Requires improvement

Barnet, Enfield and Haringey Mental Health NHS Trust

Community-based mental health services for adults of working age

Quality Report

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Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RRP01	Edgeware Community Hospital	Barnet Assessment Service	HA8 0AD
RRP23	Barnet General Hospital	Barnet Community and Support Recovery Team East/Recovery Enablement Team East	N9 0PD
RRP01	Edgeware Community Hospital	Barnet Community and Support and Recovery Team West/ Recovery Enablement Team West	HA8 0AD
RRP23	Barnet General Hospital	Barnet East Wellbeing Clinic	N9 0PD
RRP01	Edgeware Community Hospital	Barnet West Wellbeing Clinic	HA8 0AD
RRPXX	Trust Headquarters	Enfield Assessment Service	N14 5SH
RRP16	Chase Farm Hospital	Enfield Complex Care	EN2 8JL

Summary of findings

RRPXX	Trust Headquarters	Enfield East Community Support and Recovery Team	EN1 3EP
RRPXX	Trust Headquarters	Enfield West Community Support and Recovery Team	N9 0PD
RRPXX	Trust Headquarters	Enfield East Wellbeing Clinic	EN1 3EP
RRPXX	Trust Headquarters	Enfield West Wellbeing Clinic	N9 OPD
RRPXX	Trust Headquarters	Haringey East Community Support and Recovery Team	N22 8JT
RRPXX	Trust Headquarters	Haringey West Community Support and Recovery Team	N22 8JT
RRPXX	Trust Headquarters	Haringey Wellbeing Clinic	N22 8JT

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

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

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

Summary of findings

Ratings

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

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

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 services for adults of working age as **requires improvement** because:

There were concerns about safety that could impact on staff and patients. At the Haringey East CSRT and Haringey West CSRT services, interview rooms were not fitted with alarms and there were not always sufficient personal alarms for staff to access when using these rooms. Staff working in the teams were not always following the trusts lone working policy and the mobile phones provided by the trust did not always work. This could compromise their safety when visiting people in their homes. Also there were examples of medication being stored, transported and administered that were not safe.

Patients who were taking high doses of anti-psychotic medication were not being closely monitored to ensure they had the appropriate physical health checks. Teams were not always maintaining good communication with GPs in order to obtain the results of physical health checks or keep them updated with the progress with their mental health.

There were concerns about progress with recruitment in some teams and the use of temporary staff was leading to patients experiencing changes in their care co-ordinator.

Managers of teams were not always escalating concerns through the risk register or using leadership skills to make improvements where needed.

However, staff demonstrated an appropriate understanding of safeguarding and their role and responsibilities. Most care plans we reviewed were holistic, personalised and recovery orientated. We observed positive and meaningful interactions between staff and patients. Patients were supported with training and employment opportunities when well enough. Teams saw urgent referrals quickly and responded appropriately when patients phoned in. Staff proactively engaged with patients who were difficult to engage and had good morale despite the challenges they faced. Staff demonstrated innovative practice, specifically the build a bike programme.

Summary of findings

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

Are services safe?

Requires improvement

We rated safe as **requires improvement** because:

- Interview rooms were not all fitted with alarms and in some CSRTs there were insufficient personal alarms for staff to access when using these rooms.
- Staff were not all following lone working protocols. Trust mobile phones did not always work, which meant that staff were relying upon personal phones to check back in with base.
- There were examples of poor medication storage, medication being transported unsafely and staff not taking with medication administration cards when administering medication in peoples' homes.
- The Haringey CSRT's clinic room was small and unsafe.
- Haringey East CSRT cover arrangements meant that care co-ordinator caseloads could unexpectedly double and were not safe.
- CSRTS had not always updated risk assessments. Staff did not always monitor risks for patients on the waiting list for the service.

However, staff knew how to report incidents. Teams learned from incidents and there was evidence of changes made as a result. Staff demonstrated an appropriate understanding of safeguarding and their role and responsibilities.

Are services effective?

Requires improvement

We rated effective as **requires improvement** because:

- There were no systems in place to identify patients who were prescribed high dose anti-psychotics to ensure that the specific health checks these patients may require were undertaken.
- Staff referred patients to GPs for physical health checks. We found that staff did not follow up results with GPs. Teams had not developed links with the GP practices within their patch and did not always feedback to GPs the outcome of care programme approach reviews.

However, where issues relating to capacity were identified these had been appropriately assessed and recorded and where appropriate best interests meetings and decisions were taken. Most care plans we reviewed were holistic, personalised and recovery orientated. Patients subject to community treatment orders (CTOs) had their rights explained to them. Patients were able to access psychological therapies.

Summary of findings

Are services caring?

Good

We rated caring as **good** because:

- We observed positive and meaningful interactions between staff and patients.
- Patients and carers felt that staff displayed genuine concern and adapted to their individual needs.
- Patients were supported with training and employment opportunities when well enough.
- The clinic environments were warm and welcoming.
- Patients had access to and were aware of individual advocacy services.
- Most patients were encouraged to give feedback on the services they received.

However, some care plans we reviewed demonstrated a lack of continuous involvement in care planning from patients. Some patients felt that access to care co-ordinators by telephone was difficult.

Are services responsive to people's needs?

Good

We rated responsive as **good** because:

- Teams saw urgent referrals quickly and responded appropriately when patients phoned in.
- Staff proactively engaged with patients who were difficult to engage.
- Staff cancelled appointments only when absolutely necessary.
- Patients knew how to complain and received feedback. Staff knew how to handle complaints.

However, the trust did not set targets for recovery teams to initially assess people referred to them. Between teams there were varying local targets in place from 2 to 10 weeks. There were no mechanisms in place to measure performance against these local targets. Staff varied on how to follow up patients who did not attend appointments.

Are services well-led?

Requires improvement

We rated well-led as **requires improvement** because:

- Some managers and staff had little awareness of the information used to monitor performance and were not making improvements based on this data.
- Whilst staff had the ability to submit items to the risk register, some longstanding issues such as the risks associated with lone working and staffing had not been included in the local risk register.

Summary of findings

- Managers were not always using their leadership skills to make improvements where needed.

However, staff were aware of and reflected the organisations values and objectives. Staff knew the senior managers in the organisation. Staff had good morale despite the challenges they faced. Staff demonstrated innovative practice, such as the 'build a bike' programme.

Summary of findings

Information about the service

Barnet, Enfield and Haringey Mental Health Trust provides a range of community based mental health services for people of working age and older people with mental health problems.

The trust had three assessment teams. These teams were Barnet Assessment Service, Enfield Assessment Service and Haringey Assessment Service. Assessment services provide an initial specialist mental health assessment for people referred to community mental health services.

The trust had six community support and recovery teams (CSRT). There were two in each borough of Barnet, Enfield and Haringey. Community recovery teams supported patients who had complex mental health and social care needs.

The trust had three complex care teams. There was one in each borough and these provided treatment and support to people with complex mental health problems on the care programme approach who did not have a diagnosis of psychosis

The trust had three early intervention services (EIS) teams. There was one team in each borough and the EIS worked with younger people who experienced a first episode of psychosis.

The trust had three wellbeing clinics, one in each borough. Wellbeing clinics incorporated clozapine clinics. Patients prescribed clozapine could attend the clinic, have the required tests and receive their results and prescription all within a few minutes.

We inspected the following services.

The two Barnet CSRT's

The two Enfield CSRT's

The two Haringey CSRT's

The Barnet and Enfield assessment services

The Enfield complex care team

All the wellbeing clinics

CQC had not previously inspected these services.

Our inspection team

The team who inspected community based mental health services for adults of working age consisted of one CQC inspection manager, two CQC inspectors, two nurses, one specialist doctor, one psychiatrist, one psychologist, one social worker and one expert by experience.

Why we carried out this inspection

We inspected this core service as part of our on-going 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 and carer's by attending local groups.

Summary of findings

During the inspection visit, the inspection team:

- Visited the team bases and looked at the quality of the team environments and observed how staff were caring for patients
- Accompanied staff on eight home visits
- Spoke with 39 patients and 11 carers and collected 11 completed comments cards.
- Spoke with one service manager and 11 team or deputy team managers
- Spoke with 49 other staff members; 20 nurses, 12 social workers, six consultant psychiatrists, three healthcare assistants, three clinical psychologists, one admin manager, one discharge co-ordinator, one dual diagnosis worker, one pharmacist and one occupational therapist.
- Looked at 27 care records of patients
- Looked at a sample of medication records
- Looked at twelve community treatment order records
- Attended one multi-disciplinary team meeting and one clinical governance meeting
- Observed a psychology group for patients
- Observed three care programme approach review meetings
- Looked at a range of policies, procedures and other documents related to the running of the service.
- Carried out a specific check of medication management at a sample of teams.

What people who use the provider's services say

We spoke with 50 patients and their relatives both in person and over the telephone. We received feedback from 11 patients from comment cards which we collected from comment boxes that we had placed in community teams before the inspection. We attended a carer's forum in Haringey. We also received information about community services from local organisations and individuals.

Patients we spoke with felt the service was caring and recovery focused. They said that the clinic environments were mostly clean and hygienic. The majority of patients told us the information leaflets provided by the teams were particularly useful. Some patients felt access to care co-ordinators was difficult and said they did not have a copy of their care plan. Patients were positive about staff and felt they were caring and approachable. Some patients complained about a lack of consistency in their care co-ordinator and doctor as they had experienced frequent changes.

Good practice

- Some community teams had dual diagnosis, discharge co-ordinators and substance misuse workers as part of the team.
- The Haringey East and West CSRTs completed specific functional assessments for living skills. They used this to inform the provision of groups for patients. Staff had developed the 'walk and talk' group and 'build a bike programme' as a way of reaching out to people more effectively. The build a bike project was a progressive programme that combined building a bike with developing friendships and growing in confidence. The trust had nominated the programme for an award.

Areas for improvement

Action the provider MUST take to improve

- The trust must ensure that all interview rooms are fitted with alarms or there are enough personal alarms for all members of staff.
- The trust must ensure there are safe systems for storage and transportation of medication, medical waste and sharps.

Summary of findings

- The trust must ensure that staff carrying out trust business follow the trusts lone working policy and have access to a working mobile phone.
- The trust must ensure there is a system to identify patients prescribed high-dose antipsychotic medication so that there can be checks to ensure their physical health is being monitored.
- Managers must develop and use their leadership skills to ensure the challenges facing the teams are escalated where needed and addressed.

Action the provider SHOULD take to improve

- The trust should ensure a date is confirmed for the Haringey CSRTs to have access to an appropriate clinical treatment room.
- The trust should ensure that recruitment continues so the majority of staff are permanent employees in order to improve continuity of care for patients. This is a priority in Haringey.
- The trust should ensure that staff complete mandatory training.
- The trust should ensure risk assessments are monitored and updated when needed
- The trust should ensure that patients are supported to have physical health checks and that the team are aware of significant healthcare issues and how these are being addressed.
- The trust should ensure that patients are monitored while they are on the waiting list to receive treatment from the team, to provide support if they deteriorate.
- The trust should ensure that staff working in the CSRTs feel well informed about the learning from serious untoward incidents from other parts of the trust.
- The trust should ensure staff take medicines cards with them when visiting patients at home to ensure they administer the correct medication.
- The trust should ensure systems are in place to develop working relationships with GPs.
- The trust should ensure staff supervision is undertaken regularly across all teams.
- The trust should ensure that there are accurate training records in place for staff.
- The trust should ensure staff follow trust guidance and policy around patients who do not attend appointments.
- The trust should ensure the local team risk registers are kept up to date so risks can be escalated as needed.

The trust should ensure that team managers make good use of information to support their management of the team.

Barnet, Enfield and Haringey Mental Health NHS 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
Barnet Assessment Service	
Barnet Community and Support Recovery Team East/ Recovery Enablement Team East	
Barnet Community and Support and Recovery Team West/Recovery Enablement Team West	
Barnet East Wellbeing Clinic	
Barnet West Wellbeing Clinic	
Enfield Assessment Service	
Enfield Complex Care	
Enfield East Community Support and Recovery Team	
Enfield West Community Support and Recovery Team	
Enfield East Wellbeing Clinic	
Enfield West Wellbeing Clinic	
Haringey East Community Support and Recovery Team	
Haringey West Community Support and Recovery Team	
Haringey Wellbeing Clinic	

Detailed findings

Mental Health Act responsibilities

- Not all staff had received training on the MHA. Despite this, staff we spoke to at CSRT teams demonstrated a good understanding of the MHA, particularly as it related to community treatment orders. Not all staff within CSRTs were aware of the recent revisions to the MHA code of practice.
- A small number of patients within each team were subject to community treatment orders (CTOs). We reviewed the care and treatment records of 12 patients receiving a service who were subject to a CTO. Staff completed CTO documentation and associated care plans appropriately and patients had been informed of their rights. Paperwork was up to date and stored appropriately.
- At Enfield East CSRT, we observed that records showing consent to treatment had not been attached to prescription charts. To mitigate this, staff told us they would check the patients record of consent on the patient electronic record system.
- Staff had access to administrative support and legal advice on the implementation of the MHA.
- Patients subject to CTO or section 117 aftercare were able to access advocacy services.

Mental Capacity Act and Deprivation of Liberty Safeguards

- The trust did not provide mandatory training addressing the MCA to all staff. Staff were able to access MCA training provided by the local authority if requested. Staff were able to identify patients where there had been concerns about their capacity.
- Staff at Barnet East CSRT said that all staff had completed the MCA training and that professional support was available. We spoke with staff about the MCA and observed that some did not have a good understanding around the MCA and could not tell us the five statutory principles. Some staff in Enfield East CSRT expressed a lack of confidence about assessing patients' capacity under the MCA.
- Staff could refer to copies of the relevant policies in regards to mental capacity. These were available on the trust intranet. Staff knew where to get advice about the MCA within their team and the wider trust.
- We identified three patients at CSRT teams where there had been recent concerns regarding capacity. Discussions with staff and examination of the patient records demonstrated that the most appropriate professional had carried out a decision specific capacity assessment. All patients had been found to have capacity with regards to this decision. If assessments had indicated the patient did not have capacity, staff understood that a best interests meeting and best interest's decision was necessary.
- Managers and staff were not able to identify arrangements the trust had in place to monitor adherence to the MCA within the trust.

Requires improvement

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

- Most teams we visited had accessible alarm systems that staff could use in an emergency. At Haringey East CSRT and Haringey West CSRT services we observed that some interview rooms did not have alarms or that they were placed next to doors and away from desks so in an emergency staff might not be able to reach them. Staff mitigated this by assessing patients before interviews and requesting personal alarms. Staff did not feel there were enough alarms for all members of the team. This posed a risk as staff would have to conduct interviews without a feasible alarm system.
- Clinic rooms contained audit checklist logs for cleaning, temperature (room and fridge), and infection control and equipment maintenance. Staff had the necessary equipment to carry out physical examinations and treatment. Medication was stored in lockable cupboards and fridges had locks. Staff signed and dated sharps boxes. Fridge and room temperatures were recorded.
- Barnet East CSRT, Barnet West CSRT, Enfield East CSRT and Enfield West CSRT shared clinic rooms with the wellbeing clinic used for clozapine clinics and depots. Haringey East CSRT and Haringey West CSRT shared a clinic room that was not fit for purpose. The room was small and had no treatment couch. Staff had to turn their backs to patients when preparing injections, which was unsafe. Staff informed us there were plans to move across the hall into a larger room but we did not see evidence of this.
- The sites we visited were clean, tidy and well organised. Staff adhered to Infection control principles on all sites. We observed staff washing hands and using gloves during clinics.

Safe staffing

- At the time of the inspection, the trust had recently reviewed staffing levels across the community services. As part of this process the trust had used a recognised tool to establish the number, grade and discipline of staff required for each team.
- Barnet East CSRT had an establishment of seven qualified nurses. Staff felt there were appropriate numbers of staff to provide services. Vacancy rates were 1.8% and permanent staff sickness levels were 1%. The manager informed us that four community psychiatric nurses (CPN) were not included in the establishment levels and that they were hoping to recruit these positions by January 2016. The service had seen a turnover of four doctors in the consultant psychiatrist position since August 2015. Staff felt the change in consultants affected continuity, but added that locum staff were experienced and managed well.
- Barnet West CSRT had an establishment of six qualified nurses. The service had a vacancy rate of 12.9% and 38 shifts in the previous six months had been filled by temporary staff. A regular locum covered a vacant CPN post within the team. A social work post had recently become vacant and a locum was also in place to cover this. At this service there were no long term sickness absences.
- Enfield East CSRT had an establishment of eight qualified nurses. Staff felt that establishment levels were safe and that they could meet patients' needs. Vacancy rates were 11.7% and permanent staff sickness levels were 6.9%. Long term locum staff covered two nursing vacancies. Staff absorbed the caseload of a nurse who was on long-term sick leave with the post not covered. Temporary staff had filled 287 shifts with 224 shifts unfilled in the previous 6 months. Long-term locums also covered two social worker vacancies. Recruitment to the vacant posts was underway with some new staff already due to start. A staff grade locum doctor was in post within this team, with the post added to the specialist registrar (SPR) rota from next year.
- Enfield West CSRT had an establishment of seven qualified nurses. Most staff felt establishment levels were safe but some felt they were on the verge of being unsafe. Vacancy rates were high at 21.6% and permanent staff sickness levels were 3.9%. Temporary staff had filled 174 shifts while 200 shifts were unfilled in the previous six months.
- Haringey East CSRT had an establishment of seven qualified nurses. Vacancy rates were 5.9% and

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permanent staff sickness stood at 3.6%. Temporary staff filled 244 shifts with six shifts unfilled. Within Haringey, there were seven approved mental health professionals (AMHPs) for the whole borough. Three of these were in the Haringey East CSRT and the manager found this disproportionate. A further four AMHPs were being trained across the borough, bringing the total to 11, but as two of the trainees were from Haringey East CSRT, they would still be supplying five of the boroughs 11 AMHPs. The manager commented that AMHP duty often ran over into their CSRT time, for example writing AMHP reports or taking time off in lieu from Mental Health Act assessments. Senior managers made a case for additional staffing to avoid the risk of caseloads potentially rising to unsafe levels of 50.

- Haringey West CSRT had an establishment of nine qualified nurses. There had been a reduction of four positions due to a restructuring of services, which affected caseloads. Staff felt the establishment was coping with the workload but felt there were issues with continuity due to high use of locum workers. Vacancy rates were 17% and permanent sickness levels were 3.5%. Temporary staff filled 270 shifts. Staff told us that senior management had recognised the problems with staffing and had put a business case forward to increase the establishment.
- Due to the high number of referrals at the Barnet assessment service the establishment had been increased and locum staff were being used.
- Caseload sizes varied across the service between 36 in Enfield East CSRT and 10 in Haringey West CSRT. Average caseloads across teams were 30 per care co-ordinator. Caseloads were weighted and took into account patients' needs as well as other duties that staff covered. Staff told us caseloads were manageable and safe, but busy. The implementation of the recovery enablement team (RET) at Barnet and Enfield CSRT's had contributed to lower average caseloads. At the beginning of the year in Barnet East CSRT, average caseloads were 30 but had dropped to 24. Staff at Enfield West CSRT staff we spoke with felt that caseloads were "just" safe but agreed that the implementation of the RET had alleviated concerns over caseloads. Staff felt there was a heavy burden on female staff due to the diverse community as female patients preferred to have same sex care co-ordinators.
- Appropriate arrangements were in place to cover vacant posts within teams, with the exception of Haringey East CSRT where three CPN posts were not covered. CSRT teams operated a duty system and at Haringey East CSRT and Haringey West CSRT, staff had buddies who covered each other. This meant that at each CSRT when care co-ordinators were not available there was a system in place to respond to patients' contacts and needs. However, at Haringey East CSRT, when staff were absent, the buddying system meant that some staff effectively had their caseloads doubled. Staff told us this was not manageable as some staff were on long-term sickness. Some staff were concerned that the effective doubling of caseloads in these circumstances was not manageable and was unsafe. An example of this was when a depot injection was accidently administered a week late when the care co-ordinator was off sick. Staff told us the electronic recording system recorded that the depot was given a week late. The manager in Haringey East CSRT had implemented a robust system to identify patients for discharge. The overall team caseload had reduced from over 700 to 315 in the last 18 months.
- Consultant psychiatrists within Haringey East CSRT and Haringey West CSRT commented that they had high case loads of over 400. They thought that more speciality registrars should be available within the borough to alleviate the pressure on them.
- There were no patients who were waiting for allocation of a care co-ordinator at any of the services we visited. CSRT teams prioritised patients discharged from wards and home treatment teams as well as through tribunals or discharge planning through the forensic pathway.
- CSRT's reviewed caseloads and identified patients for discharge. Within Enfield East CSRT, the manager, consultant and care co-ordinator held a weekly caseload management session to identify patients who may be appropriate for transfer or discharge. Other teams in the borough were rolling out this model. Barnet East CSRT had a similar meeting before the substantive consultant psychiatrist left the trust.
- Locum staff covered vacant posts appropriately. For example, in Barnet CSRT West, locum staff were on long-term temporary contracts to cover vacant posts, which provided consistency of care. Within Enfield East CSRT and Haringey East CSRT there had been a high turnover of staff over the last 12 months as a result of

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reconfiguration of services and the use of locum staff to cover vacant posts. Within Haringey East CSRT staff reported that 19 locums had been in post within the last 12 months. The managers of teams expected that recent locum staff would be able to stay in post to provide consistency of care for patients. At Enfield West CSRT, almost half of staff were locum. Locum staff were experienced and managed caseloads well. However, staff were apprehensive if multiple locum staff left at the same time and how they would manage the increased workload.

- Patients told us they had rapid access to a psychiatrist when required. Nonetheless, this did not necessarily mean it would be with the patient's own psychiatrist.
- Mandatory training provided by the trust included breakaway techniques, CPA and assessing risk, equality and diversity, first aid, infection control, health and safety, information governance, resuscitation and safeguarding. The majority of adult community team staff had a completion rate of 75% or above for trust mandatory training. The Early Intervention service in Haringey and the Enfield community rehabilitation services both had a completion rate under 75%. Areas where teams were non-compliant included breakaway training, care plan approach/clinical risk assessment training, resuscitation levels two and three (adult basic life support and automatic external defibrillator/ immediate life support). Approved mental health professionals (AMHPs) completed mandatory training in the MHA and MCA. Locum staff completed an induction and had to be up to date with training before starting.

Assessing and managing risk to patients and staff

- Staff completed risk assessments upon initial contact but did not always regularly update them. For example at Haringey East CSRT, 12% of patients (54 in total) had not had their risk assessment updated. This was showing as red in the team's key performance indicators (KPI). The manager had reviewed each patient's care records and had identified that the majority (48) were patients who were being care co-ordinated by medical staff. The manager attributed the reviews not taking place due to the high number of locums who had been in post. The service had now permanently appointed a consultant. The consultant was reviewing and updating risk assessments for identified patients. Barnet West CSRT had not met its KPI with regards to risk assessments as 14% of patients did not have an up to date risk chronology.
- Patients' care plans included information on what to do in a crisis. This included information about who to contact during office hours (care co-ordinator or the person covering for them) and out of hours (contact the crisis team). Patients confirmed that they received information on who to contact in a crisis from their care co-ordinator. Advanced directives/decisions were not in place at the services we visited.
- Information provided by the trust showed that some teams were not meeting targets relating to patients' physical health. For example, in three of the previous six months up to and including November 2015, performance data for Enfield East CSRT showed that between 11% and 25% of patients had not had received a physical health check. At Haringey East CSRT a patient had two recent admissions to the Whittington for physical health problems. Staff documented the admission but there was no information about what the problem was, what treatment they provided and how they would follow it up. Records we reviewed showed that staff had not been in contact with the Whittington or the GP to get an update regarding physical health or that they had even asked the patient what the diagnosis or treatment for the physical health problem was.
- We saw a good example of staff responding to deterioration in a patients' health at Barnet West CSRT where during the home visit it was apparent that the patient's physical health and mobility needs had deteriorated. The visiting CPN recognised this as a concern discussed their concerns with the patient and agreed an action plan with them, for example arranging a home visit and alerting their GP.
- Patients received a letter with their initial appointment from the team. This included details of the crisis team so that patients could contact them if their situation changed whilst they were waiting for the appointment. However, Haringey East CSRT told patients to only contact the team if they could not keep their appointment. It did not tell them what to do if their

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situation changed. For patients on waiting lists, there were no measures in place to detect changes in risk level. This was of particular concern as patients waited up to eight weeks for their initial appointment.

- Staff we spoke to across all teams had attended safeguarding training and demonstrated an appropriate understanding of their role and responsibilities. Staff discussed safeguarding at weekly team meetings and it was a standing item on the agenda. Within teams in Barnet and Enfield teams there was an identified safeguarding lead and safeguarding champions. Staff knew who they were and spoke with them about possible safeguarding concerns. Teams in Haringey had a safeguarding champion. Within Haringey, teams reported delays when they reported safeguarding concerns to the local authority (LA). Staff said that there needed to be improved feedback about the outcomes of investigations. Managers attended strategy meetings when they could to stay involved but there was not a robust system to share outcomes. As a result in some cases, staff had instigated and led their own safeguarding investigations due to delays in getting a response from the LA safeguarding team. Where this had been the case they had kept the LA safeguarding team up to date. Staff told us this had been raised in senior management groups and that they were working to establish better linked outcomes.
- At Barnet, Enfield and Haringey recovery teams patients' records demonstrated that staff had recognised safeguarding concerns, reported it to other agencies and participated in safeguarding meetings. Teams took immediate steps to safeguard patients. The patients' care records demonstrated that staff took appropriate actions to safeguard patients. The safeguarding record was detailed and comprehensive, easy to locate and follow.
- The trust had a lone working policy in place to support staff working alone in the community and promote their safety. Staff completed daily movement sheets. If staff did not return to the office at the end of the day, they rang to let other staff know. If a member of staff had not called in, then the "access" (duty) worker would phone them. Staff escalated this to a manager if there was no response. Staff also conducted home visits in pairs if a patient was unknown or assessed as high risk. Staff we spoke with felt that phones often did not work and that they were at potential risk when out on home visits as they also did not carry safety devices. A staff member went out on a visit and did not complete a daily movement sheet. Staff told us this was common. At the time of the inspection, there had been no incidents related to lone working. Staff we spoke with also felt the policy was not robust and had the potential to be unsafe.
- We looked at medicines management practice, including the transport, storage and dispensing of medicines at CSRT teams. Barnet East CSRT, Barnet West CSRT, Enfield East CSRT and Enfield West CSRT teams used adapted briefcases or medicines bags to transport medicines, syringes and a used sharps disposal. Within Haringey East CSRT and Haringey West CSRT teams, staff transported medicine in their own personal handbags or backpacks and the trust had not supplied adapted briefcases or medicine bags.
- At some sites, for example Barnet West CSRT, teams did not store medicines. The wellbeing clinic provided medicines and they were located on the same site. The wellbeing clinic at Edgware community hospital appropriately managed medicines stocks and medicines requiring refrigeration were appropriately stored. Teams checked fridge temperatures regularly and that they remained within acceptable parameters. Medication administration record sheets were available within the clinic room, were referred to before medicines were administered and were updated when medicines had been administered.
- At the wellbeing clinic at Lucas House, 200 to 240 patients attended the clinic for blood tests and medication. Staff would sometimes record changes in prescriptions incorrectly. Each time this issue occurred, staff raised an incident form and fast tracked patients who did not receive medication.
- Medicines at Enfield West CSRT were stored in the clinic room. Staff had rotated stocks of medicine. Whilst stock levels appeared appropriate there were no minimum reorder levels for stock items. At this site no community pharmacist visited and CPNs took responsibility for all medicines management. Where required, medicines were stored in refrigerators, and the temperature monitored and recorded. Refrigerator temperatures were maintained within appropriate levels. Medicines records for patients were stored within the clinic room. At Haringey East and West CSRT teams, the fridge where some medicines were stored was frequently above the

Requires improvement

Are services safe?

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

higher parameter. Staff checked fridge temperatures daily and recorded that it was too hot to use. Staff had communicated the issue with each other, but neither team took responsive action.

- CPNs ensured correct medicine and doses were administered and took medicine cards with them. However, there was no system for recording when CPNs removed or returned medicines charts to the clinic room. The exception to this was Haringey East CSRT, where staff did not take medicines cards with them when they visited patients at home to administer medicines. Staff wrote details of the medicines they were due to administer in their diary. Staff did not directly refer to the patients medicines chart when they administered medicine. The risk of incorrect medicine or doses administered increased because of this.

Track record on safety

- There were seven serious incidents between June 2014 and June 2015 in the CSRT teams. Three of these incidents occurred at Haringey East CSRT, all involving the death of patients. Each was subject to an on-going investigation.
- There were eight serious incidents between June 2014 and June 2015 in the complex care teams. There was one homicide in the Enfield complex care team.

Reporting incidents and learning from when things go wrong

- Staff were able to demonstrate an awareness of the trust's incident reporting procedures. We reviewed incident records and observed that staff knew what they should be reporting and how to report it. Team managers reviewed all incident reports. However, they did not receive statistical information that showed the number of incidents reported by their team over a set period, or that identified any themes in the incidents that were reported.
- Staff were open and transparent to patients and explained incidents to patients if something went wrong. Staff received feedback and shared lessons regarding incidents at a local level. Staff told us they previously received feedback on trust-wide incidents but that this had recently stopped. The manager at Barnet West CSRT had been involved in investigating incidents that had occurred within other teams locally and had fed back this learning to their own team during its weekly meeting.
- Staff debriefed after incidents and met at multi-disciplinary meetings as well individual sessions to discuss learning around incidents.
- Staff described changes that had happened as a result of incidents occurring within their team. For example, learning that related to communication between teams. Some staff told us that having embedded dual diagnosis workers within some teams had improved communication.

Are services effective?

Requires improvement

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

- Patients' care records had comprehensive assessments completed in a timely manner. Most of the care plans were personalised and holistic. However, at Barnet West CSRT, two of the seven care plans did not contain information about the patient's strengths and were not recovery orientated. One of the care plans was not holistic and did not contain the patient's views.
- Information was stored electronically, with some paper records also maintained. Records were accessible. An electronic documentation system was used trust wide and all teams were able to access the information input by other professionals/teams within the trust. At Barnet East CSRT, the psychologist kept paper records in a lockable cupboard.

Best practice in treatment and care

- We saw evidence that staff used national institute for health and care excellence (NICE) guidelines when planning and delivering treatment. Staff we spoke with received regular updates about NICE and explained how the access to art project is in line with the most recent schizophrenia guidance. Staff said they used smoking cessation guidance to support six patients who quit smoking.
- Psychological therapies offered were in accordance with those recommended by NICE. These included family interventions, cognitive behavioural therapy (CBT) and access to art therapy. Psychologists were part of the team at all the sites we visited with the exception of the wellbeing clinics. At Enfield West CSRT, therapy options were limited, with no access to family or art therapy.
- We observed a group led by a psychologist at Enfield East CSRT. This was the opening session and it focussed on the signs and symptoms of psychosis. The group was inclusive, informative, supportive, set clear ground rules and allowed patients to share their experiences.
- Staff's consideration of patients physical healthcare needs varied among teams. Community services did not have a system or tool that readily identified patients who had been prescribed high-dose antipsychotics. We asked staff to identify patients from their caseload who had been prescribed high-dose antipsychotics. At Enfield East CSRT and Haringey East CSRT staff struggled to do this and had to draw upon their own knowledge. We looked at the care records for one patient at each service identified as being prescribed high-dose antipsychotics. For both patients their notes identified that they should be referred back to their GP for physical health checks. However, there was no record of this taking place. Where patients had received physical health checks with their GP, staff had not contacted the GP to find out the results.
- The wellbeing clinics incorporated clozapine clinics. Patients prescribed clozapine could attend the clinic have the required tests, receive their results and prescription all within a few minutes.
- Staff used the health of the nation outcome scales, the recovery star and the clinical outcomes in routine evaluation to measure outcomes of patients. The trust did not have a formal agreement on what to use and staff told us they were still working on agreeing which outcome measure to use.

Skilled staff to deliver care

- All new staff received an induction before they began their role. Locum staff received an induction to make sure they understood trust policies and procedures.
- Teams had access to a full range of mental health disciplines. CSRTs included nurses, social workers, psychologists, psychiatrists and support workers. Teams had employed and embedded employment advisors. Enfield East CSRT, Enfield West CSRT, Haringey East CSRT and Haringey West CSRT also had discharge co-ordinators, dual diagnosis specialists and substance misuse workers as part of the team. Barnet East CSRT and Barnet West CSRT did not have occupational therapists as part of the team. At Enfield East CSRT and Enfield West CSRT, nurses prescribed medication and so they did not have regular input from a community pharmacist.
- Most staff received regular supervision every four to six weeks. At Barnet West CSRT, supervision was undertaken approximately once every three months. Staff told us they were able to speak to their manager regarding case management queries in between supervision. The manager had not provided supervision frequently due to the numbers of staff who needed supervision directly as well as prioritising other responsibilities. The manager appropriately supported

Are services effective?

Requires improvement

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.

staff could access the manager for support and individual case discussions. At Haringey East CSRT, the manager felt supervision was difficult to conduct regularly due to staff changes including staff leaving. When undertaken, staff told us the supervision was effective. Managers at Barnet West CSRT and Enfield West CSRT did not have systems in place to monitor the frequency of supervision.

- Clinical staff who received supervision from non-clinical managers, for example a social worker, received additional clinical supervision from a nurse manager. Staff confirmed that these arrangements were in place. Nurse prescribers received additional supervision regarding prescribing from a consultant psychiatrist.
- All CSRT staff had completed their appraisals within the last 12 months.
- In addition to mandatory training, staff could access specialist training. The trust nominated staff for vocational or post graduate training. In the Haringey East CSRT team there were staff who had received training to be CBT practitioners and a nurse had recently completed a medication prescribing course. Trust staff could also access local authority training. The trust had annual funding panels that could nominate people for specific training. Staff kept records of any specialist training in supervision files. However, records of this training were not readily available for managers to access. At Barnet CSRT West when the team manager accessed the local authority training data base, no up-to-date training records were available. At Enfield East CSRT, the manager was not sure that the local authority training database was up to date for staff from his team who had completed training. This meant that managers did not have ready access to records that detailed the training that staff had completed. Managers kept records in different places and were sometimes not up to date.
- Systems to manage staff performance were in place within the trust. No staff were subject to performance management at the time of the inspection. The manager at Haringey East CSRT gave an example of a staff member who was performance managed and explained the processes undertaken.

Multi-disciplinary and inter-agency team work

- Community teams had multidisciplinary meetings that took place once a week. The meetings were structured and had standing agenda items. Items on the standing agenda included a business slot, a case discussion slot and a new referrals slot. CSRT meetings also discussed patients on a community treatment order and forensic patients. Teams discussed safeguarding concerns, which meant that the whole team had an overview of safeguarding concerns within the team portfolio. In Barnet East CSRT, Barnet West CSRT, Enfield East CSRT and Enfield West CSRT the RET regularly joined MDT meetings. CSRT meetings focused on clinical governance once a month. Staff used the meeting to discuss complaints, incidents, the friends and family test as well as patient feedback. Staff we spoke with felt MDT meetings worked well and any negatives related to staffing issues.
- There was effective handovers within teams. The use of buddying arrangements between care co-ordinators meant that if their care co-ordinator was off patients would be able to make contact with staff who knew about them.
- During the most recent reconfiguration of the service, the trust had restructured CSRT teams to include a recovery enablement team (RET). The RET team were able to offer short or medium levels of support to patients who no longer required the higher levels of support offered by the CSRT but were not ready for discharge. At Barnet East CSRT, Enfield East CSRT this was working well, with patients discharged from CSRT to the RET. Both CSRT teams had completed a review of patients to identify those who were appropriate for discharge to the RET team. This meant that staff were able to free up capacity to take newly referred patients onto their caseloads. Upon completion of their involvement the RET could then discharge back to the care of the GP.
- The CSRTs informed us of delays in moving patients in between teams. CSRT's said that there could be delays in transferring patients between the CSRT and complex care teams. Staff and managers described "defensive" practice where movements between the psychosis and non-psychosis pathways and vice versa could be difficult. To improve relationships and facilitate the smooth transfer of patients, managers from both teams had introduced monthly meetings. Teams agreed that the meetings had worked well and joint assessments were taking place.

Are services effective?

Requires improvement

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.

- CSRTs experienced delays with patients whose mental health had deteriorated and where they were assessed as requiring support from home treatment teams (HTT). This was because the HTT did not always have the capacity to support the patient. This was raised as a particular issue in Haringey. The CSRT managers were planning to have regular meetings with the assessment teams and the HTTs.
- The Haringey East CSRT commented that there were long delays in getting patients transferred to the community rehabilitation team.
- Each of the CSRTs had developed links with other agencies to provide a range of services. These included links with organisations providing housing, tenancy support workers, support with accessing community services, benefits advice and third sector organisations such as MIND.
- The trust did not have systems in place for locality teams to develop working relationships with GPs in their geographical patch. Additionally, performance data produced by the trust showed that some CSRTs were not keeping GPs up to date on the care and treatment they were providing. For example, in November 2015 Enfield East CSRT had not notified GPs of the outcome of new patient's assessments 11% of the time. Where patients were receiving on-going care and treatment, for Enfield East CSRT the GP had received an update following a recent CPA in only 50% of patients in November 2015.

Adherence to the MHA and the MHA Code of Practice

- Not all staff had received training on the MHA. Despite this, staff we spoke to at CSRT teams demonstrated a good understanding of the MHA, particularly as it related to community treatment orders. Not all staff within CSRTs were aware of the recent revisions to the MHA code of practice.
- A small number of patients within each team were subject to community treatment orders (CTOs). We reviewed the care and treatment records of 12 patients receiving a service who were subject to a CTO. Staff completed CTO documentation and associated care plans appropriately and patients had been informed of their rights. Paperwork was up to date and stored appropriately.
- At Enfield East CSRT, we observed that records showing consent to treatment had not been attached to prescription charts. To mitigate this, staff told us they would check the patients record of consent on the patient electronic record system.
- Staff had access to administrative support and legal advice on the implementation of the MHA.
- Patients subject to CTO or section 117 aftercare were able to access advocacy services.

Good practice in applying the Mental Capacity Act

- The trust did not provide mandatory training addressing the MCA to all staff. Staff were able to access MCA training provided by the local authority if requested. Staff were able to identify patients where there had been concerns about their capacity.
- Staff at Barnet East CSRT said that all staff had completed the MCA training and that professional support was available. We spoke with staff about the MCA and observed that some did not have a good understanding around the MCA and could not tell us the five statutory principles. Some staff in Enfield East CSRT expressed a lack of confidence about assessing patients' capacity under the MCA.
- Staff could refer to copies of the relevant policies in regards to mental capacity. These were available on the trust intranet. Staff knew where to get advice about the MCA within their team and the wider trust.
- We identified three patients at CSRT teams where there had been recent concerns regarding capacity. Discussions with staff and examination of the patient records demonstrated that the most appropriate professional had carried out a decision specific capacity assessment. All patients had been found to have capacity with regards to this decision. If assessments had indicated the patient did not have capacity, staff understood that a best interests meeting and best interest's decision was necessary.
- Managers and staff were not able to identify arrangements the trust had in place to monitor adherence to the MCA within the trust.

Good

Are services caring?

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

Our findings

Kindness, dignity, respect and support

- We observed caring and respectful behaviour by staff when interacting with patients. The home visits we shadowed across all the teams demonstrated that staff were responsive, showed concern, and provided appropriate practical and emotional support.
- Most patients we spoke with were very positive about the care and treatment they received. Patients described staff as caring, kind and welcoming. However some patients felt that access to a care co-ordinator was difficult and there was a lack of consistency from psychiatrists. They did mention that they were treated well and generally had no problems or major concerns.
- Staff were responsive to patients' needs. Reception staff were considerate and we observed kind interactions between staff and patients. Staff answered telephones quickly and effectively. Staff showed a good understanding of the needs of individual patients.
- Records were securely stored. Staff considered confidentiality when discussing patients and when sharing their information with other agencies.

The involvement of people in the care they receive

- Most patients were aware of their care plans and felt involved in the care they received. However at Enfield West CSRT we spoke to some patients who did not have a copy of their care plan. One patient we spoke with at Barnet West CSRT did not know that the discussions they had with care co-ordinators went into their care plan.
- Home visits to patients with complex needs showed that they were supported and encouraged to maintain independence and that the risks associated with this were identified, monitored, reviewed and managed.
- Staff identified carers as part of the patient's initial assessments and on-going reviews. Carers had the opportunity to undertake their own carer's assessment. Information about carer's groups and networks was available at each site. Carer's groups and networks were able to offer emotional support and practical advice on matters such as benefits.
- Sites displayed information about advocacy services. Staff were also aware of how patients could contact advocacy. However, some patients told us that they were not aware of advocacy services.
- Patients were part of staff recruitment. Recent service reconfigurations had included a consultation with patients and carers.
- CSRTs had systems in place to survey a sample of their patients each month. Each CSRT site collated feedback from these surveys into a "you said, we did" poster in the reception area. At, Haringey West CSRT patients wrote in a response book to give opinions on the services they received. At Enfield West CSRT some patients commented that they felt they didn't have the opportunity to give feedback to the service.

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 had established a hub, a central point where GPs could make referrals and seek advice. However, the assessment service, CSRT managers and staff that we spoke with had little awareness of the hub.
- The majority of referrals to the assessment services came from GPs, patients, carers and other professionals involved in patients' care. The assessment service triaged urgent referrals and forwarded them to the crisis team. They referred non-urgent referrals to the most appropriate community team for follow up. Some managers and staff commented that this process meant that patients had to repeat their stories at each stage to a different professional.
- Patients discharged from services within the last two years could re-refer themselves directly to the service if their circumstances changed.
- Community services did not have target times in place with regards to referral to treatment times. CSRT teams aimed to review referrals within 72 hours of receipt. Managers allocated referrals to staff. CSRTs offered most new referrals an initial appointment within two weeks of referrals being received.
- At Haringey CSRT East, staff usually saw patients within six to eight weeks of their referral being received from the assessment service.
- At each of the CSRTs and RETs there were waiting lists for psychology input. The trust had set a target time of 18 weeks from referral to treatment time. Each team we visited had a waiting list for psychological therapies. In each team, there was a wait of two to three months for a psychology assessment and then an additional two to three month wait for treatment to commence. Based on this information some teams may not have been achieving the 18-week target. However, data showing the actual referral to treatment time for psychological therapy was not available.
- Staff responded appropriately when patients phoned in. Where care co-ordinators were not available patients were able to speak to their buddy or to the duty worker.
- Staff described a range of measures they would take to engage with reluctant patients. These included low intensity approaches to build therapeutic relationships, creating networks with family and other professionals to build a picture of the patient and being flexible about appointment times and places (using a risk based approach).
- Clear referral criteria were in place for all teams. Staff noted that many referrals to the Haringey RET were declined. This meant the Haringey CSRTs were not able to use the RET to progress patients along their care pathway and discharge them from the CSRT caseload. Staff commented that this put them under additional pressure with caseloads.
- In Haringey East CSRT, care co-ordinators commented that staff in the wellbeing clinic did not always tell them when patients did not attend for their depot.
- Staff within CSRTs gave us different accounts of the trusts policy for patients who do not attend (DNA) their appointment. Some staff said that a new referral should be closed if they did not attend on two occasions, others said on three occasions. Other staff said that risks should be reviewed if patients missed their first appointment, and that contact should be made with the referrer to discuss with them before closing. The trust could not be sure that all staff were aware of and followed trust guidance regarding DNA appointments. Staff told us the service were looking to set up a text messaging service that will send a reminder to patients the day before their appointments.
- Staff tried to be flexible with appointment times where possible. Appointments ran on time. Staff informed patients if appointments did not run on time. Patients told us that appointments were rarely cancelled and that staff always attended.

The facilities promote recovery, comfort, dignity and confidentiality

- At Barnet West and East CSRT, Enfield East CSRT and the Haringey CSRTs, waiting areas were bright, spacious and inviting. Waiting areas at Enfield West CSRT had tired furnishings, were dimly lit and unwelcoming to patients. Enfield West CSRT staff were aware of this and had applied for funding to improve the area through the dragon's den programme but had been unsuccessful.

Are services responsive to people's needs?

Good

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

- There were a full range of rooms to support treatment and care, including interview and therapy rooms. Each team had access to a suitably equipped clinic room with the exception of Haringey East CSRT and Haringey West CSRT.
- Interview rooms were adequately sound proofed.
- In each reception area a range of information leaflets were available for patients on local services and how to complain. Sites displayed information regarding advocacy.

Meeting the needs of all people who use the service

- Patients with mobility issues could access community venues and adjustments had been made. These included the use of entrance ramps, installation of lifts and adapted toilets.
- Information leaflets were available in the reception areas of team buildings. The leaflets contained information that was translated into multiple languages, especially those that reflected the diverse population that made up the boroughs.
- The trust had put systems in place for all staff to access interpreters, either on the telephone or for face to face interviews. Staff were aware of these and accessed them appropriately. Staff at Barnet CSRT East expressed that it could be a challenge to get interpreters for patients attending appointments.
- Each of the CSRTs we visited had diverse local populations. Staff and managers demonstrated an awareness of the local population and their needs, for example particular ethnic groups that had formed communities within their boroughs.

Listening to and learning from concerns and complaints

- CSRT teams received 14 complaints over the last twelve months, two of which were upheld. Early intervention services received four complaints over the last 12 months, none of which were upheld. Assessment services received 18 complaints over the last 12 months, 15 of which were upheld. Common themes for complaints in the CSRT related to staffing changes, involvement of families and appointment times.
- Team managers investigated informal complaints and met with the complainant to discuss their complaint and the outcome. Where the complaint investigation identified that things had gone wrong this was explained to patients
- Patients knew about the trusts complaints procedures and received responses to their complaints. They told us they would feel comfortable raising a complaint with their care co-ordinator or the manager of the service. Information on how to complain was displayed in reception areas.
- Staff knew about the trust's complaints procedure and sign posted patients who wished to make a complaint.
- Managers were involved in the investigation of complaints and gave staff feedback on complaints investigations.

Are services well-led?

Requires improvement

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

Our findings

Vision and values

- Staff knew the trust's values and felt their teams' values correlated with the trust's values.
- Staff knew who senior managers within the trust were. A few senior managers had recently visited some of the teams. Senior leaders within the trust were aware of the challenges staff faced and that they supported and listened to staff. An example of this was a senior manager who made a business case to the trust board to increase establishment levels at a team to avoid higher caseloads.

Good governance

- Staff and managers commented on the volume of paperwork that staff were required to complete, for example for monitoring purposes or when referring patients to funding panels. Local authority and health panels were not integrated, and separate paperwork was required for each. Some staff expressed concern at the amount of time they spent completing paperwork and how this took them away from direct activity with patients.
- The trust used a range of key performance indicators to monitor team performance. These included a quality assurance audit and a performance score card. Forums and meetings to review performance were in place. These included a bi monthly senior management group meeting and a monthly quality improvement group where key performance indicators, finance and other matters, such as sickness and absence were reviewed. Not all managers were aware of, or could produce the performance information relating to their teams. This indicated that performance data was not always accessible to teams and was not being used to improve services. We observed a number of indicators, for example carers assessments that were RAG rated as red over several reporting periods. Within Enfield East CSRT, two indicators had been rated as red for the previous four months. Staff did not have an action plan on how the KPI was expected to improve.
- Team managers had sufficient authority and stated that the trust understood the challenges of delivering their service.
- Managers raised concerns over desktop computers and IT equipment in general. They felt it could be challenging on days when the whole team was based in the office. The Barnet West CSRT manager told us that administrative support was limited which meant that some administrative tasks could be passed on to the manager or clinicians.
- Each CSRT held a risk register. Items from this could be fed into a directorate risk register, and if necessary, added to the trust risk register. Haringey East CSRT had identified recent high staff turnover, the use of locums and staffing levels on the team risk register, as well as the clinic room and poor quality trust mobile phones. Staff had only added items to the risk register in November 2015. Staff informed us that the issues had been flagged over many months and in the case of the mobile phones for several years. This meant that for Haringey East CSRT areas of risk were not being effectively flagged or communicated across the service line or to senior managers as they were not being added to the team risk register in a timely manner. Different teams had a range of issues to resolve. This meant that managers had to use their leadership skills to ensure they were escalated where needed and addressed.
- Staff sickness rates were generally low. The team with the highest sickness rate was the Haringey Early Intervention service (15.9%). This was 9% higher than the team with the second highest sickness rate, Enfield East CSRT, which had a sickness rate of 6.9%. Quality indicator groups monitored sickness and absence rates monthly.
- Staff were aware of and knew how to raise concerns. They told us they were confident they could raise a concern without victimisation. Staff gave an example where there was a concern over working practices. They escalated this to senior management who dealt with it effectively. Staff were aware of and knew how to use the trusts whistleblowing process.
- Whilst staff in community teams felt under pressure, their morale was generally very good. The majority of staff told us they felt supported by their team and team manager. However, staff at Haringey West CSRT felt tired and that workloads could be overwhelming. The service had recently not had much long term sickness but they told us that more staff were becoming fatigued. Staff felt that team working and mutual support were positive aspects of their role.

Are services well-led?

Requires improvement

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.

- Staff were involved in consultation before the recent service reconfiguration.

Commitment to quality improvement and innovation

- The Haringey East and West CSRTs completed specific functional assessments for living skills. They used this to inform the provision of groups for patients. Staff had developed the 'walk and talk' group and 'build a bike programme' as a way of reaching out to people more effectively. The build a bike project was a progressive programme that combined building a bike with developing friendships and growing in confidence. The trust had nominated the programme for an award.

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
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **Regulation 12 HSCA 2008 (RA) Regulations 2010** **Safe care and treatment** Care and treatment must be provided in a safe way for patients The trust did not ensure there was a system to identify patients prescribed high-dose antipsychotic medication to monitor that they are having the appropriate physical health checks. The trust did not ensure medication was stored, administered and transported in a safe manner at all times. This was a breach of regulation 12

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment **Regulation 15 HSCA 2008 (RA) Regulations 2010** **Premises and equipment** All premises and equipment used by the provider must be secure, suitable for the purpose for which they are being used.

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **Regulation 18 HSCA (RA) Regulations 2014 Staffing** The trust had not ensured sufficient numbers of suitably qualified, competent, skilled and experienced staff being deployed. The team managers were not always escalating issues of concern or ensuring that they used their leadership skills to improve the operation of the teams. This was a breach of regulation 18(1)(2)
	Clinic environments used by staff did not have sufficient alarms to enable staff to call for assistance if needed. Staff doing lone working did not always have phones that worked and were not always following lone working procedures. This was a breach of regulation 15(1)