Care Quality Commission

Camden and Islington NHS Foundation Trust

Community-based crisis services

Quality Report

Tel: 020 3317 3500
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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	South Camden Crisis Resolution and Home Treatment Team	NW1 0PE
St Pancras Hospital	TAF01	North Camden Crisis Resolution and Home Treatment Team	NW3 5BY
Highgate Mental Health Centre	TAF72	Islington Crisis Resolution and Home Treatment Team	N19 5JG

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 provides community-based crisis services to people in the boroughs of Camden and Islington. The service is provided by three teams: Islington crisis resolution and home treatment team, South Camden crisis resolution and home treatment team and North Camden crisis resolution and home treatment team. The teams provide access to crisis care in the community, home treatment to those in crisis and gate-keep admissions to trust inpatient beds.

The community-based crisis services provided a good service. The teams had clear processes in place to make sure that people using the service were safe. When incidents occurred, these were investigated and learning identified. The service was also working to improve its processes for managing medicines.

The service provides support 24-hours a day, seven days a week. There were appropriate assessments undertaken and people were supported by multidisciplinary teams.

Most staff felt supported in their roles and received regular supervision.

Feedback from people using the service was mostly very positive and they told us they felt that staff were caring. However, we found that staff had a poor understanding of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS) and that assessments of capacity were not detailed enough.

The teams' performance was assessed, but people's feedback was not analysed on an ongoing basis to make sure that themes were identified.

Summary of findings

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

Are services safe?

Overall, the service was safe. It had clear structures and processes in place to make sure that services delivered were safe and responsive.

However, information used to monitor the service could include more feedback from people using the service.

Are services effective?

There were appropriate assessments undertaken and services' accreditation demonstrated that they followed best practice.

Staff had a poor understanding of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS) and assessments of capacity were not detailed enough.

We also found that some systems for managing medicines should be improved.

Are services caring?

Feedback from most people we spoke with was that staff were caring and responsive to their needs. We also observed that staff were respectful, skilled and sensitive in the way they delivered care.

Are services responsive to people's needs?

Services were responsive to people's needs. They were located close to people and responded to all referrals. The teams provide support 24-hours a day, seven days a week, and we saw that staff tried to be person-centred in the way they planned care.

Are services well-led?

The service had identified the need to make sure that there was consistency between the three teams.

The trust had produced a service definition document, and was also producing plans for how the service could be developed.

Most staff felt supported in their teams.

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 within 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 and reports of these inspections were published between April 2011 and March 2014. At the time of this 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 provides community-based crisis services to people in the boroughs of Camden and Islington. The service is provided by three teams: Islington crisis resolution and home treatment team, South Camden crisis resolution and home treatment team and North Camden crisis resolution and home treatment team. The teams provide access to crisis care in the community, home treatment to those in crisis and gate-keep admissions to trust inpatient beds.

The teams have close links to the trust's three crisis houses: the North Camden crisis house, the South Camden crisis house and the women's crisis house. In Camden, people who use services also have access to two recovery centres.

Our inspection team

Our inspection team was led by:

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

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.

Summary of findings

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 Unit (PICUs).
- Services for older people.
- Adult community-based services.
- Community-based crisis services.

We visited the community-based crisis 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 departments (A&E) at University College Hospital and the Whittington Hospital. In addition, we inspected the inpatient and some community services for older people and visited 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.

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

Most people we spoke with were positive about their experiences with the crisis resolution and home treatment teams. They told us that staff were kind and

responsive to their needs. Many told us that they appreciated receiving support in the community, rather than as an inpatient. However, some people, their carers and relatives told us it was hard to get access to the team sometimes, and that communication could be improved.

Good practice

- The Islington crisis resolution and home treatment team has a formal programme for peer support. This is where people who have recent experience of receiving support provide peer support to people currently receiving care.

Areas for improvement

Action the provider MUST or SHOULD take to improve

Action the provider MUST take to improve

- Staff must be able to understand and apply the Mental Capacity Act to make sure that people's human rights are maintained.

Summary of findings

Action the provider SHOULD take to improve:

- Management of medicines should be formalised to make sure that medicines are transported and recorded appropriately.
- Feedback from people using the service should be analysed on an ongoing basis to make sure that themes are identified.
- The involvement of carers should be further developed to make sure that, when appropriate, they are kept informed of people's progress.

Detailed findings

Camden and Islington NHS Foundation Trust

Community-based crisis services

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Islington Crisis Resolution and Home Treatment Team	Highgate Mental Health Centre
South Camden Crisis Resolution and Home Treatment Team	St Pancras Hospital
North Camden Crisis Resolution and Home Treatment Team	St Pancras Hospital

Mental Health Act responsibilities

During the inspection we saw the crisis resolution and home treatment teams were acting in accordance with the Mental Health Act and Code of Practice. We saw that referrals were made, where appropriate, to the Approved Mental Health Professional (AMHP) team for assessments to be undertaken. When people were supported by the team on Section 17 leave, the team would monitor their status appropriately. Staff we spoke with told us they felt the team could improve the recording of staff assessing the capacity of people to consent.

Mental Capacity Act and Deprivation of Liberty Safeguards

Staff we spoke with were varied in their knowledge of the Mental Capacity Act. Some staff did not demonstrate good knowledge of the needs to assess a person's decision specific capacity. It was not always recorded in people's notes that their capacity to consent had been assessed where appropriate. Staff had not all received training in the Mental Capacity Act.

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

Overall, the service was safe. It had clear structures and processes in place to make sure that services delivered were safe and responsive.

However, information used to monitor the service could include more feedback from people using the service.

Our findings

Track record on safety

The service had a clear system for the reporting of incidents. When we spoke with staff they explained to us the process they used to report incidents through the electronic reporting system. They told us they felt confident in being able to report incidents. Staff told us that incidents would be discussed at supervision sessions and team meetings. Some staff told us they felt the criteria for what to report could be clearer and that they were not always sure what should be reported.

Information on safety was collected from a range of sources to monitor performance in each team. Each team was collecting a range of indicators within a 'Balanced Scorecard', which recorded the performance of the teams against a range of indictors. This included clear targets, such as ensuring that more than 85% of people using the service have a risk assessment completed or updated within three days of assessment. In quarter four 2013/14 the Islington team had achieved 100%, the South Camden team 93% and the North Camden team 77%. The performance against these targets was monitored on an ongoing basis so that where needed improvements could take place.

In addition to the 'balanced scorecard', the service had a 'clinical dashboard'. This monitored whether key documentation had been completed within the electronic records system. There was also a weekly management report, which provided up-to-date information, such as the number of people who did not attend appointments. Staff were completing an activity management tool where they recorded the amount of time they spent in face-to-face contact with people.

Some staff we spoke with expressed concern that the monitoring of the service was too quantitative in approach and did not reflect the reality of the time and responsiveness they needed to show people. We saw examples of feedback forms being used to collect information from people who were using the service. However, recent information from these had not been analysed in any of the teams. This meant the themes from this feedback may be missed.

The service did not have a formal report that brought together all information from complaints, feedback from people using the service and performance information, although staff told us these would all be discussed during team meetings.

Learning from incidents and improvingsafety standards

Learning points from incidents were identified and plans put in place to improve safety. Feedback from recent incidents was shared with staff in team meetings. Staff we spoke with gave some examples of feedback they had received from incidents. Staff were able to show us examples of incident reports that had been circulated with relevant learning points identified to them. The managers within the teams told us they would share learning points between the teams at their regular meetings.

When serious incidents had occurred the trust had investigated these. In early 2014, there had been a number of incidents associated with the Camden crisis pathway. In response to this potential cluster, at the time of the inspection the trust had undertaken an initial meeting in order to begin an internal review. The meeting focused on the identification of common themes and identified a number of immediate actions.

When safety alerts were issued by the central alerting system these were shared with staff. For example, when we visited the North Camden team they told us they were discussed at fortnightly business meetings.

Are services safe?

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

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

Information on how to report safeguarding was clearly displayed in the team offices. For example, in the office of the North Camden team information on safeguarding was displayed on a board. This included the principles, a flowchart of what to do, and an information sharing flowchart. Most staff had received training in safeguarding. At the end of quarter four 2013/14, 100% of staff had undertaken mandatory safeguarding training in the North and South Camden teams. In total, 94.4% of staff in the Islington team had completed the training. Staff we spoke with were able to describe to us how they would report concerns and the procedure they would follow. Team leaders told us they felt the trust had appropriate advice teams available should they be required.

We found that the teams had reliable systems in place to mitigate the risks to people using the service and staff. The service was available in both boroughs 24-hours a day, seven days a week. Access to the team was through a central telephone number. One staff member was responsible for carrying a pager, which would record if someone had called and they had been unable to answer. This meant they could then ensure that the person was called back. Work within teams was distributed and allocated at daily handover meetings.

The service had a clear lone working procedure. This involved the risk assessment of people, using phone calls, visiting in pairs, and office-based appointments where appropriate. All staff had mobile phones so they could contact the central team. Staff we spoke with told us that if a person required a dual visit this would be accommodated.

Appropriate equipment was available to assist staff to do their job. Personal protective equipment, such as gloves, were available should these be required. The teams had pool cars they could use for undertaking home visits.

Records were managed on an electronic system. We looked at examples of notes for people using the service and saw these were mostly being completed regularly. If information needed to be shared with other teams, within the trust or the person's GP, this was being completed.

Assessing and monitoring safety and risk

Staff were aware of the needs of people using the service and were able to explain how they were supporting people.

Appropriate handovers took place at the beginning of shifts. We observed these in each of the teams. Each of these appropriately discussed the risks associated with people using the service. For example, at the handover meeting we observed for the South Camden team we saw a multidisciplinary team conducted a safe handover and transfer. Information was shared and tasks allocated. The capacity of people to makes decisions and the management of risk behaviours was discussed. Positive risk management was promoted.

The teams had a step-by-step procedure for referral screening, assessment, risk assessment, outcome measure and discharge. When we visited, we saw this was displayed in the office for the South Camden team. When a person was referred to the team, an initial assessment may be undertaken. These were only undertaken by appropriately qualified staff. When a core assessment was undertaken it would include taking past history, allergies, social circumstances, family behaviours, risk history and the physical healthcare needs of the person. The teams had physical healthcare lead staff to provide advice and support to colleagues and ensure people's physical healthcare needs were met.

We saw that a person's risk was monitored and reviewed on a daily basis and this informed how staff would support a person. If a person was deemed to be at increased risk, staff were responding to this. Some staff we spoke with raised a concern regarding the level of risk of some of the people they were supporting. They told us that they felt some would benefit from an inpatient admission, which could be difficult to get. However, they told us that if they escalated a concern they would usually get a bed.

The staffing levels within the team were safe. We looked at recent staff rotas for the teams. These showed that there were three staff on in the morning and three in the afternoon. There was one member of staff for each borough at night. Vacancy levels in the South Camden Team were 36.2% at the end of quarter four 2013/14, although recent and ongoing recruitment had reduced this. Bank and agency staff were being used to cover vacancies. Most staff we spoke with told us that although they felt under pressure, the staffing was safe. The Islington team had recently increased its staffing at the weekend to three members of staff to ensure it had an adequate resource to meet the needs of people using the service.

Are services safe?

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

Understanding and management of foreseeable risks

Staff and managers we spoke with told us they felt they would be able to manage most foreseeable risks. For example, if they had short-term unexpected staff shortages they would prioritise work to ensure people were supported. They would also have a clear process for escalating their concerns. Some staff we spoke with told us they felt they were placed under pressure when escalating concerns regarding access to inpatient beds, but in most cases a bed would be secured.

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

The service was effective. There were appropriate assessments undertaken and services' accreditation demonstrated that they followed best practice.

Staff had a poor understanding of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS) and assessments of capacity were not detailed enough.

We also found that some systems for managing medicines should be improved.

Our findings

Assessment and delivery of care and treatment

The service had a clear process for undertaking assessments. When a core assessment was undertaken it would include taking past history, allergies, social circumstances, family behaviours, risk history and the physical healthcare needs of the person. Initial plans were put in place with the person and these were monitored on a daily basis within the team.

The teams had physical healthcare lead staff to provide advice and support to colleagues and ensure people's physical healthcare needs were met. When we looked at records of people using the service we saw that their physical healthcare needs were being assessed. For example, people were being referred for blood tests when appropriate. When we spoke with staff they told us this was an area they had been working on improving.

Guidance on best practice was sent to staff via email. We were told that the manager would raise any key areas with staff at team meetings.

Although we saw some good examples of the capacity of someone to make a decision being discussed, this was not being consistently applied. Staff we spoke with were variable in their knowledge of the Mental Capacity Act. Some staff were knowledgeable about this role and we saw some examples of staff assessing the capacity of people to make decisions. Other staff did not demonstrate good knowledge of the need to assess a person's decision specific capacity. It was not always recorded in people's notes that their capacity to consent had been assessed where needed. Staff had not all received training in the Mental Capacity Act.

We checked the management of medications in the North Camden and Islington teams and we found that some improvements were required. Supplies of pre-packed medicines were kept in the crisis team offices. These medicines were taken by staff to people who were being supported with their medicines in the community. The medicines were stored securely, and at the correct temperatures to remain fit for use. However, the bags used to transport medicines were not lockable.

Nursing staff and support workers were authorised to transport medicines and supervise medicines in the community. Support workers who supervised the administration of medicines in the community, had received training to do this.

Staff who supervised medicines for people in the community were meant to make a record on the persons prescription chart, as well as their electronic care record. When we checked a sample of prescription charts and care records, we saw that detailed notes were made on people's electronic records when medicines were supervised. Staff did not take prescription charts out with them when they supervised medicines in the community, and there were gaps on these prescription charts where staff had not signed for supervising medicines.

The trust had a draft Medication Management Procedure for the crisis teams, due for implementation in June 2014.The draft policy says: "All current medicines (including those obtained via the GP or other services) and homeopathic medicines should be written on the prescription chart, to provide a comprehensive record of all current medicines being taken by the patient" and "any member of the team may transport dispensed medicines to patients. The medication should be in an approved carry case/bag, marked (preferably inside the carry case/ bag) with the trust name, and kept locked." At the time of the inspection this was not happening.

Outcomes for people using services

The service was collecting data on a number of metrics to assess how it supported people. These were collected in the 'Balanced Scorecard' and weekly management report.

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.

For example, the percentage of people using the service with evidence of a weekly care plan review was being recorded. The number of people referred again following discharge was also monitored.

We found that the teams were following guidance. The Islington crisis resolution and home treatment team is accredited with the Royal College of Psychiatrists' home treatment accreditation scheme from January 2013 to January 2016. This means it has shown through the accreditation process that it meets most standards and best practice.

The service was working to improve how it supported people. For example, psychologists within the community services had also initiated the psychologically informed consultation and training (PICT) model of joint working with the team. This support for staff 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

Most staff we spoke with told us they felt supported in their roles and had good access to training. Most told us they had received formal supervision sessions from managers and had found this useful. In quarter four, 2013/14, 100% in North Camden, 88% of staff in South Camden and 100% staff in Islington were recorded as having received practice supervision within the last month. We looked at examples of records of these and they demonstrated that staff were discussing their roles and the support they required. Medical staff we spoke with told us they felt supported by senior clinicians. Most staff told us they had received annual appraisals and had performance development plans in place.

When staff began working in the teams they were being supported to ensure they had the skills to undertake their role. We were told that staff would receive an induction when they began working for the team and would start in a supernumery role. However, there was no formal induction checklist for teams to follow to ensure all key areas had been covered.

There was a preceptorship programme for new band 5 nursing staff. However, some teams had a large number of inexperienced staff, for example the South Camden team. Although they were very enthusiastic and committed, the lower numbers of experienced staff may have an impact on the support they are able to give to people using the service. Some staff had received training in mentorship to support colleagues and other staff were undertaking a band 6 leadership development course.

Staff were undertaking mandatory training courses, including training in infection control, information governance, and equality and diversity. The uptake of this was being monitored on an ongoing basis.

The three office locations the teams were working for all had rooms were people using the service could be met with. The office spaces had appropriate private space for handover discussions to take place, although the Islington handover meeting was undertaken in a very small room.

Multi-disciplinary working

The teams demonstrated a multidisciplinary way of working. When we observed planning and handover meetings, we saw that these included staff from nursing, medical and social work backgrounds. We saw that staff were able to use their individual skills and that decisions made were multi-disciplinary in nature. Staff told us they also found the input of psychology to be helpful, although felt this could be increased. All the teams had regular input from the pharmacy and felt this was helpful in their planning of care. Specialist advice was being sought. For example, a member of the children's and families team was attending meetings with the South Camden team. There were some variations in the composition of the teams. For example, the North Camden team did not have a social worker in the team. None of the teams had any occupational therapists as part of the team.

Skills were being developed. For example, in the North Camden team a member of staff from the older people's service had been seconded to help share their expertise.

Mental Health Act (MHA)

During the inspection we saw the teams were acting in accordance with the Mental Health Act (MHA) 1983 and the MHA Code of Practice. We saw that referrals were made, where appropriate, to the Approved Mental Health Professional (AMHP) team for assessments to be undertaken. When people were supported by the team on Section 17 leave, the team would monitor their status appropriately.

Are services caring?

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

Summary of findings

Feedback from most people we spoke with was that staff were caring and responsive to their needs. We also observed that staff were respectful, skilled and sensitive in the way they delivered care.

Our findings

Kindness, dignity and respect

Most people using the service were positive about the kindness and respect staff had shown them. The following were examples of some of the positive feedback we received from people or their relatives:

"The service was so good. I couldn't believe it."

"The service is supportive and responsive."

"The nurses are very kind. They talk to me nicely."

"The crisis team have been crucial to my wellbeing."

When we looked at feedback from people using the service in Islington, most people were very positive about the care and support they had received. In 2014 the Islington team had received 48 service user feedback forms. In total, 83% of people who responded to the question, "How would you rate the quality of service you have received" rated it excellent or good. Comments included the following:

"Nice, understanding, patient workers."

"The service was helpful to me because I was able to speak to someone who is trained in this specific field and therefore I wasn't being judged or ridiculed."

"The help is instant and the staff are very friendly."

"The (inevitable and understandable) lack of personal knowledge the team had of me and my history."

Some carers and relatives that we spoke with told us they felt that some members of staff in the team were not as good as others and it depended on which member of staff was supporting their relative in how caring they were.

We shadowed staff in all three teams to observe how they interacted with people. We saw staff supported people in a respectful manner, showing compassion. Before visiting someone at home staff phoned ahead to agree permission for their appointment and repeated this when at the person's home.

People using services involvement

Staff were involving people in decisions about their care. 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. For example, when we observed staff having an appointment with someone using the service in South Camden we saw that staff worked with the person to agree how they would support them. At the end of the appointment what had been discussed was summarised and the person agreed. The care plans we reviewed showed clear evidence of people deciding what was important for them and how they wanted to be supported.

In the 2013, national community mental health survey, the average rating by people using the service was eight out of 10 for the health or social care worker seen most recently taking the person's views into account. This was similar to other trusts.

The trust had programmes to involve people who had used the service to support people. In the Islington team a programme of peer support workers was being used. These people, who had recently received support from the service, were working with people currently receiving support to provide a peer support. They would work with the person to produce a personal recovery plan of the support the wished to receive. The peer support workers received weekly supervision from staff to help them fulfil this role.

Independent Mental Capacity Advocates (IMCA) and Independent Mental Health Advocates (IMHA) were available should people wish to talk with them. However, some people we spoke with told us they felt it could be hard to get access to an advocate in the community.

Information leaflets were available for people using the service.

Emotional support for care and treatment

We saw that staff demonstrated a high level of emotional support to people using the service. They took time to explain information and support people in a sensitive manner. The model of care of the crisis teams promoted supporting people in the community, rather than admitting

Are services caring?

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

them to inpatient facilities. People who required short periods of support could access services in the trust's three 'crisis houses'. This helped maintain people's independence.

Staff were aware of and supported people with their individual circumstances. When we observed handover and planning meetings we saw that wider family needs were discussed and assessed. For example, a children and families worker was attending team meetings once a month in South Camden.

Staff were signposting people to other services that may be of use to them. For example, when we shadowed staff in Islington we saw staff signposting people to other long-term support services.

When we spoke with relatives of people, many told us they felt that communication with staff was not as good as it could be. Some felt they were not kept informed by staff. They also felt that the information available to them could be improved to improve their knowledge of local services.

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

Services were responsive to people's needs. They were located close to people and responded to all referrals. The teams provide support 24-hours a day, seven days a week, and we saw that staff tried to be person-centred in the way they planned care.

Our findings

Planning and delivering services

The team received referrals from a number of sources. These included, other community teams and inpatient wards in the trust, GPs, and via liaison services based at the three local NHS acute trusts. People who had received support from the team in the past could self-refer. The teams had no exclusion criteria and all referrals to the team were assessed. The aim of the team, stated within the service definition document, was to provide a safe and effective home-based assessment and treatment alternative to inpatient care. The team supported people for a short period of time, before referring to other services or discharging the person. This could include referral to one of the trust's specialist community teams, such as the personality disorder team or the complex depression anxiety and trauma team.

The team are based in three geographically located teams and people using the service were being either supported through home visits or appointments at the team offices. The trust has worked with local commissioners to provide access to three 'crisis houses'. These short-stay residential services allow people, who may otherwise require full inpatient admission, to remain in a community situation whilst receiving support. In Camden, people using the service also have access to two recovery centres. This allows people to access day therapeutic services whilst living in the community.

The teams try to support people's independence by supporting them in the community. During planning meetings we observed that the team also promoted positive risk taking to try and ensure people did not become dependent upon the team. We saw examples where the teams were respectful of an individual's decisions and right to make what may be deemed poor decisions. During these meetings we also saw that the team discussed the individual needs of the person and looked to signpost them or make appropriate referrals to other services that may be of use to them, such as local charities. Planning was person-centred and there was flexibility in the care pathway to meet the individual needs of the person.

The teams were building links with other local services supporting people. For example, they were developing liaison links with local GPs to try and ensure people were referred correctly to them.

The teams were looking at developing how they could meet the needs of some difficult to support groups. For example, the managers within the team had been meeting to discuss how they met the needs of homeless people.

Right care at the right time

The teams provided support 24-hours a day, seven days a week. At all times there was a person responsible for carrying a pager in each team to ensure that all referrals were received. At night, the service will not visit people, apart from the Islington team who undertake some assessments at the Whittington Hospital, but will offer telephone advice and make appointments for the following day. When someone is referred to the team an assessment will be undertaken. The liaison teams based at the A&E departments at University College Hospital and The Royal Free Hospital can undertake assessments and add people to the team caseload. People who have previously received support from the team can self-refer. People we spoke with told us they appreciated this. For, example one person told us "I can contact the crisis team at any time I need to. They have always been very helpful". When we spoke with some carers, they told us they felt the team could be slow to respond to concerns.

Referrals to the team were discussed at daily handover meetings and we observed appropriate follow up was undertaken immediately. Due to the nature of supporting people as a team, people did not have a named worker. Contact was through the central number. This was to ensure that their concern was always responded to. Some people we spoke with told us they felt this meant there was a lack of continuity in the support they received.

The team has no upper age limit and supported people with functional conditions of all ages. There was no specific older person's crisis team at the trust.

Are services responsive to people's needs?

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

The service had a service definition document. This noted that the service had no exclusion criteria for its service. Staff told us that the service was a catch all and that it was important that they had the flexibility to provide whatever support they could. The outcome the team was aiming for was to successfully manage and support people in the community, who may otherwise have to be an inpatient. During the inspection some staff expressed concern that they felt this meant they sometimes had to support people who were very acutely unwell and may benefit from an inpatient admission.

Care Pathway

The service sought to respond to an individual's needs. Care planning followed set assessments that included a person's individual equality characteristic, such as their cultural background. Interpreters could be sought when required. Staff also explained that if a person requested support from a male or female member of staff, this would be accommodated. Staff had received training in equality and diversity.

Some teams were trying to improve links with inpatient services to ensure communication was improved. For example, members of the Islington team were visiting wards at Highgate Mental Health Centre weekly, to speak with staff and people using the service. This had the aim of ensuring that people who could potentially be managed by the team in the community were identified.

Learning from concerns and complaints

Information leaflets were available for people regarding 'Advice, complaints and feedback'. This included information on how to complain should people wish to. Information on independent advocacy services was also included in this leaflet. The staff we spoke with told us they would listen to people if they raised a concern. If they could not address it themselves they would refer the person to their manager or the complaints process.

The three teams had received five complaints in the last 12 months. Complaints were taken seriously and responded to. 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.

Learning points identified from complaints were discussed at team meetings and, if appropriate, within individual formal supervision sessions.

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

The service had identified the need to make sure that there was consistency between the three teams.

The trust had produced a service definition document, and was also producing plans for how the service could be developed.

Most staff felt supported in their teams.

Our findings

Vision and strategy

The service had a service definition document and an operational policy. This clearly stated the role of the team, to provide an alternative to inpatient admission. The service had no exclusion criteria for its service. Staff told us they felt this was important as it enabled them to see and assess all people.

During the inspection we noted differences between the teams, for example in the medical support provided. The trust had identified the need to provide consistency and a manager had been recently appointed to cover the three teams. A plan was starting to be developed to merge the two Camden teams and provide a consistent one consultant per team model.

Staff we spoke with were generally positive about the vision for the service and its role within the trust, although some expressed concern over having to support acutely unwell people.

Responsible governance

The trust had clear systems in place for the reporting and investigation of concerns. When serious incidents had occurred the trust had investigated these. In early 2014, there had been a number of incidents associated with the Camden crisis pathway and, in addition to individual investigation, were being looked at in conjunction to see if there were any common themes.

Performance was managed regularly through a number of reports, such as the 'balanced scorecard'. There were regular performance meetings amongst the teams, where issues such as performance, incidents, and plans for improvement were discussed.

The service did not have a formal report that brought together all information from complaints, feedback from people using the service and performance information, although staff told us these would all be discussed during team meetings.

Leadership and culture

Most staff we spoke with within the three teams told us they thought their team manager was good, open and supportive. Many also told us they felt there teams were supportive and that they worked well together. We were told by staff that the changes that had been made at the trust had been difficult, but morale was now much better. Some people told us they felt these changes could have been managed better.

Staff in each team told us they felt there was an open culture at the trust. For example, one person told us "The values of trust are good". However, some members of staff told us they felt they came under pressure not to admit people they felt would benefit from support in inpatient wards.

At the time of the inspection there was one vacancy for team leader, South Camden, and other members of staff in management positions were in interim roles. Recruitment had been undertaken and new staff members were due to start. However, some staff told us they found the lack of stability in the teams difficult.

Engagement

The views of people using the service was not being collected and analysed in a robust manner in all the teams. The service had a new service user evaluation and feedback form. However, at the time of the inspection these had not been analysed yet.

People using the service had access to information on Independent Mental Capacity Advocates and Independent Mental Health Advocates should they wish to talk with them. Some people we spoke with told us they felt it was difficult to access an advocate in the community.

The trust had some programmes to involve people who had used the service. There were user groups for both boroughs. The North Camden team had used people using the service in recent recruitment. In the Islington team a programme of peer support workers was being used. These people, who had recently received support from the service, were working with people currently receiving support to provide a peer support.

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.

Most of the staff we spoke told us they felt well supported by their managers. They told us they had regular team meetings and received support on a daily basis from colleagues. Many members of staff told us they had felt they were not listened to by management in the past, but this improving.

Performance improvement

Regular performance dashboards were produced by the team managers and fed back to trust management. They included monthly key performance feedback about areas such as 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. Staff told us they were held to account where issues were raised. For example, some told us they had increased their awareness in relation to physical healthcare.

Staff were recording their face-to-face contact time with people and recording this on a performance management and resource allocation tool. They had a target of having 70% face-to-face contact. Many staff we spoke with told us they felt this target did not take into account the variation in their role and was too quantitative in approach.

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)