

**Good** 

North East London NHS Foundation Trust

# Community-based mental health services for adults of working age

## Quality Report

NELFT NHS Foundation Trust

Trust Head Office

Goodmayes Hospital site

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## Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/unit/team)	Postcode of service (ward/unit/team)
RAT	Trust Head Office	Community Recovery Team	E11 2DH
RAT	Trust Head Office	Community Recovery Team	E17 3HP
RAT	Trust Head Office	Community Recovery Team	IG11 9LX
RAT	Trust Head Office	Access Assessment and Brief Intervention Team	IG11 9LX
RAT	Trust Head Office	Access Assessment and Brief Intervention Team	E11 2DH

# Summary of findings

RAT	Trust Head Office	Access Assessment and Brief Intervention Team	E17 3HP
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This report describes our judgement of the quality of care provided within this core service by North East London NHS Foundation Trust. Where relevant we provide detail of each location or area of service visited.

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

Where applicable, we have reported on each core service provided by North East London NHS Foundation Trust and these are brought together to inform our overall judgement of North East London NHS Foundation Trust.

# Summary of findings

## Ratings

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

### Overall rating for the service

Good



Are services safe?

Requires improvement



Are services effective?

Good



Are services caring?

Good



Are services responsive?

Good



Are services well-led?

Good



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

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

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

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

# Summary of findings

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# Summary of findings

## Overall summary

We rated community-based mental health services for adults of working age as **good** because:

- The teams were safely staffed, with recruitment progressing to fill vacancies.
- Staff in all the teams demonstrated a good understanding of safeguarding policies and procedures to keep people safe from abuse.
- The caseloads of the teams were monitored regularly in meetings and individually in supervision. There were effective internal meetings and communication with the rest of the mental health pathway was good.
- The community recovery teams had developed a physical health clinic and were expanding the amount of physical health screening available to people who used the service.
- Nearly all of the people who use the service and carers we spoke with were positive about the care and treatment that they were receiving. They said that staff were respectful, kind and caring.
- The teams had good access to psychiatry support and could arrange appointments at short notice, or get support from a doctor when they needed it.
- Currently the community recovery teams did not operate a waiting list for allocation which meant that new referrals could be seen in a timely way.

However:

- In some electronic records at the community recovery teams, risk assessments were not being recorded fully, and updated in a thorough manner, which meant that information that care professionals may need to use was inaccurate.
- The AABITs had a fragmented approach to physical healthcare. People who moved between teams had varying input from GP's regarding their physical health. The relationship between the teams and primary care impacted people's understanding of their care plans which were delivered by the GP.
- There was a lack of involvement of people who used the service in the creation of some of the care plans in the community recovery teams, and some care plans we looked at were limited and did not reflect a broad, recovery focused, set of goals for every person.
- A log of complaints received by each team, and progress to resolve complaints, was not available for us to view in the community recovery teams at the time of our visit.

# Summary of findings

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

### Are services safe?

We rated safe as requires improvement because:

- Although current risks were reviewed in weekly zoning meetings in each community recovery team, staff did not record and update risks within some people's records in a manner that was sufficient to demonstrate that risks were known and that risks had been mitigated.
- In 10 of the 19 electronic records, the risk assessments that we reviewed had a number of omissions. These included: a failure to update risk in a timely way, risk statements were limited in content and contained no formulation or crisis plan, the absence of a risk assessment for violence where historic issues were known by the team.
- People who used the AABIT service who were deemed low risk could be overlooked. They told us that they were not informed of their ongoing plans and did not always get a response when asking services for general support and advice.

However:

- All teams had sufficient staff to ensure that people received a comprehensive mental health service. The service was addressing historic recruitment issues.
- The caseload numbers for care coordinators were well managed in each team.
- Each team had a well-equipped clinic to carry out any physical assessments.
- Staff demonstrated that they were aware of the learning from recent incidents.
- Staff demonstrated that they had a good knowledge of local safeguarding procedures.

**Requires improvement**



### Are services effective?

We rated effective as good because:

- We found evidence that showed the teams had implemented best practice in their clinical work. We saw good sharing of information within the team and to other parts of the service such as home treatment and inpatient services and external agencies.
- People who use services had good access to employment and vocational advice.
- The physical health needs of people were being addressed at the community recovery teams by new clinics set up in each team.

**Good**



# Summary of findings

- Staff received annual appraisal and regular supervision which included reviewing current issues on their caseload.
- We saw that staff skills were being developed to expand the interventions and treatments available to people who used the service.
- Staff in the AABITs completed comprehensive assessments of peoples' needs in a timely manner which enabled staff to develop meaningful care plans with people who use services.

However:

- The standard of care planning was variable in all the community recovery teams. Most noticeably, in respect of evidence of people's involvement in creating their care plans and the absence of a broad range of personalised goals for each person.
- The AABITs did not provide assessment of people's physical health needs and knowledge of these relied upon good communication across different services.

## Are services caring?

We rated caring as good because:

- The people we spoke with who use the service all said that they were treated with respect and found the staff to be supportive and helpful.
- We observed that people were being given choice and information about their treatment in the clinical activities that we observed.
- People who use services were involved in recruitment decisions about appointments to the community recovery teams.

Good



## Are services responsive to people's needs?

We rated responsive as good because:

- Each team had effective processes in place to manage referral, assessment and allocations. There was no waiting list at the community recovery teams, and appointments could be arranged easily.
- The service was delivered in a flexible way with people seen in the community, including in their own homes, by care coordinators and doctors when needed. . Teams were regularly meeting target times for assessing people and we saw that this was continuing to improve. A satellite clinic had been established to make access in the east of the borough easier for people to attend appointments.

Good



# Summary of findings

- Managers were restructuring the community recovery teams to enable better communication links with primary care, and working to address barriers which prevented people from being discharged to more appropriate support.

However:

- During our inspection staff told us that they recorded and responded to complaints informally and recorded these on a system separate to the trust complaint recording system. We were not able to view the log of current complaints at any of the teams we visited, as the complaint log was inaccessible to the managers at the time of the visit.

## Are services well-led?

We rated well-led as good because:

- All the staff we spoke with said that they were well supported by their local managers and that there was a good team structure, with regular and effective meetings.
- Staff were encouraged to contribute to service improvement.
- We saw evidence that the trust had listened and responded to the staff concerns about the impact reduced staffing was having on workload pressure in one team and took appropriate action.
- We saw initiatives to improve access for people who use services and respond to the impact of recent team moves.
- Managers were working to improve the range of interventions the team could offer by developing the skills of staff.

However:

- Many staff we spoke with told us that the recent service changes, staff vacancies and difficulties with recruitment, had impacted on staff morale, and increased workloads.

Good





# Summary of findings

## Information about the service

The community recovery teams form part of the trust's mental health services in the community. They provide a specialist mental health service for adults of working age (18-65) with serious and/or enduring mental health needs who meet the teams' criteria for the Care Programme Approach. Each team also incorporates assertive outreach workers, who work with people who services find harder to engage and may have a history of higher risk.

The teams are made up of health and social care professionals including psychiatrists, social workers, psychiatric nurses, occupational therapists and support time recovery workers. Psychology services were not located in the same building as the teams but regular contact was provided by a named psychology link worker for each team.

At the time of inspection the three teams were at different stages of reorganisation. The community recovery teams were changing internal processes to mirror the GP clusters in their area. This meant that the team would be divided to reflect this with the aim to improve links with primary care.

The access assessment and brief intervention teams (AABIT) are specialist teams of mental health

professionals who provide a single point of access for all adults who present with a mental health need which cannot be met by their GP. Their primary function is to carry out a comprehensive assessment of needs. They offer a range of short term, recovery focussed, treatments and psycho-social interventions for people who do not need long term care and treatment. Each of the four boroughs of Redbridge, Barking and Dagenham, Havering and Waltham Forest had its own AABIT.

We inspected the following services:

Community Recovery Team, Waltham Forest

Community Recovery Team, Redbridge

Community Recovery Team, Barking and Dagenham

Access Assessment and Brief Intervention Team, Waltham Forest

Access Assessment and Brief Intervention Team, Redbridge

Access Assessment and Brief Intervention Team, Barking and Dagenham

These services had not been previously inspected.

## Our inspection team

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# Summary of findings

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These services had not been previously inspected.

## Why we carried out this inspection

We carried out this inspection as part of our ongoing comprehensive mental health inspection programme.

## How we carried out this inspection

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

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

Before the inspection visit, we reviewed information that we held about these services, asked a range of other organisations for information and sought feedback from patients at two focus groups.

During the inspection visit, the inspection team:

- Visited three team bases, looked at the quality of the team environments and observed how staff were caring for people who use services.
- Spoke with 22 people using the service.
- Spoke with two carers.
- Spoke with the managers of each of the three community recovery teams.
- Spoke with 22 other staff members of the community recovery teams including five nurses, three social

workers, two psychologists, four support time recovery workers (STR), four consultant psychiatrists, three occupational therapists and the lead for personalisation.

- Spoke with 29 staff from the Access Assessment and Brief Intervention Teams (AABIT) of all disciplines.
- Collected feedback from 40 patients using comment cards.
- Looked at 37 care records of people who use services.
- Attended and observed one morning meeting, one allocations meeting, one bed management meeting and one zoning meeting at the community recovery teams. Attended two Access Assessment and Brief Intervention Team multidisciplinary meetings and two handovers.
- Attended and observed one Care Programme Approach review meeting.
- Attended five assessment meetings, and three telephone assessments.
- Looked at a range of policies, procedures and other documents relating to the running of the service.

# Summary of findings

## What people who use the provider's services say

All but one of the people who used the service whom we spoke with thought that the service they received was good and the staff were caring, compassionate and respectful. They said they were involved in their care and had been given information about treatments, including medicines, and other services. They confirmed they had been given a copy of their care plan. They told us that if they needed to see a doctor that this was arranged quickly by the team.

One person who used the service spoke negatively about poor communication from their care coordinator. Some people using the AABIT told us that they were not always sure of the content of their care plan and that discharge planning was unclear.

Two carers we spoke with were complimentary of the support and involvement they had with the community recovery teams. They both highlighted that confidentiality was always well maintained.

One carer felt that the Waltham Forest community base at Larchwood was not always well cleaned.

## Good practice

- Each community recovery team has set up a physical health assessment clinic to improve access to physical health monitoring for people who used the service. Waltham Forest community recovery team was recruiting a general nurse to join the team to expand the monitoring of physical health. The team doctors ran a Friday clinic at Redbridge community recovery team. The Barking and Dagenham team converted a mental health practitioner post to a general nurse post to improve physical health monitoring.
- Redbridge community recovery team ran a satellite depot clinic in the east of the borough at the

Goodmayes site. This was created when the east team became co-located at Mellmead House in the west of the borough. The aim was to reduce travelling distance for people due to the change of team location.

- Mental health practitioners in each team were being trained in offering family interventions in psychosis to support their work with people and their families.
- The Waltham Forest community recovery team was a pilot site for Open Dialogue, a psycho-social approach to working with people experiencing mental health crisis. Ten staff were receiving four weeks of residential training.

## Areas for improvement

### Action the provider **MUST** take to improve

#### Action the provider **MUST** take to improve

- The trust must address the standards of the assessing and recording of the risks of people who use the services of the community recovery teams. Accurate and complete risk assessments were not in place for each person, including risk formulation, nor was there evidence in all risk assessments of risks being updated regularly or after any significant event.

### Action the provider **SHOULD** take to improve

#### Action the provider **SHOULD** take to improve

- The trust should address the standards of care plans in the community recovery teams. Some care plans we saw did not include the involvement of the person using the service in the creation of the plans, nor did they evidence a broad range of recovery focussed goals for each person.
- The trust should ensure that an accessible system for recording and resolving of complaints is in place for each team. The complaint log for complaints resolved informally at each of the three community recovery teams could not be accessed by managers at the time of our visit.

## Summary of findings

- The trust should ensure that all people being supported by the access assessment and brief intervention teams are aware of their care plans.

## North East London NHS Foundation Trust

# Community-based mental health services for adults of working age

### Detailed findings

#### Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Community Recovery Team, Waltham Forest	Trust Head Office
Community Recovery Team, Redbridge	Trust Head Office
Community Recovery Team, Barking and Dagenham	Trust Head Office
Access Assessment and Brief Intervention Team, Waltham Forest	Trust Head Office
Access Assessment and Brief Intervention Team, Redbridge	Trust Head Office
Access Assessment and Brief Intervention Team, Barking and Dagenham	Trust Head Office

#### Mental Health Act responsibilities

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

- We were unable to speak directly to any people with a community treatment order (CTO).

- We did see the care records for three people where the CTO documentation was stored on the trust's Windip system. Whilst CTO paperwork was present there were gaps in some letters and review dates in these records.

# Detailed findings

- We were informed during our visit that training in the Mental Health Act has become mandatory training for staff working in the community recovery teams and we saw training data to reflect this.

## Mental Capacity Act and Deprivation of Liberty Safeguards

- Overall we found good evidence in the practice and application of the Mental Capacity Act/Deprivation of Liberty Safeguards. Staff had recently completed mandatory training in MCA/DoLS.
- We found references to capacity decisions within the care records that we viewed and observed in clinical meetings issues of mental capacity being discussed.
- Mental Capacity Act and Deprivation of Liberty information and contact details were displayed on notice boards in the teams' reception areas.

# Are services safe?

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

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

## Our findings

### Safe and clean environment

- All the sites were clean and tidy. The Waltham Forest team base was an old building and this was reflected in some rooms with fading décor and cracked walls.
- The reception areas had ample space for people to sit and were well organised, apart from at Barking and Dagenham where there was no recording system in place for signing visitors in and out of the building.
- The clinic rooms were clean and tidy. Appropriate, well maintained, equipment was available for physical health checks. Medicines were safely stored.
- In two bases interview rooms were fitted with alarm buttons, or staff had access to a portable alarm. However, there were interview rooms at the Redbridge team which were not alarmed.
- The automatic opener for the front door at Mellmead House (Redbridge team) was out of use on our visit.
- There were issues with interior door closures at the Barking and Dagenham community recovery team. This meant that doors would not close properly unless locked. Despite attempts by the manager to address the building issue, it had remained unresolved. This compromised confidentiality and raised concern about safety. We observed staff placing bins and chairs against doors to attempt to keep them from opening. These presented a barrier to exiting the room quickly.

### Safe staffing

- The community recovery teams staffing establishment for qualified nurses was: Waltham Forest 20, Barking and Dagenham 19, Redbridge 10. Vacancy rates for qualified nurses were Waltham Forest 0, Barking and Dagenham 1, Redbridge 1. Managers informed us that recent recruitment had been successful for some positions, and that the speed of recruiting new staff had improved. New staff had start dates at the Waltham Forest team.
- Staffing levels at the AABITs were adequate. However there were three qualified nurse vacancies, three social

worker vacancies, and two administrative staff vacancies at the Redbridge AABIT. The shortage of staffing at the team had delayed the recruitment process. The manager informed us that covering annual leave and allowing staff time for training was an issue. The team leader had limited the amount of assessments carried out each day to protect staff from unsafe and stressful practice.

- The Redbridge AABIT had nine different locum consultants in an 18 month period. Staff told us that the locums had been of a high standard. The current locum was known to the service and was expected to remain until the end of the year. The regular consultant was due to return from long term leave in the coming months.
- Managers and staff of the community recovery teams told us that recent service restructuring had caused some staff to leave and that there had been a recruitment freeze within social care posts whilst this was happening. The manager at Waltham Forest told us that the team had complained about the impact of the vacancies on the team and the trust had responded by temporarily filling more vacancies while recruitment happened.
- Managers in all teams said that the new TRACK recruitment system had made recruitment easier and quicker for them. This meant they could review progress of recruitment on their desktop.
- Waltham Forest community recovery team had the highest sickness rate with seven staff on long term sickness absence. The manager confirmed this was 14% of the team establishment. It was also the team with the highest staff turnover, six members of staff in the last 12 months.
- Staff told us that regular agency staff were being used to cover vacancies and that they were well established in the team and known to staff and people who used the service to ensure consistency in the service people received.
- However, staff said that the turnover and vacancy rates in two of the teams, Waltham Forest and Redbridge community recovery teams had a negative impact on the morale of the team.

# Are services safe?

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

- Each community recovery team comprised a service manager, senior clinical team leads, nurses, social workers, occupational therapists, psychiatrists, STR workers, administrative and reception staff. Team sizes varied but most noticeable was that Barking and Dagenham had ten STR workers while the other teams had one or two. We were told by staff, that the teams were cohesive with good and respectful communication. We observed professional and supportive interaction between staff of all disciplines during the zoning meeting, the allocations meeting and clinical meetings with people who used the service
- The care coordinator caseload sizes were consistent across the teams. Recovery team caseloads were 25-30, and Assertive Outreach Teams AOT 10-14. There was evidence of regular review of cases and case load size in supervision records.
- Staff who offered brief intervention had an average caseload size of 25. People, who were offered brief intervention, following assessment, were allocated an appropriate keyworker at a weekly meeting. Keyworkers were emailed this information with an expected contact date depending on need and risk. Team leaders were aware of caseload numbers and the amount of people requiring assessment. Staff were delegated accordingly to manage the workload safely.
- There was no waiting list for assessment or allocation at the community recovery teams when we visited. We were told that the new pathway to prioritise first episode of psychosis referrals was placing pressure on completing all assessments in a timely way as the number of assessments was growing in each team.
- Staff told us that access to psychiatrists was good. That doctors in the teams were approachable and flexible. This was confirmed by comments from people who used the service who told us that it was easy to arrange an appointment with their doctor when they needed one.
- Staff across the AABITs told us the workload was demanding but good support was available from managers and colleagues. Staff were appropriately qualified, and we saw staff undertaking comprehensive assessments to ensure that peoples' needs were

identified. However, they felt that people with a green risk rating were often overlooked. People who used services confirmed this and they were sometimes unclear of their ongoing care plan.

- We attended a Waltham Forest AABIT meeting where people who had been identified for brief intervention were allocated to keyworkers. All clinical leads and consultant attended. Each person was discussed at length with projector access to RIO (the trust's electronic patient record). An outline of likely interventions was agreed and a keyworker (either nurse, occupational therapist, social worker or psychologist) was allocated dependant on need.
- Staff reported that they were up to date with mandatory training. We saw mandatory training figures in two of the community recovery teams and rates were over 80%, including the Mental Capacity Act/Deprivation of Liberty Safeguards MCA/DoLS. Staff in the AABITs had an average of 90% for attendance at mandatory training. Staff told us that they receive texts from the training department reminding them to attend mandatory training.

## Assessing and managing risk to patients and staff

- At the three community recovery teams there was a wide variation in the quality and completeness of the risk assessments that we viewed. In 10 of the 19 care records reviewed we found a range of issues affecting the accuracy and usefulness of the information. For instance, two risk assessments had not been updated for several years (2011/2014). In another not all sections of the risk assessment were completed, meaning it was limited in content. There was no formulation of risks and the crisis plan was very basic. In one risk assessment the risk recorded was assessed as low, but the care coordinator reported that the person using the service was 'risky'. One record had no risk assessment of violence though the team was aware of historic issues. In one record there had not been any update to the risk assessment since it was first made. In another the care plan stated the person was at risk of self-harm but there was no record of this in the risk assessment. In one the risk assessment was not updated following a significant act of aggression.
- At the AABITs we viewed 38 care records and all showed that staff had undertaken a risk assessment at the initial



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assessment. All staff rated risk as red, amber or green. Risk ratings were discussed daily at the multidisciplinary meetings. One risk assessment viewed at Barking and Dagenham AABIT had not been updated since 2012.

- We observed a member of staff at Redbridge AABIT completing an assessment without fully exploring a person's suicidal thoughts which could lead to an inaccurate assessment of risk.
- Each community recovery team held a weekly zoning meeting where the current situation and risks of people using the service were reviewed and given a red/amber/green rating. The meeting we observed was well attended by different disciplines. Known current risks were discussed and plans made. Outcomes of the meeting were recorded in the electronic progress notes.
- Each team had a duty system where two team members were allocated to respond to telephone calls and to react appropriately should further actions be needed. They also provided a point of contact for people who did not have a care coordinator, or if the care coordinator was absent. Staff told us issues arising from contact with the duty system could be escalated to other team members such as arranging for a people to have an urgent appointment or to be visited at home.
- We observed an allocations meeting where new referrals were discussed and where plans were made for people who used the service who needed to move from recovery workers to assertive outreach workers.
- The AABITs had an open referral with capacity to see urgent referrals. People could attend between office hours and be assessed on the day. We observed the process to good effect at both the Redbridge and Waltham Forest teams.
- We observed that each team had a lone working protocol in place. Team members recorded their external visits in a central place. People with identified risks were always seen at base or in pairs. Staff used a signing in and out board to communicate where they were going and what time they were due back. The community recovery teams had a known hostage phrase in place to use if they were in danger, but this was not the case in the AABITs.

- The Redbridge AABIT occupational therapist lead reviewed all people seen by support time recovery workers to ensure that risks were managed.
- Staff we spoke with were knowledgeable about safeguarding processes and how to raise an alert. Each team had a safeguarding lead. Safeguarding information and contacts were displayed on notice boards at each team base.
- All teams had access to a safeguarding administrator who logged alerts and the progress of the safeguarding investigation.
- Staff from the AABITs and the community recovery teams met to ensure a safe and appropriate transfer of care

## Track record on safety

- Information provided by the trust showed that between November 2014 and October 2015 the total number of serious incidents requiring investigation by the community recovery teams was ten. There were 13 serious incidents at the AABITs in the same period.

## Reporting incidents and learning from when things go wrong

- Staff demonstrated that they knew how to report incidents on the trusts incident reporting system. This allowed the severity of the incident to be rated and records actions of what to do next.
- Staff told us that serious incidents were investigated by a trust serious investigation team. Once the report was completed the team feedback to the staff. Managers confirmed that they were involved in these investigations and in the creation of action plans to implement lessons learned. We saw examples of investigation reports with actions to implement learning. The team leader at Waltham Forest AABIT completed audits in response to incidents.
- Staff showed us on the trust electronic system how the number of open investigations and progress of these could be monitored by each team.
- The Waltham Forest AABIT had a caseload of 1047 and reported one incident on the DATIX system in the week prior to our inspection.

# Are services safe?

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- At Dagenham and Barking community recovery team we saw that the manager was working with trust security and estates departments to remodel the reception area following an incident in 2015. This incident was recorded on the trust electronic system and actions included a security review of the reception area.
- Staff told us that lessons learned from investigations were discussed in team meetings and we saw records that this was happening. The Redbridge community recovery team had a serious incident forum for team members every two months. The outcomes of recent trust investigations were shared with team members and decisions made where the team needed to change practice.
- A member of staff at Redbridge AABIT told us that they had not received adequate feedback from an incident regarding a double homicide.
- Staff told us that the trust would hold regular forums for staff to attend following incidents that had broader lessons for the wider trust.
- We case tracked an incident at the Barking and Dagenham community recovery team reception in May 2015. We found that there had been a previous aggressive incident some weeks earlier that had also placed people in the building at risk. Both incidents were recorded on the DATIX system. However the second incident had been rated as 'low risk' and the event was not raised as a serious incident to be investigated by the trust's serious incident team.

# Are services effective?

Good 

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

## Our findings

### Assessment of needs and planning of care

- Information including care plans and progress notes was securely stored on the trust's electronic care records system. All staff had access via desktop computers and some staff told us they had mobile devices where they could log in when away from the team base.
- Staff we spoke with in the community recovery teams explained that any documents needing to be stored on electronic notes had to be uploaded to a second system Windip. Staff across the teams expressed frustration at having to use both systems. We had experience that the Windip system was slow and often was unavailable when we tried to access records. This was confirmed by AABIT staff who told us that using the Windip system could be time consuming.
- AABIT staff completed outstanding initial assessments which included comprehensive core assessments for people who were new to secondary mental health services. These were completed immediately after assessing the person. Staff would remain after hours if necessary to complete.
- At the community recovery teams we looked at the electronic records of 19 people who used the service during the inspection. Care plans were in place for all but one person. There was a wide variation in quality and content in the plans that we saw. Evidence of a broad range of needs considered and plans that were holistic and recovery focused, was absent in some of the care plans. On many records there was no evidence of the involvement of people who use services in creating the plan.
- We looked at 38 care records of people who used the AABIT service. We saw that the care plans were not always recorded correctly on RIO. Staff told us that this was due to high workloads. However we saw that plans included in progress notes considered all aspects of the person's circumstances, were individualised, and included goal setting.
- The AABITs made plans for peoples' discharge but staff told us that those rated green could be overlooked due

to the need of others on the caseload. Staff said that caseloads were unnecessarily high and stretched resources made it difficult to plan appropriate discharge for everyone.

### Best practice in treatment and care

- There was evidence that during assessments staff had considered the National Institute for Health and Care Excellence (NICE) when planning and delivering treatment. We heard this discussed in CPA and clinical discussions and staff were able to describe NICE recommendations when we spoke with them. This included access to cognitive behavioural therapy (CBT) and family therapy, the monitoring of physical health and medicines reviews, and advice and support with benefits and housing.
- The AABITs had a varied approach to clinical audits. The team leader at the Redbridge team was recently in post and was not currently auditing clinical practice. The team had plans to start auditing occurrences when people did not attend appointments and the source of referrals. They had been auditing informal complaints from telephone calls and shared this information at team meetings. The team leader at Waltham Forest was auditing issues arising from incidents. Auditing of date stamping referrals and caseloads had led to improved safer practice.
- Psychological therapies could be accessed by referring people who use the service to the psychology team. Each community recovery team had a link psychologist who regularly attended community recovery team meetings. A similar arrangement was in place for the AABITs. Interventions available included a hearing voices group, a bi-polar awareness group, mindfulness, cognitive behavioural therapy (CBT) exposure group, managing stigma and family interventions. We were informed by managers that discussions had started regarding whether psychology would become embedded in the community recovery teams.
- People who used the service had access to other treatment pathways but needed to match criteria for treatment. They included dialectical behaviour therapy (DBT), mindfulness-based cognitive therapy (MBCT) and

# Are services effective?

Good 

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

coping with emotions on the mood disorder pathway, and access to DBT, cognitive behavioural therapy (CBT) and positive psychology on the personality disorder pathway.

- We attended an anxiety group run by an occupational therapist from Redbridge AABIT. People rated their progress with 'Here I am now', an anxiety rating tool, after each session. It was well attended and people told us that it had helped their anxiety and confidence.
- Waltham Forest AABIT had a working document which kept track of activities in the local borough. It was available for people in all interview rooms. An occupational therapist from the team was the trust's employment retention lead. They supervised three employment advisors in the other boroughs and attended a quarterly employment partnership group. They were active in all events involving employment across the four boroughs.
- All teams had access to an employment and vocation worker and were linked to services run in the community by the Richmond Fellowship.
- The AABITs had good links with housing and benefit agencies. STR workers took the lead on supporting and signposting people with these social issues. A Redbridge worker had made good links with probation, sexual health and lesbian, gay and transgender (LGBT) agencies.
- The community recovery teams had recently reorganised to reflect the local GP clustering. The aim was to improve the relationship with primary care and to assist with confidence and communication, particularly when people were being discharged from the service. The Redbridge team had recently held an engagement meeting with local GPs to facilitate this.
- The AABITs did not prescribe medicine as normal practice. Consultants would recommend regimes and communicate these to GPs for prescribing. Consultants did have access to FP10 prescription pads to use if people needed urgent medicines from a pharmacy. These were securely locked and their use was audited.
- The AABITs did not routinely monitor peoples' physical health. GPs were responsible for this, including monitoring Lithium blood levels. Doctors were able to carry out electrocardiograms (ECG) and blood tests in

emergency situations. Staff told us they had plans to introduce groups which addressed physical health. These included a well-being group and a physical screening drop-in group.

## **Skilled staff to deliver care**

- Staff in all teams were appropriately qualified and consisted of a range of professional backgrounds including nursing, medical, occupational therapy, psychology, and social work. All teams had band 7 clinical leads for the different professions.
- The staff records we viewed showed that staff were up to date with their appraisals which happen annually. We saw that staff were receiving regular supervision, which included a review of cases they were working with and the sessions were clearly recorded. The supervision structure was supported by senior posts in social work, occupational therapy and nursing in each team. All teams had supervision trees that ensured staff were supervised by the appropriate person.
- Staff at Redbridge AABIT reported exceptional supervision arrangements from the occupational therapy lead. They told us that this helped manage their demanding workloads. The team leader was reviewing the use of the electronic recording tool (RIO) as part of supervision to ensure the system was used correctly.
- Two staff from Barking and Dagenham AABIT had recently completed training in best interest decisions. These staff were also currently receiving approved mental health professional and management training. The team leader had also applied to the team recovery implementation plan (TRIP). The training supports teams to use resources available (staff and people who use services) to promote recovery. The team had plans to include people who use services in their business meetings.
- We saw the minutes and actions arising from team meetings that were held regularly and were well attended at each community recovery team.
- Staff told us that the trust was very supportive with training and development. On our inspection we saw that staff were involved in the Open Dialogue training and also there was a commitment to develop staff to

# Are services effective?

Good 

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offer Family Therapy. The general nurses who had joined teams had been given support with mental health medicines and trained in administering anti-psychotic medicines and understanding their side effects.

- We saw evidence that temporary staff completed a detailed induction process in their first week working within the team. A completed checklist was kept by the manager which showed that temporary staff were given knowledge about the team and the people who use services that the team was supporting.
- In the AABITs band two, three and four clinical staff received the care certificate training, which is the benchmark for providing unqualified staff with the fundamental standards of care. The teams had a good approach to appointing champions to take a lead in clinical areas. These were chosen on clinical experience and interest.
- The team leader of Redbridge AABIT told us how she had taken prompt action to address the poor performance of the administration department.

## Multi-disciplinary and inter-agency team work

- All of the community recovery teams had regular multi-disciplinary team meetings, business meetings and zoning meetings. We observed a zoning meeting at Waltham Forest which was well co-ordinated and the current issues for people who used the service were clearly presented and updates placed on to clinical records. Waltham Forest also had a daily morning meeting which reviewed the top six people of concern on that day. This covered risk, the next contact and treatment plans.
- The AABITs had daily meetings to review the previous 24 hours. The Redbridge team were piloting afternoon meetings so more medical staff could attend. Complex cases were discussed and people were allocated to keyworkers for medical reviews. The meeting took place in the main office to allowing staff to continue working. It was common practice for staff to come in and out of the meeting.
- The AABITs held weekly multidisciplinary meetings to discuss people on their caseload. They reviewed risk ratings and discussed at length people with ratings of red or amber. However people rated as green were not

discussed and therefore could be overlooked. The current situation of people rated as green would be reviewed if they contacted the AABIT or if they were flagged up by other agencies.

- Waltham Forest AABIT had a separate allocations meeting to ensure people were referred to an appropriate brief intervention. For example short term key working or psychotherapy based group work. All new referrals that had been assessed as requiring a brief intervention by the team were reviewed by the clinical leaders. They then handed over decisions to the staff who would be delivering the brief intervention.
- Approximately one third of AABIT referrals did not require brief intervention but may have had social needs. All teams had excellent links with external agencies such as housing, employment support, the citizen's advice bureau, primary care, psychology (IAPT) and probation. People signposted to these services were provided with useful mental health contacts by letter.
- Approximately one third of Redbridge AABIT referrals were considered inappropriate. The team had delivered training to GPs and distributed information on appropriate referral criteria in an attempt to improve on this number. However funding for this training was no longer available.
- During our inspection Waltham Forest AABIT received a presentation from a primary health care worker about a new service that could be used as a step down to primary care. The service would be able to give people depot injections allowing a number of people to be discharged from the Waltham Forest team caseload.
- Members of the community recovery teams, the AABITs and the Home Treatment Team (HTT) attended each other's team meetings. Members of the HTT attended recovery team zoning meetings once per week.
- We observed a bed management meeting conducted via video conferencing between inpatient ward managers and the deputy managers of the Redbridge community recovery team. In the meeting the progress of patients' admissions was discussed and plans were made to have the appropriate community team support available when the person was ready for discharge from hospital.

# Are services effective?

Good 

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- The community recovery teams held regular meetings with the trust's Access and Assessment and Brief Intervention Teams (AABIT). The Waltham Forest AABIT used a comprehensive checklist before referring to the community recovery teams. This helped ensure inappropriate referrals were minimised.
- The community recovery teams met regularly with the Early Intervention in Psychosis (EIP) teams. Staff said that there was additional pressure with the requirement to prioritise new people referred by EIP due to the first episode of psychosis pathway.

## **Adherence to the Mental Health Act and the MHA Code of Practice**

- AABIT staff had a good understanding of the MHA code of practice and its guiding principles. They told us that they did not support people who were on Section 17 leave or community treatment orders (CTO). They were aware that people with these care plans would be supported by the community recovery teams.
- The people who use the service that we spoke with told us that they were aware of their rights, and their access to an Independent Mental Health Advocate (IMHA).
- Staff told us that medicine leaflets are given to people who use the service along with explanations about rights, how to appeal, legal advice and leaflets, mandatory conditions and recall details so that they had this information if they needed it.
- During our visit it was confirmed by staff that Mental Health Act training had become a mandatory training course for staff working in the community recovery teams.

## **Good practice in applying the Mental Capacity Act**

- We saw that there was information about the Mental Capacity Act on notice boards in the team bases giving information and contact details.
- We saw evidence of the assessment of capacity and best interest decisions in the care records we viewed.
- There was variation in staff knowledge about capacity assessments when we spoke with them, however most staff had recently completed the mandatory capacity/DoLs training.
- At Barking and Dagenham community recovery team five staff were being trained as best interest assessors. At Waltham Forest a team doctor had recently held a workshop for staff on the MCA to support them in their work with people.



# Are services caring?

Good 

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

## Our findings

### Kindness, dignity, respect and support

- Staff we spoke with demonstrated a caring and respectful attitude to each other and also to the people who use the service and their carers. We observed staff carefully and sensitively explaining treatment options and working patiently with a person who was distressed.
- We observed five AABIT assessments and at all times staff interacted with people who use services, and carers, in a respectful and compassionate manner. This included resolving difficult situations in a professional way.
- At Redbridge AABIT we saw staff being dismissive of people who were waiting for assessments. We observed a carer, who asked how long they would have to wait, receiving no information or reassurance. They were not updated on waiting times and there was no access to cold water in the waiting area. The issue was raised with the trust during the inspection and an action plan was produced to address this.
- The people who use the service, and carers, that we spoke with, told us that staff were caring and generous in the way that they dealt with their issues. They particularly praised the way the workers managed their confidentiality.

### The involvement of people in the care they receive

- The majority of the 19 care plans that we reviewed at the community recovery teams had limited goals which appeared generic rather than personalised to the person using the service. There was infrequent mention of the involvement of the people who use the service in the preparation of the plans.
- Occupational therapy staff in the community recovery teams showed us that they had recovery tools available in the teams. We did not see evidence of this being used

with people to develop their care plans. Most staff that we spoke with did not reference self-assessment or recovery care plans when discussing how to plan with people whose care they co-ordinated.

- We observed, during a care programme approach meeting (CPA) and an outpatient meeting, that people who use the service were able to influence the choice of treatment options and to discuss a change in current treatment due to medicine side effects. Staff were respectful and responsive to the wishes of people using the service in each case and took time to explain the benefits and consequences of changes that could be made.
- We observed AABIT staff involving people during assessments and exploring the support they needed.
- People who used the AABIT service received their care plans via a letter sent to the GP. Some people told us that they were not aware of this and that it had not been explained to them. The Waltham Forest team leader had acted upon a concern from a person who was distressed at the language used in the care plan. The service was now routinely offering people an easy read care plan.
- With one exception, all people who use the service whom we spoke with told us that they had been involved in decisions about their care and treatment and had been given information which allowed them to make choices and changes.
- People who use the service had been involved in the recruitment panels for recent appointments to the community recovery teams.
- Carers groups were available in all four boroughs.
- Information about how to contact an advocacy service was present in all the three sites waiting room notice boards.
- People we spoke to said they were informally invited to give feedback on services, but teams did not routinely offer entry/exit surveys to monitor peoples' experience or satisfaction.

# Are services responsive to people's needs?

Good 

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

## Our findings

### Access and discharge

- The trust provided referral to assessment times for the AABITs for a year period (not specified) across the service. Out of 6910 routine referrals 6622 (96%) were seen on time. Out of 258 urgent referrals 248 (96%) were seen on time.
- Staff told us the trust was commissioned to respond to urgent referrals within two weeks and standard referrals within six weeks. Staff confirmed that there was no waiting list currently for assessment and allocation to the community recovery teams.
- The average monthly referral and discharge rates for the community recovery teams: Barking and Dagenham ten referrals and eight discharges; Waltham Forest 30 referrals and 15 discharges; Redbridge eight referrals and five discharges.
- Staff in the community recovery teams told us that most referrals come from the inpatient wards and the Access and Assessment and Brief Intervention Teams. Referral rates from Early Intervention in Psychosis teams had increased due to a new pathway and staff told us that this was beginning to put pressure on the delivery time of other assessments.
- Staff at the community recovery teams told us, and this was confirmed by the feedback of people who use the service, that appointments could be arranged at short notice and all staff worked flexibly to meet people's needs.
- People who were identified as requiring further assessment by the AABITs were given urgent or routine categories. The Redbridge team, and the Barking and Dagenham team, had a target of completing urgent assessments within six weeks. The Waltham Forest team had a target of completing urgent assessments within twenty four hours and routine assessments within two weeks. The team had extended hours, working until 8pm during the week and until 1pm on Saturday.
- All AABITs had walk-in clinics which allowed urgent referrals to be seen immediately. We observed staff at the Redbridge team assessing a person who had self-referred. It was an effective assessment and led to the person being referred to the home treatment team (HTT). Staff informed the acute crisis and assessment team (ACAT) of the referral and followed this up to ensure that the person had arrived. They did not have the capacity to accompany the person to the assessment which meant that they had to make their own arrangements.
- Staff confirmed that the Did Not Attend (DNA) procedure was to have a clinical review after a person did not attend an appointment to consider options to engage with the person.
- The Barking and Dagenham community recovery team was working with GPs to assist the discharge of people who received depot medicines, and had transferred a member of staff to the Access and Assessment Team to enable people to be discharged from the community recovery team.
- Managers told us that there were barriers to discharging people back to primary care services from the community recovery teams and that they were addressing these. In Waltham Forest the community recovery team was collaborating with a group of local GP practices by offering staffing to a new discharge pathway to primary care. 25 people who no longer required care and treatment under CPA would be discharged to a new service with 11 GP practices
- AABIT staff told us that the number of inappropriate referrals used up valuable resources. Recent promotion of the service had increased the number of inappropriate referrals.

### The facilities promote recovery, comfort, dignity and confidentiality

- There leaflets and notices visible in all the public areas of the community bases which included: advocacy services, how to make a complaint, the Mental Capacity Act and DoLS. All information was in English. Staff told us that they could print information in other languages on request.
- At Barking and Dagenham there was a design problem with door closures. This led to some doors not closing properly and conversations could be heard in the corridor outside. This could lead to a breach of confidentiality for people who use services.



# Are services responsive to people's needs?

Good 

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

- The environment at Barking and Dagenham was bleak with stark, blank walls which did not promote a warm and welcoming environment for people who use services.
- Staff who delivered the telephone triage at the Waltham Forest AABIT were based in a room adjoining the reception area. The system for people talking to the receptionist was faulty resulting in people having to talk loudly. This in turn led to those receiving telephone calls needing to speak loudly to the caller. We were concerned that people's confidentiality could be compromised until this issue was resolved.
- A carer told us that since the Redbridge AABIT team had moved premises their relative had found it difficult to attend appointments.

## Meeting the needs of all people who use the service

- Parking was available at all sites and there were disabled parking bays allocated near the entrance to the buildings.
- On our visit to Redbridge (Mellmead House) the automatic door opener was out of use, as was the toilet in the waiting area.
- The Waltham Forest AABIT had an automatic door that opened outwards making it difficult for people using wheelchairs to enter independently.
- Staff were aware of the ability to print information in other languages but copies of the most frequently encountered languages were not on display. Staff showed good knowledge of how to obtain interpreter support for people who used the service if required.
- The Redbridge community recovery team had created a satellite clinic in the east of the Borough to reduce the need for people to travel a distance to get to Mellmead House for their appointments

## Listening to and learning from concerns and complaints

- According to information supplied by the trust there were ten complaints concerning the community recovery teams that we inspected between May 2014 and December 2015. We viewed the complaint log in all three teams and reviewed the complaint resolution for two of these complaints. One complaint concerned non-disabled people parking in the reserved parking zones. It was evident that staff were fully aware of the actions agreed in the resolution of this complaint. We witnessed them checking with visitors to ensure that they were not blocking access to this parking bay.
- Staff in the community recovery teams told us however that they resolved complaints locally and did not log them via the trust's formal complaint procedure. Managers told us a log for locally resolved complaints was held on the trust DATIX system. When asked to see the log for complaints resolved and recorded in this way none of the three team managers was able to access the information. Therefore we were unable to review the numbers and content of recent complaints made to the service.
- Staff told us that they acted to resolve complaints quickly. We saw information in the waiting areas advising people how to raise complaints.
- The team leader of Redbridge AABIT had started recording the themes of telephone complaints. We saw minutes from a team meeting that showed these had been shared with staff.
- People who used the service and carers told us that they felt confident raising any concerns, or making a complaint, to staff in the teams. One carer had raised a complaint which she felt had been resolved.

# Are services well-led?

Good 

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

## Our findings

### Vision and values

- Many of the staff we spoke with were aware and knowledgeable about the trust's vision and values. Staff told us that the values now form the structure of their supervisions and appraisals. The records we saw confirmed that the trusts values were being put in to action in this way.
- Staff told us that for the most part they felt supported by senior managers and were able to express their opinions. Staff told us the Director of Nursing had visited the sites. Staff told us that they had made comments to the Chief Executive and had received a response to this by email.
- Staff in all the teams remarked on the support and leadership of their service manager. Staff at Redbridge community recovery team felt that things had improved since the current manager came in to post.

### Good governance

- We saw that staff were receiving regular supervision and appraisal. It was apparent that there had been improvements in the amount of staff who had completed their mandatory training and that there had been a recent push to complete Mental Capacity Act/ DoLS course.
- Staff we spoke were aware of the trust's whistleblowing policy. They told us that they were confident in raising any issue within the team to the service manager. At Waltham Forest community recovery team staff had collectively raised the impact of staff vacancies to the service manager. This was escalated to senior managers and an agreement was made to extend the amount of temporary staff working in the team.
- The team leader at Waltham Forest AABIT had been required to make a number of changes since being in post. They were mindful of the impact of this and had a good approach to change management to ensure the team remained supported. The team leader at the Redbridge AABIT had taken a lead with poor performance in the administration department. They had submitted a plan for a central administration department to enable sickness and annual leave to be covered more effectively.

- We saw regular, well attended, team processes such as the zoning meeting, and minutes from the business meeting.
- There were excellent opportunities for professional development with access to internal and external courses. Many community recovery service staff were engaged on development programmes during the time of inspection.
- We saw good implementation and knowledge of safeguarding processes and evidence of the MCA being used in clinical records.
- At the time of our visit there were two members of staff suspended from their post or working with restricted duties in the community recovery teams. One in the Redbridge team and one at Waltham Forest.

### Leadership, morale and staff engagement

- Many of the staff that we spoke with in the community recovery teams told us that team morale had suffered recently due to the impact of service changes, long standing colleagues leaving the team and extra workloads due to sickness absence and recruitment difficulties. Some staff stated that although they felt supported by immediate colleagues and their line manager, they did not feel valued by the trust. Staff confirmed that this was reflected in the most recent staff survey results.
- The Waltham Forest community recovery team was conducting a stress audit to evaluate the current health of the team in relation to work pressures.
- All staff we spoke said that they valued the support from their colleagues in the team and that they felt their team was cohesive. We observed professional and respectful interactions between team members at all teams. In meetings all professional disciplines and grades of staff were able to make contributions to the discussion.

### Commitment to quality improvement and innovation

- The trust shared the outcomes of the National Audit of Schizophrenia which was conducted in August 2015. Recommended areas of improvement included access to Family Therapy.

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Good



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- The community recovery teams are a pilot site for Open Dialogue which introduces new approaches to assisting people experiencing mental distress. Staff spoke positively about the investment of time in developing staff to deliver this new model.
- Staff across all the community recovery teams were receiving training in Family Interventions in Psychosis and will be able to offer this as an intervention to more people who used the service once completed.

This section is primarily information for the provider

## Requirement notices

### Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment
Diagnostic and screening procedures	<b>Regulation 12 HSCA 2008 (Regulated activities) Regulations 2010</b>
Treatment of disease, disorder or injury	<b>Safe care and treatment</b>
	In the community recovery teams the trust did not have adequate risk assessments recorded in all peoples' electronic records to ensure that care and treatment was provided in a safe way. Risk assessments were limited in content, and not updated in a timely way, or after significant events.
	This was a breach of Regulation 12 (1) (2)(a)(b)

This section is primarily information for the provider

## Enforcement actions

### Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.