on which liquid medicines are opened.
- The trust should ensure that all managers are fully competent in using the electronic incident reporting system.
- The trust should ensure the progress in the provision of supervision is consistent across all wards and that staff are sufficiently supported to carry out their duties.
- The trust should ensure that team meetings are held on all wards to enable staff to be aware of and contribute to discussions about assessing, monitoring and improving quality and safety,

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

- The trust should ensure that advocates visit patients promptly.
- The trust should ensure that staff explain to patients how the Mental Health Act applies to them when they are admitted and repeat this if the patient does not understand the information.
- 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.
- The trust should ensure that sleeping accommodation does not compromise patients' privacy and dignity.
- The trust should ensure that leadership is consistently provided on all wards and sufficient interim arrangements are put in place if wards are temporarily without a permanent ward manager.
- The trust should ensure that staff have completed training designated as being mandatory.

Community-based mental health services of adults of working age

Good  

Key facts and figures

Barnet, Enfield and Haringey Mental Health Trust provide a range of community based mental health services for adults of working age throughout the London boroughs of Barnet, Enfield and Haringey. Some adults receiving services may be subject to conditions under the Mental Health Act 1983.

Teams visited:

- A sample of the locality teams in each borough. The locality teams offer treatment and support to people in the community between the ages of 18 and 65 years with schizophrenia, bi-polar affective disorder, psychotic depression and other psychiatric disorders. Each borough is divided into locality teams based on geographical location and aligned to GP surgeries in the same geographical patch.
- The Early Intervention Service (EIS) in each borough, which provides specific support and treatment for patients experiencing a first episode of psychosis. Teams provide a service to people between the ages of 18 and 65 years, over a three-year period.
- The Barnet Intensive Enablement Team (IET) provides community-based rehabilitation treatment and support for adults with moderate to severe mental health difficulties.
- The Enfield Community Rehabilitation Team who offer treatment and support to people whose mental health problems requires them to reside in a 24-hour supported/residential accommodation, helping patients with coping, relationship and social skills to improve and maintain good health.

CQC previously inspected this core service in September 2017, and issued an overall rating of requires improvement.

This inspection was announced (staff knew we were coming) to ensure that everyone we needed to talk to was available. It was part of a wider trust inspection.

The team that inspected the service comprised four CQC inspectors, three CQC managers, two CQC pharmacists, and four specialist advisors, two of whom were consultant psychiatrists and two were registered mental health nurses.

Before the inspection visit, we reviewed information that we held about these services and information requested from the trust.

During the inspection visit, the inspection team:

- visited eleven services and looked at the quality of the environment
- spoke with 24 patients and six carers who were using the service
- observed nine patient appointments, with the patients' consent
- spoke with eleven team managers
- spoke with senior managers, including assistant clinical directors and community service managers
- spoke with 56 other staff members including consultant psychiatrists, registered mental health nurses, clinical psychologists, occupational therapists and social workers.
- attended and observed seven meetings, which included risk management / 'zoning' meetings
- observed one depot clinic

Community-based mental health services of adults of working age

- observed one well-being clinic
- reviewed 47 care and treatment records
- reviewed medicines management
- looked at a range of policies, procedures and other documents relating to the running of the service.

Summary of this service

Our rating of this service improved. We rated it as good because:

- Since the last inspection in September 2017, Haringey and Enfield community-based mental health teams had made good improvements to the services they provided. In particular, Haringey had made good progress in regards to our previous concerns. At the last inspection, staff across Haringey community services reported a culture of bullying and felt unable to raise concerns. During this inspection, this was no longer the case. Staff told us there was an open culture. They felt able to raise concerns and bullying was no longer an issue. At the last inspection, in Haringey, leaders had not identified key challenges and governance systems were not robust. During this inspection, leaders had a good understanding of the services they managed, had good oversight of key challenges and robust governance systems were in place to monitor risk and performance. However, in Barnet, we found the Early Intervention Service (EIS) and the West and South Locality Teams were not of the same standard compared to the other eight teams we visited, and required some improvement.
- Since the last inspection in September 2017, staff in the locality teams told us that communication with local GPs had improved since the reconfiguration to locality-based teams as they were now aligned with local GPs in their geographical patch. The GPs had direct communication links with the consultant psychiatrists in the locality teams.
- All clinical premises where patients received care were safe, clean, well equipped, well-furnished and well maintained.
- The teams were actively working to recruit staff, via public advertisements and recruitment open days. The trust had developed a care coordinator training programme, which developed existing band five workers into band six care coordinator posts. Managers told us this was still in its infancy, but it was a positive strategy to recruit into these posts. Despite this work, there were still teams where there were significant vacancies such as the Barnet West and Haringey East locality teams. Here they used long term locums to try and maintain the consistency of care. There were also teams where they were struggling to recruit staff from a particular professional background. For example, the Barnet West Locality Team had been without a permanent consultant psychiatrist for two months and at the time of the inspection, the team had a locum consultant psychiatrist in place, however, the specialist registrar post remained vacant. Care co-ordinators in Haringey and Barnet EIS had high caseloads on average of 22, which was not in line with the nationally recommended maximum of 15.
- In nine of the eleven teams we visited, staff demonstrated good assessment and management of risk to patients and staff. Teams participated in regular multi-disciplinary meetings where risk was robustly discussed. Staff followed good lone working practice, which enhanced their safety when meeting patients. However, the Barnet West and South Locality Teams did not always assess and plan how to manage risk robustly. Staff did not always update risk assessments following changes in circumstances or incidents.

Community-based mental health services of adults of working age

- Staff treated patients with compassion and kindness. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition. Patients knew how to complain or raise concerns. Information about how to complain was on display in the patient waiting room in the service we visited.
- Teams in Haringey and Enfield demonstrated a commitment to learning, continuous improvement and innovation. In Haringey, the South Locality Team and Early Intervention Service had participated in a research trial with a local university. This trialled a model of mental health care that involved a consistent family and social network approach and always involved the patient. Staff spoke very highly of this approach and its benefits for patient experience.
- Since our last inspection, the trust had made improvements to reporting of incidents and learning from when things go wrong, most staff had access to specialist training, most staff received regular supervision, and patients received the required aftercare when in relation to the Mental Health Act.

However:

- Patients identified as in need of a Mental Health Act (MHA) assessment were not always assessed promptly and there were significant delays to MHA assessments. Staff request that a patient is assessed under the MHA when they think that the patient is posing a risk to themselves or others. Delays in completing assessments mean that people may be at risk of harm. Staff across all teams told us that MHA assessment delays was a significant issue for their team, and told us of incidents where patients' safety had been compromised whilst waiting for a MHA assessment. Despite the delays in MHA assessments being completed, the trust was working closely with other agencies, including the police and social services, to address these delays.
- Although the teams had made improvements in supporting patients with their physical health needs since our last inspection, teams still needed to develop and embed the necessary skills to effectively support patients. Staff did not always promptly review patients' medical test results for abnormalities and physical health well-being clinics were not always of a good quality.
- In all three Early Intervention Services, care plans were generic and were not always personalised to demonstrate they met the needs of the patients. It was not always clear what interventions staff were offering to patients to support them with their first episode of psychosis, and did not always reflect the National Institute of Health and Care Excellence recommendations.
- Although there was good sharing of information within teams in each borough, there were no formal systems in place to share information across the three boroughs. This meant that teams in different boroughs would not always be made aware of good practice occurring in other teams, or incidents and learnings.
- Whilst we saw good examples of mental capacity being appropriately considered and assessed in most teams, Barnet Early Intervention Service did not evidence that capacity assessments were completed for all patients who may have had impaired capacity.
- Although the trust had worked hard since our last inspection to reduce waiting times for psychological therapies, some patients continued to wait a long time for psychological interventions. Barnet had the highest waiting times, with some patients waiting up to 18-months for individual and specialist group psychological therapies. The trust was aware of this and working to reduce this further.

Is the service safe?

Inadequate  

Our rating of safe went down. We rated it as inadequate because:

Community-based mental health services of adults of working age

- Patients identified as in need of a Mental Health Act (MHA) assessment were not always assessed promptly and there were significant delays to MHA assessments. Staff across all teams told us that MHA assessment delays was a significant issue for their team, and told us of incidents where patients' safety had been compromised whilst waiting an unacceptable time for a MHA assessment. Between 1 April 2019 to 30 June 2019, in Haringey, 73% of patients waited more than 10 days for an assessment, Enfield, 13% and Barnet, 45%. Such delays could compound patient distress and risk, while creating further delays for associated services, including A&E departments, the ambulance service, the police and places of safety.

However:

- The teams were actively working to recruiting staff, via public advertisements and recruitment open days. The trust had developed a care coordinator training programme, which developed existing band five workers into band six care coordinator posts. Managers told us this was still in its infancy, but it was a positive strategy to recruit into these posts. Despite this work there were still teams where there were significant vacancies such as the Barnet West and Haringey East locality teams. Here they used long term locums to try and maintain the consistency of care. There were also teams where they were struggling to recruit staff from a particular professional background. For example, the Barnet West Locality Team had been without a permanent consultant psychiatrist for two months and at the time of the inspection, the team had a locum consultant psychiatrist in place, however, the specialist registrar post remained vacant. Care co-ordinators in Haringey and Barnet EIS had high caseloads on average of 22, which was not in line with the nationally recommended maximum of 15.
- In nine of the eleven teams we visited, staff demonstrated good assessment and management of risk to patients and staff. Teams participated in regular multi-disciplinary meetings where risk was robustly discussed. Staff followed good lone working practice, which enhanced their safety when meeting patients. However, the Barnet West and South Locality Teams did not always assess and plan how to manage risk robustly. Staff did not always update risk assessments following changes in circumstances or incidents.
- All clinical premises where patients received care were safe, clean, well equipped, well-furnished and well maintained.
- The teams had a good track record on safety. 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. When things went wrong, staff apologised and gave patients honest information and suitable support. However, teams needed to improve how they shared lessons learned with teams in the different trust boroughs.
- Staff received basic training to keep patients safe from avoidable harm. Where staff had gaps in their completion of mandatory training, managers were aware of this and plans were in place to address this. The number of patients on the caseload of the locality-teams, and of individual members of staff in these teams, was not too high to prevent staff from giving each patient the time they needed.
- 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. However, in the Barnet South Locality Team, staff needed to improve their safeguarding practice.
- The service used systems and processes to safely prescribe, administer and record medicines. Staff regularly reviewed the effects of medications on each patient's physical health. However, in Haringey and Barnet wellbeing clinics, recorded temperatures were consistently above the recommended range. This meant the efficacy of medicines may have been compromised.

Community-based mental health services of adults of working age

Is the service effective?

Good  

Our rating of effective improved. We rated it as good because:

- Staff completed a comprehensive assessment of all patients. Since our last inspection in September 2017, the Barnet, Enfield and Haringey Locality Teams, the Enfield Community Rehabilitation Team and Barnet Intensive Enablement team had made good improvements to patient care plans, and were individualised, holistic and recovery orientated.
- Staff provided a range of treatment and care for the patients based on national guidance and best practice. They ensured that patients were supported with employment, housing and to live healthier lives.
- Since the last inspection in September 2017, staff in the locality teams told us that communication with local GPs had improved since the reconfiguration to locality-based teams as they were now aligned with local GPs in their geographical patch. The GPs had direct communication links with the consultant psychiatrists in the locality teams.
- Managers supported staff with appraisals, supervision and opportunities to update and further develop their skills. However, in Haringey South East Locality Team, supervision was low, where staff had received 58% of their expected supervision in the last 12 months.
- In Barnet Intensive Enablement Team, staff had identified a gap in service provision for patients with autism, and were working in partnership with Mencap who delivered autism training and discussed clinical cases to enable them to provide effective support.
- 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. The teams had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation. In Haringey, the primary care team in the Central Locality Team, worked well with local GP surgeries to support patients with their mental health with the aim to of supporting them to stay in primary care services.
- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice. For most patients' subject to a CTO, the legal paperwork was in good order and staff discussed their rights with them.

However:

- While the services had made some progress in supporting patients with their physical health needs, further improvements were needed. For example, half the records we reviewed at Barnet Early Intervention Service did not demonstrate adequate support for patients' physical healthcare. An unregistered member of staff provided the physical health well-being clinic.
- In all three Early Intervention Services, care plans were generic and were not always personalised to demonstrate they met the needs of the patients. They did not always specify what interventions staff were offering to patients to support them with their first episode of psychosis, and did not always reflect the National Institute of Health and Care Excellence recommendations.
- Although there was good sharing of information within teams in each borough, there were no formal systems in place to share information across the three boroughs. This meant that teams in different boroughs would not always be made aware of good practice occurring in other teams, or incidents and learnings.

Community-based mental health services of adults of working age

- Whilst we saw good examples of mental capacity being appropriately considered and assessed in most teams, Barnet Early Intervention Service did not evidence that capacity assessments were completed for all patients who may have had impaired capacity.

Is the service caring?

Good   

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

- Staff treated patients with compassion and kindness. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.
- Staff gave patients help, emotional support and advice when they needed it. Most patients said there were enough staff and had regular contact with their care team.
- Staff directed patients to other services and supported them to access those services if they needed help. For example, supporting them with educational, medical and housing needs.
- Staff involved patients in their care and treatment and gave them access to their care plans.
- Staff informed and involved families and carers appropriately. The Early Intervention Services facilitated a carer group each month, where staff provided support and information to carers and encouraged them to provide mutual support for each other.

However:

- The teams acknowledged that they needed to improve how they received feedback from patients. The way in which teams gained feedback from patients was inconsistent between teams. However, in the Barnet Intensive Enablement Service, staff gave patients a survey to feedback on the service they received as part of the care programme approach meeting

Is the service responsive?

Good   

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

- The service was easy to access. Its referral criteria did not exclude patients who would have benefitted from care. Staff assessed and treated patients who required urgent care promptly and patients who did not require urgent care did not wait too long to start treatment. Staff followed up patients who missed appointments.
- The teams were meeting the set target time from referral to assessment. All locality teams we visited were meeting the 13-week target for referral to assessment, and all three Early Intervention Services were meeting the two-week referral to assessment target.
- Across the teams there were a range of rooms and equipment to support treatment and care.
- Staff encouraged patients to develop and maintain relationships with people that mattered to them, both within the service and the wider community. For example, in the Haringey Early Intervention Service, staff supported patients to attend the local gym and also ran a bike group, where patients refurbished second hand bikes and received training to get on the road safely.

Community-based mental health services of adults of working age

- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff.

However:

- Although the trust had worked hard since our last inspection to reduce waiting times for psychological therapies, some patients continued to wait a long time for psychological interventions. Barnet had the highest waiting times, with some patients waiting up to 18-months for individual and specialist group psychological therapies. The trust was aware of the challenges in accessing psychological therapies, and had measures in place for each borough to continue to work on reducing waiting lists.
- The interview rooms at Haringey North East and South East Locality Teams and Barnet West and South Locality teams did not provide adequate soundproofing. However, access to the corridor leading to the interviews was secured using an electronic fob system, so the traffic of people outside these rooms was small.
- Although managers told us that staff and patients had easy access to interpreters and/or signers. In the Enfield Early Intervention Service, we found an example where a patient who could not speak English did not always have access to an interpreter to support them to be involved in their care and treatment.

Is the service well-led?

Good  

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

- Leaders had the skills, knowledge and experience to perform their roles. Most team managers had been working in the community teams for many years. They demonstrated good competence in their leadership roles and a dynamic approach to continually improve the services they delivered.
- Staff knew and understood the provider's vision and values and how they were applied in the work of their team.
- Staff felt respected, supported and valued. Teams described morale as good, but they noted that it could fluctuate according to work pressures such as caseload and capacity demands. They reported that the provider promoted opportunities for career progression. They felt able to raise concerns without fear of retribution.
- At the last inspection in September 2017, staff across Haringey community services raised concerns about a culture of bullying and not feeling able to safely raise concerns. During this inspection, this was no longer the case. Staff in all of the Haringey community services that we visited reported an open culture and felt able to raise concerns without fear of retribution.
- Staff had access to support for their own physical and emotional health needs through an occupational health service. Teams took part in regular mindfulness sessions to support their well-being.
- 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.
- Teams had access to the information they needed to provide safe and effective care and used that information to good effect.
- Teams in Haringey and Enfield demonstrated a commitment to learning, continuous improvement and innovation. In Haringey, the South Locality Team and Early Intervention Service had participated in a research trial with a local university. This trialled a model of mental health care that involved a consistent family and social network approach and always involved the patient. Staff spoke very highly of this approach and its benefits for patient experience.

Community-based mental health services of adults of working age

However:

- Prior to our inspection, the trust had no agreed standards for reporting delayed MHA assessments. This meant that the trust did not have robust systems in place to monitor the number of delayed MHA assessments. However, since the inspection, the trust demonstrated a responsive approach to our concerns. They introduced a system so that any MHA assessment not meeting the five-day standard would be reported via the trust incident reporting system.
- The teams acknowledged that they needed to improve how they received feedback from patients and carers. The way in which teams gained feedback was inconsistent between teams.

Areas for improvement

Action the provider **MUST** take to improve

- The trust must ensure that it works 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 provider **SHOULD** take to improve

- The trust should review staffing levels in the Barnet West and South Locality Teams to ensure there are enough staff to safely and effectively deliver care and treatment to patients. The trust should continue its recruitment drive for permanent staff in the Barnet West Locality and Haringey North East Locality team to limit the impact on consistency of care.
- The trust should ensure that staff regularly update patients' risk assessments, including after a change in circumstance or an incident, to ensure safe management of risk.
- The trust should ensure that staff in Haringey and Barnet Early Intervention Services have manageable caseloads, in line with national recommendations.
- The trust should ensure staff develop and embed the necessary skills to support patients with their physical health care needs.
- The trust should ensure that staff in the Early Intervention Services proactively offer interventions to patients in line with national guidelines and quality standards, and ensure care plans reflect these interventions.
- The trust should continue to improve waiting times for patients to access psychological interventions, and ensure that patients are safely monitored whilst waiting for the interventions.
- The trust should ensure that all staff have a sufficient understanding of the relevance of the Mental Capacity Act and are able to identify patients who might have impaired capacity, and assess and record capacity assessments when needed.
- The trust should ensure there are formal systems in place for teams to share information, such as learning from incidents and good practice across the three boroughs.

Specialist eating disorders service

Good  

Key facts and figures

Barnet, Enfield and Haringey Mental Health NHS Trust provides a specialist inpatient eating disorder service for up to 20 adult women and men. The service is located in a ward at Phoenix Wing, St Ann's hospital.

The service is registered with the Care Quality Commission to carry out these regulated activities:

- Treatment of disease, disorder or injury
- Assessment or medical treatment, for persons detained under the Mental Health Act 1983

This inspection was carried out during a comprehensive inspection of the trust during June 2019 which was announced in advance.

The CQC previously inspected this service in September 2017.

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 patients' needs?
- Is it well-led?

Before the inspection visit, we reviewed information that we held about the service and asked a range of other organisations for information.

During this inspection we:

- visited Phoenix wing the specialist eating disorders ward
- spoke with the ward manager, service lead and service manager
- checked the quality and safety of the ward environment
- observed how staff worked with patients
- spoke with 5 patients who were using the service
- spoke with 8 staff, including psychiatrists, doctors, nurses, occupational therapists, psychologists and a social worker
- read three staff supervision records and three appraisal records
- attended and observed a multi-disciplinary meeting and a ward round.
- checked three patient records including medicines records, risk assessments and care plans
- read a range of policies, procedures and other documents relating to the operation of the service.

Specialist eating disorders service

Summary of this service

Our rating of this service improved. We rated it as good because:

- The management team had improved the quality of the service since our previous inspection by improving the ward environment.
- The service provided safe care. The ward environment was safe and clean. The ward had enough nurses and doctors. Staff assessed and managed risk well. They minimised the use of restrictive practices, managed medicines safely and followed good practice with respect to safeguarding and the management of incidents.
- The ward teams included the full range of specialists required to meet the needs of patients with an eating disorder. Managers ensured that these staff received training, supervision and appraisal. The multidisciplinary team was effective and worked well with other services to ensure positive outcomes for patients.
- Staff understood and discharged their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, and understood the individual needs of patients. They actively involved patients and families and carers in decision-making.
- The service managed the use of beds well in partnership with community services and patients were discharged promptly once their condition warranted this.
- The service was well-led, and the governance processes ensured that ward procedures ran smoothly.
- The service had a positive and open culture and staff were committed to continuously improve the service and the care pathway for patients with an eating disorder.

Is the service safe?

Good  

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

- The service provided safe care and treatment for patients with an eating disorder. The trust had improved the safety of the ward environment since our previous inspection.
- The service had enough nursing and medical staff. The trust ensured staff received training to keep patients safe from avoidable harm.
- Staff assessed and managed risks to patients with an eating disorder well and followed best practice. There were no inappropriate blanket restrictions.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so.
- Staff had easy access to clinical information and it was easy for them to maintain high quality clinical records.
- The service used systems and processes to safely prescribe, administer, record and store medicines. Staff regularly reviewed the effects of medicines on each patient's physical health.

Specialist eating disorders service

- The service had a good track record on safety. 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.

Is the service effective?

Good   

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

- Staff thoroughly assessed the physical and mental health of patients on admission. They then developed individual care plans, which they reviewed regularly through multidisciplinary discussion and updated as needed. Care plans reflected the patient's assessed needs and were personalised, holistic and recovery-oriented.
- Staff provided a range of care and treatment interventions consistent with national guidance on best practice for patients with an eating disorder. They ensured that patients had good access to physical healthcare and supported patients to live healthier lives.
- Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives.
- The multidisciplinary team included the full range of specialists required to meet the needs of patients with an eating disorder. Staff had the range of skills and experience to provide high quality care. Managers supported staff with appraisals, supervision and training opportunities to update and develop their skills in relation to eating disorders. Managers provided an induction programme for new staff.
- Staff from different disciplines worked together as a team to benefit patients. The multidisciplinary team had effective working relationships with other relevant teams within the organisation and with external services, such as the local acute hospital.
- 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 explained patients' rights to them.
- Staff supported patients to make decisions about their care and treatment. They understood the provider's policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly for patients who might have impaired mental capacity.

Is the service caring?

Good   

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

- Staff treated patients with compassion and kindness. They understood the individual needs of patients and supported patients to understand and manage their eating disorder.
- Staff involved patients in risk assessment and care planning and acted on their views.
- Staff informed and involved families and carers appropriately.

Specialist eating disorders service

Is the service responsive?

Good  

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

- The trust had made improvements to the ward environment since our previous inspection, and it was now more suitable for patients with an eating disorder. Patients and staff had been involved in planning the facilities at a new in-patient service for patients with an eating disorder which was due to open in the summer of 2020.
- Staff worked with community services and acute care health specialists to optimise the care pathway for patients with an eating disorder
- The service met the needs of all patients who used the service - including those with a protected characteristic. Staff helped patients with communication, advocacy and cultural and spiritual support.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team.

Is the service well-led?

Good   

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

- Leaders had the skills, knowledge and experience to perform their roles. They had a good understanding of eating disorder services and were visible in the service and approachable for patients and staff.
- Staff knew and understood the provider's vision and values and how they were applied in the work of their team.
- Staff felt respected, supported and valued. They reported that the provider promoted equality and diversity in its day-to-day work and in providing opportunities for career progression. They felt able to raise concerns without fear of retribution.
- Our findings from the other key questions demonstrated that governance processes operated effectively at ward level and that performance and risk were managed well.
- Staff had access to the information they needed to provide safe and effective care and used that information to good effect.
- Staff engaged actively in local and national quality improvement activities.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that the service provider was not meeting. The provider must send CQC a report that says what action it is going to take to meet these requirements.

For more information on things the provider must improve, see the Areas for improvement section above.

Please note: Regulatory action relating to primary medical services and adult social care services we inspected appears in the separate reports on individual services (available on our website www.cqc.org.uk)

This guidance (see goo.gl/Y1dLhz) describes how providers and managers can meet the regulations. These include the fundamental standards – the standards below which care must never fall.

Regulated activity

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

Treatment of disease, disorder or injury

Regulation

Regulation 9 HSCA (RA) Regulations 2014 Person-centred care

Regulated activity

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

Treatment of disease, disorder or injury

Regulation

Regulation 12 CQC (Registration) Regulations 2009 Statement of purpose

Regulated activity

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

Treatment of disease, disorder or injury

Regulation

Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment

Regulated activity

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

Treatment of disease, disorder or injury

Regulation

Regulation 18 HSCA (RA) Regulations 2014 Staffing

Our inspection team

Jane Ray, Head of Inspection, led this inspection.

An executive reviewer, Martin Gower, Chairman at Midlands Partnership NHS Foundation Trust, supported our inspection of well-led for the trust overall.

The team included 25 further CQC inspection staff, 15 specialist advisers, and three experts by experience.

Executive reviewers are senior healthcare managers who support our inspections of the leadership of trusts. Specialist advisers are experts in their field who we do not directly employ. Experts by experience are people who have personal experience of using or caring for people who use health and social care services.