Camden and Islington NHS Foundation Trust

Adult community-based services

Quality Report

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Locations inspected

Name of CQC registered location	Location ID	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
St Pancras Hospital	TAF01	Mental Health Assessment and Advice Team	NW1 0AS
St Pancras Hospital	TAF01	Complex Depression, Anxiety and Trauma Team	WC1X 9DN
Highgate Mental Health Centre	TAF72	Personality Disorder Service	N19 5JG
Highgate Mental Health Centre	TAF72	North Islington Rehabilitation and Recovery Team	N7 8US
St Pancras Hospital	TAF01	South Camden Rehabilitation and Recovery Team	NW5 2TX

This report describes our judgement of the quality of care provided within this core service by Camden and Islington NHS Foundation Trust. Where relevant we provide detail of each location or area of service visited.

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

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

Summary of findings

Ratings

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

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

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

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

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

Summary of findings

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Summary of findings

Overall summary

Camden and Islington NHS Foundation Trust adult community-based services provide assessments and support services for adults coming into contact with mental health services for the first time. They also provide services for people who have complex depression, anxiety, trauma and personality disorder needs and require longer term support.

The adult community-based services provided a good service. There was visible leadership in all the services we visited and the staff had a clear sense of the vision of the service and how this was going to be achieved. There were also good systems in place for supporting staff, for example through individual and group supervision sessions, team meetings and daily briefings.

We saw good use of best practice and clinical guidelines in both the personality disorder and complex depression, anxiety and trauma services. This meant that people received a service that was supported by evidence and research. People who use the service felt that the staff understood their needs and worked together with them. Staff and people valued having a service user representative employed by the trust, although this role was only present in the personality disorder services.

There were a number of areas where the service should make improvements. This included training staff in areas relevant to their work, such as the Mental Capacity Act 2005 or training to support people whose behaviour is challenging, or when to use physical interventions.

Summary of findings

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

Are services safe?

There were systems for reporting incidents and learning lessons from these to prevent them from happening again. Risks to people were identified through assessments, as well as the ongoing monitoring and review of people and risk management plans.

Staff had been trained in safeguarding and responded appropriately to any concerns raised.

Are services effective?

Full assessments of people first entering mental health services were carried out, and both the internal and external professionals worked well together. People had access to a range of therapies that were in accordance with best practice, national guidelines and benchmarking of services.

There were a high number of staff vacancies that were being recruited to, and that were currently being covered by locum staff. Permanent staff received mandatory training and ongoing training linked to their continuing professional development.

Some staff were not aware of their responsibilities under the Mental Capacity Act 2005.

Are services caring?

People felt listened to and respected by the staff. They felt fully involved in their support and worked with staff to ensure that the treatment they received was what they wanted and needed. This was reflected in the care plans, which were individualised for each person.

Are services responsive to people's needs?

People were able to access services across a number of different community sites. They also received a service that was individualised and suited their needs. Complaints were taken seriously, investigated and responded to promptly, and staff learned from complaints.

Waiting times were measured to monitor the responsiveness of the services. There were also programmes of support for people waiting for therapy services. However, we did find a couple of people who had waited much longer than the target time for an appointment for a full assessment.

Summary of findings

Are services well-led?

Leadership of the adult community-based services were effective. There were also systems in place to capture information and report this to the trust's senior managers. The staff were committed to their work and aware of the future plans of the service, and of the trust, and they understood where they fitted into this.

People who use the service had opportunities to be involved although some people were not aware of the service user engagement initiatives.

Summary of findings

Background to the service

Camden and Islington NHS Foundation Trust is the largest provider of mental health and substance misuse services to residents in the London boroughs of Camden and Islington. They also provide substance misuse services in Westminster and substance and psychological therapies services in Kingston-upon-Thames.

Services are provided to adults of working age, adults with learning disabilities and to older people.

The trust has three registered locations. These are their two main inpatient facilities at the Highgate Mental Health Centre and St Pancras Hospital. They have also registered a nursing home for older people at Stacey Street. The trust provides community-based services throughout the boroughs of Camden and Islington. Those located in Camden fall under the registration at St Pancras and those in Islington fall under the registration at the Highgate Mental Health Centre.

The people who use the services provided by the trust come from diverse ethnic and social backgrounds encompassing the extremes of wealthy and deprived areas. They also serve a large immigrant population speaking over 290 languages and a transient population of young adults.

The trust works with partner agencies and the voluntary sector to provide a range of services. The services are delivered through five divisions:

- Acute division.
- Rehabilitation and recovery division (psychosis services).
- Community mental health division (non-psychosis services).
- Services for ageing and mental health division.
- Substance misuse division.

Camden and Islington NHS Foundation Trust has been inspected on nine occasions. At the time of this comprehensive inspection there was non-compliance at two locations. Stacey Street Nursing Home was non-compliant with outcome 9: management of medicines. St Pancras Hospital was non-compliant with outcome 2: consent to care and treatment and outcome 4: care and welfare. We followed-up this non-compliance as part of our inspection and found the trust had made the necessary improvements.

Camden and Islington NHS Foundation Trust adult community-based services provide assessments and support services for adults coming into contact with mental health services for the first time. They also provide services for people who have complex depression, anxiety, trauma and personality disorder needs and require longer term support.

The adult community-based services were based throughout the boroughs of Camden and Islington. In addition to the services we inspected, the trust also provides a wide range of community based services. These include outreach services, early intervention services, crisis services and services to older people, of which some will be included in other core service reports.

During 2012 to 2013, mental health services in Camden and Islington had a major reconfiguration, moving from community mental health teams to more specialised teams. A mental health assessment and advice team was also introduced. This acts as a single point of entry for all new mental health referrals in the two boroughs. The reconfiguration also resulted in the separation of services for people diagnosed with psychosis and those without psychosis.

People with psychosis are supported through the rehabilitation and recovery teams. We visited the North Islington and South Camden rehabilitation and recovery teams during our inspection.

People without psychosis receive support from the personality disorder service and the complex depression, anxiety and trauma service. We visited both of these teams during this inspection.

Our inspection team

Our inspection team was led by:

Chair: Dr Steve Colgan, Medical Director, Greater Manchester West NHS Foundation Trust

Summary of findings

Team Leader: Jane Ray, Care Quality Commission (CQC)

The team of 35 people included: CQC inspectors, Mental Health Act commissioners, a pharmacist inspector and two analysts. We also had a variety of specialist advisors which included consultant psychiatrists, psychologists, senior nurses, junior doctors and social workers.

We were additionally supported by four Experts by Experience who have personal experience of using or caring for someone who uses the type of services we were inspecting.

Why we carried out this inspection

We inspected this core service as part of our comprehensive Wave 2 pilot mental health inspection programme. This trust was selected to enable CQC to test and evaluate its methodology across a range of different trusts.

How we carried out this inspection

To get to the heart of people who use services' experiences of care, 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?

The inspection team always inspects the following core services at each inspection:

- Acute admission wards.
- Health-based places of safety.
- Psychiatric Intensive Care Units (PICUs)
- Services for older people.
- Adult community-based services.
- Community-based crisis services.

We visited the adult community-based services of Camden and Islington NHS Foundation Trust from 27 to 30 May 2014. Before visiting, we reviewed a range of information we hold about the provider and asked other organisations to share what they knew about the provider.

Before our inspection, we met with five different groups of people who use the services. We also met with two carers groups from the two boroughs of Camden and Islington. They shared their views and experiences of receiving services from the provider.

We visited both the hospital locations and the nursing home, and inspected all the acute inpatient services and crisis teams for adults of working age. We also visited the psychiatric intensive care unit at the Highgate Centre and went to two of the three places of safety. These are located in the accident and emergency (A&E) departments at University College Hospital and the Whittington Hospital. In addition, we inspected the inpatient and some community services for older people, as well as a sample of the community teams.

During our visit the team:

- Held focus groups with different staff members such as nurses, student nurses and healthcare assistants, senior and junior doctors, allied health professionals and governors.
- Talked with patients, carers, family members and staff.
- Looked at the personal care or treatment records of a sample of patients.
- Observed how staff were caring for people.
- Interviewed staff members.
- Reviewed information we had asked the trust to provide.
- Attended multidisciplinary team meetings.
- Collected feedback using comment cards.

Summary of findings

The team would like to thank all those who met and spoke to inspectors during the inspection and were open and balanced with the sharing of their experiences and their perceptions of the quality of care and treatment at the trust.

What people who use the provider's services say

We spoke with people who use the service, and their relatives or carers. Most people we spoke with were positive about their experience of using the community services. However, some people said that they did not feel well supported during the reconfiguration, and some were still upset about this. People did tell us that improvements had been made since then and that they were receiving a service that met their needs. However, some were worried that services would be withdrawn "like they were before".

People felt that the staff were kind and supportive, and that they worked with them to identify their needs and support their goals. Some people said they would like to be involved in the trust more, but did not know how to do this in a way that meant something to them. In addition, some carers felt that there were variations in the knowledge, skills and experience of the staff who were supporting people.

Good practice

- There was visible leadership in all the services we visited and the staff had a clear sense of the vision of the service and how this would be achieved.
- We saw good use of the best practice and clinical guidelines in the personality disorder and complex depression, anxiety and trauma services. This meant that people received a service that was supported by evidence and research.
- Employing a service user representative was valued by staff and people who use the service, but this role was only present within the personality disorder services.

Areas for improvement

Action the provider MUST or SHOULD take to improve

Action the provider MUST take to improve

- The development of procedures, training and management to ensure the effective use of the Mental Capacity Act and Deprivation of Liberty Safeguards has started. However, this needs further development so that staff can use the legislation with confidence to protect people's human rights.

Summary of findings

Action the provider SHOULD take to improve

- The trust should ensure that staff have received training to support people whose behaviour is challenging, or when to use physical interventions. Staff and people who use the service could be put at risk if they do not know how to support someone appropriately when they are angry or distressed.

Detailed findings

Camden and Islington NHS Foundation Trust

Adult community-based services

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Mental Health Assessment and Advice Team	St Pancras Hospital
Complex Depression, Anxiety and Trauma Service	St Pancras Hospital
Personality Disorder Service	Highgate Mental Health Centre
North Islington Rehabilitation and Recovery Team	Highgate Mental Health Centre
South Camden Rehabilitation and Recovery Team	St Pancras Hospital

Mental Health Act responsibilities

In each of the community teams there was at least one Approved Mental Health Professional (AMPH) who was available to initiate an assessment under the Mental Health Act, if necessary. The AMPH within the team worked on a rota basis with other members of the AMPH team to ensure appropriate AMPH cover should an assessment be required.

Mental Capacity Act and Deprivation of Liberty Safeguards

The majority of staff we spoke with demonstrated a good understanding of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) and their responsibilities under this. However, staff we spoke with in the assessment and advice team did not convey a clear understanding of capacity within the MCA, and spoke about this only within the remit of the Mental Health Act.

We also found that in the assessment and advice team, unlike the other teams we visited, there was no Best Interest Assessor within the team to provide advice on capacity issues. In the other teams we found that capacity

Detailed findings

was assessed from first meeting the person, and there were records of capacity and best interest assessments having taken place for areas such as self-neglect, physical health issues and people's finances.

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

Summary of findings

There were systems for reporting incidents and learning lessons from these to prevent them from happening again. Risks to people were identified through assessments, as well as the ongoing monitoring and review of people and risk management plans.

Staff had been trained in safeguarding and responded appropriately to any concerns raised.

Our findings

Track record on safety

We were shown the electronic system used for the recording and reporting of incidents. The system ensured senior managers within the trust were alerted to incidents promptly and could monitor the investigation and response to these. The staff we spoke with gave us examples of incidents they had reported, and of significant incidents in other parts of the community services, demonstrating they were aware of these and of changes to practice made to prevent recurrence.

Staff told us about the trust directives of encouraging the reporting of incidents/abuse encountered, and they felt able to report incidents they would typically not have previously. Within the Personality Disorder service the staff told us they were establishing how to apply these thresholds.

Learning from incidents and improving safety standards

Within the community services we saw many examples that learning from incidents had taken place. For example, the assessment and advice team ensured that referrals to other organisations and voluntary services were followed up to so that people continued to receive support. The complex depression, anxiety and trauma (CDAT) service was carrying out work to ensure care plans were up-to-date and make improvements to the risk planning process. The personality disorder service (PD) had initiated extra safety measures when dealing with potentially risky situations, in response to an incident.

Throughout the community services we found that incidents were shared with teams during team meetings and through group and individual supervision sessions. 'Debriefing' sessions took place following an incident and staff spoke about using these to reflect on their own behaviour and learning needs in response to incidents, to learn from and prevent recurrence. Changes were monitored by the team manager and through team meetings.

Reliable systems, processes and practices to keep people safe and safeguarded from abuse

The community teams we visited consisted of trust staff and social workers who were seconded from the local authority of Camden or Islington. This meant that the teams could respond promptly to any safeguarding issues using a multidisciplinary approach. The staff we spoke with had a clear understanding of safeguarding and their responsibilities in relation to identifying and reporting safeguarding issues. Within the rehabilitation and recovery teams staff told us how they received safeguarding referrals from inpatient wards, and would initiate the alert and investigation of these. All the staff we spoke with knew who was the safeguarding lead for the trust and felt able to contact them for advice when needed.

During our visits to the community services we observed staff responding promptly to safeguarding concerns, such as the taking of referrals over the phone, recording these on the computerised systems and alerting relevant safeguarding teams. Similarly, we saw that meetings were arranged immediately with the team manager to discuss the safeguarding information, and strategy meetings planned for the following day with relevant external professionals invited.

The training records confirmed that staff had received training in safeguarding and that this was kept up-to-date. The two team managers in the assessment teams had been trained to Level 3 in safeguarding so they could help with investigations. Locum staff we spoke with said they did not receive formal safeguarding training from the trust but were coached and supervised through a buddy system with substantive staff.

Are services safe?

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

Within the community teams there was a lone working policy that staff were aware of, and buddy arrangements so that staff knew where other staff were when visiting people in their home. Each situation was risk assessed and joint visits of two professionals took place where necessary.

Assessing and monitoring safety and risk

Within the care records we saw that risks people presented to themselves and others had been assessed and reviewed regularly to ensure people received appropriate support. Risk management plans detailed the actions that were required to minimise the risk to the individual and any triggers/risk behaviours that people needed to be aware of, and strategies for coping with these. The staff told us that risks were reviewed each time they had contact with a person, and in case management meetings and Care Programme Approach (CPA) meetings, where people received this input. This ensured that the level of support and treatment people received was monitored and adapted to any changes in the person's mental health or social circumstances.

For people referred to the assessment team, an initial risk assessment was carried out and actions taken based on level of risk they presented with. The referrals were monitored and triaged by a senior practitioner to ensure that risks were prioritised and they had been invited for an assessment, or a referral made to the Approved Mental Health Professional Service (AMHPS), where they were at high risk of harm to themselves or others. All records of contact with the person were recorded in the computerised care records system (RiO), and monitoring of these by team managers took place through actions being recorded on a clinical dashboard, so that people referred to the service received timely treatment.

We asked staff about any training they had received in diffusing challenging situations and where needed the use of physical interventions to support people. Within the PD service the staff said they had been trained in 'high expressed emotion' to support people who were unsettled. However, in the other teams we received varied responses. Some staff said they had received training in breakaway techniques, de-escalation or control and restraint; whereas others said they had not received any training. The training records did not show that staff had received training in these areas, which could put them, and people who use the service at risk if they did not know how to support someone appropriately when they were angry or distressed.

Understanding and management of foreseeable risks

Across the teams the staff described each team's procedures for following up where people did not attend for appointments. These ranged from telephone contact, to home visits and sending of letters. They showed us how they recorded this, and the information sent to the person's GP to keep them informed.

Within the CDAT, PD and rehabilitation and recovery services there were systems for keeping in touch with people who had been referred for treatment and were on the waiting list. For example, within the CDAT team people were 'RAG rated' to ensure that people most in need were prioritised to receive the service, and regular contact was made by the Shared Allocation Team (SAT) with all people who did not require a care coordinator, whilst they awaited therapy. Within the recovery and rehabilitation services there was a 'first intervention team' who held new referrals and people who were due to step down from the service, so that contact was maintained with people whilst they waited for further support.

Within the assessment team they told us about how they identified risk where a number of doctors were due to be on study leave, and how they had managed appointments around this and made arrangements for medical support from other teams.

Are services effective?

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

Summary of findings

Full assessments of people first entering mental health services were carried out, and both the internal and external professionals worked well together. People had access to a range of therapies that were in accordance with best practice, national guidelines and benchmarking of services.

There were a high number of staff vacancies that were being recruited to, and that were currently being covered by locum staff. Permanent staff received mandatory training and ongoing training linked to their continuing professional development.

Some staff were not aware of their responsibilities under the Mental Capacity Act 2005.

Our findings

Assessment and delivery of care and treatment

The assessment team was the single point of access to all the community services. The team carried out the initial assessments of all people who had been referred to the service, and this was undertaken by two of the practitioners from the team. The team included mental health nurses, social workers and doctors, and was led by a consultant psychiatrist. All new referrals were triaged and assessed on the day they were received, and allocated to one of the team, according to the needs of the person and the specialism and caseload of the staff member. There were a number of sites throughout Camden and Islington where people could have their full assessment, and this was arranged when booking the appointment to make this more accessible for them.

Where a person was referred onto one of the other community teams or therapy services, the initial assessment was shared, which meant that people did not always have to repeat the same information at each assessment. Following each stage of the assessment people were provided with a detailed letter outlining the assessment outcome and of any further planned support and the plans for this, in accordance with their identified needs.

Any physical health or medical needs of the person was recorded as part of the assessment process, and staff demonstrated a clear knowledge of individual needs and how they could impact on people's mood and behaviour. There was evidence of good liaison with the person's GP to ensure that all relevant physical health issues were captured. The care records also showed that people were supported through physical care pathways, such as being supported to attend appointments and see specialists.

The majority of staff we spoke with demonstrated a good understanding of the Mental Capacity Act 2005 and their responsibilities within this. However, staff we spoke with in the assessment and advice team did not convey a clear understanding of capacity within the MCA, and spoke about this only within the remit of the Mental Health Act. There was a Best Interest Assessor within the team to provide advice on capacity issues. In the other teams we found that capacity was assessed from first meeting the person, and there was evidence of capacity and best interest assessments having taken place for areas such as self-neglect, physical issues and people's finances.

Outcomes for people using services

The reconfiguration of the community services that took place approximately two years previously enabled the development of specialist teams, such as the CDAT and PD services, to provide people with more specialist support from trained professionals. These services provided a number of therapeutic interventions, such as cognitive behavioural therapy, mentalisation-based therapy, systemic and psychodynamic therapy.

We saw examples of the use of national guidance and best practice tools throughout the services we visited. The PD service used the Structured Clinical Management (SCM) model, which is based on psychologically-informed best practice within mental health and gives a framework to guide their work with people in areas such as crisis planning. The service also implemented the use of National Institute of Clinical Excellence (NICE) Personality Disorder Guidelines in their work with people, and the care records showed that there was a strong emphasis on working in partnership with people during their assessment and care planning. People who used the service also confirmed this, saying it made them feel respected and involved in deciding what they needed.

As a benchmarking tool the staff within the CDAT service told us about their use of the Structured Clinical Interview Dependency scale (SCID), particularly with people who are

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new to using mental health services to enable a clear diagnosis and tailored support to meet people's needs. The people who use this service commented that they found the CDAT service beneficial and that it met their needs.

We also saw evidence of the use of NICE guidance in relation to supporting people with depression, obsessive-compulsive disorders and family therapy for use with the relatives of people using the CDAT service.

The psychologists within the community services had initiated the Psychologically Informed Consultation and Training (PICT) model of joint working in areas such as primary care teams and inpatient services. This had the aim of supporting more effective working with people with a personality disorder and other complex presentations to promote better outcomes for people who use the service and those supporting them.

Staff, equipment and facilities

In all the teams we visited the staff said they felt well supported and that there was good team work that took place. Staff were committed and proud of the work they did and the services in which they worked. We saw evidence of regular individual and group supervision for staff, as well as team meetings that took place regularly throughout the week and month.

The feedback we received from some carers was that there were variations in the knowledge, skills and experience of the staff who were supporting people. We found that there was a number of newly recruited and newly qualified staff in the community services, who were enthusiastic about their work. They told us they had a good induction and felt very supported in their new role. Whilst a high number of staff in the community services were new in post or were locum staff, the potential risks of their lack of experience was mitigated through them being closely supervised and managed by experienced staff to ensure that people received a good level of service. We also found that in the CDAT and PD therapy teams, individual therapy sessions were carried out by experienced, permanent staff only.

The staffing levels within the community teams were adequate to meet the needs of people who used the service. However, there were vacancies across all the teams. For example, the assessment team had vacancies for four social workers and three administrators. Whilst these vacancies were covered by locum staff, the staff we spoke with told us they felt pressured and at times unable to give people the service they felt they needed. In relation to this, within the rehabilitation and recovery teams, we found limited implementation of the recovery model to support people to have a more meaningful life. Staff within the North Islington rehabilitation and recovery team told us that they were unable to implement this due to low staffing levels, and staff not having the time to undertake the training in the recovery model.

The majority of people who use the service said that the staff understood their needs and were able to support them in the way they needed. The staff we spoke with conveyed a good knowledge of the needs of the people who used the service and this ensured people were supported safely. Staff within the community services told us they had access to training and could keep up-to-date with their continued professional development (CPD), and we saw some certificates on display in the CDAT team, showing that staff had undertaken training in behavioural interventions and family therapy.

All staff undertook a mandatory training course called 'Safe and Sound', though some felt that this was very brief and did not cover everything they needed to know in mandatory areas, due to all courses being carried out on one day. Some staff also said that training, in addition to the mandatory training, was quite hard to access, or there were long waiting times for these. The training records showed that staff undertook relevant training in areas such as infection control, information governance and fire safety.

The buildings in which some of the teams were accommodated did not promote the work of the teams. For example, the assessment team was in a building with a number of other teams, which had an impact on the availability of rooms for meeting people in private for their assessments to take place. People who use the service of the CDAT team commented that the walls in the meeting rooms were so thin that they could hear what was happening in the next room, and worried about being overheard. However, we were informed by staff and people who use the service that this was mitigated through staff in the adjoining rooms vacating these whilst a person was in consultation. Both teams are moving to purpose designed and renovated premises in September 2014.

Multi-disciplinary working

Most of the community teams consisted of a team of professionals which included nurses, a consultant psychiatrist, psychologist, social worker and occupational

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therapist. Within the assessment team the aim was that two professionals of different disciplines carried out the assessment, so that there was a holistic approach to assessing people's needs, and there was direct access to social services involvement. Where disciplines were not represented in the team, such as no occupational therapist in the assessment team, then a referral was made to ensure that the people were assessed appropriately.

The PD team carried out in-reach work with people using the PD service, who had been admitted into an inpatient unit. The team attended ward rounds and gave advice to the staff of how best to support the person, to ensure that they received a seamless service.

We were shown examples of positive working with teams from other organisations who provided physical health care in relation to people's specific medical needs. Advice from these teams was incorporated into the care plans so that the trusts adult community teams could support people with physical issues that affected their mental health. An example of this was work with palliative care teams for people with a terminal illness.

The community teams used the 'Docman' computerised system to communicate promptly with GPs, to ensure that information was conveyed promptly. There was also ongoing work promoting joint working with GPs to support people who could be hard to engage with.

Mental Health Act (MHA)

In each of the community teams there was at least one Approved Mental Health Professional (AMHP) who was available to initiate an assessment under the Mental Health Act, if necessary. The AMHP within the team worked on a rota basis with other members of the AMHP team to ensure appropriate AMHP cover should an assessment be required.

Are services caring?

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

Summary of findings

People felt listened to and respected by the staff. They felt fully involved in their support and worked with staff to ensure that the treatment they received was what they wanted and needed. This was reflected in the care plans, which were individualised for each person.

Our findings

Kindness, dignity and respect

During our inspection we saw that staff communicated with people who use the service in a calm and professional way. We observed telephone conversations where staff acknowledged people's distress and gave reassurance in an unhurried manner. The feedback we received from people who use the service was that the staff were caring, un-patronising and listened to them.

However, some people reflected upon the changes that took place to the community services and how they felt unsupported at this time, and that their needs were ignored. However, they were positive about the services they received since that time and that they now received appropriate support.

People using services involvement

The feedback we received from people was that they felt involved in their treatment, and worked in partnership with the staff in deciding what support they wanted. The care plans we reviewed showed clear evidence of people deciding what was important for them and how they wanted to be supported. The correspondence sent to people of the plans of care include comments such as 'you said/described – we will do', which demonstrated the involvement of people in identifying their needs and goals.

People spoke about the service working with them and giving them the information to make decisions about their life and support needs, and they felt this was the right support for them.

The staff spoke of working in collaboration with people to ensure they were committed and engaged in their support, however staff within the North Islington and South Camden rehabilitation and recovery teams said this was not always possible as the staffing pressures had an impact on the choice of services available to people.

Each service undertook feedback surveys to seek the views of people who use the service. A sample of recent surveys across the assessment service showed that the majority of people felt they received an excellent or good service. The feedback to twelve questions asked was very positive, with some minor areas for improvement noted by the team, such as improvements to the reception area.

Within the CDAT service the feedback was similarly positive and people felt involved in their care and treated with respect. Some negative comments related to the environment and others to the care plans. The service had acknowledged this was an issue, as the care plans were written in a letter format to people, and had plans to make these documents clearer.

Within the PD service there was a service user consultant who was valued by the staff and people who used the service. They were fully involved in the service, attending meetings and co-facilitating groups and training. Staff spoke of their bringing a 'human-side' to the way they worked, such as in the terminology and language they used.

Emotional support for care and treatment

People who use the service told us they received emotional support through the individual support and group work they were involved in. Where people needed support, care plans were developed around emotional distress, and their need for support with substance misuse issues.

Are services responsive to people's needs?

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

Summary of findings

People were able to access services across a number of different community sites. They also received a service that was individualised and suited their needs. Complaints were taken seriously, investigated and responded to promptly, and staff learned from complaints.

Waiting times were measured to monitor the responsiveness of the services. There were also programmes of support for people waiting for therapy services. However, we did find a couple of people who had waited much longer than the target time for an appointment for a full assessment.

Our findings

Planning and delivering services

Throughout the community services there was a clear care pathway to ensure that people received the right support for their needs. The people we spoke with reflected on the recent changes to community services, where they felt they did not receive a good service during that time. However, they felt that they now received a service that was more individualised and focused on their needs. Similarly, whilst staff told us they felt the changes had not been managed well, they felt that the outcome was positive and that people now had access to specialised services and therapies.

The rehabilitation and recovery community teams were spread throughout Camden and Islington, so that people could receive support close to where they lived. Each team was operated differently to the other community teams, however, through cross-management meetings and the same divisional line management, they worked alongside each other to promote a seamless service to people. In each team the staff were aware of the targets they needed to meet and this was monitored by the managers of each team.

Right care at the right time

The responsiveness of the community teams was monitored. The rehabilitation and recovery team monitored the waiting times of people being referred to the service and allocation to a practitioner. The average findings ranged within expected targets, which showed that people generally received a seamless service.

The monitoring of the service showed that approximately 82% of people referred to the team were assessed within 15 days which exceeds the expected standard of 80% agreed with commissioners for people who are not in crisis. We did find that one person had not had a full assessment since having been referred by their GP in December 2013, whilst another had been waiting for over 31 days before receiving an appointment. We alerted the team manager to this as this significantly exceeded the 15 day target. Staff explained that some delays were due to the difficulties in accessing rooms for booking appointments, due to the number of other services using the building. However, we were informed that there were plans for the team to move to a new site later on in the year, and this was confirmed by senior management within the trust.

Within CDAT and PD services, there were systems in place to mitigate people waiting a long time for therapy services. Within the PD service this was through the implementation of a pre-therapy group to gradually introduce people to working in group settings and the expectations of this. People we spoke with said that they benefitted from this, and it made them more prepared for the group therapy sessions. The CDAT team had a wellbeing programme of up to 20 weeks, which included people gaining advice in areas such as support with welfare, social and employment issues whilst they waited for specialist therapy input. This meant that people were encouraged to engage with services whilst waiting for appropriate treatment.

Staff within all the services told us about the people living in the boroughs of Camden and Islington who accessed support. They identified that it was a predominantly young population, with a lot of overseas students, where there was a high transient population. In accommodating the diverse needs the staff told us they had access to interpreter services. If a person wanted an assessment by a certain gender of staff, then this would be accommodated.

Letters and communication to people could also be provided in a person's own language or in large print for people with a visual impairment. In the CDAT service the staff told us they would try and be responsive to the needs

Are services responsive to people's needs?

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

of people who were refugees and had been subject to imprisonment and torture, by ensuring that the rooms they used were light and spacious, so not to trigger a traumatic experience.

Similarly, staff in the assessment team acknowledged the high anxiety needs of some people, accessing mental health services for the first time. In response to this they were able to offer assessments at different community team bases, or carry out assessments in the person's home if necessary.

Within the PD services there was a service user consultant employed, who told us that in response to concerns rasied by people who use the service, a change was made from the initial two year maximum for the length of receiving a therapy service, to a more needs based approach, with no set time limit.

Care Pathway

The care pathway was initiated through the assessment team, which was a single point of access, where referrals were received from GPs, people self-referring, the police and through voluntary services. The assessment team would carry out the initial assessment and signpost people to services, refer them to their GP, refer people onto the recovery and assessment team or to one of the therapy services of the CDAT or PD team. The team were also able to initiate an Asperger's assessment through the learning disability community team, who would come to the service to meet with the person.

Learning from concerns and complaints

We saw information on display in the waiting areas of how people could make a complaint. Most of the people we spoke with told us that they felt able to raise complaints about their care and these were listened to. The staff we spoke with told us they would listen to people if they raised a concern and if they could not address it themselves they would refer the person to the senior member of the staff team.

We looked at the records of some complaints received and the correspondence relating to these. We found that complaints were taken seriously and responded to promptly. The complainant was provided with an individualised response to their complaint and given contact details of other bodies they could raise a complaint with if they were dissatisfied with the outcome of the complaint.

The team meeting minutes showed that complaint issues were discussed in team meetings, and actions taken to ensure that lessons were learnt. Examples of this included a team acknowledging the need to involve GPs earlier in the stages prior to a person being discharged from the service, and ensuring that information provided to people contains the correct contact information.

Are services well-led?

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

Summary of findings

Leadership of the adult community-based services were effective. There were also systems in place to capture information and report this to the trust's senior managers. The staff were committed to their work and aware of the future plans of the service, and of the trust, and they understood where they fitted into this.

People who use the service had opportunities to be involved although some people were not aware of the service user engagement initiatives.

Our findings

Vision and strategy

Staff felt that at local level the service was well–led and there was a clear leadership of the service. They were all aware of the strategy and future plans to improve the service. Staff also spoke positively about senior managers, who had visited them in their team, which they said helped them feel more connected to the trust board, and aware of the vision and values of the trust.

Responsible governance

There were regular performance and divisional meetings amongst the team managers, where issues such as performance, incidents, and plans for improvement were discussed. Team managers felt that their line managers had a good awareness of what was happening within their service and of the challenges they faced. The staff told us they felt that their concerns were listened to and acted upon. An example of this was in the assessment and advice team, where they had highlighted concerns to the Chief Operating Officer about the need for more staff, and this was acted upon through the recruitment of three new staff members.

There was a clear management structure and staff knew who to contact within the trust to seek support with specific issues. For example, when we asked staff about safeguarding processes they told us they would seek advice from the trust safeguarding lead if they required it.

Leadership and culture

Within the community teams we found that there was effective leadership, where staff felt supported in their work and part of a team. All staff we spoke with told us that there was good morale in their teams and that staff were proactive in their approach to work. Staff said that their managers at service level were visible, accessible and approachable. The staff had an awareness of the senior leadership team of the trust, though were unclear of some people's roles and their scope of responsibility.

A number of staff spoke about the changes that had taken place within the community services, where they felt that this had not been managed well, where there was a "lack of respect" for the staff and people who use the service, as they were not kept informed about what was happening, and there was a lot of changes to the care coordination of people. However, staff said that they had now embedded the changes and the trust was a much more positive place to work. Staff said that they were encouraged by senior managers to be honest about their work and any challenges they faced. They said that pressures on their work and service were acknowledged and known and actions were taken to make improvements. However, a number of staff expressed concern that it can take a "long time" for changes to be made, such as in the advertising and recruitment of staff to vacancies.

Engagement

We were informed about the trust's Service User Alliance as being a way that people could have their voices heard within the services. Feedback we received from a user group was that they felt the alliance was too "high level", and that more needed to be done to involved people in a day-to-day basis.

The PD and CDAT teams ran a Service User Forum every two months. The minutes of recent meetings we viewed demonstrated a high number of staff present at the meeting, with fewer people who use the service. However, people told us they valued this meeting, felt that it was relevant to them, and that they were equal participants in it.

Within the PD services there was a service user consultant employed, who was valued by the staff and other people who use the service. Staff told us they had brought a more 'human side' to their meetings and the terminology that they used, such as stopping referring to people as 'cases', and changing the initial two year maximum for the length of receiving a therapy service, to a more needs based approach.

Are services well-led?

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

All the staff we spoke said they felt well supported at service level by their managers, and had regular team meetings and reflective practice meetings within each team. Staff felt engaged in their work and able to suggest improvements to the working environment to enable a more efficient service. The staff told us they knew what was going on in the trust through the weekly communication bulletin from senior managers, intranet updates and through reading the board reports.

Performance improvement

Within the community services dashboards were completed by the team managers, which fed back to the trust. They included monthly key performance feedback about areas such as caseloads, number of referrals, discharges, staff absence and staff training and also where people did not attend for appointments.

The staff were aware of team and performance targets for their area of work and told us that these were discussed and monitored by their manager through team meetings and individual supervision sessions, such as the number of contacts with people who use the service.

Compliance actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

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 18 HSCA 2008 (Regulated activities) Regulations 2010** **Consent to care and treatment** The trust did not have suitable arrangements in place for obtaining and acting in accordance with the consent of people or where that did not apply for establishing and acting in accordance with people's best interests. Mental capacity assessments lacked explanation of how capacity had been assessed. Many staff had little or no knowledge of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. This was a breach of Regulation 18 (1)(a)(b) (2)