Camden and Islington NHS Foundation Trust

Quality Report

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Core services inspected	CQC registered location	CQC location ID
Acute Wards	Highgate Mental Health Centre St Pancras Hospital	TAF 72 TAF01
Psychiatric intensive care unit	Highgate Mental Health Centre	TAF 72
Health–based places of safety	St Pancras Hospital	TAF01
Services for older people – wards and community services	Highgate Mental Health Centre St Pancras Hospital	TAF72 TAF01
Community-based crisis services Adult community-based services	Highgate Mental Health Centre St Pancras Hospital	TAF72 TAF01

This report describes our judgement of the quality of care at this provider. It 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.

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.

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Overall summary

The trust was well-led by the Board the executive team and senior managers. Their work was supported by strong governance arrangements and a comprehensive quality assurance process. This meant that they were aware of the areas that needed improvement and were at different stages of addressing them.

People using the services were treated with dignity and respect. The majority of the service users and carers we spoke with said staff were kind and we observed many positive interactions. We also saw that the trust was supporting people to be actively engaged in their own care and also to be involved in the development of the services.

We saw many areas of good and innovative practice across a range of units and teams within each core services, and the trust had much to be proud of. We also found good collaborative working relationships with partner agencies such as social services. We saw that the trust genuinely wanted to put the people who used their services at the centre of their work.

There were, however, a few areas that could have an impact on the safety and effectiveness of the service being delivered. These were predominantly found in the inpatient, rather than the community, services. Although the trust had started to address these issues, there was still more to be done.

Our greatest concerns were in the acute inpatient services where ligature points were putting people's safety at risk. In addition, the consistency of people's acute inpatient care was sometimes being affected by ward moves, which were not based on clinical need. We were also concerned about the safety of older people, as procedures to reduce the risk of falls were not being fully used. At ward level, lessons from previous serious untoward incidents were not always being shared effectively to reduce future risks to people using the service.

Staff, mainly in inpatient services, were not always confident in using the Mental Capacity Act 1983 and Deprivation of Liberty Safeguards (DoLS). This meant that people might not be properly involved in decisions about their care. In some cases, it meant that they could be deprived of their liberty without the correct authorisations in place, which would contravene their human rights.

It is our view that the provider needs to take steps to improve the quality and safety of their services. We found that they are currently in breach of regulations.

We will be working with them to agree an action plan to help improve the standards of care and treatment.

Summary of findings

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

We always ask the following five questions of the services.

Are services safe?

The trust had systems in place to report and monitor incidents and, where needed, it ensured that serious untoward incidents were investigated appropriately. However, in a few services, mainly inpatient wards, the learning from incidents was not being shared quickly or widely enough to try and prevent similar incidents occurring again. In addition, falls guidance needed to be updated to consider recent NICE guidance and used by the staff on the older people's inpatient wards.

Staff were generally well informed and trained in the use of safeguarding processes.

The trust was having problems recruiting nurses, but it was actively addressing these. Also temporary staff were being used a lot in some areas but there were enough staff to provide safe care.

In the last year, two-thirds of restraints used had been face-down, which was potentially unsafe. The trust was reviewing its guidelines and some staff were waiting for retraining, in line with recent guidelines from the Department of Health. However, more work on this was needed to ensure staff were all working in line with the latest guidance.

There were multiple ligature points on the acute wards across the trust. Since March 2014 four people have attempted to take their own lives and this sadly resulted in one death. The trust had identified the ligature points. A major refurbishment of the inpatient estate combined with a ligature control programme meant some work to reduce these had taken place and was due to continue after our inspection. Individual clinical risk assessments were in place. During our inspection, ward managers and staff could not tell us how they managed risks posed by the ligature points as part of a planned approach to keep people safe on the ward.

Other factors that put people at risk included the issue of illegal drugs coming on to the acute wards and psychiatric intensive care unit. There were also concerns about the different patient needs on the inpatient older people's wards. Although the trust had taken steps to address these issues, more input was needed to improve patient safety.

Are services effective?

Staff, mainly in inpatient services, were not always confident in using the Mental Capacity Act 1983 and Deprivation of Liberty Safeguards

(DoLS). This meant that people might not be properly involved in decisions about their care. In some cases, it meant that they could be deprived of their liberty without the correct authorisations in place, which would contravene their human rights.

The trust used external accreditation and internal audits well to evaluate many aspects of the services it provided.

Management of medicines had improved across the trust. However, the trust's own medicines risk register showed that more improvements were needed and that these should be fully implemented so that medicines were managed safely.

During their stay in hospital, people were given physical health checks to help them maintain good physical health.

Staff received training and development to improve their effectiveness. The need for some specific training to support staff in their areas of work was identified during the inspection. The trust needed to do more work to make sure that staff receive management supervision to a consistently high standard.

The Mental Health Act 1983 was being used appropriately at the time of the inspection and there had been significant improvements in ensuring people were aware of their rights.

Are services caring?

Before and during our inspection, people told us that most staff treated them with kindness, dignity and respect.

The trust had made progress in getting people involved in developing their care plans. In addition, people had more consistent care co-ordinators and there was access to one-to-one time with staff for people using inpatient services. We saw, however, that there were still occasions where this does not happen, so the trust should continue to improve this.

The trust put people's recovery at the centre of their work and we saw this happening in practice.

We also saw and spoke to carers who felt that they were appropriately and positively involved. However, some carers felt that this could also be improved, especially for people in crisis.

Are services responsive to people's needs?

Many of the services provided by the trust are responsive. However, we repeatedly heard from senior staff in the trust, as well as staff in the inpatient and community teams and people using services, that there were challenges and concerns about how the needs of people using the acute care pathway could be met. The main issues were around accessing an acute inpatient bed. This affected people in a

number of ways, including having to be placed in hospitals outside the trust. People were sometimes moved between wards for non-clinical reasons, which had an impact on the consistency and quality of care they received.

We saw many positive examples of how the trust respects people's diversity and human rights.

The outcomes of complaints were also being used to improve the care provided by the trust.

Are services well-led?

The trust was well-led and had a clear vision, shared values and direction. The recently appointed chair was well received and was leading on many positive changes, in particular engaging people who use the services. Staff and patients also said that senior staff were accessible and open.

The governance arrangements in place enabled areas of the trust's work to be reviewed effectively. The non-executive directors were also very engaged in this process.

Although people who use the services and staff still felt negatively about the major change programme that took place in 2012, most were positive about the future and staff morale was improving. The trust acknowledged that there were things they could have done better and that they were working to re-connect with staff. The trust was also working to develop leadership for the future for those in managerial and leadership roles.

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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.

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
- Services for older people
- Adult community-based services
- Community-based crisis services

We visited the mental health 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 provided by the trust across the boroughs of Camden and Islington. We also met with two carers groups from the two boroughs. They shared their views and experiences of receiving services from the provider.

We visited both of the hospital locations and the nursing home and we 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 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.

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- 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.

Information about the provider

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 at St Pancras Hospital. They have also registered a nursing home for older people at Stacey Street. The trust provides community-based services throughout 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.

In 2008, the trust became the first care trust to successfully achieve foundation status. The trust currently employs nearly 1,400 people, including nursing, medical, psychology, occupational therapy, administrative and management staff.

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 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. As part of the inspection the CQC followed up the non-compliance from previous inspections and found the trust had completed all the actions for these to now be compliant

What people who use the provider's services say

Before our inspection, we met with people who use services provided by the trust through five different user groups. These included the Islington Borough User Group, the South Camden Rehabilitation and Recovery User Forum, the Patients' Council at the Highgate Mental Health Centre, the Camden Borough Users Group and the Highgate Users Forum. We also met two groups of carers, one in Camden and one in Islington.

We heard a lot of positive feedback about the trust. We were told that the staff seem nice, that the trust wants to

Summary of findings

listen to feedback and that it seems open to involving people. People told us that senior staff from the trust attended user forums. We were also told that one-to-one sessions between staff and patients were taking place more regularly.

People who use the services were positive about some of the services. These included residential services that helped to prevent people needing inpatient services, such as the four crisis houses, especially Drayton Park and Highbury Grove. The trauma stress clinic was also praised. People told us that they were looking forward to the opening of the Recovery College later in the year.

We were given very mixed feedback about the inpatient services. Some people said that they felt safe and that the wards were becoming more homely. There were also positive comments about wards where there was access to ensuite bathrooms and use of the internet. However, other people said that they did not feel safe and told us that illegal drugs were being brought onto the wards and personal items were being stolen.

Some people told us that they were worried about becoming unwell as they were concerned there were not enough acute admission beds. Others said that they thought people moved wards too many times and were discharged too quickly. People also told us that it was hard to get section 17 leave, which made it difficult to go to a cash point or pick up more clothes if needed. While some people said the wards were tidy, others told us that the outside areas were scattered with litter and cigarette ends.

In terms of food, some people who use services said that the choice had improved, while others said that portions were too small and the evening meal was too early. We were told that staff did not have enough time to speak to people on some of the wards, and that there had also been staff changes. While some people told us about activities they really enjoyed, such as the music groups at the Highgate Centre, others said that there were not enough activities, for example sport. We were also told that when things are broken, such as the ward phone, it can take several weeks for this to be fixed.

Many people who use services told us that they still felt negatively affected by the changes to community services in 2012. People said that while there were a lot of good services, they were worried that the support they receive from the trust was coming to an end. We were told that people would like more continuity of support and to be able to refer themselves to more services. People also said that accessing advocacy services in the community can be hard and some people said that they would like access to more psychological therapies.

Carers told us that they had good access to social workers. However, others said it can be hard to get hold of doctors and that review meetings were delayed. While some carers were happy with the care planning, others said they did not feel accepted as the key contact in the care of the person. Carers told us they were assessed but that there was then no funding to support them.

Good practice

Trust-wide:

- We observed staff supporting patients with care and compassion. They were also committed to providing good quality services.
- The trust has a stable senior executive team. Staff and stakeholders spoke very positively about the recently appointed chair Leisha Fullick (who joined in September 2013) and the Chief Operating Officer (who joined January 2013).
- The trust uses crisis houses as part of a care pathway to offer the least restrictive option to hospital admissions, which is well received by people who use the services.
- There is an improved performance monitoring system as part of the trusts quality assurance framework. This has provided better information at ward, team and divisional level and supported service improvement.
- The trust provides a liaison service to health-based places of safety in three local acute hospital accident and emergency departments, rather than in the trust's own premises. These were working well.

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- The pharmacy service was brought in-house in April 2014 and the management of medicines has improved.
- The trust makes sure that people using their inpatient services receive physical health care as well.
- Governors are supported to be actively involved in the trust. User involvement is also promoted by the trust, but they recognise that needs to be developed further and plans are being developed.
- The trust provides a strong range of leadership and management development programmes and staff value the access they have to continuous professional development.
- The trust undertakes a considerable amount of innovative research and staff told us how much they valued participating in this work.
- Staff morale is gradually improving after a difficult period after a major change programme in 2012.

Acute inpatient wards:

- Staff on all acute admissions wards were very caring and showed kindness and concern when interacting with people.

Older people's services:

- There was a low use of anti-psychotic medicines for treating older people.
- The trust was recovery-focused.
- The care home liaison service, which provided rapid assessment and support, and skilful care home staff.
- The compassionate care initiative used in the community teams.

Community crisis services:

- The Islington crisis resolution and home treatment teams has a formal programme for peer support workers. These are people who have recent experience of receiving support, who provide peer support to people receiving care.

Adult community services:

- There was clear leadership in all the services we visited and staff had a clear sense of the vision and direction of the service.
- In the personality disorder and complex depression, anxiety and trauma services, we saw good use of best practice and clinical guidance, so that people received a service that was supported by evidence and research.
- Staff and people who use the service valued the employment of a service user representative, though this role was only present within the personality disorder services.

Psychiatric intensive care services:

- We observed good occupational therapy input. We were also told that there were plans to improve therapy services further to meet National Association of Psychiatric Intensive Care and Low Secure Unit (NAPICU) standards.

Health-based places of safety

- The liaison teams had well developed multi-agency policies and procedures, with skilled staff undertaking individual and responsive care.

Learning disability services:

- The community learning disabilities teams were integrated between health and social care staff, and provided in-reach services to the inpatient ward. People on the ward had continuity of care as support they received in the community continued in hospital. The integrated team and shared team office meant that health and social care could easily speak to one another for advice and support.
- Easy-to-read information was available for people with a learning disability. This included standard hospital care plans, medication information and how to raise concerns.

Areas for improvement

Action the provider MUST or SHOULD take to improve

Action the provider MUST take to improve

Staff working in the acute wards must be clear about the steps they need to take to reduce the risk of ligature points to patients, while work to reduce these is taking place. The acute wards had many ligature points. Although these had been assessed by a specialist

surveyor and a programme of building work was scheduled to start just after our inspection, and individual clinical risk assessments were in place, ward staff were not clear about how this risk should be managed.

- There were a number of falls in the inpatient services for older people. The policy for managing the risk of falls must be updated to consider recent NICE guidance and staff must follow this guidance.
- Learning from serious untoward incidents must be shared across wards and teams quickly. Staff must be supported to understand and use these lessons to improve their service.
- 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, especially in inpatient wards and the crisis resolution and home treatment teams, can use the legislation with confidence to protect people's human rights.
- The movement of patients between acute inpatient wards for non-clinical reasons must be kept to the minimum. Where it is unavoidable, arrangements must be in place to ensure that a thorough handover takes place to promote continuity of care.
- The trust must ensure that the action plan for the PICU, which is part of the 'rapid improvement plan', is kept up to date. This is to ensure the actions are completed quickly so that people using the service receive the appropriate care and treatment.

Action the provider SHOULD take to improve trust wide services:

- Recruitment, especially of nurses, remains a challenge despite a very active recruitment campaign. This means that there is a high use of temporary staff, especially on the inpatients wards, which reduces consistency of care. The trust should continue to actively recruit for staff in line with the workforce plan until the numbers of permanent staff improve and the use of temporary staff is reduced.
- Improvements in the areas identified in the medicines risk register need to be implemented to make sure medicines are managed safely.
- The trust should aim to provide psychological therapies that reflect patient choice about the timing and venue for the appointment and type of therapy received.

Action the provider SHOULD take to improve acute inpatient services

- Risk assessments should be in place for people going on leave. This is to ensure that potential risks for people when they were outside the hospital have been considered.
- The procedures to address the issue of illegal drugs coming onto the acute admission wards should be reviewed as this is an ongoing issue.
- Cancelled escorted leave should be monitored as this has an impact on the quality of the care people using the acute inpatient services receive.
- Procedures on the use of restraint should be updated to reflect current guidance on the use of face down restraint only as a last resort. Staff should be updated on this change in approach while waiting for their refresher training.
- Therapeutic activities should be consistently available throughout the week at the Highgate Mental Health Centre.
- People should be adequately supported following assaults from other people on the ward. The service should also address a perceived failure of ward staff to take prompt action to protect them from further assaults.
- People should have access to a lockable space to keep their possessions safe.

Action the provider SHOULD take to improve learning disability services

- Staff supporting people with a learning disability while they are inpatients, should have training to enable them to deliver a high standard of care.
- Access to electronic records should be improved for people working in the community teams. The community teams were integrated between two councils, the mental health trust, and an acute health trust (for the speech and language therapists). Each of these organisations had their own separate electronic record system, which staff found frustrating and time consuming. Some staff could only access one of the

systems, and would have to ask colleagues for information on other systems. Other staff had to enter the same information into both a health and a social care record.
- Care plans for people with learning disabilities in inpatient services should be comprehensive and reflect their need. For example, there were no health actions plans or positive behaviour plans, and there were also gaps in the communication plans.
- The trust should follow through the recommendations made in the Royal College of Psychiatrists' review of learning disability services (January 2014).

Action the provider SHOULD take to improve the psychiatric intensive care services

- The trust should continue to ensure that there are adequate arrangements in place to make sure people are safe, for example in relation to the management of illegal drugs on the ward. The provider should review its implementation and management of illegal substances procedures.
- The trust should continue to recruit permanent staff to reduce dependency on temporary staff.
- Staff should enter the seclusion room when needed to make sure that observations are carried out safely
- Staff should all update their training on the use of restraint, to make sure that they are using the latest guidelines to minimize the use of face down restraint.
- Where rapid tranquillization is used, patient observations should be consistently recorded.
- Staff should continue to complete the training identified in the competency assessment.
- The trust should ensure there are enough activities available on the ward to meet the people's needs.
- People using the service should have regular access to one-to-one support in line with the trust's own targets.
- Where issues are raised at the ward community meeting, such as a broken public telephone, this should be addressed quickly.

Action the provider SHOULD take to improve services for older people

- The trust should ensure that shared garden space is safe for people with dementia and long term mental health conditions.
- The trust should continue to review whether having people with different needs on inpatient wards is a safe and effective model of care.
- The trust should work towards management of staff supervision being undertaken more consistently.

Action the provider SHOULD take to improve community crisis services:

- The 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 they are kept informed of people's progress when appropriate.

Action the provider SHOULD take to improve adult community services

- 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.

Camden and Islington NHS Foundation Trust

Detailed findings

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

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The trust had systems in place to report and monitor incidents and, where needed, it ensured that serious untoward incidents were investigated appropriately. However, in a few services, mainly inpatient wards, the learning from incidents was not being shared quickly or widely enough to try and prevent similar incidents occurring again. In addition, falls guidance needed to be updated to consider recent NICE guidance and used by the staff on the older people's inpatient wards.

Staff were generally well informed and trained in the use of safeguarding processes.

The trust was having problems recruiting nurses, but it was actively addressing these. Also temporary staff were being used a lot in some areas but there were enough staff to provide safe care.

In the last year, two-thirds of restraints used had been face-down, which was potentially unsafe. The trust was reviewing its guidelines and some staff were waiting for retraining, in line with recent guidelines from the Department of Health. However, more work on this was needed to ensure staff were all working in line with the latest guidance.

There were multiple ligature points on the acute wards across the trust. Since March 2014 four people have attempted to take their own lives and this sadly resulted in one death. The trust had identified the ligature points. A major refurbishment of the inpatient estate combined with a ligature control programme meant some work to reduce these had taken place and was due to continue after our inspection. Individual clinical risk assessments

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were in place. During our inspection, ward managers and staff could not tell us how they managed risks posed by the ligature points as part of a planned approach to keep people safe on the ward.

Other factors that put people at risk included the issue of illegal drugs coming on to the acute wards and psychiatric intensive care unit. There were also concerns about the different patient needs on the inpatient older people's wards. Although the trust had taken steps to address these issues, more input was needed to improve patient safety.

Our findings

Track record on safety

When preparing for an inspection, we look at 52 different indicators that may reflect potential risks for a trust. For Camden and Islington NHS Foundation Trust there were no elevated first tier risks identified.

All trusts are required to submit notifications of incidents to the National Reporting and Learning System and between April 2013 and March 2014, 306 incidents were reported. The proportion of reported incidents that were categorised as harmful was within the expected range.

It is expected that trusts report all incidents both major and minor.The Strategic Executive Information System records serious incidents and never events. A total of 63 serious incidents were reported by the trust as having occurred between April 2013 and the end of March 2014. Of these, 43% happened in the patient's own home and 25% happened in ward areas. The most common incident type for the trust was the 'unexpected death of a community patient' (in receipt of a service from the trust) which accounted for 27% of the incidents.

During this time there were no 'never events'. These are serious, largely preventable, patient safety incidents. The trust had also not previously reported any never events since April 2011.

Overall, the trust had been a low reporter of incidents compared to trusts of a similar size. The trust told us how it had managed to increase the reporting of incidents. Islington Clinical Commissioning Group told us that from October 2013 the numbers of incidents being reported had increased and the incidents of violence and aggression were reducing. The increased reporting of incidents was also reflected in the internal reports produced by the trust.

A cluster of unexpected deaths occurred in March and April 2013. The trust instigated a cluster review of these deaths, with an external panel and independent chair. While there were lessons to be learnt from each case, there were no overarching systemic issues identified in terms of the services provided by the trust. The clinical commissioning group commented favourably on the candour and good practice shown by the trust during this investigation. Just before this inspection, there were again a cluster of deaths associated with people linked to the Camden Crisis Pathway. A formal internal review was taking place with a panel chaired by the Medical Director.

The NHS Safety Thermometer is designed to measure a monthly snapshot of areas of harm showed that falls were the greatest risk for the trust, particularly for inpatients on wards for older people. While the reported numbers of falls was below the England average throughout most of the period from April 2013 to February 2014, there were three months when the numbers of falls spiked above the average. The trust figures showed that from January to March 2014 there were 88 slip, trips and falls of which 24% were on Pearl Ward.

The trust had a policy on the management of falls but this needed updating to reflect the current NICE guidelines. While the trust had provided a patient safety alert to advise staff on how to respond to falls, the staff on the inpatient wards for older people were not using this. From looking at patient records these showed that the many factors that could contribute to patient falls had not been considered in practice. A compliance action has been made about the management of falls in older people's inpatient services.

Every six months the Ministry of Justice publishes a summary of Schedule 5 recommendations (previously rule 43) which had been made by coroners with the intention of learning lessons from the cause of death and preventing further deaths. In the latest report covering the period from October 2012 to March 2013 two concerns regarding the trust were raised.

Detailed findings

Learning from incidents and improving safety standards

On a quarterly basis the trust produces an 'aggregated incident, complaints and claims report'. This is a comprehensive document which details all the incidents and where in the trust they took place. It also identifies trends and what action is taking place in response to the incidents. Examples of areas that were considered in detail included violence and aggression, restraint, falls, medication incidents, people missing from care and substance misuse incidents.

This report was considered in detail by the quality committee which reports to the board. Sections of the report are shared with groups throughout the trust and feed into divisional meetings. We were also able to see that the trust produced patient safety alerts that were sent to staff where they wanted to make them aware of a specific risk and how this should be managed.

For serious untoward incidents a root cause analysis was undertaken. Three of these were selected and looked at in detail. These were all completed thoroughly and clearly identified lessons learnt.

We found a mixed picture across the trust in terms of learning from incidents. In the inpatient acute services lessons were not being shared between wards. In the inpatient services for older people lessons from serious untoward incident investigations were not being shared with staff in a timely manner. In the psychiatric intensive care unit, lessons had been shared but staff were not able to articulate these and show how they were being used to improve safety on the ward. Staff must be able to use learning from incidents in their directorate and team. A compliance action has been made about having effective systems in place to ensure learning from incidents across the services where this was not happening consistently.

The trust had decided to implement the 'Safe Wards' initiative starting initially on Rosewood Ward as a way

of improving interactions with people using the service in order to reduce the number of violent and aggressive incidents.

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

Staff we spoke with understood the importance of safeguarding vulnerable adults and protecting children. The trust policy was up to date and clearly advised staff how to raise an alert and who to contact. The trust had a safeguarding manager and there was an ongoing programme of developing safeguarding champions. The trust actively participated in safeguarding boards.

The current levels of training in safeguarding as reported by the trust in March 2014 is 96% for level 1 and 81% for level 2. These figures do not reflect the fact that a few staff teams have higher numbers of staff who have not completed this training. The level 3 training for staff who would be investigators stands at 78%. Stakeholders told us that investigations are not always seen through. Further work is needed on this to ensure safeguarding investigations are undertaken to a high standard by trained staff.

The trust monitors its safeguarding incidents and trends are monitored by the safeguarding committee which feeds into the quality committee to the Board. Both Islington Clinical Commissioning Group and Camden Council have both recognised an increase in safeguarding referrals from the trust which is a positive development.

The trust undertakes regular audits to evaluate how well child and adult safeguarding policies are put into practice. An initiative has been agreed with Islington Clinical Commissioning Group that safeguarding would be a standard agenda item on each staff member's supervision but when this was audited in January 2014 over half the staff said this was not happening in practice. This is an area of ongoing work for the trust.

Some people on acute inpatient wards are saying that they do not always feel safe and that they do not feel adequately supported by staff after they have been assaulted by another patient. This is an area where the trust should improve.

Risk register

The trust has a well-established risk register. This monitors progress with addressing the identified risks. The trust also has divisional risk registers which are used by the staff working in those areas.

Safe staffing levels

We looked at whether the trust provided safe staffing. In 2012, the trust undertook a major change programme. This reconfiguration referred to by staff and people who use the services as 'the changes' affected the roles and in many cases the terms and conditions of staff working for the trust and it was apparent during the inspection that the trust is still recovering from this difficult period.

Detailed findings

Staff vacancies are monitored by ward and team on a monthly basis. At the end of March 2014, the vacancy rate across the trust varied between divisions with the highest vacancy rates in recovery and rehabilitation 22% and acute 16%. The wards and teams with the highest vacancies were Opal (36%) and Malachite (37%) at the Highgate Mental Health Centre and the Assessment and Advice team (28%).

We looked in detail at the staffing levels across three acute inpatient wards at the Highgate Centre to ensure there were enough staff to meet the levels prescribed by the trust and if needed additional staff for close observation of individual people who needed this support. We found that while the trust made significant use of temporary staff, they did on most occasions have sufficient numbers of staff.

We were told by the ward managers for some of the acute inpatient services that they were not always able to provide escorted leave when people wanted.

Senior staff in the trust told us about the recruitment that is taking place to ensure more permanent staff are in place. The most significant challenge for the trust is the recruitment of nursing staff. They have undertaken a number of large recruitment events over the past year. They have also looked at the selection process, introducing a number of competency tests to ensure the staff they are recruiting have the appropriate values and skills. They have worked closely with the universities and also recruited from Ireland. At the time of the inspection some staff had been recruited and pre-employment checks were taking place and another large recruitment event was planned.

We were also told about how alongside the recruitment of new staff there is a separate exercise, the Meridian project looking at the productivity of existing staff, mainly in community teams, where for example the levels of face to face contact are being measured to see where this needs to improve.

Staff sickness across the trust is low with an average figure of 2.7% compared to other mental health and learning disability trusts. Sickness is monitored by team and outliers identified so that action can be taken. The current turnover of staff calculated by the trust was at 8.2% at the time of the inspection.

Use of physical interventions

Staff had been trained in the use of physical interventions through the Middlesex University. They understood that the use of physical interventions would be used only as a last resort. Staff understood that the use of physical interventions must be recorded as an incident. The quality of these recordings have improved and so previous non-compliance from the last inspection at St Pancras had been addressed.

The use of restraint had been thoroughly analysed across the trust as part of the quarterly report that looks at incidents. From mid- October 2013 until mid-April 2014, there had been 172 incidents reported that involved restraint and a third of these took place on the Psychiatric Intensive Care Unit (PICU). Two–thirds of the restraints were face-down and medication was administered in 77% of the restraints. New guidance published by the Department of Health in April 2014 called 'Positive and Safe' includes new guidelines on the use of face-down restraint which aims to reduce its use. Staff told us that they were still using face-down restraint but when their training was refreshed they were being trained to use alternative approaches. Senior staff told us that thry are working with the Department of Health to access national training that is being rolled out and revisiting the guidance on restraint. Further work was needed on this to reduce the risk of physical and psychological harm to patients and staff.

The only seclusion rooms in the trust were the two located on Coral Ward in the PICU. In the six months before the inspection, seclusion had been used on 40 occasions. This had been appropriately recorded. The seclusion room had a camera and two way audio-communication. When undertaking the 15-minute observations of the patients in seclusion staff said that they would do this without entering the seclusion room. It was found that this did not ensure that staff could tell if a patient was breathing if they were lying down. Staff should enter the room where needed to carry out safe observations.

Risk to individuals

Individual risk assessments were looked at across all the areas inspected. It was found that these were generally completed well and being used. On the acute wards it was noted that risk assessments were not always being completed for people going on leave, which could mean that potential risks to people when they were outside the hospital may not always have been considered.

Detailed findings

Understanding and management of foreseeable risks

The trust has governance processes to oversee and manage risk. These are considered by the quality committee or the audit and risk committee and through them feed into the board.

The trust risk register highlights many of the risks associated with the poor physical

environment on the St Pancras Hospital site. The trust will be undertaking a major redevelopment of this site over a number of years. Senior staff said a project manager has been appointed to manage this work.

Medical devices and resuscitation equipment

We looked as part of this inspection at the safety of equipment being used by the trust. We were aware from the trust's risk register that work with a private company was still ongoing to do a full inventory of all the medical devices in the trust and check they are all working. We specifically looked at emergency resuscitation equipment on wards where physical interventions are used. All the equipment had received a full annual maintenance check and was regularly checked by the ward staff.

Management of ligature points

Our last inspection at St Pancras found multiple ligature points in acute wards and no risk assessments for how this would be managed for individuals. At this inspection, we found that the acute wards across the trust still had ligature points. Since March 2014 four people have attempted to take their own lives and this sadly resulted in one death.

Some work had taken place or was planned to manage this risk:

- Firstly individual patients had clinical risk assessments that addressed their potential self-harm and considered how this could be managed through for example the use of higher levels of observation. This met the requirements of the last inspection.
- The trust had also employed a specialist surveyor who had looked at potential ligatures across the wards and had identified those which were the highest risk. These assessments of risk were available on the wards and the intention is to update these six monthly or following an incident but they did not state how the risks would be mitigated.
- Some environmental improvements had taken place at the Highgate Mental Health Centre, including the replacement of smoke detectors on Coral and Sapphire Wards, replacement of pull cords with push buttons on assistance alarms and removing a smoking shelter from the garden. At St Pancras some smoke detectors had been relocated and the in-house maintenance team had done some work to remove shelves, racks and box in window winders as well as some other changes.
- Some changes have been made in response to specific incidents such as removing cupboard doors on 10 wards at the Highgate Mental Health Centre with the same starting to happen at St Pancras. In addition, all the bath taps had been removed at the Huntley Centre in March 2014. The inspection team were concerned this blanket approach was reactive and did not consider the needs of patients although the trust explained this was in response to the coroners report.
- Just after the inspection a programme of work was starting at the Huntley Centre to deliver what senior staff have said is a comprehensive anti-ligature programme. Another programme of work is planned at the Highgate Mental Health Centre subject to board approval in July.

At this inspection the main concern was that ward managers and staff were not able to clearly articulate how they managed the potential risks of ligature points in the wards as part of a planned approach to keep patients safe. Therefore there was a risk of unsafe care as systems were not in place that were clearly understood by staff to manage the risks posed by the unsafe environment.

After the inspection the trust produced a patient safety alert to support ward staff to think about how they would manage the risk of ligature points. This was positive but the impact of this would still need to be evaluated.

Use of illicit drugs

Before and during the inspection we heard from people who use the service and staff that there was a problem with illegal drugs coming onto the PICU and the acute admission wards. This was confirmed by people using the service. There was also a programme of work led by the Trust Local Security Management Specialist. This has included the use of drug sniffer dogs and also support from the local safer Neighbourhood Team. This had been successful to a degree but staff were aware that drugs continued to come onto the wards but they did not know how. The trust had a policy in place in respect of searching premises, patients and/or their property which had last been revised in 2010. The date for reviewing the policy was

December 2013 and was therefore overdue. The policy described the search procedure and the use of drug dogs in inpatient settings as a form of drug detection. The policy stated that 'all patients have the right to receive care in a safe environment, free from drug and alcohol use.' Whilst there has been some progress this is still an ongoing issue.

Mix of patients on inpatient wards for older people

The older people's inpatient wards accommodate people with a range of needs. This is hard for the staff to manage as the differing needs of the patients sometimes led to incidents of violence and aggression. While the staff were trying to diffuse these incidents and prevent people getting harmed the specialist inspectors felt that the mix of patients should be reviewed. Senior staff in the trust told us that they were already planning to change the function of Garnet Ward later in the year as a way of improving patient safety and care.

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

Staff, mainly in inpatient services, were not always confident in using the Mental Capacity Act 1983 and Deprivation of Liberty Safeguards (DoLS). This meant that people might not be properly involved in decisions about their care. In some cases, it meant that they could be deprived of their liberty without the correct authorisations in place, which would contravene their human rights.

The trust used external accreditation and internal audits well to evaluate many aspects of the services it provided.

Management of medicines had improved across the trust. However, the trust's own medicines risk register showed that more improvements were needed and that these should be fully implemented so that medicines were managed safely.

During their stay in hospital, people were given physical health checks to help them maintain good physical health.

Staff received training and development to improve their effectiveness. The need for some specific training to support staff in their areas of work was identified during the inspection. The trust needed to do more work to make sure that staff receive management supervision to a consistently high standard.

The Mental Health Act 1983 was being used appropriately at the time of the inspection and there had been significant improvements in ensuring people were aware of their rights.

Our findings

Medicine management

Arrangements for the supply of medicines were good, so people did not have delays in receiving treatment. Medicines were stored safely in the areas we inspected.

Prescription charts were clear and fully completed in all areas except one, providing evidence that people were receiving their medicines as prescribed, when they needed them. Medicine management at Stacey Street Nursing Home was now working well and the compliance action from the previous inspection was completed. Some improvements were needed in recording and transportation of medicines in the crisis team at Highgate Mental Health Centre. Also, some improvements were needed in the psychiatric intensive care unit where observations of people who had received rapid tranquilisation needed to be consistently recorded.

The latest medicines incident report showed that there had been 40 medicines-related incidents across the trust in the three-month period between January and the end of March 2014, with only 3% resulting in minor injury (adverse reaction to drug) which is comparable to other quarters.

However, we were concerned that the most recent medicines risk register supplied by the trust identified that there is currently a high level of risk in certain areas related to medicines, such as reporting and learning from medicines incidents, and a medium level of risk in other areas, such as review and gap analysis for medicines standard operating procedures (SOPs), and lack of awareness of medicines policies. The trust has an action plan in place to address these risks by 1 October 2014. These identified improvements in the areas identified in the medicines risk register that need to be implemented to ensure the safe management of medicines.

The pharmacy department at Highgate Mental Health Centre supplied medicines for the trust, with a satellite dispensary at St Pancras. This was open five days a week, with a limited service at weekends. There was an agreement with the Whittington Hospital to provide out-of-hours advice and medicines. Wards kept an extensive stock of commonly prescribed medicines to limit the number of individually dispensed medicines. Outside of these times, there was a pharmacist on call. Therefore there was access to pharmaceutical advice and medicines 24-hours a day.

We saw that people were provided with information about their medicines. Pharmacist and ward staff both discussed

changes to people's medicines, and mental health medicines information leaflets were available for people. Ward staff we spoke with told us that arrangements for medicine supplies were good. This meant that patients had access to medicines when they needed them without delays.

The trust carried out regular audits on controlled drugs, rapid tranquilisation and medicines reconciliation. There were no audits on missed doses, however, there were plans to begin auditing other critical areas of medicines management. The trust told us that the focus in the past year had been on improving the clinical service to wards as this had not been provided before 2013. There was an allocated pharmacist to each ward and area and the frequency of visits varied, depending on the type of ward. For example the admission wards had daily visits. Pharmacists also attend ward 'board' meetings to discuss medication issues. Pharmacists provided clinical input by screening prescription charts, providing advice to staff and talking to patients about their medicines.

We saw that people were supported to self-administer topical medicines and insulin. On the rehabilitation units, although people were supported to self-administer, there were no individual lockers available so when people were self-administering, staff kept their medicines. Therefore people on the rehab wards could not be fully independent with their medicines before leaving the ward. The trust told us that the self-administration policy was out of date and in the process of being revised, and that individual lockers would be considered.

Comprehensive assessments

Individual assessments were in place for people using the services in all the areas that were inspected. This included assessments of people's physical healthcare needs.

Use of the Mental Capacity Act

At our last inspection at St Pancras, we found the trust to be non-compliant in relation to outcome 2: consent to care and treatment. This was mainly in relation to people receiving sufficient information about their detention under the Mental Health Act. It was also mentioned that people's capacity had not been assessed.

During this inspection the understanding by nursing staff and the use of the Mental Capacity Act (MCA) was very mixed across the trust. Many of the nursing staff especially in inpatient services deferred to the medical staff to lead on MCA issues. Senior staff told us that in the trust there is not a lead for the MCA or for Deprivation of Liberty Safeguards (DoLS) although funding had been agreed for the creation of a MCA coordinator and for a Mental Health Law lead manager.

Staff induction and safeguarding training did briefly touch on the MCA and DoLS. There was not a MCA or DoLS policy in place, but there were flowcharts to help staff understand the process they would need to follow.

The trust provides training to ward managers that can then be shared with other staff. An external trainer had provided input into Stacey Street Nursing Home and Garnet Ward. In addition training was being arranged by social services that staff were being supported to access.

Before the inspection, the trust was asked for the number of applications for DoLS authorisations in the previous six months and they said no applications had been made. At the time of the inspection a few applications had been made for older people, mostly at Stacey Street.

The impact of many staff not feeling confident in their knowledge and application of the MCA and DoLS is that people's consent may not be appropriately sought and in some cases they could be deprived of their liberty which would contravene their human rights.

Promoting good health

The trust had met their annual quality improvement target set by the clinical commissioning groups for people receiving an inpatient service to receive a physical health check during their admission. Stakeholders had commended the trust on its work with primary care to promote the physical health care of people living with an enduring mental illness.

The trust had implemented an initiative which is a modified Medical Early Warning System (MEWS). The aim of this was to try and identify and reduce the risk of someone suffering a sudden death. Nurses were being trained to use this tool and we saw this was progressing well.

The trust acknowledged that there is more work to be done to promote good health. For example it was not meeting a quality improvement target set by the clinical commissioning group in relation to involving, agreeing and adopting a care plan intervention for smoking cessation

although we did see some good practice where people had agreed to accept support with reducing or stopping smoking. There have also been significant improvements with a dedicated smoking cessation matron.

Outcomes for people using services

The trust had a very comprehensive performance dashboard which was a compilation of key performance indicators and targets. This dashboard was available at a divisional and team level and was discussed at divisional performance meetings. The information was RAG rated, which meant that the performance is colour coded (red, amber or green) so that each ward or team can clearly see their performance. The performance dashboards were brought together into a quarterly report that was submitted to the board. During the inspection staff told us that they were aware of this information and used it to make changes in their services. We heard positive comments from staff across the organisation about how this data had enabled them to be better informed and had contributed to improvements in the service.

The trust also carried out a large number of ongoing audits, including divisional clinical audits as well as one off audits where they wanted to look at a specific issue.

As part of their quality assurance system the trust participated in the Royal College of Psychiatrists' quality improvement programmes. Two wards are accredited (Malachite and Montague) with their adult inpatient accreditation service. The ECT service and the Islington Crisis Resolution and Home Treatment Team have also participated in the accreditation process. The trust also participated in some national clinical audits including the National Audit of Schizophrenia in 2011, the National Audit of Psychological Therapies in 2013 and Prescribing Observatory for Mental Health (POMH - UK).

In addition, the trust had a very active research programme and said that they were ranked second highest of all mental health trusts in London for research and development in terms of grants, activity and publications. They had an alliance with the division of psychiatry in University College London. They were also developing nursing research capacity. Staff told us about their research work and how this was greatly valued by the trust

Staff training and development

The trust provided a two-day corporate induction training course for all new starters and we were told that this was well organised.

The trust had six training courses which were mandatory including fire safety, infection control, safeguarding, health and safety, information governance and equality and diversity. The uptake of these is monitored and at the end of March 2014 the uptake of this training had improved with three divisions reaching the 80% target. The progress of individual wards and teams can be monitored so action could be taken as needed.

Many staff spoke positively about the opportunities they had for professional development and the training they had received.

An example of this were some nurses telling us about the training they had received so they could undertake non-medical prescribing. Nursing staff also told us about how if they had a diploma this could be topped up to a degree.

We did find that in the learning disability inpatient service, which consisted of beds on an acute ward, the nursing staff had not received training on supporting people with learning disabilities. This was also raised as an area for improvement when the service took part in the Royal College of Psychiatrists' National Audit of Learning Disability Services. Staff working in some of the adult community teams told us they had not all been trained in supporting people, whose behaviour was challenging, which could put the person or themselves at risk from not knowing how to support someone appropriately if they were angry or distressed.

In terms of the professional revalidation of doctors the trust told us that this was a rolling programme and being successfully completed. The NHS England revalidation team have said that the trust had achieved an 87% appraisal rate and there were no concerns about revalidation.

In terms of staff supervision, the trust monitors the numbers of staff who have received supervision through its scorecard process. Most teams were meeting a target of 90% receiving monthly supervision. The inpatient wards were finding it the hardest to meet this target. Stakeholders specifically mentioned that some social care staff had reported inadequate supervision arrangements but recognised the mechanisms put in place by the trust to

monitor what supervision was taking place. Staff did tell us that the quality of supervision was variable. For example some psychologists told us about the very good supervision they received and when we looked at supervision records on the older person's inpatients wards we saw the content of what was discussed varied. Ensuring the content and quality of supervision was of a consistently high standard across its services was an ongoing challenge for the trust.

Access to meaningful activities

Previous CQC inspection reports had identified access to meaningful activities as an issue across the trust. The trust had responded by providing additional activity coordinators. The trust monitored the numbers of patients on inpatient wards involved in or offered at least four activity sessions a week and most wards had been meeting this target with the exceptions of Jade and Laffan. We saw some excellent person-centred therapeutic activities being provided across the trust, for example the introduction of a fitness session on Rosewood Ward which had been requested by the women using that service. People using the acute wards at the Highgate Centre specifically told us that there were not enough activities at the weekend and we did not see many activities happening on the psychiatric intensive care unit as ward staff were needed to carry out observations and other essential work on the ward.

Multi-agency and multidisciplinary working

Both Camden and Islington adult social services commented favourably on joint working with the trust. Partnership agreements (Section 75) were in place to provide a range of integrated services. Many teams were multidisciplinary consisting of health workers with social workers. Positive examples of joint work were observed during the inspection for example in the memory services for older people and the community learning disability teams. Camden adult social services had also commented on the improved use of direct payments.

Islington Clinical Commissioning Group also commented on the development work that was underway to develop shared care protocols between the trust and primary care. The trust had already improved its performance towards meeting a quality target to send GPs a discharge notification within five days of the person being discharged. However work was still needed to ensure the quality of the information was sufficient as an audit showed that only 65% contained all the necessary information. The trust still needed to meet a quality target for sending GPs a record of the CPA review or updated care plan within 10 days of the review meeting. This is one of the trusts quality priorities this year.

We also saw many good examples of multidisciplinary working for example ward meetings, team meetings and review meetings. We also saw community and inpatient teams working together well, especially in relation to discharge planning.

Mental Health Act (MHA)

At the last inspection at St Pancras, we found that some people had no evidence of having their rights explained to them. At this inspection we found that information on people's rights were displayed and there were records to show that people were consistently informed about their rights. The trust had also carried out audits to check this was happening.

The Mental Health Act reviewers checked that all the appropriate documentation was in place to reflect what was required in the Mental Health Act and Code of Practice, and in most cases this was correct. We asked to see what ongoing audits the trust undertook to ensure this was always the case. We were told that this ongoing audit is in development.

Senior staff told us that funding had been approved to appoint a more senior team leader post to oversee the Mental Health Act and Mental Capacity Act, and this post needs to be filled.

Are services caring?

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

Summary of findings

Before and during our inspection, people told us that most staff treated them with kindness, dignity and respect.

The trust had made progress in getting people involved in developing their care plans. In addition, people had more consistent care co-ordinators and there was access to one-to-one time with a named nurse for people using inpatient services. We saw, however, that there were still occasions where this does not happen, so the trust should continue to improve this.

The trust put people's recovery at the centre of their work and we saw this happening in practice.

We also saw and spoke to carers who felt that they were appropriately and positively involved. However, some carers felt that this could also be improved, especially for people in crisis.

Our findings

Kindness, dignity and respect

Before and during the inspection, we heard lots of positive feedback from people about how they felt staff treated them with kindness, dignity and respect. We also observed many examples of positive interactions between staff and people who use the service throughout the inspection visits. There were occasions when people felt that staff were too busy and did not have enough time to speak to them.

Stakeholders said they also received consistent feedback, from people who use services, saying that staff were caring and compassionate.

The CQC Community Mental Health Patient Experience Survey 2013 showed that 79% of the people who responded said staff who they had most recently seen had treated them with dignity and respect, another 17% said this happened to some extent and 4% did not feel they had been treated with dignity and respect.

People using the services did give us examples of how they felt their privacy and dignity could be improved. For example we heard about how people had been told by staff that the key to their bedroom had gone missing and that they had to ask staff to lock or open their room. We also heard about people not having access to a lockable space.

Involvement of people using services

The inspection looked at whether people were being involved in decisions about their own care. At the previous inspection at St Pancras the trust was non-compliant as most people were not aware of their care plan, did not have a copy and it was not clear if people had been given the opportunity to be involved in developing their care plan.

At this inspection most people told us that they felt informed about their care and had been offered the opportunity to be involved in decisions even if they had not wanted to do so.

Emotional support for care and treatment

People told us about the importance of their relationship with a care coordinator to support them with their care and treatment. The main concern raised by people with long term conditions was that since the organisational changes in 2012 they had experienced more changes of care coordinators which can cause distress to the individual and affect the consistency of care. The trust had monitored the numbers of care coordinators for people receiving a care programme approach (CPA). In 2012 there were 1,192 people receiving a CPA. Of these, 52% had one care coordinator for the whole year, 28% had two, 13% had three, 5% had four and a small number had more. In 2013 there were 1,802 people receiving a CPA. Of these 72% had one care coordinator, 22% had two, 5% had three and a small number had more. It can therefore be seen that the numbers of people who had experienced a change of care coordinator had reduced but for those still affected by these changes it can be an unsettling experience.

People who were using inpatient services also told us about the importance of individual time with their named

Are services caring?

nurse. We heard feedback that access to these individual sessions had improved especially in the acute services at St Pancras. In the psychiatric intensive care unit this was proving hard to achieve.

The carers we spoke to prior to and during the inspection gave mixed feedback on their experiences of being involved and being able to provide support to the person receiving care and treatment. We saw and heard about some very good practice in involving carers. Some told us a carers assessment had been completed but this had not led to any additional support. There is a Carers Partnership Group and this fed into the Service User and Staff Experience Committee.

Throughout the inspection we heard about the work done by the trust to support people with their recovery. One of the key initiatives was the development of a Recovery College with courses starting in September 2014. This will involve people who use services and trust staff across the professions.

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

Many of the services provided by the trust are responsive. However, we repeatedly heard from senior staff in the trust, as well as staff in the inpatient and community teams and people using services, that there were challenges and concerns about how the needs of people using the acute care pathway could be met. The main issues were around accessing an acute inpatient bed. This affected people in a number of ways, including having to be placed in hospitals outside the trust. People were sometimes moved between wards for non-clinical reasons, which had an impact on the consistency and quality of care they received.

We saw many positive examples of how the trust respects people's diversity and human rights.

The outcomes of complaints were also being used to improve the care provided by the trust.

Our findings

Planning and delivering services

The trust worked closely with commissioners, local authorities, people who use services, GPs and other local providers to understand the needs of the people it serves and to plan and design services to meet their needs.

The major change programme in 2012 gave the trust an opportunity change the trusts clinical model and to implement services along care pathways. While this was mainly seen as a positive development, we did hear about the difficulties for people who did not fit into one care pathway and of the challenges of moving between care pathways.

We heard about the teams who support people who may be hard to engage, for example the assertive outreach team and the focus homeless outreach team. We were told throughout our inspection of how individual services have worked to make their services more responsive for people who use them.

While the trust aims to support and treat people as near to Camden and Islington as possible, they do need to place some people who need acute beds or female psychiatric intensive care unit (PICU) beds in the independent sector mainly within the greater London area. For people needing an acute bed or a male PICU bed this is due to a lack of bed capacity within the trust at the time this is needed. People needing a female PICU bed are cared for by one independent sector provider as agreed with commissioners as the trust does not provide this service. From April 2013 till February 2014 there were 131 placements – 76 acute and 55 PICU.

With the exception of Rosewood (female acute ward) and Coral (male PICU ward) all the other inpatient accommodation is mixed gender, but does provide appropriate levels of privacy in terms of the location of bathroom facilities.

Assessment and advice team

The trust operate two assessment and advice teams that act as the first point of contact for most non-urgent or emergency referrals to the trust. The team phone back people within two hours to discuss their referral. The target was for people to have their appointment for a full assessment within 10 working days, but in March 2014 this was achieved for 64% of the people contacting the Camden team and 57% for the Islington team. This target was reviewed with commissioners and increased to 15 working days. The target was then achieved for 83% of people contacting the Camden Team and 82% for the Islington Team. There were a small number of people who had been waiting an extremely long time for an appointment (over 50 days).

The staff at the assessment and advice teams talked about the challenge of booking appointments with the most appropriate staff in a building with limited rooms available for these appointments. The service is relocating to the St Pancras site where more rooms will be available. Referral to this service is through the GP.

Access to other teams

There were a number of services where referrals could be made directly without going through the emergency and

advice team. These included: the memory service, substance misuse service, early intervention service, improving access to psychological therapies service and focus outreach street population service.

Access in a crisis

People who needed help urgently could go to the health-based places of safety suites in the accident and emergency (A&E) departments at the three local acute hospitals, the Whittington, Royal Free and University College Hospital. The trust provided a liaison service to those facilities and during the inspection we saw these services working well.

The crisis resolution and home treatment teams provided home based treatment for people in crisis and 'gate keep' the admissions to the acute inpatient wards. As well as being accessible by professionals, people who have used the team can re-refer themselves which was positively received. These teams were accessible 24-hours a day, although at night this was mainly for phone-calls rather than home visits. This service received mainly positive feedback although a few people who used the service told us about delays in making contact with staff.

Referral to treatment times

There were a few services where the referral to treatment exceeded the target. This included the complex depression anxiety and trauma team and the personality disorder team. The commissioners were providing additional funding to reduce waiting times for a range of services. The trust had also tried to mitigate these waits, for example in the personality disorder team people could join a pre-therapy group.

Access to psychological services

Stakeholders told us that there had been a significant improvement in the waiting time performance for improving access to psychological therapies (IAPT). These services were based in primary care with more than 90% of GP surgeries having an IAPT worker on site. The trust had more than 8,000 patients entering treatment each year. The National Audit for Psychological Therapies report in 2013 found that the trust was very similar to the national average for referral to treatment times. It also found the therapies were in line with NICE guidance. There were however lower levels of patient choice about the timing, venue for the appointment and type of therapy. This reflects what people told us about psychological therapies.

Discharges

The number of patients who experienced delays to their discharges varied. In February 2014 only one patient experienced a delayed discharge and in March 2014, eight patients had a delayed discharge. Stakeholders told us that the trust worked well with the local authorities to address challenges, such as housing issues and that the trust had an excellent performance in transfers of care.

Care pathway

Throughout our inspection we heard repeatedly from senior staff in the trust, people using services, staff working in inpatient and community teams, about the challenges and concerns about meeting the needs of people using the acute care pathway. This mainly centred on the pressures of accessing an acute inpatient bed. The challenges that were brought to our attention were:

- The trust has very high levels of bed occupancy – between October and December 2013 this was 96.4% compared to the England average of 85.9%. It is generally accepted that when occupancy rates rise above 85% it can start to affect the quality of the care provided to patients and the orderly running of the hospital.
- Staff from the crisis resolution and home treatment teams told us that they felt at times they were supporting people who needed an inpatient admission. They often had to escalate a request for an inpatient bed before one was found.
- Staff from the crisis houses told us that they felt at times that they were supporting people who should have been in an acute inpatient service.
- Staff across the trust told us that most people accessing an acute inpatient bed are detained under the Mental Health Act .
- We heard that the pressures on beds are so great that inpatients who go on leave may not have a bed when they need to return as this is being used by another person.
- In order to manage with the existing numbers of beds some people using the service experienced several moves between wards, not due to clinical need, during one admission. Some people were transferred to wards where they did not know, or were not known by, the multidisciplinary team. While the trust had worked to reduce the number of people moving wards at night, this was still happening in some cases. There were

informal agreements rather than a clear protocol on the management of transfers between wards. This meant that transfers of people between wards was not managed in a planned and coordinated way which had a detrimental effect of people's care and hospital experience. A compliance action is made regarding this for acute inpatient services.

- People using the service told us they were concerned about how quickly they were discharged. One person said "they discharge you as soon as you can do up your shoes". The average length of stay had decreased in the last year and for the last quarter of 2013-14 about 30% of people stayed 1 -10 days, 20% 11 – 20 days, 18% 21 – 30 days and then the numbers gradually reduced with a small number 7% staying over 100 days.
- Re-admissions – the trust has benchmarked re-admissions and these were not out of line with the performance of other trusts.

Equality, diversity and human rights

People's diversity and human rights were respected. Attempts were made to meet people's individual needs including cultural, language and religious needs. Contact details for representatives from different faiths were on display in the wards. Local faith representatives visited people on the ward and could be contacted to request a visit. There was a faith room available to people although staff told us that the faith room was kept locked and inaccessible to people at the weekend. The reason for this was not clear.

Interpreters were available to staff and were used to assist in assessing people's needs and explaining people's rights as well as their care and treatment. Leaflets explaining people's rights under the Mental Health Act 1983 were available in different languages. During our review of people's healthcare records on the wards we noted that interpreters had accompanied people to multidisciplinary meetings when the person did not speak English well.

A choice of meals was available. A varied menu enabled people with particular dietary needs connected to their religion, and others with particular individual needs or preferences, to access appropriate meals.

A women's forum, open to all women who use the service, met every month. The forum encouraged women to talk about issues important to them and any concerns they had during their admission, particularly related to their gender.

Learning from concerns and complaints

The trust carefully monitored complaints. The target was for there to be an acknowledgement sent to the complainant within 10 days and a response in 25 days. For the final quarter of 2013/14, 58% of the complaints had received a response within the 25 days. This result had fluctuated throughout the year and achieving a consistent response time is an ongoing area of work for the trust.

The complaints were analysed by division and by category of complaint. The acute division received the greatest number of complaints with 'communication' and 'patient journey' being the greatest causes of complaints.

Senior staff explained that complaints are discussed at divisional meetings so that trends can be monitored and lessons learnt.

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 trust was well-led and had a clear vision, shared values and direction. The recently appointed chair was well received and was leading on many positive changes, in particular engaging people who use the services. Staff and patients also said that senior staff were accessible and open.

The governance arrangements in place enabled areas of the trust's work to be reviewed effectively. The non-executive directors were also very engaged in this process.

Although people who use the services and staff still felt negatively about the major change programme that took place in 2012, most were positive about the future and staff morale was improving. The trust acknowledged that there were things they could have done better and that they were working to re-connect with staff. The trust was also working to develop leadership for the future for those in managerial and leadership roles.

Our findings

Vision and strategy

The trust developed a set of shared values in 2012/13. This work involved more than 500 people who used the service and staff. These values described how the trust aims to interact with people who use the service, carers and staff within the organisation and their ambition to provide an excellent experience for everyone they work with.

Their 'Changing Lives' values are as follows:

- We are welcoming, so you feel valued.
- We are respectful, so you can feel understood.
- We are kind, so you can feel cared for.
- We are professional, so you feel safe.
- We are positive, so you can feel hopeful.
- We work as a team, so you can feel involved.

The vision of the trust was that "people who use the Camden and Islington services will have the best prospect of recovery, within the resources we have available". This was underpinned by strategic aims under the categories of Excellence, Innovation and Growth. The trust also had clear objectives going forward.

We found that the trust's visions and values were displayed in wards and at team bases and that most staff understood what these were.

Responsible governance

The trust had a Board of Directors who were accountable for the running of the trust. There was a clear governance structure that consisted of committees that reviewed areas of the trust's work, feeding into the board. These committees had clear terms of reference, membership and decision making powers. It was noted that the board papers that go on the trust website only consisted of the minutes of the meeting and not the papers that were discussed.

We looked particularly closely at the work of the Quality Committee, Audit and Risk and Service User and Staff Engagement Committee. We could see these were meeting regularly and had senior executive and non-executive involvement.

We met the non-executive director who chairs the Quality Committee. They told us that the information considered by the committee had improved in detail and incorporated more analysis. It was also informed by feedback from people who use services and the governors. They were also able to explain how non-executive directors undertake a programme of visits as well as undertaking a number of roles to contribute to their knowledge of the trust and governance processes.

We heard about the work that was taking place to support board development including away days and accessing training provided by the King's Fund. The chair acknowledged that there is still further progress to be made.

The exception to this positive governance work was in the PICU where there was a "rapid improvement plan in place".

Are services well-led?

The associated action plan and records fo meetings did not show clearly when targets were completed or expected to be completed in order to provide assurance that this work was progressing as expected.

Leadership and culture

External stakeholders told us that the trust had a strong management team who are very experienced and involved. We were told that they listened to people who used the services. The recently appointed chair had been very well received. The chief operating officer was also a more recent appointment and was felt to be very strong with many staff we spoke with valuing his input and support. We were told that the culture of the trust had become more open.

We were told by people who use the services of the trust that they found senior staff accessible and that they were willing to attend meetings and listen to concerns raised.

Staff told us that there were many examples of clinical staff and managers working well together. We heard that people felt able to challenge and raise issues. Staff also told us how they valued working for a smaller trust and how this helped with communication.

As we visited wards and teams we heard that staff generally felt well supported at a local level. The trust acknowledged that there were some managers in the trust whose performance could improve and that they were addressing this where needed through formal processes.

Service user engagement:

The trust had a Service User Involvement Strategy and from this launched the Service User Alliance. Each division of the trust had their own user forum. This provided a formal opportunity for people who used services to feed into the decision making process of the trust by, for example, helping to develop and ratify key policies.

In each borough there was a jointly commissioned borough user group. Senior managers from the trust attended meetings and at the meetings that were attended as part of the preparation for the inspection we were told that senior staff were accessible.

Throughout our inspection we were able to see many examples of user involvement through ward and group meetings that provided opportunities for people to discuss what was happening in the service. Access to advocacy services was in place for inpatients. Community patients said that recent changes in the provision of advocacy services in Camden was making it harder to access services in a timely manner although it was recognised that the new provider needed some more time to develop its service.

Council of governors members told us that with the arrival of the new chair their opportunities for involvement had increased which was well received.

A relatively new committee has been established called the Service User, Staff Experience and Quality Working Group which reports to the Board. This had undertaken a mystery shopper exercise identifying areas for improvement particularly in relation to reception areas. The trust also took part in the Patient Led Assessment of Clinical Environments (PLACE) and 17 people who used services had been trained and made up 50% of the assessment team. We also heard about the “privacy and dignity walks” undertaken by people who used the services and who then reported back their findings.

The trust had also undertaken a number of surveys to get feedback on some specific services. We did hear in the crisis resolution and home treatment teams that feedback from people who used the service had been collected but had not been collated or used.

Staff engagement

The trust acknowledged the impact on staff morale following the organisational changes in 2012. The most recent staff survey showed that there had been an improvement in staff morale. The trust introduced ‘Changing Lives’ an organisational development programme to co-produce the value base and visions as part of the process for reconnecting with staff. The most recent NHS staff survey showed that the trust scored in the top 20% for communication between senior management and staff and staff feeling able to contribute towards improvements at work. However the trust scored within the bottom 20% in relation to staff experiencing physical violence, harassment, bullying, abuse or staff experiencing discrimination. Senior staff were very aware of these results and the need to address the potential causes of these scores.

The trust had also recognised the low use of the whistleblowing process. In the year 2013–14 there were 11 whistleblowing alerts and four of these were alerts made to CQC, where these, with the consent of the person, were shared with the trust. The trust said that at the time of the

inspection the whistleblowing telephone line was managed by the human resources department, but it recognised that people might feel more comfortable raising issues with a more external body.

Performance improvement

The trust had a strong management and leadership development programme. The trust was accredited by the Chartered Management Institute to deliver a level 3 certificate in First Line Management. So far 75 staff had enrolled in the programme and 46 had passed. The course had been evaluated positively by Middlesex University and the programme lead won an award in the National Management Awards in 2013. The trust also provided a clinical leadership programme in partnership with another trust. This leadership programme was well received by the staff who had received the training.

This section is primarily information for the provider

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 10 HSCA 2008 (Regulated activities) Regulations 2010 Assessing and monitoring the quality of service The trust did not have an effectively operating system to share learning from incidents in order to make changes to people's care in order to reduce the potential for harm to service users. This was in breach of Regulation 10(2)(c)

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 10 HSCA 2008 (Regulated activities) Regulations 2010 Assessing and monitoring the quality of service provision People were not being protected against the risks of inappropriate or unsafe care and treatment by means of the effective operation of systems designed to identify, assess and manage risks to people. Although numerous ligature risks had been identified on all inpatient acute wards, staff were not able to articulate how they were being managed or mitigated on a day to day basis. This was a breach of Regulation 10 (1)(a)(b)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA 2008 (Regulated activities) Regulations 2010 Care and welfare of people who use service The trust had not taken proper steps to ensure that each person using the service was protected against the risks of receiving care or treatment that was inappropriate or

This section is primarily information for the provider

Compliance actions

unsafe. Some people using inpatient acute services experienced several moves between wards for non-clinical reasons during one admission. Of these, some people were transferred during the night and/or went to wards where they did not know, or were not known by, the multidisciplinary team. There

were informal agreements rather than a clear protocol in place to manage transfers between wards safely and ensure continuity of care and treatment.

This was a breach of Regulation 9(1)(b)(i)(ii)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA 2008 (Regulated activities) Regulations 2010 Care and Welfare of Service Users The trust did not ensure that service users were protected against the risk of receiving care and treatment that was unsafe by having an up to date policy for managing falls and by ensuring that guidance provided to staff is effectively used within the older people's inpatient services. This was breach of Regulation 9(1)(b)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 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. Many staff in inpatient areas had little or no knowledge of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards and this meant that decisions were being made that might not take into account people's human rights. This was a breach of Regulation 18 (1)(a)(b) (2)

This section is primarily information for the provider

Compliance actions

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 10 HSCA 2008 (Regulated activities) Regulations 2010 Assessing and monitoring the quality of service The trust did not have a clear action plan on the Psychiatric Intensive Care Unit showing when targets were completed or expected to be completed. Staff we spoke to on the ward were also not clear about progress with meeting targets. As this ward is undergoing such significant changes which could impact on patient safety and care clarity would be expected. This was in breach of Regulation 10(2)(c)