Requires improvement

Barnet, Enfield and Haringey Mental Health NHS Trust

Community-based mental health services for adults of working age

Quality Report

RRRTrust Headquarters
St Ann's Hospital
St Ann's Road
London
N15 3TH
Tel: 020 8702 3000
Website: www.beh-mht.nhs.uk

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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	Edgware Community Hospital	Barnet North Locality Team Barnet East Locality Team Intensive Enablement Team Barnet Wellbeing Clinic	EN5 3DJ
RRP01	Edgware Community Hospital	Barnet South Locality Team Barnet West Locality Team	EN5 3DJ
RRPXX	Trust Headquarters	Enfield West Community Support and Recovery Team	N9 0PD

Summary of findings

		Enfield Wellbeing Clinic Enfield Early Intervention Service	
RRPXX	Trust Headquarters	Enfield East Community Support and Recovery Team	EN1 3EP
RRPXX	Trust Headquarters	Haringey East Community Support and Recovery Team Haringey West Community Support and Recovery Team Haringey Wellbeing Clinic	N22 8JT
RRPXX	Trust Headquarters	Haringey Complex Care Team	N15 3TH

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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Overall summary

We rated community-based services for adults of working age as **requires improvement** because:

During this inspection, we found that services had addressed some of the issues that caused us to rate it as requires improvement following the December 2015 inspection. However, at this inspection we found areas where further improvement was required particularly in the Haringey adult community teams.

- Since the last inspection, in December 2015, we found that some improvements in risk assessment and risk management had taken place. However, in some teams we had ongoing concerns about the way that risk was assessed, managed and documented and the impact this had on patients. Some patients did not have up to date risk assessments and management plans in place. Also some risk management plans were not being following consistently. This included ensuring that patients met with their care co-ordinator at agreed intervals.
- We found that some teams had not ensured that patients' care plans were up to date and person-centred, reflecting holistic assessments and care planning and that patients' and their carers' views were represented.
- At the last inspection in December 2015, we found that some teams were not supporting patients to have physical health checks and that the teams were not always aware of or able to respond appropriately to significant physical healthcare issues. Staff did not always document in care records how patients' physical health needs were being addressed. During this inspection, we found that whilst there had been improvements some teams were not following up patients who had physical healthcare needs by ensuring that information on their records was up to date. When information was requested from GPs, this was not followed up in a systematic manner. If there was no response, from GPs, it was not clear that the service had tried to ensure that all attempts were made so that physical health information was up to date and that staff in the team, particularly staff prescribing medication, were informed about current levels of risk related to physical health needs.
- At the last inspection in December 2015, we found that some team managers were not using their leadership skills to ensure that issues raised within the teams were escalated and addressed in a timely manner. During this inspection, we found that whilst the governance processes had improved there were significant gaps in the governance within Haringey community services and in particular in Haringey West community support and recovery team (CSRT). Some staff had not received regular supervision, team meetings had not been recorded and therefore there was no evidence that incidents, complaints and performance data were regularly discussed. The governance meetings within the borough did not reflect the need for the team's performance to improve.
- Staff across Haringey community services, in all the teams we visited, raised concerns about a culture of bullying and feeling the culture was not open in a way that enabled them to safely raise concerns.
- At the last inspection in December 2015, we found that there were some teams, particularly in Haringey, which had high levels of locum staff. During this inspection, we found that while the trust had put efforts into staff recruitment and in particular, nurse recruitment, there were some teams in Haringey which continued to have a high proportion of locum staff and that this could have an impact on the continuity of care for patients in this team.

However:

- The trust had made a number of improvements since our last inspection in December 2015.
- In December 2015, we found that staff were not using the trust lone working policies and all staff did not have access to mobile phones when in the

Summary of findings

community. During this inspection, we saw that the trust had updated lone working policies and staff were aware of their local lone working policies and followed them.

- In December 2015, we found that patients who were prescribed high dose anti-psychotic medication were not being systematically identified by the teams to ensure that they were receiving appropriate checks on their physical health. During this inspection, we found the teams had developed systems to identify patients who were prescribed high dose anti-psychotic medication.
- In December 2015, we found that Haringey CSRTs did not have access to appropriate clinic rooms. This was no longer the case.
- In December 2015, we found that all staff had not had access to mandatory training and team managers did not have accurate training records for staff. During this inspection, we found that most staff had access to mandatory training. Mandatory training information was available for team managers and senior managers, although there were no systems in place to monitor or collate information about non-mandatory training completed by staff.
- In December, 2015, we found that staff were not taking medicines administration records when visiting patients at home. This was no longer the case. We found that medicines were managed, dispensed and transported safely.
- Most patients we spoke with were positive about the support which they received from the service.
- Barnet teams had developed much closer working links with primary care and had developed a link working team, which meant that communication had improved with GPs.
- Teams were aware of local risk registers and most teams told us that they felt the working environment was positive and that they were able to raise concerns.
- Most teams had ensured that staff received regular clinical and managerial supervision.
- At the last inspection in December 2015, we found that patients were not consistently being monitored while on waiting lists for support, which meant that there was a risk that they could deteriorate and staff would not be aware. We found this had improved.

Due to the immediate concerns we had, after the inspection, we asked the trust to take immediate action in Haringey West CSRT. This was because we were concerned that the team were not effectively identifying, assessing, managing and recording risk. The trust provided us with a comprehensive action plan, which addressed the immediate concerns and we are continuing to monitor this.

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:

- In our inspection in 2015, we found that some teams did not update risk assessments following risk events. At the current inspection, we saw there had been an improvement in some teams. However, in Haringey West CSRT and in Enfield West CSRT some risk information was not updated in care records. Risk management plans were not consistently robust. Some risk management plans, which were specific about frequency of visits, were not adhered to by staff and it was not clear in the records why this was the case. This meant that there was a risk that people were not being effectively managed safely in the community.
- In the inspection in 2015, we found that some teams had not ensured that staff working in the community support and recovery teams had access to information about incidents across the service so that learning could be embedded across all community teams and in all boroughs. At this inspection we found this had improved, but in Haringey West CSRT, it was not clear that learning from incidents was embedded in team practice. We saw examples of recommended actions following an incident, which had not resulted in changed practice and this had not been identified at governance meetings within Haringey. The team had also not had regular recorded team meetings, which included discussions about learning from incidents, complaints and performance data.
- In our inspection in December 2015, we saw that some teams, particularly in Haringey, had high numbers of locum staff. During this inspection, we saw that this continued to be the case. The trust had undertaken recruitment programmes for nurses and established new pathways for newly qualified nurses to move into community services. In Haringey East CSRT, most of the locum staff had been in the service for over one year but in Haringey West CSRT, this was not the case. This meant that there was a risk that this had an impact on continuity of care for patients.
- Community Support and Recovery Teams in Enfield and Haringey and Locality teams in Barnet did not hold long waiting lists. However, in Haringey West CSRT, we found that patients were put on a waiting list for allocation when a previous care coordinator left and there had been no systematic way of remaining in contact with those in this position to ensure that the team were aware when there was a risk of relapse. There

Summary of findings

was a reliance on patients in this position contacting the team proactively when they did not have a care coordinator and that meant there was a risk deteriorating health may not be picked up or addressed. We were told during the inspection that this had changed and that patients on the waiting list were being contacted by duty workers.

However:

- In our inspection in December 2015, we raised concerns about a number of areas of medicines management including storage and transportation. This had been addressed at this inspection.
- In our inspection in December 2015, we raised concerns about the effectiveness of lone working policies. During this inspection, we saw that staff across the services had a good understanding of lone working policies.
- In our inspection in December 2015, we identified that all staff did not have access to alarms when seeing patients in interview rooms. This was no longer the case.
- Most teams showed a good understanding of how to report incidents and had understanding of recent incidents in their teams and how this contributed to improving practice.
- The patient accessible areas in the team bases were clean, well-kept and welcoming.
- Staff had a good understanding of safeguarding adults and children policies and procedures and were able to give examples when they had needed to use this policy.

Are services effective?

Requires improvement

We rated effective as **requires improvement** because

- 9 out of the 14 care plans we checked in Enfield West and Haringey West CRSTs were not holistic and person-centred and did not reflect recovery focussed planning.
- Teams were not monitoring patients whose physical health checks were being carried out by their GPs. Information from tests was not always available on the electronic records and it was not always clear what efforts had been made to chase up this information from GPs.
- Team managers did not have a record of specialist training their staff had undertaken or wished to access for their professional development.
- Patients who were restricted by particular orders by the Ministry of Justice who were required to have regular contact with their care coordinator (or social supervisor) had not been seen as regularly as their care plan indicated.

Summary of findings

- Care plans did not consistently identify where patients were subject to s117 funding which was where the local clinical commissioning group (CCG) had a responsibility to provide funding for aftercare when a patient had previously been detained under section 3 of the Mental Health Act.
- The understanding of the Mental Capacity Act and how it was used in community settings was mixed. Although there was no record of staff training, most staff were aware of the relevance and principles in their work. However, we saw that some records were not identifying capacity issues clearly. Where assessments of capacity took place for specific issues, these were not consistently recorded with best interest's decisions taken so that the reasons the actions were taken, or not taken, by professionals was clear.

However:

- Patients had access to most psychological therapies in line with NICE recommended guidance.
- In Haringey Complex Care Team the service used outcome measures to understand the effectiveness of the team and the service it delivered.
- In our inspection in December 2015, we saw that some teams had no way of identifying patients who were prescribed high-dose anti-psychotic medication. During this inspection, we found that this had been resolved.

Are services caring?

Good

We rated this caring as **good** because:

- Most of the feedback we received from patients and carers across the services we visited was positive.
- Patients were encouraged to provide feedback about the services which they received.
- Enfield EIS had organised an event with patients to provide further information about the services they provided.
- Some services, including early intervention services, had specific carers groups and the Enfield EIS which we visited, organised group trips and events.
- Staff referred to patients and carers with understanding, empathy and respect.
- Staff provided kind and empathetic care when we observed home visits and clinic visits.

However:

Summary of findings

- Some patients told us that they had not received information about the process of change, which was taking place in the community, and had not had the opportunity to be involved in the discussions about the changes taking place in their care.

Are services responsive to people's needs?

Good

We rated responsive as **good** because:

- Teams within the trust met the targets for ensuring that people were assessed in a timely manner following their referrals to the service.
- At our previous inspection in December 2015, we found that staff in the trust were not following the trust policy on patients who did not attend appointments. During this inspection, we found there had been an improvement.
- Some teams were able to provide specific support for patients from local communities with a different culture or for whom English was not their first language. For example, Haringey and Barnet services had specific groups for people with post-traumatic stress disorder in community languages like Farsi and Turkish.
- Haringey Complex Care Team had an open day which involved interpreters who spoke Turkish, Farsi and Tamil to ensure the event was inclusive.
- Information was available to patients about how to make complaints and complaints were discussed at clinical governance meetings. Two patients we spoke with who made formal complaints to the trust told us that they were satisfied with the outcome.

However:

- There were longer waiting times in some teams to provide support to patients who needed individual psychology support. This was highest in Enfield where the wait from assessment to treatment was 11 months. There were also longer waiting times for the specialist complex care teams. Patients were offered access to groups led by psychologists while waiting for individual therapy.

Are services well-led?

Requires improvement

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

- Whilst the trust governance processes had improved since the previous inspection, these had not identified the challenges in

Summary of findings

the Haringey services. While a number of meetings at various levels took place, it was not clear from the minutes of these meetings that issues of concern, for example, gaps in performance, were being discussed and addressed robustly.

- Staff across the Haringey community teams reported that there was a culture of bullying and that they did not feel able to speak out. This had been identified in the staff survey.
- The trust did not have a clear agreement on how to manage the performance of staff who were seconded into the trust and there was a risk that this would have an impact on the quality of care delivery.

However:

- Most teams had regular, recorded team meetings which including information about performance data, incidents, complaints and learning from positive practice across the trust.
- Some teams had embraced quality improvement and had worked on specific projects which had positive outcomes for the service.
- Most staff we spoke with were happy working for the trust. They knew the senior staff within the trust and told us that they were approachable.
- Information was available to team managers relating to the performance of their teams so that they could identify the areas of improvement.

Summary of findings

Information about the service

Barnet, Enfield and Haringey Mental Health Trust provide a range of community based mental health services for adults of working age.

The trust was in the process of redesigning some of the ways that these services were configured. This change had taken place in Barnet and was due to take place in Enfield and Haringey over the next six months following the inspection. As a result the team configurations were different in the different boroughs.

Enfield and Haringey had assessment teams, which took initial referral information and then referred people on to the community mental health services if they required additional support. In Barnet, there were primary care link worker teams, which worked from GP surgeries and took initial referrals.

There were three early intervention services, which covered the three boroughs and provided specialist support for adults who were experiencing their first episode of psychosis.

Barnet services were divided into four locality teams, which worked on a geographic basis and linked in with specific GP surgeries. Barnet also had an Intensive Enablement Team, which focused on recovery and rehabilitation of people who were in supported living and care home settings in the borough.

Enfield and Haringey each had two community support and recovery teams (CSRT). Each team either covered the east or west of the borough. These teams supported people who had a primary diagnosis of psychosis and had complex mental health and social care needs.

Enfield and Haringey also had rehabilitation teams, which worked with people who were moving on from the more intensive community mental health support.

There were complex care teams in Enfield and Haringey who worked with people who had complex mental health and social care needs but who did not have a diagnosis of psychosis.

There were three wellbeing clinics, one in each borough. Wellbeing clinics incorporated clozapine clinics. Patients prescribed clozapine could attend the clinic, have required tests and receive their results and prescriptions as they waited.

Our inspection team

The team that inspected community based mental health services for adults of working age consisted of one CQC inspection manager, three CQC inspectors, two CQC assistant inspectors two nurses, two consultant psychiatrists, one senior occupational therapist, one social worker and one expert by experience.

Why we carried out this inspection

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

We undertook this announced comprehensive inspection in September 2017 to find out whether Barnet, Enfield and Haringey Mental Health NHS Trust had made improvements to community based mental health services for adults of working age since our last comprehensive inspection of the trust in December 2015.

At our last comprehensive inspection of the trust, in December 2015, we rated community based mental health services for adults of working age as requires improvement overall with requires improvement in safe, requires improvement in effective, good in caring and responsive and requires improvement in well-led. We found that the trust had breached regulations within the community based services for adults of working age.

Summary of findings

We issued the trust with three requirement notices. These related to the following regulations under the Health and Social Care Act (Regulated Activities) regulations 2014

Regulation 12 Safe Care and Treatment

Regulation 15 Premises and Equipment

Regulation 18 Staffing

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 focus groups.

During the inspection visit, the inspection team:

- visited 14 teams which provide care and treatment to adults of working age who have mental health needs in the community in Barnet, Enfield and Haringey. This included community locality teams, specialist teams such as the intensive rehabilitation team and complex care team, wellbeing clinics and one early intervention team
- visited team bases across the three boroughs including looking at the quality of the environments, clinic room areas and waiting room areas
- accompanied staff on four home visits and observed two clinic appointments with the patients' consent
- observed three multi-disciplinary team meetings
- attended the weekly personality disorder stream assessment workshop
- met with the team managers of all the teams we visited and the three service managers responsible for community services in Barnet, Enfield and Haringey
- spoke with 82 other staff members including doctors, community nurses, psychologists, social workers, occupational therapists, team administrators and community engagement workers
- spoke with 33 patients during the inspection week, either face to face or by telephone
- spoke with four family members or carers
- received feedback from focus groups before the inspection
- received feedback through three comments cards from comments boxes placed before the inspection.
- received feedback directly from one carer immediately after the inspection
- looked at care records including care plans and risk assessments for 42 patients and a sample of medication charts across the wellbeing clinics we visited
- looked at a range of policies, procedures and other documents relating to the running of the service

What people who use the provider's services say

Most of the people we spoke with during the inspection, including those who attended the services we visited, people who we spoke with on the phone and feedback we received from comments cards, were positive about the services.

Patients and carers told us that staff were empathic and listened to them and that they found the support that they received helpful.

Summary of findings

Some patients told us that there had been a lack of consistency when their care coordinators had left the team. Some patients at Haringey Complex Care Team told us that they were concerned about delays to their treatment but they were satisfied with the treatment itself.

Good practice

- In Barnet and Haringey, the services provided interpreters in groups for Turkish and Farsi speaking patients. The Haringey Complex Care Team had an event with Farsi, Tamil and Turkish interpreters present to increase community access.
- The Early Intervention Service in Enfield had put on an event in conjunction with patients who used the service to explain what the service did and how it could help people who were new to the service and their family members.

Areas for improvement

Action the provider MUST take to improve

- The trust must ensure that patient risk assessment and management is clearly documented, updated and understood by staff within the teams that provide community support for adults of working age within the trust. This includes ensuring that they meet with their care co-ordinator at the intervals agreed in their risk assessment.
- The trust must ensure that patient care plans are person-centred and holistic and that the staff update care plans as necessary. Where care plans are agreed with the patient, they must be followed or reviewed.
- The trust must ensure that information about physical health is recorded when needed in the patients' care plans. Where GPs are not responding to requests for information about physical health needs this must be recorded in the patient's records and there must be systems in place to monitor and chase this information.
- The trust must ensure that governance systems identify services which are not performing well and where needed that the appropriate improvements are made. This is particularly in relation to Haringey community services.

Action the provider SHOULD take to improve

- The trust should ensure that all staff, including staff seconded to the trust and locum staff have access to regular individual supervision.
- The trust should ensure that where there are high levels of locum staff, that the number of changes in care co-ordinators is monitored to limit the impact on consistency of care.
- The trust should ensure that where learning from incidents takes place following an investigation, that there are processes in place to ensure that any necessary action is taken and monitored through governance processes.
- The trust should monitor waiting times for patients to access individual psychological therapies and review service provision where needed.
- The trust should ensure that all staff have a sufficient understanding of the relevance of the Mental Capacity Act and its scope in community mental health services for adults of working age.
- The trust should continue to work to support staff affected by bullying.
- The trust should ensure that staff and patients are engaged in changes to services that happen within the trust and that they are given sufficient information about this.
- The trust should ensure that team managers have a way of monitoring non-mandatory training and are aware of the additional training that members of their teams have so they can judge what further training may be needed.

Summary of findings

- The trust should ensure that where patients are entitled to support under s117 of the Mental Health Act that this is recorded clearly in their clinical notes.

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 North Locality Team Barnet East Locality Team Intensive Enablement Team Barnet Wellbeing Team Barnet South Locality Team Barnet West Locality Team	Edgeware Community Hospital
Enfield West Community Support and Recovery Team Enfield Wellbeing Clinic Enfield Early Intervention Service Enfield East Community Support and Recovery Team Haringey East Community Support and Recovery Team Haringey West Community Support and Recovery Team Haringey Wellbeing Clinic Haringey Complex Care Team	Trust Headquarters

Mental Health Act responsibilities

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

- Staff had a good understanding of the Mental Health Act and the Mental Health Act Code of Practice as it related to work with patients in community settings.

Detailed findings

- Records of patients who were subject to community treatment orders across the teams we visited were complete, up to date and accurate and staff knew where information could be found.
- Staff were supported by Mental Health Act Administrators in each borough and they knew where they could ask advice about issues relating to the Mental Health Act.
- The trust did not record training specifically related to the Mental Health Act.
- Patients who were subject to restricted sections of the Mental Health Act with continued oversight of the Ministry of Justice were not being seen as frequently as their care plans determined in Haringey West CSRT. In Enfield West we saw one record where a patient, who was subject to these restrictions, and had not seen their care coordinator/social supervisor at regular intervals.

Mental Capacity Act and Deprivation of Liberty Safeguards

- Most staff had a good working understanding of the Mental Capacity Act as it applied to their practice. This was not a mandatory training course within the trust. However, staff received training during their induction.
- Staff were aware of the principles of the Mental Capacity Act and they were aware of how to seek advice if they required additional information. The trust policy relating to the Mental Capacity Act was available on the trust intranet.
- We saw some care records where there had been assessments of capacity documented. However, these were documents in patients' progress notes rather than specifically in a Mental Capacity Act section of the electronic records as reflected in the trust policy.We saw one example of a record in Barnet East and one record in Haringey West where capacity assessments had been made but it was not clearly documented in the records how the decisionshad been made and what decisions had been made in the best interests of the patient involved. This showed that some of the recording relating to the Mental Capacity Act was not sufficiently clear to establish the outcome of the assessments.

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

- All the teams we visited had access to interview rooms and reception areas where staff saw patients. These areas were kept clean and tidy. The services monitored the cleanliness of the communal areas to ensure that this was the case and domestic staff visited the services on a regular basis and completed records of areas which had been cleaned. The records we reviewed were comprehensive and up to date.
- At our previous inspection in December 2015, we found that some of the rooms in Canning Crescent where the Haringey East and Haringey West community support and recovery teams (CSRTs) were based had alarms in rooms which were not easily accessible to staff and there were not always enough alarms for staff to use. During this inspection, we found that this was not the case. All staff across the sites, had access either to alarms in the rooms or personal alarms, which they used to ensure that there was a means to call for assistance if required. In the Barnet community teams, we found that these alarms were not tested regularly. This meant that there may be a risk that staff would not be able to respond in a timely manner if an incident occurred and an untested alarm did not work.
- During our previous inspection in December 2015, we saw that the clinic rooms used at Canning Crescent where the Haringey East and Haringey West CSRTs were based were not fit for purpose as the room was small. During this inspection, we saw that the clinic room had moved to a more appropriate environment.
- All the services we visited that provided outreach support to services in the community had access to clinic rooms. Some teams which were co-located shared clinic rooms. We checked these clinic rooms and found that they were all clean and there were regular audits of their cleanliness and infection control, which were monitored.
- Staff in the teams we visited had access to equipment to monitor physical healthcare observations such as blood pressure, weight, height and pulse. All services calibrated this equipment on a regular basis.
- Staff adhered to infection control principles and were aware of guidance provided by the trust relating to infection control, including handwashing. Teams displayed information about infection control across all the sites.
- Electrical equipment used in the services had been tested for safety and was visibly clean.

Safe staffing

- Community services across the trust were in the process of reconfiguring with a move to locality-based teams. This change had already taken place in Barnet, where we visited the Barnet North, Barnet South, Barnet East and Barnet West teams. It was due to take place at the time of our inspection in Enfield and Haringey where the services were still divided between community support and recovery teams and some specialist teams for example, complex care teams and separate assessment teams. In addition to these teams, there were some specialist teams in Barnet, such as the early intervention service and the intensive rehabilitation team. The trust used a safe staffing tool to establish the numbers of staff needed in each team.
- Across the services some staff were appointed by the local authority and were seconded into the service. While these posts had staff in place, in the Haringey West CSRT, three social work posts were being covered by locum staff. We asked the team manager why these positions had not been filled and were told that there were delays in the local authority recruitment processes. This had an impact on the cohesiveness of care coordination in the Haringey West CSRT.
- Staff turnover rates varied across the teams. The team with the highest turnover rate in August 2017 (rolling 12 month figures) was Haringey West CSRT, which had a

Requires improvement

Are services safe?

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

28% turnover rate. Haringey East CSRT had a turnover rate of 20%. Sickness levels across a 6 month period was highest in in the Barnet intensive reablement team with 12% and 7% in the Haringey West CSRT.

- All the teams we visited had sufficient access to medical staff.
- Caseloads varied widely across the teams based on the role of the team and the borough. In Barnet, the average caseloads across the locality teams were around 20. In Enfield and Haringey, care coordinators in the CSRT had higher caseloads at around 30. Approved Mental Health Professionals, who had additional duties in carrying out Mental Health Act Assessments in their respective boroughs, had smaller caseloads and new members of staff generally had smaller caseloads initially. Managers reviewed the skill and experience of staff when allocating caseloads.
- At our inspection in December 2015, we identified that the trust should ensure recruitment continues so that the majority of staff are permanent employees in order to improve continuity of care for patients. This was a priority in Haringey. At this inspection, there had been slight improvement across the three boroughs. The trust had taken action to address recruitment and staff development where they were able to. However, in Haringey East CSRT, 24% of staff were locum and there was a 33% vacancy rate. In Haringey West CSRT, there was a 25% vacancy rate with 15% of staff being locums. The service had taken steps to address this by starting a new development programme to support band five nurses to progress to band six positions. Additionally the majority of locum staff in the Haringey East CSRT had been with the service for long periods of up to three years, which improved continuity of care. In Haringey West CSRT, the locum staff had not been in post for longer than a year and there was a risk that this was impacting the continuity of care provided to patients.
- In Enfield East CSRT there was a 20% vacancy rate which was five posts and only 1.2% was covered by locum staff. In Enfield West CSRT there was a vacancy rate of 23% with 9% filled by bank or agency workers. In the Early Intervention Service in Enfield, there were six vacancies which was 42% vacancy rate and 27% of the team were bank or agency workers. This meant that there was a risk that staffing was not sufficient to meet the needs of the services in Enfield.
- Most teams had undertaken the required mandatory training. Where there were gaps in training, staff had booked training in and were due to attend or team members had been on leave and the lack of training was accounted for. Across the community based mental health teams for adults of working age that we visited, mandatory training had been completed by 88% of staff. This was lowest in Haringey East CSRT with 85% and highest in Barnet East at 97%.

Assessing and managing risk to patients and staff

Assessment of patient risk

- At our previous inspection in December 2015, we identified that the trust did not ensure risk assessments were monitored and updated when needed. At this inspection there were improvements in some teams where risk assessments were updated regularly and changes in levels of risk were documented by members of staff. However, we had specific concerns about the assessment and management of risk in the Haringey West CSRT. As a result of this, we asked the trust to take immediate action following our inspection. The trust provided an action plan and confirmed that they had reviewed risk management and assessment within the team immediately and were continuing to monitor this.
- Staff undertook risk assessments at the initial meetings with patients and that risk was constantly reappraised and any changes in risk were recorded in patients' risk assessments. Staff used a recognised risk assessment tool. Most of the records we checked across the services we visited had current risk assessments in place.
- At Haringey West CSRT five of seven risk assessments were not updated with the most current risks, including significant risks. For example, one record referred to a risk situation in the community, which had been followed up with a Mental Health Act assessment. While we could see, from the record, that a decision had been made not to detain the patient and for the team to see the patient in the community, there was no updated information about the risk or the outcome of the assessment. Another patient had a significant injury and there was no information in the most current risk assessment about this. We were told by a member of staff that when a care coordinator was on leave, even for a significant period of time, no one would update risk

assessments in their absence. This meant that there was a risk that patients who were being seen within the team did not have up to date risk assessments where current risk was identified and documented.

- We reviewed seven care records in Enfield West CSRT. In three of the files we checked, risk assessments were not up to date. For example, one risk assessment had not been updated since the patients' inpatient admission in April (we visited the CSRT in September). This meant that the team were not consistently updating risk assessments when patients were initially reviewed by the team. Another patient, who had left the country for a period, had not had their risk assessment updated since July, even though there had been significant risk events in the intervening period. This meant that we could not be confident that all care coordinators were consistently assessing risk and ensuring that it was documented in a timely manner.
- Services were open during daytime working hours (9am – 5pm Monday to Friday). Staff provided patients with information, which directed them to out of hour's services when the services were not available. Most patients had crisis plans which included information about what to do in an emergency out of hours and which identified trigger factors that may identify when someone was beginning to deteriorate.

Management of risk

- Staff identified and responded to changing risks to, or posed by patients. Staff did this through reporting of incidents, weekly multi-disciplinary meetings that updated the profile of patients and supervision where staff discussed patient risks with supervisors. Risk management plans mostly demonstrated regular review after an incident, for example a patient who did not attend an appointment. However, we identified concerns in the way that risk management was documented in some risk assessments. For example, in Haringey West CSRT we identified two patients who were subject to restrictions in place from the Ministry of Justice on the condition that they had regular contact with their care coordinator (known as a social supervisor). This contact had not taken place with the frequency that had been agreed and was recorded in their care plans. This presented a risk, which had not been managed effectively. We observed one team meeting in Haringey West CSRT and saw that while individual patients were discussed with the team, because there were a number of patients identified to discuss (over 50), there was a risk that team members may not be able to recall significant risk management information, particularly when they were on duty or were working with patients who were not allocated to them specifically. The minutes of the team meetings in Haringey West CSRT had not been consistently taking place as no dedicated administrative support had been available to the team manager. This was despite this being a learning point from an incident in February 2017. This meant that we could not be confident that there were robust systems in place in the Haringey West CSRT to manage risk, which had been identified.
- At our previous inspection in December 2015, the trust did not ensure that patients were monitored while they were on the waiting list to receive treatment from the team, in order to provide support if they deteriorated. At this inspection there were small waiting lists at some of the services or they had no waiting lists. However, Haringey West CSRT had a waiting list of 20 patients. While some of these patients were awaiting initial allocation, 11 were waiting for reallocation following the departure of a care coordinator. The team manager told us that they were beginning to contact patients on this list proactively but this had not been happening regularly prior to September 2017. Prior to this they had advised patients to proactively contact the duty worker if they had concerns about their mental health. This meant that there was a risk that patients who had been identified and assessed as needing care coordination and who were deteriorating, may not be identified in a timely manner if they did not recognise their own deterioration.
- In the Haringey Complex Care Team, the patients on the waiting list for a single intervention were contacted if they were waiting longer than six months. Only low risk patients were identified for a single intervention. Anyone considered moderate to high risk was allocated to a different team. Anyone identified as moderate to high risk was seen by the MAP (mood, anxiety and other personality disorders) stream who proactively managed their waiting lists. Referrals were reviewed by staff weekly and high risk patients were prioritised for assessment. Staff carried out a telephone screening of all new referrals. Anyone needing a new referral was

Requires improvement

Are services safe?

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

usually seen within two weeks. This team used an available clinician system to respond to people on the waiting lists. Staff were allocated to this role each day to support the administration staff.

- At inspection in December 2015, we identified that staff did not follow the trust's lone working policy and did not have access to working mobile phones. At the current inspection this had improved. Each service we visited had developed a local policy devised within the team. Staff were aware of their local lone working policy, including the use of code words to identify when they were in danger.

Safeguarding

- Staff across the services we visited had a good understanding of safeguarding and were aware of where and how to report concerns. They were able to give examples of how they used safeguarding frameworks and policies to ensure that both children and adults were safeguarded.
- They were aware of local trust contacts and where to seek advice if they needed further information or had concerns; this included both internal and external contacts.
- Staff in Barnet and Enfield spoke about the positive links they had with the local authority and how they worked together. Staff across the Haringey teams, raised concerns about the timeliness of responses from the local authority and this was recorded on the local team risk register as a concern, so reflected that this had been discussed and escalated locally.

Staff access to essential information

- Staff within the teams we visited accessed an electronic database, which held patient records. This meant that information from different sites and teams were collated and staff could have access to the most up to date records.
- Staff across the service told us that they had experienced difficulties at times with their access to the electronic database. However, they were aware of contingency plans in place if they were unable to access the main electronic database.
- All staff working within the teams, including locums and students or trainees, had access to the main database and were able to access relevant information when necessary.

Medicines management

- At our previous inspection in December 2015, the trust did not ensure that there were safe systems for the storage and transportation of medicines, medical waste and sharps. At this inspection, we saw improvements had been made. Staff transported medicines in secure, lockable briefcases. Staff stored medicines in locked cupboards and locked fridges. All medicines were within their expiry dates and all opened liquids had an expiry date sticker completed. Staff had access to appropriate medicines disposal facilities, including sharps bins and pharmaceutical waste bins, which were dated appropriately.
- At our previous inspection in December 2015, the trust did not ensure that there was a system to identify patients who were prescribed high dose anti-psychotic medication so that staff could carry out additional checks to ensure patients' physical health was monitored appropriately. At this inspection, teams had put systems in place to ensure that patients prescribed high dose antipsychotic medication were identified. For example, by ensuring this information was logged as an alert, which opened when a patients' electronic record was opened on the electronic database or ensuring that patients who were prescribed high dose anti-psychotic medication were flagged at team meetings. Staff were aware of patients specific needs regarding monitoring.

Track record on safety

- The trust reported 19 serious incidents, which required investigation across the community teams between 1 July 2017 and 30 June 2017.The majority of incidents, 17 of 19, were related to actual or suspected self-harm.

Reporting incidents and learning from when things go wrong

- Most staff we spoke with were aware of the types of incidents, which needed to be reported and how they were reported. However, two staff members in the Haringey West CSRT told us that there were incidents

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that they had witnessed that they felt, in retrospect, should have been reported but were not. Reporting levels for incidents varied significantly across the services. For example, between April 2017 and August 2017, Haringey East CSRT had reported 62 incidents and Haringey West CSRT had reported 28 incidents.

- Managers had access to information about all the incidents, which were reported within their teams and were able to review this information regularly. Each borough had a specific meeting across inpatient and community services to review incidents and learning from incidents and this was fed back in team meetings and during supervision with staff.
- Most staff were aware of incidents, which had taken place in their service in the year prior to the inspection visit, and were able to refer to them. Where there had been serious incidents, staff had taken immediate action and this was followed up with identified learning from incidents. However, in some cases, this learning had not been embedded. The services reported to borough-based meetings which reviewed all incidents within the boroughs on a monthly basis. We checked the minutes from this meeting and saw that extensive conversations and discussions took place. Most teams discussed incidents and learning from incidents in their team meetings. However, there were no minutes for the Haringey West CSRT until September 2017 and it was not clear that this was used as a way to share information about serious incidents. Staff we spoke with told us that they did not consistently have regular supervision or receive feedback about reported incidents, which meant that we could not be provided with assurance that learning was taking place in this team.
- Staff we spoke with understood the duty of candour. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients, or other relevant persons, of certain notifiable safety incidents and provide reasonable support to that person.
- Most staff told us that when there were serious incidents in the services in which they worked, they had access to additional support through supervision and reflective practice in order to debrief.
- Staff gave examples of changes made as a result of feedback from incident investigations. For example, a recent incident flagged the use of jargon language in a care record that did not capture an appropriate amount of information. In Haringey East CSRT, staff met and conducted group work developing a prompt for home visits. In Enfield West CSRT, we saw that there had been an incident where a patient had been recalled from a community treatment order (CTO) but there had been no bed available. This had led to additional coordination of information between the community team and the inpatient and bed management team. In the Haringey Complex Care Team, staff gave examples of how they learned from serious incidents. The service had learned from a trust audit of suicides last year. This had emphasised the need for staff to ask patients particular questions in relation to suicidal ideation. The consultant psychiatrist in that team was the chair of the serious incident review group and brought the learning back to the team.

Are services effective?

Requires improvement

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Our findings

Assessment of needs and planning of care

- Patients in Haringey and Enfield were initially assessed by the local assessment teams who then passed information on to the relevant teams in the boroughs. Patients who were referred to the local teams were assessed, usually in a timely manner. These assessments were predominantly comprehensive. However, we found some assessments and care plans were not updated or not in place. For example, in Haringey West CSRT, where we looked at seven care plans and assessments and they were not person-centred or comprehensive. Even when information was added from the patient perspective, it did not show that holistic care planning was taking place. For example, a patient goal was defined as "I will have regular contact with my care coordinator" and the activity to be completed was "I will see my care coordinator" but there was no the detail which explained what purpose and function the care coordination visits would have. In two of the care plans, we saw that frequency of visits by care coordinator was established but there was no record that these visits were taking place with the agreed frequency. We also saw that two patients did not have any care plans in place. We looked at seven care records in Enfield West CSRT and saw that care plans were not person centred, holistic and recovery focused. For example, one care plan for a patient who was subject to a community treatment order (CTO), only referred to the conditions of the CTO in the care plan and not to the holistic needs of the patient.
- In the Intensive Enablement Team in Barnet, there was a strong focus on recovery and this was reflected in the home visit from this team that we observed.
- At our previous inspection in December 2015, patients were not supported to have physical health checks and teams were not consistently aware of patients' significant physical health conditions and how these were being addressed. At this inspection, we saw that there had been some improvement. Some care plans included physical health sections and staff were asked to write to GPs for information about patients' physical health needs and to share information with them before care programme approach (CPA) review meetings. Wellbeing clinics were in place in the three boroughs and some physical health checks were completed when patients came in for depot injections. Staff in Barnet had more consistent and embedded links with local GPs but in Enfield and Haringey, we found that while staff were sending letters out to GPs to request results of physical health checks. It was not always clear that these had been followed up or recorded why there were not records on file if they did not receive a response (for example, stating that the GP had not replied despite two attempts to make contact). This meant that for some patients, it was not possible to see what the current situation was regarding their physical health needs and there was a risk that key information, which would be useful to staff, was being missed.
- In Barnet, staff told us that the borough was developing a new quality assurance system for focussing on information about physical healthcare and that medical staff conducted regular audits of patients' physical healthcare in the borough.
- Each team had a local 'heat map'. This was information which summarised the key performance data for the team and included the results of regular audits. These identified physical healthcare as a target, this was measured by care coordinators sending information requests to GPs for physical health checks rather than the information being received back. There was a risk that this would give a false assurance that information was being collected, rather than requested.

Best practice in treatment and care

- Medical and non-medical prescribers ensured that medicines were prescribed in accordance with National Institute for Health and Care Excellence guidance. Psychiatrists referred to guidance when prescribing medication and they discussed decisions around medication with patients and documented this.
- All services had access to psychological therapies recommended in accordance with NICE guidance. This included cognitive behavioural therapy and family interventions. Staff also ran groups for patients including social clubs at Canning Crescent, walk and talk and gardening groups. Some teams, such as the Haringey Complex Care team, offered additional therapies, for example, cognitive analytic therapy and

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longer term psychodynamic psychotherapy. The short behaviour track within this service offered anger management and behavioural activation for treating depression as well as other therapeutic approaches. We were told about some delays to access to individual psychology input but this varied between the teams and the boroughs. For example, in Barnet, while each team had a dedicated psychologist, psychologists across the borough also worked in a hub which took referrals from all teams so that anyone in any team in the borough would not be disadvantaged if the psychologist in that particular team did not have capacity. In Enfield, the early intervention service did not have access to a family therapist, which is recommended for early intervention services in order to be able to provide support.

- In Enfield and Haringey services, patients were referred to different teams according to their primary needs. For example, there were stand-alone complex care teams that specialised in working with people who had diagnosed post-traumatic stress disorder or personality disorders. People whose primary need was based on their experiences of psychosis were referred to the community support and recovery team and if it was their first episode of psychosis, the early intervention team was be involved. Once referred to the CSRT, patients who were progressing towards discharge could be referred to the recovery enablement team (RET). In Haringey this was a separate team but in Enfield these were specialist members of staff within the CSRT. These teams were able to provide additional, usually short term support to patients who did not require ongoing high levels of support but may require additional support before discharge.
- At our inspection in December 2015, the trust did not have systems in place to develop working relationships with GPs. At this inspection, we saw some improvement. In Barnet teams had adopted a new model of working where a link working team was embedded in GP practices and were able to build ongoing relationships with the GP surgeries directly which improved communication between GPs and the trust.
- In Enfield and Haringey staff sent emails to GPs with updated information about patients they had assessed or when information about a patient's care and treatment changed. However, when staff sent requests for information from GPs, there was not a consistent approach to ensuring this was followed up or pursued. For example, when requesting updates on physical health checks and other information from the GPs.
- In the Haringey Complex Care team, outcome information was presented at monthly clinical governance meetings. Since April 2017, the team had been measuring outcomes for patients systematically using a patient outcome database. This online system allowed staff to record the results of completed outcome measurement tools such as clinical outcomes in routine evaluation for each patient at different stages of treatment and produce graphs showing the overall effects of treatment. Patients were asked by staff to complete outcome measures pre-assessment, during treatment and at the end of therapy. Patients were provided with electronic tablets to measure overall gains. This team was beginning to embed this way of working and measuring the effectiveness of treatment. All teams used the health of the nation outcome scales to measure progress of patients during their care.
- Teams had social workers who were seconded from the local authorities and were able to provide specialist support in social care issues.
- In Barnet and Haringey, the teams had access to employment support workers who were able to provide specific support for patients including CV drafting, training and interview preparation as well as lead on some volunteering and apprenticeship projects. Teams told us that they had good links with local authorities.
- Staff across the teams had started to work on a variety of quality improvement projects. For example, Barnet locality teams were developing a quality assurance system for monitoring and ensuring the quality of information about physical healthcare. The trust had also identified a need to improve the focus on physical healthcare and had appointed physical healthcare leads in each of the boroughs.
- Staff participated in a variety of audits across the services. For example, in the Haringey complex care team, staff in the PTSD stream had conducted an audit of why patients dropped out of treatment in order to determine whether action could be taken to support the completion of therapy. The outcome of the audit identified social issues such as housing as being reasons

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for patients dropping out of treatment. Other audits that took place across the teams included audits of care records including care plans and risk assessments and there had been an audit of staff supervision in Barnet.

Skilled staff to deliver care

- Staff across a wide range of disciplines worked with the community mental health teams in the trust. As well as doctors and nurses, the teams included clinical psychologists, social workers, occupational therapists, recovery support workers, employment support workers and dual diagnosis workers.
- All staff received an induction into the team and the trust. Locum staff received local inductions. This provided them with the key information and access to policies to work effectively within their roles.
- At our previous inspection in December 2015, staff were not all receiving regular supervision. This was not the case at this inspection. We saw significant improvement in this area. Team managers tracked when staff had both clinical and managerial supervision to ensure that this was carried out. Supervision was used to ensure that information was shared with staff and that they were also supported in their roles. Some teams accessed group supervision or reflective practice groups in addition to individual supervision. However, the records in Haringey West CSRT showed that not all staff had had access to regular supervision on a monthly basis over the six months prior to the inspection and some staff members in the team told us that they had not had access to regular supervision. Records showed that one member of staff who had started in the team in August 2017, had not had any recorded supervision at the time of our inspection and another member of staff who started in the team in May 2017, had only had supervision once, in May 2017. Both of these members of staff were locums. There were also two other members of staff who had not had more than two supervision meetings since March 2017 when there was an expectation within the team that this would take place monthly. This meant that there was a risk that these members of staff were not receiving sufficient support and oversight to ensure that they were providing the best quality of care to patients in the team. There was also a risk that information was not being shared and that staff were not being given the opportunity to reflect on their work in order to develop their practice.
- Staff across the service told us about opportunities to access specialist training. For example, some staff had access to specialist training around working with people with personality disorders and cognitive behavioural therapy. In Haringey West, some members of the team had been given opportunities to develop their careers in the trust as one member of staff had been seconded for a social work course and another member of staff had been supported to undertake training as a CBT therapist. In the Haringey complex care team staff had undertaken training around working in groups and the open dialogue model. However, team managers did not routinely record the specialist training which staff had undertaken and some training, for example, around autism in Barnet, was accessed through the local authority but the team managers were not able to identify who had completed this training.
- Managers told us that they were supported to address poor performance speedily.

Multi-disciplinary and inter-agency team work

- All the teams we visited had regular multi-disciplinary team meetings where issues related to patients were discussed. Most teams had weekly clinical team meetings with separate management or clinical governance meetings but some teams combined them to one meeting. In Haringey East CSRT, the team met daily to update risk information relating to specific patients. We attended two multi-disciplinary meetings within the services during our inspection and saw that staff discussed individual patients' needs and allocation during these meetings. In one team where there was no approved mental health professional (AMHP) based in the team, an AMHP from the relevant local authority attended the team meeting.
- In Haringey West CSRT, some staff told us that there had been difficulties in the timeliness of Mental Health Act Assessments after they had been requested. We asked the trust for information regarding all the incidents which had been logged in the six months prior to the

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inspection which related to delays in MHA assessments due to the lack of availability of AMHPs. There had been one incident reported where the AMHP reported that they had late notice of the planned assessment.

- Staff in the teams we visited reported to us that they had good working relationships with other teams within the organisation, including crisis resolution and home treatment teams, ward teams, early intervention services and other specialist teams in the borough. However, in Haringey, some staff told us that there were occasionally difficulties in working with the crisis resolution and home treatment team due to their capacity and they felt that some patients needed more support than the team were able to offer due to their acuity levels. Staff from the link work teams (in Barnet) and assessment teams (in Enfield and Haringey) regularly attended meetings with other community mental health teams and other team members attended their meetings to ensure that information was shared. CSRTs also worked with discharge intervention teams when patients were admitted to inpatient wards following a relapse in their mental state. Staff from the community worked with this team to provide a planned exit pathway from the wards.
- Community mental health teams had good working relationships with teams external to the trust. This included local authorities safeguarding teams, police and housing teams including housing associations, which provided supported accommodation.
- Social workers within the teams we visited were predominantly seconded into the trust from the local authorities. As the trust employed few social workers directly, they worked with the local authorities who employed social workers to ensure that these staff in the services were supported. There had been a social work lead in the trust but at the time of our visit, this post was vacant.

Adherence to the Mental Health Act and the Mental Health Act Code of Practice

- Most staff we spoke with had a good understanding of the Mental Health Act (MHA) and the Mental Health Act Code of Practice and how it impacted on their work in the community. Some community teams had approved mental health professionals (AMHPs) based within the team who were also social workers. In Haringey, staff raised concerns about the numbers of AMHPs in the local authority area and told us that this had an impact on the amount of time it took to access a Mental Health Act assessment for people in the borough. The trust did not directly employ any AMHPs as they were seconded from the local authority.
- Staff had access to administrative support and legal advice related to the Mental Health Act and the Mental Health Act Code of Practice. Staff were aware of how to contact local Mental Health Act administrators or the central MHA team in the trust for advice.
- The Mental Health Act administrators worked with local community teams to ensure that reminders were sent out relating to patients who were subject to community treatment orders (CTO) about their right to appeal if they wished to.
- We checked some CTO records in the services we visited. Team managers had access to information related to how many patients in their teams were subject to CTOs. We saw that the relevant paperwork, which was required, was held in the community teams and had been uploaded to the electronic database system.
- However, we checked records of three patients who were restricted under the Ministry of Justice and had access to a social supervisor who is a member of staff in the community who has oversight of patients who are restricted and reports back to the Ministry of Justice quarterly. We saw that for two patients in Haringey West and one patient in Enfield West, the allocated social supervisors had not seen the patients with the frequency determined in their care plans. The Ministry of Justice Guidance for Social Supervisors states that patients subject to these restrictions should be seen a minimum of once a month by their social supervisors. In the three cases we reviewed this was not happening and there was no oversight in the teams of the frequency that social supervisors were seeing patients who were subject to restrictions.
- Staff were aware that patients who were subject to CTOs had access to advocates and ensured that patients had the relevant information relating to this.

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- Care plans across the teams did not consistently identify clearly where patients were subject to funding through s117 aftercare arrangements.

Good practice in applying the Mental Capacity Act

- Training related to the Mental Capacity Act was not mandatory in the trust. However, most of the staff we spoke with told us that they had accessed training. Training on the Mental Capacity Act was also included in staff inductions.
- Staff were aware of the principles of the Mental Capacity Act and they were aware of how to seek advice if they required additional information. The trust policy relating to the Mental Capacity Act was available on the trust intranet.
- We saw some care records where there had been assessments of capacity documented. However, these were documents in patients' progress notes rather than specifically in a Mental Capacity Act section of the electronic records as reflected in the trust policy. We saw one example of a record in Barnet East and one record in Haringey West where capacity assessments had been made but it was not clearly documented in the records how the decisions had been made and what decisions had been made in the best interests of the patient involved. This showed that some of the recording relating to the Mental Capacity Act was not sufficiently clear to establish the outcome of the assessments.

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

- Most patients and carers that we spoke with were positive about the services provided by community services. Prior to the inspection, we attended focus groups with people who used services and we received some feedback directly, which raised some specific concerns about people's individual experiences. For example, two patients we spoke with who were supported by the Haringey complex care team told us that while they were positive about the service they received, they had had to wait considerable amount of time for treatment to start.
- We observed two home visits in Barnet and Haringey services. Throughout these visits, we observed that staff were respectful when speaking with patients and provided support, assurance and guidance where needed. We went on one visit specifically with the intensive reablement team in Barnet and saw that the work they did was focussed on recovery.
- Most staff we spoke with discussed patients with respect and compassion. We observed that the focus of the teams was on patient-centred work and reflected the trust values.
- Staff in the services showed a good understanding of the needs of individual patients and were able to give examples of how they supported the diverse communities that they worked with. However, some staff in Enfield told us that they thought they would be able to improve how they worked with different communities in the borough as it had not been something that had been significantly prioritised.
- Staff across the teams told us that they felt comfortable raising concerns about disrespectful or discriminatory behaviour if they saw it.
- Staff had a good understanding of confidentiality. Records were held securely.
- Staff in two of the Barnet teams and in Haringey West CSRT told us that there had been periods where there had been high turnover of staff and patients had been allocated locum care coordinators after short periods. This meant that there was a risk that patients would not be enabled to build longer term relationships with patients.

Involvement in care

Involvement of patients

- Some patients told us that they were aware of their care plans but others told us that they did not feel involved. For example, in Barnet, we checked ten care records and there was some evidence of involvement of patients in the records. We spoke with six patients, three of the six patients knew they had care plans and two of these said they felt their care plans reflected their views. In Enfield we spoke with nine patients, two patients told us that they were aware of their care plans. However, we saw seven records and while in some of the care plans there was a reflection of the patient voice, three of the records did not reflect the views of the patients in the team.
- In Haringey we looked at seven care plans. The care plans we saw did not show patient involvement in care planning. One patient had a care plan which had not been updated since they had left the inpatient ward which was one month prior to the inspection visit. Another patient had been known to the team for around 6 weeks and had not had an updated care plan since 2013. This meant that we could not be assured that patients were actively involved in their care planning and that information which was important to them was included in their care plans.
- In the records, advanced decisions had not been documented but staff were aware that they could actively involve patients in advance decisions.

Involvement of families and carers

- The feedback from carers and families was mixed. Most carers were positive about the service and the information that they received from staff. One carer in Haringey, whose partner had been referred to the Haringey West CSRT, told us that they had not been given any information about their care.

Good

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- In Enfield there was a monthly carers' forum and the early intervention service in Enfield had its own separate forum for carers of patients within that service. This EIS carers' forum was held out of working hours to encourage participation.
- Staff across all the services we visited told us that they were encouraged to offer carers assessments where they were required and this was a target, which was monitored by the local and central governance teams in the monthly governance meetings. However, the data for Haringey West CSRT showed the team had consistently failed to achieve the trust target of 80% of carers being offered a carers' assessment. The figure for 2017/8 was 60% at the time of our inspection in September 2017. This meant that there was a risk that some people providing significant support to those who required the service of the team may not be getting the information, support and advice they need to care more effectively.
- Information was displayed in reception areas about how carers could access support.

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

Access and waiting times

- Most referrals came into community mental health teams from GPs although referrals were also taken from inpatient wards, crisis teams and other referrers. Referrals into the services were screened and triaged either by assessment teams (in Enfield and Haringey) or the link worker team (in Barnet) who were based in GP surgeries. These teams could also signpost people who needed different support to other more appropriate services such as the increasing access to psychological therapies (IAPT) teams in each borough. Different teams held small waiting lists to access treatment. However, staff in the Haringey complex care team told us that due to the specialist nature of some of the work they did, they found managing the waiting lists to be the biggest challenge for the team. They explained that there had been an increase in referrals to the team with no increase in the size of the team. Within this team, the target for assessment was within three months but the waiting time at the time of the inspection was four months. However, staff monitored this waiting list and ran groups for patients who were on the waiting list. Not all patients on the waiting list would be able to access these groups. Other teams had different ways of managing patients on the waiting list by ensuring that risk was assessed and managed. In Haringey West CSRT, there was a waiting list of 20 which had 9 patients who had been previously care coordinated but their care coordinator had left and they were awaiting allocation. The early intervention service in Enfield did not have a waiting list and assessed and started treatment where necessary, with new patients accessing the service within two weeks of referral. This meant that they were meeting the specific targets which had been established specifically for early intervention services.

- The provider had a target of 8 to 10 weeks from referral to treatment for the community support and recovery teams and the locality teams in Barnet. This included a target of two weeks for link workers or assessment teams to conduct an assessment and then refer to community mental health services. Referrals that took 11-13 weeks were rated amber and referrals over 13 weeks were rated red. We were sent information prior to the inspection about referral to treatment and assessment to treatment times in the trust.All the teams we visited met the target of being assessed within 13 weeks of their referral. There were no specific targets for the time between being assessed to having access to treatment. Of the teams we visited, the teams with the highest wait between assessment and treatment were Enfield recovery and enablement (RET) West team with 22 days. These patients would be referred from the CSRT so would be supported in the time which they were waiting for treatment. The Barnet East locality team had a waiting time for 14 days.

- For psychology treatment, the average waiting times from referral to assessment were 79 days in Barnet, 71 days in Enfield and 84 days in Haringey. The period from assessment to treatment was 5 months in Barnet, 11 months in Enfield and 8 months in Haringey. During this time patients were offered access to groups led by psychologists. They were also supported by care co-ordinators some of whom had received training in providing psychological therapeutic approaches.

- Community mental health services worked with duty systems so that a member of staff was allocated to ensure that someone was always available to deal with emergencies or unforeseen circumstances such as covering for other members of staff who were unavailable.

- At our previous inspection in December 2015, staff did not follow the trust policy for patients who did not attend (DNA) appointments. At this inspection, we saw some improvement. The trust had refreshed its policy in relation to patients who did not attend appointments. Staff in most teams followed up patients who did not attend appointments by contacting them on the telephone, sending letters or reminders and leaving notes for home appointments. Some staff told us that they would also visit patients at home if they were concerned. If patients forgot appointments, staff offered other appointments and if patients continued to fail to attend, this was discussed in team meetings. However, the trust DNA policy included an audit which was to be discussed in local governance meetings. We did not see evidence that this had been consistently discussed in governance meetings in local teams. We also saw little evidence in progress notes across the teams that

Are services responsive to people's needs?

Good

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showed the policy had been followed in terms of the steps taken when a patient did not attend an arranged appointment or a care coordinator visited a patient at home.

- The trust measured the proportion of appointments that patients did not attend. The DNA rates were highest in Barnet South (12.3%), Enfield East CSRT (11.9%) and Haringey West CSRT and Barnet East locality team (9.6%).
- Patients and carers told us that appointments usually ran on time and that they were usually informed if there were delays. Teams were also able to be flexible, for example, if a patient was working or had specific childcare arrangements, which needed to be considered.

The facilities promote recovery, comfort, dignity and confidentiality

- All the sites we visited had a range of rooms and equipment to support care and treatment. Patients had access to waiting areas which had adequate seating. Interview and therapy rooms were available and had adequate sound-proofing.
- In the reception areas, leaflets and information about services and local community groups were available. This included information about how to make complaints and some teams also had information about advocacy available. Different formats for information, for example, in different languages or in easy read format, was available in some teams but in all areas, this was available on request.

Meeting the needs of all people who use the service

- Across the three boroughs, we saw examples of services being tailored to meet the specific needs of local communities. For example, in Barnet, the psychology service offered a PTSD group which was attended by a Farsi interpreter to ensure that patients who had Farsi as a first language had access to this. The complex care team in Haringey had PTSD groups for Turkish speaking patients.
- Staff across the services told us how they worked with local community groups to better engage people from the diverse communities in the boroughs; this included a local Jewish group in Barnet and local Chinese, Caribbean and Romanian community centres in Haringey. The Haringey complex care team had had a recent open day for family, friends and patients using the PTSD stream involving Turkish, Farsi and Tamil interpreters in order to make the event more inclusive.
- Staff told us that they were able to book interpreters when needed and were able to give examples of when they had used interpreting services for initial assessments but also for ongoing work, when necessary.
- In all the services we visited, there were ground floor rooms available for patients with mobility difficulties. Staff in the community team were able to visit patients at home when necessary.
- The service did not record staff having specific training in working with people with autism. One member of staff in the Haringey West CSRT told us that they would not need this training because people with autism would not come into this service. This meant that there was a risk that an adult with autism and a mental illness may not receive the care and treatment that is best suited to their needs if staff did not have an understanding of their additional needs.

Listening to and learning from concerns and complaints

- Staff were familiar with trust procedures in managing and documenting complaints. Complaints were copied to the patient experience team who would record both formal and informal complaints and these appeared on the monthly 'heat' maps which managers had access to and shared with the team during team meetings.
- Staff told us that they received feedback about complaints and the investigations . This was discussed in local clinical governance meetings at team level or at borough level.
- We spoke with two patients who had made complaints in Barnet. They told us that they were both satisfied with the way the complaint had been managed and that they had been provided with feedback following their complaints.

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- Between 1 April 2016 and 31 March 2017, the community-based mental health services for adults of working age received 72 complaints. The most complaints came from the Haringey complex care Team with 13 complaints. The most common themes around complaints were all aspects of clinical care 32, communication/information to patient (written and oral) 18, and appointments (delay or cancellation) with eight. In the same time period the trust received 91 compliments. The Enfield early intervention service received the most compliments with 34.

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Our findings

Leadership

- Most staff were positive about leadership within their teams and in relation to the local borough leadership. All managers were able to articulate how their services operated and how they sought to promote better care for patients. However, across the Haringey teams, members of staff in the three teams we visited raised some concerns about bullying and not feeling able to speak out when they had concerns.
- Most staff felt able to access senior managers in the trust and were aware of the leadership teams within their own boroughs. While staff were mostly complimentary about service managers and more senior leaders in the trust, a small number of staff felt senior managers were not always supportive and that the transformation process had not been communicated well.
- During our last inspection in December 2015, in Haringey East CSRT staff said that they had raised concerns to their manager over a number of months but these concerns had only been flagged on the team risk register in the months leading up to the inspection. At this inspection, we found that managers across the service had some understanding of the key risk areas in their teams. However, we identified concerns in the documentation of care plans and management of risk in the Haringey West CSRT and although this had been reflected in some of the audit tools which had been collated through the year, there had not been action taken through the local or trust wide governance process. This meant that there was a risk that governance structures in place in Haringey may have identified some of the concerns within the team but had not taken clear action to address them.
- Staff within the service told us that they had access to leadership development opportunities. The trust had developed a programme for leadership development which included new managers having a 'passport', which documented their learning and development. This was a programme developed through the University College London Partnership, which involved a number of trusts. There were also some initiatives at a local level. For example, in Haringey, there had been a number of local management development training sessions which had looked at key areas such as change management.

Vision and strategy

- Staff across the boroughs were able to articulate the trust focus on recovery and reablement and many were aware of the enablement approach, which the trust had been focussing on. The trust had undertaken a 'refresh' of trust values and had rolled out training reflecting the trust values to local teams, which meant there was good awareness in the community services. Staff were committed to providing best quality care to patients who used the services and promoting recovery in general and this reflected the trust values.
- We received mixed feedback about opportunities to contribute to discussions about the strategy for their services. For example, workforce officers met with managers for the transformation process. However, some staff felt the trust did not communicate this well. Despite this, staff had opportunities to contribute ideas. For example, at Barnet South, the manager had developed a project in relation to goal orientation and encouraging patients to be more independent and resilient.
- Managers could explain how they were working to deliver high quality care within budgets available. The transformation process was developed to make services more cost effective and moving away from diagnosis to more location based services. Managers attended budget meetings on a quarterly basis to review staffing expenditure.

Culture

- Most teams reflected that they felt the team working was strong. They felt listened to and promoted good relations within the team. However, five members of staff across the teams raised concerns about bullying within the organisation. Some staff in Haringey told us that they did not feel able to speak out about their concerns without this having an impact on their career and they told us that they did not feel the service had an open culture and that they would be comfortable raising concerns.

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- However, we also spoke with many staff who felt that they would be comfortable to speak up and knew about the trust's whistleblowing process or freedom to speak up guardians. Most staff told us that they felt comfortable raising concerns with their managers.
- The consultant for the Haringey complex care team was the suicide lead for the trust and ran a support group for psychiatrists whose patients had died following a suicide. Team managers were very aware of the emotional needs of staff and were proactive in addressing them.
- Staff had access to a trust wide occupational health scheme. We spoke with a member of staff who had accessed this service following a period of time of sickness and they had found the service and their manager, very supportive.
- Staff were aware of recognition awards within the trust. Some staff referred to other initiatives such as the 'Dragon's Den' where senior board members judged ideas which were presented from staff across the trust and were aware that they could participate in this. Some teams had been involved in specific quality improvement initiatives and told us that they had received recognition related to these at trust wide quality improvement events, which was motivating.

Governance

- The community teams for adults of working age were divided into three borough structures for the governance processes. There were also some differences between the boroughs in how the governance processes were adopted and used. We saw that all the teams had regular team meetings. However, even within the same boroughs, some of these meetings were used in different ways. For example, in Haringey West CSRT, the team had a weekly clinical meeting where risk issues relating to individuals were discussed. While most teams we visited had a standard meeting agenda where incidents, complaints and team performance and data was discussed, this was not the case in Haringey West CSRT. These meetings had not been recorded regularly so it was not clear to see how learning from incidents was implemented. However, we saw in the Barnet and Enfield teams that regular clinical governance and business meetings took place which was separate from the clinical meetings where specific patients were discussed. This meant that information which related to the operation of the team and its' performance had a space to be discussed with all team members.
- As well as team meetings, there were local governance meetings for the three boroughs, which were held monthly. These meetings discussed incidents, complaints and performance. This meant that the senior management teams within the boroughs were able to have oversight of the key issues on a team level. Each borough also had six monthly 'deep dive' meetings where performance data was discussed in greater detail. We looked at some of the recent deep dive minutes from Barnet, Enfield and Haringey. We saw that performance data, incidents, risk registers and ongoing action plans were discussed in detail.
- Staff throughout the teams were aware of local incidents and some staff were able to talk about how learning from incidents had been implemented. However, we saw some examples of where incidents had taken place in teams and the action plans following those incidents did not appear to have been followed through. For example, in Barnet East team, there had been an incident where one of the learning points presented by staff was that they would like training around the management of patients who had Asperger's syndrome. This was documented in the team meeting minutes that we saw in May and June 2017. The team manager told us the CCG had funded a specialist with knowledge of working with people with autism; however, this had not addressed the wish of staff to access training as well. It was not clear when this outcome would be met.
- In Haringey West CSRT, we looked at a review of a serious incident, which had occurred in February 2017, and the incident review had been completed with recommendations in June 2017. This had included a recommendation that the outcome of MDT meetings should be recorded. The team manager told us that this had included the need for an administrative member of staff being available to minute the MDT meeting. However, the meetings were not recorded until September 2017. The action plans relating to specific incidents were not specifically recorded in the governance meetings. This meant that there were some local examples of incidents, which had not led to

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improved practice and there was the risk that some learning from incidents may be lost without more robust systems in place to track the learning and ensure it was implemented in a timely manner. There was no evidence that these recommendations had been followed up in wider clinical governance teams locally at the community or borough level. This meant that there were gaps in the governance systems.

- All the boroughs we visited told us that staff had the opportunity to take part in clinical audits. This included participating in the variety of audits that each team was obliged to take part in.

Management of risk, issues and performance

- At our inspection in December 2015, the trust had not ensured that all teams had local risk registers, which were up to date so risks could be escalated when needed. At this inspection all teams had a local risk register as well as having input into the borough risk registers. For most of the teams, the local risk registers reflected the key concerns identified by staff during the inspection visit. Staff were aware of how information was added to and removed from the local and borough wide risk registers.
- All services had access to robust contingency plans, which ensured that there were procedures in place in case of an unforeseen emergency, for example, if there were a failure of electricity in a building used by a team. The trust had a major incident and emergency preparedness plan, which had been updated in 2016.
- Staff were aware of the constraints on their services on the basis of cost improvement plans. In Haringey, we were told that there was a significant impact on the quality of care based on the lack of access to sufficient AMHPs.
- Managers could review dashboards at any time to review caseloads and outstanding performance indicators. Business performance managers updated managers twice a month on breaches in performance. Administrative staff in Haringey also sent reminders to the team individually about performance indicators to ensure they were met. The main key performance indicators monitored by the services were around updated risk information, CPA reviews, outcome measures being documented, service user feedback and incident reporting. However, it was not always clear how this information was being used. For example, in Haringey West and Haringey East CSRT where the 'heat' maps identified that targets were not being met consistently; we did not see this discussed in the relevant governance meetings in the Haringey Community services or the borough wide governance meetings. For example, the 'heat' maps showed that there were higher numbers of incidents in the Haringey CSRT East than Haringey CSRT West with one team having 39 (Haringey East) and the other 13 (Haringey West) in the same period between May 2017 and July 2017. The governance meetings did not interrogate the possible reasons for this discrepancy and while there was a discussion of incidents that happened, this meant that there may be a lack of discussion about incidents, which may have not been reported.

Information management

- Each team had a local heat map which reflected the key performance data relevant to the team. This included family and friends' data, feedback from audits which took place within the teams on a monthly basis, for example, relating to care plans being up to date and reflecting patients' views and risk assessments being up to date. Managers also received information about numbers of incidents reported and numbers of complaints made. Every month, each borough reported to an incident review meeting which looked at incidents across all services within the respective borough.
- Early intervention services across the three boroughs had separate steering group meetings across the trust which ensured that information was shared between the three teams directly.
- Staff had access to equipment and information technology needed to do their work. Most staff we spoke with were satisfied although some told us that there were sometimes difficulties in accessing information on the electronic databases.
- Staff had a good understanding of involving and notifying external bodies when necessary such as reporting to the local authority or commissioners as necessary.
- Information governance training was included in the trusts' mandatory training. Staff across all the teams displayed an awareness of the importance of maintaining confidentiality in respect to patient records.

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Engagement

- Staff told us how they were aware of different initiatives and news within the trust. This included local bulletins in Barnet and access to the trust intranet site across the teams. Most staff we spoke with were very happy working for the trust and felt engaged with the management.
- Patients and carers had opportunities to provide feedback about the service through the use of surveys including friends and family tests as well as feedback boxes in some of the waiting areas in community teams.
- Feedback from families and friends tests were updated on the teams' monthly 'heat maps'. This information was then discussed at most of the local team meetings and at the borough wide governance meetings.
- Senior staff in Enfield told us that service users had engaged in the reconfiguration as Healthwatch representatives had been invited to the meetings relating to changes in the service. However, most patients and carers that we spoke with told us that they had not felt that there was extensive engagement about the plans to change community services. Some patients in Enfield and Haringey were not clear how the changes would affect them and were not sure how to feed information back about this.
- Senior managers within the trusts worked closely with local authorities, commissioners and patient representative groups such as Healthwatch to ensure information was shared.

Learning, continuous improvement and innovation

- The trust was implementing a number of quality improvement initiatives in the teams we visited.
- In the Enfield early intervention service, the team had put together a recovery event in January 2017 which had been co-produced with people who used the service and involved a number of presentations by EIS and service users to help people coming into the service understand about it and to promote hope for those newly admitted into the service. This event was held at a weekend to ensure maximum attendance from service users and carers.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The trust was not ensuring that care and treatment were provided in a safe way for service users because the service was not assessing the risks to health and safety of service users of receiving the care or treatment and doing all that is reasonably practicable to mitigate any risks. This was because risk information was not being consistently updated to reflect current risk in care records in Haringey West CSRT. Where risk management plans were established, they were not being following including the frequency by which restricted patients needed to meet with their social supervisors. Staff were not ensuring that all information about physical health needs including updates from GPs were included in electronic records and where GPs had not responded to requests for information and this had not been received, there were no consistent ways of chasing this up to ensure the teams had done all they could to mitigate risk due to physical health concerns and assure themselves they were aware of the current issues. This is a breach of regulation 12 (1) (2) (a) (b)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care The trust had not ensured that service users care and treatment reflected their preferences. This was because some records in Haringey and Enfield did not have up to date care plans reflecting the service user voice and some of the care plans we looked at were

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Requirement notices

not holistic and had a very narrow focus on clinician priority. This was also reflected in feedback from service users we spoke with. This meant that service user voice was not sufficiently embedded to ensure that preferences were taken into account.

This is a breach of regulation 9 (1) (c)

Regulated activity

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

Diagnostic and screening procedures

Treatment of disease, disorder or injury

Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance

The trust had not ensured that in the Haringey community services, the local management team were ensuring that they were assessing, monitoring and improving the quality and safety of services provided in carrying on the regulated activity and that they were not working actively within systems in place in the governance structures to mitigate risk to the health, welfare and safety of service users and others who may be at risk that arises from the carrying on of a regulated activity.

This was because staff in the Haringey West CSRT had not had regular supervision and team meetings, which had been happening, had not been consistently documented and recorded. The minutes did not reflect discussion about performance was taking place and that there was sufficient information about learning from incidents across the service, borough and trust. An incident review had recommended that these minutes were documented from June and this had not taken place. This meant that there was a risk that there were not sufficient safeguards in place to ensure that where there was learning from incidents, audits and complaints, that this was followed up by changes and improvements in practice.

This is a breach of regulation 17 (1) (2) (a) (b)