Camden and Islington NHS Foundation Trust

Inspection report

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We plan our next inspections based on everything we know about services, including whether they appear to be getting better or worse. Each report explains the reason for the inspection.

This report describes our judgement of the quality of care provided by this trust. We based it on a combination of what we found when we inspected and other information available to us. It included information given to us from people who use the service, the public and other organisations.

This report is a summary of our inspection findings. You can find more detailed information about the service and what we found during our inspection in the related Evidence appendix.

Ratings

Overall trust quality rating	Good
Are services safe?	**Requires improvement**
Are services effective?	**Outstanding**
Are services caring?	**Good**
Are services responsive?	**Good**
Are services well-led?	**Good**

We rated well-led (leadership) from our inspection of trust management, taking into account what we found about leadership in individual services. We rated other key questions by combining the service ratings and using our professional judgement.

Summary of findings

Background to the trust

Camden and Islington NHS Foundation Trust was formed in April 2002 and became a foundation trust in 2008. The trust provides mental health and substance misuse services for adults in the boroughs of Camden and Islington. It does not provide children's mental health services. It provides early intervention services for patients from age 17 and a half. The trust also provides psychological therapies and substance misuse services to the borough of Kingston.

The trust provides the following core services:

• Acute wards for adults of working age and psychiatric intensive care units

• Long stay/rehabilitation mental health wards for working age adults

• Wards for older people with mental health problems

• Mental health crisis services and health-based places of safety

• Community-based mental health services for older people

• Community-based mental health services for adults of working age

• Community mental health services for people with learning disabilities.

The trust also provides the following specialist service:

• Substance misuse services.

The trust operates from two registered locations: Highgate Mental Health Centre and St Pancras hospital. At the time of the inspection, Stacey Street, a home from which the trust had provided continuing care to elderly people, had closed and the trust was in the process of deregistering the location. The trust provides 243 beds. It provides its community and rehabilitation services from a number of locations throughout the boroughs.

The trust serves a population of 471,000 across Camden and Islington. The population is very diverse with over 290 languages spoken. There is a high mobile population consisting of students, immigrants and people moving in and out of the area. The population has a larger population of those aged 20-40, but relatively few children and older people. In Kingston, the trust serves a population of about 200,000. The population is diverse, with 31-34% of people coming from black and minority ethnic communities.

The trust has an income of about £152 million and employs approximately 2000 staff.

The trust's main NHS partners are the clinical commissioning groups (CCGs) for Camden and Islington.

The trust has been inspected 12 times since registration. We conducted a comprehensive inspection of the service that was published in March 2018. At this inspection, we rated the trust good overall. We rated it requires improvement for safe, outstanding for effective and good for the other three questions: effective, caring, responsive and well-led.

Overall summary

Our rating of this trust stayed the same since our last inspection. We rated it as Good 

Summary of findings

What this trust does

Camden and Islington NHS Foundation Trust provides mental health services across three locations in the London boroughs of Islington and Camden. This includes a range of inpatient and community mental health services to adults and older people, including improving access to psychological therapies services, and substance misuse services. It also some psychological-based services and substance misuse services in the borough of Kingston.

Key questions and ratings

We inspect and regulate healthcare service providers in England.

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs, and well-led?

Where we have a legal duty to do so, we rate the quality of services against each key question as outstanding, good, requires improvement or inadequate.

Where necessary, we take action against service providers that break the regulations and help them to improve the quality of their services.

What we inspected and why

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

We inspected four core services as part of our ongoing checks on the safety and quality of healthcare services. We carried out comprehensive inspections of three core services:

- Acute wards for adults of working age and psychiatric intensive care units
- Long stay/rehabilitation mental health wards for working age adults
- Mental health crisis services and health-based places of safety

At the time of the inspection, the trust was in the process of building a new health-based place of inspection. We did not inspect the current provision located in three local acute trusts. When the new health-based place of safety opens, we will inspect it.

In addition to the comprehensive inspections of core services, we carried out a focused inspection of the trust's Community-based mental health services for adults of working age, in which we reviewed the Safe key question.

Our comprehensive inspections of NHS trusts have shown a strong link between the quality of overall management of a trust and the quality of its services. For that reason, all trust inspections now include inspection of the well-led key question at the trust level. Our findings are in the section headed 'Is this organisation well-led'.

What we found

Overall trust

Our rating of the trust stayed the same. We rated it as good because:

- We rated two of the core services we inspected comprehensively as good overall and one as requires improvement overall. Following the inspection, seven of the trust's core and specialist services in the trust were rated good overall and one was rated as requires improvement overall.
- We rated well-led for the trust overall as good.

Summary of findings

- There was good, effective leadership at all levels of the organisation. The trust senior leadership team was visible across the trust and modelled openness and transparency. The board and senior leadership team had set a clear strategy and staff were aware of what it was. Since the last inspection, the trust had refreshed their strategic priorities.
- The trust worked effectively in partnership with other stakeholders across north London. It had entered a formal alliance with Barnet, Enfield and Haringey NHS Mental Health Trust, which was progressing well. It had continued to work with people using its services to develop innovative models of care. It had an excellent clinical strategy that guided its work and service developments.
- Clinical premises where patients received care were mostly safe, clean, well equipped, well furnished, well maintained and fit for purpose. The wards at St Pancras hospital did not provide a good environment for patient care, but the trust had undertaken remedial work to address risks and had plans to build new wards.
- The service had enough staff, who knew the patients and received statutory and mandatory training to keep patients safe from avoidable harm. The trust had worked hard to reduce its vacancies and develop new roles. Since the last inspection published in March 2018, the trust had reduced the size of the team caseloads in its mental health crisis services. Nevertheless, some teams and wards continued to have challenges with staff vacancies although temporary staff were used where needed.
- Staff across the trust worked hard to reduce the use of restrictive interventions. Most acute wards for adults of working age and psychiatric intensive care units had taken part in the Safewards initiative and initial data showed reductions in restrictive interventions.
- Staff provided care that was personalised, holistic and recovery-oriented. Staff treated patients with compassion and kindness. They respected patients' privacy and dignity. Staff were proactive in involving families and carers in patient care, when appropriate.
- The trust had systems in place for escalating and gaining assurance on risk. This included the corporate risk register and board assurance framework. It had appropriate arrangements in place to oversee the management of medicines, the Mental Health Act and safeguarding.
- Services treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and wider services.
- The trust engaged positively with service users and staff. This included a wide range of co-production work. The trust was also extending the number of peer support workers. Plans were in place to develop a trust strategy for user involvement and to ensure this was embedded throughout the organisation. The trust was working to improve staff health and well-being, for which it had produced a strategy.
- Staff had been engaged in various ways to learn, improve and innovate and were given time to do this in their day to day roles. The trust was committed to delivering a Quality Improvement (QI) programme and had invested in this across the organisation. The QI programme had flourished since the last inspection and was well embedded across the trust

However:

- The trust was experiencing high demand for its acute wards for adults of working age and psychiatric intensive care units. When beds were not available, some patients had to be placed in beds in external hospitals in the private sector, which may be out of the local area, and on temporary beds that compromised their privacy and dignity.

Summary of findings

- Patients identified as in need of a Mental Health Act (MHA) assessment were not always assessed promptly. Staff did not complete some assessments for more than four weeks due to delays in obtaining a warrant and accessing support from the police, who only provided limited time-slots to support assessments. Staff continued to monitor patients waiting for assessments and would offer more intensive support to patients where this was possible.
- Some community-based mental health services for adults of working age teams, and individual members of staff in these teams, had caseloads that were too high to allow the staff to give each patient the time they needed.
- The trust was completing serious incident investigations appropriately, but it was continuing to miss the timescales. Whilst the senior leaders were aware of this and plans were being considered to establish a central team to undertake this work as part of the alliance, these improvements were not yet taking place
- The trust had started work to meet the needs of staff and patients with protected characteristics, but more work was needed. For example, staff networks required strengthening. This work needed further promotion so that the trust could become a beacon of good practice.

Are services safe?

Our rating of safe stayed the same. We rated it as requires improvement because:

- At this inspection, we rated three of the four services we inspected as requires improvement for safe. When these ratings were combined with other existing ratings from previous inspections, three of the trust's services were rated requires improvement for safe and six were rated good.
- Patients identified as in need of a Mental Health Act (MHA) assessment were not always assessed promptly. Staff did not complete some assessments for more than four weeks due to delays in obtaining a warrant and accessing support from the police. Staff continued to monitor patients waiting for assessments and would offer more intensive support to patients where this was possible.
- Some community-based mental health services for adults of working age teams, and individual members of staff in these teams, had caseloads that were too high to allow the staff to give each patient the time they needed.
- Staff in the acute wards for adults of working age and psychiatric intensive care units did not always record that they had monitored patients' vital signs following the administration of rapid tranquilisation.
- The Crisis resolution and home treatment teams did not have a robust system in place to keep an audit trail for medicines in stock. Staff did not always count and record the medicines the teams had received and dispensed, which meant they may not always have an accurate oversight of the medicines for which they were responsible.

However:

- Clinical premises where patients received care were mostly safe, clean, well equipped, well furnished, well maintained and fit for purpose. The wards at St Pancras hospital did not provide a good environment for patient care, but the trust had undertaken remedial work to address risks and had plans to build new wards. Staff had experienced some delays in repairs being completed, but senior managers were aware of the problem and were working with contractors to improve the timeliness of repairs.
- The service had enough staff, who knew the patients and received statutory and mandatory training to keep patients safe from avoidable harm. The trust had worked hard to reduce its vacancies and develop new roles. Since the last inspection published in March 2018, the trust had reduced the size of the team caseloads in its mental health crisis services. Nevertheless, some teams and wards continued to have challenges with staff vacancies and used temporary staff where needed.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse, and they knew how to apply it.

Summary of findings

- Staff across the trust worked hard to reduce the use of restrictive interventions. Most acute wards for adults of working age and psychiatric intensive care units had taken part in the Safewards initiative and initial data showed reductions in restrictive interventions.
- Staff had easy access to clinical information and it was easy for them to maintain high quality clinical records, whether paper-based or electronic. Staff kept detailed records of patients' care and treatment. Records were clear, up to date and easily available to all staff providing care.
- Most services used systems and processes to safely prescribe, administer, record and store medicines. Staff regularly reviewed the effects of medicines on patients' physical health. However, in some wards staff had not completed all necessary checks of equipment and staff in some mental health crisis teams did not always audit trail for medicines in stock.
- The trust managed most patient safety incidents well. In February 2019, an alleged homicide took place on Coral Psychiatric Intensive Care Unit. In response, the trust had taken immediate actions to ensure the safety of its wards. It had investigated the incident and made changes in response to recommendations.
- Staff recognised incidents and reported them appropriately. When things went wrong, staff apologised and gave patients honest information and suitable support. While there was ongoing work to improve the timeliness of incident investigations, the reports were completed to an appropriate standard.

Are services effective?

Our rating of effective stayed the same. We rated it as outstanding because:

- At this inspection, we rated all three services we inspected as good for effective. When these ratings were combined with other existing ratings from previous inspections, three of the trust's services were rated outstanding for effective and five were rated good.
- The trust continued to work with people using its services to develop innovative models of care. It had an excellent clinical strategy that guided its work and service developments. Since the last inspection, for example, the Camden Primary Care Mental Health Network had been established. This team worked in a network with other providers, so that more people experiencing mental health problems could be supported in primary care.
- Staff assessed the physical and mental health of all patients. Staff developed individual care plans, which they reviewed regularly through multidisciplinary discussion and updated as needed. Most care plans reflected the patients' assessed needs, were personalised, holistic and recovery-oriented. Staff in the mental health crisis services were undertaking work to improve the care plans they shared with patients.
- Most staff received regular supervision and an annual appraisal, although there were some wards in which supervision rates were lower. The trust provided all new staff with an induction to their place of work and access to ongoing training and professional development.
- Staff from different disciplines worked together to benefit patients. They supported each other to make sure patients had no gaps in their care. The wards and teams had effective working relationships within the organisation and with relevant services outside the organisation.
- Staff provided a range of care and treatment interventions consistent with national guidance on best practice. They ensured that patients had good access to physical healthcare and supported patients to live healthier lives.
- Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives. Across the wards and teams we visited, staff told us about quality improvement initiatives they were undertaking to improve quality.

Summary of findings

- The trust had appropriate arrangements in place in relation to Mental Health Act administration and compliance. Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice.
- Staff supported patients to make decisions on their care for themselves. They understood the provider's policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly for patients who might have impaired mental capacity.

However:

- The trust had limited clinical psychology resource in its inpatient wards. On both the long stay or rehabilitation mental health wards for working age adults and the acute wards for adults of working age and psychiatric intensive care units clinical psychology time was limited.

Are services caring?

Our rating of caring stayed the same. We rated it as good because:

- At this inspection, we rated all three services we inspected as good for caring. When these ratings were combined with other existing ratings from previous inspections, six of the trust's services were rated good for caring and two were rated outstanding.
- Across all services, staff treated patients with compassion and kindness. They respected patients' privacy and dignity. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.
- Staff involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided. Patients on Coral Psychiatric Intensive Care Unit, for example, were invited to attend patient 'huddles' to provide feedback on any concerns they had on the ward and how staff could better support them.
- Staff were proactive in involving families and carers in patient care when appropriate. On Montague Ward, for example, staff had supported a patient to visit their family many miles away. However, the acute wards for adults of working age and psychiatric intensive care units did not have any formal systems in place to gather feedback from families and carers.

Are services responsive?

Our rating of responsive stayed the same. We rated it as good because:

- At this inspection, we rated two of the three services we inspected as good for responsive. We rated one service as requires improvement for responsive. When these ratings were combined with other existing ratings from previous inspections, five of the trust's services were rated good for responsive, one was rated as requires improvement and two were rated outstanding.
- Staff planned and managed discharge well. They liaised well with services that would provide aftercare and were assertive in managing the discharge care pathway. As a result, patients did not have excessive lengths of stay and discharge was rarely delayed for other than a clinical reason.
- Patients could access advice and support. The mental health crisis service was available 24-hours a day and was easy to access, including through a dedicated crisis telephone line.
- The design, layout, and furnishings of most services and premises supported patients' treatment, privacy and dignity. Patients on most wards had their own bedroom with an en-suite bathroom. However, acute ward environments at the St Pancras Hospital site had limited space and did not provide a therapeutic environment for patients. However, staff

sought to improve the environments. Staff on Laffan Ward had, for example, worked with a charity and students from a local art college to improve the decoration of the ward. The trust also had advanced plans to build new wards. Since the last inspection, Dunkley Ward had reduced its shared bedrooms from three to two. Managers were in the process of putting a business case together to eliminate the remaining two shared bedrooms.

- The food on the inpatient wards was of a good quality and patients could make hot drinks and snacks at any time.
- Staff met the needs of all patients who used the service, including those with a protected characteristic. Staff helped patients with communication, advocacy and cultural and spiritual support.
- Services treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and wider services.

However:

- The trust was experiencing high demand for its acute wards for adults of working age and psychiatric intensive care units. When beds were not available, some patients had to be placed in beds in external hospitals in the private sector, which may be out of the local area. To manage high demand when local private sector beds were not available, the trust had decided that patients could be placed in temporary beds in quiet lounges on the wards. Using these rooms compromised the privacy and dignity of patients. Senior managers attended daily bed management meetings to identify any blocks to patients being discharges and ensure patients could access beds as quickly as possible. The trust had also continued to review its pathway and had managed to reduce the number of patients staying on its wards for more than 50 days.

Are services well-led?

Our rating of well-led stayed the same. We rated it as good because:

- There was good, effective leadership at all levels of the organisation. We rated all three of the core services we inspected as good for well-led. When these ratings were combined with other existing ratings from previous inspections, six of the trust's services were rated good for well-led and two were rated outstanding.
- The trust had a capable and experienced leadership team. The previous year had been very challenging due to a number of unexpected changes in both the executive and non-executive members of the board. However, the chair, chief executive and other senior leaders across the trust had worked together to provide continuity. Members of the leadership team were open about the challenges and believed they were now through this difficult period. New members of the team were settling into their roles and felt well supported by longer standing colleagues.
- The trust provided strong leadership following a serious incident of an alleged homicide on Coral ward. Managers took immediate actions to keep patients and staff safe, and longer-term work to investigate and learn from the incident had taken place. During the inspection, we found that nursing leadership had been increased at night. Leaders had been very mindful about the psychological well-being of patients, carers and staff.
- The leadership team recognised the importance of being visible and approachable and had sought to increase their accessibility to staff. Board members had well-structured arrangements to visit services across the geographical area served by the trust.
- The board and senior leadership team had set a clear strategy and staff were aware of what it was. Since the last inspection, they had refreshed their strategic priorities. They had added another priority which was to keep service users, carers and staff safe. Work was underway to refresh the clinical strategy. This was being done in partnership with the neighbouring trust to reflect the needs of the population across north-central London. Staff and patients were engaged in this work. The trust's strategic priorities were well embedded in its work.

Summary of findings

- The trust worked effectively in partnership with other stakeholders across north London. It had entered a formal alliance with Barnet, Enfield and Haringey NHS Mental Health Trust, which was progressing well. Suitable arrangements were in place to oversee this work. The trusts had identified 10 workstreams where working together provided benefits for patients and staff.
- The trust was starting to review its internal structures to reflect the importance of delivering care in a place. This was being done in a thoughtful manner and senior leaders were engaged with the early work.
- The trust supported staff to develop. Arrangements were in place to promote leadership development for staff across the organisation. The leadership development programme was being refreshed to provide leaders with the skills to carry out their roles.
- The trust recognised the need to put improving culture at the centre of their work. To help guide this work, they were refreshing their cultural 'pillars'. The trust was also taking part in a 'culture collaborative' established by NHS Improvement. Throughout the inspection, most staff spoke positively about the culture of the trust and said they enjoyed working for the organisation. The trust promoted staff being able to 'speak up'. They had decided to change the arrangements for the Freedom to Speak Up Guardian, and this was starting in December 2019. There had been a period where the previous post-holder was not available, and the cover arrangements had not been very robust.
- The trust had strengthened its governance structures and processes since the last inspection with an introduction of three programme boards sitting beneath the board sub-committees. This enabled senior staff from across the trust to look in more detail at specific areas before presenting papers to the sub-committees. Following the serious incident on Coral ward, the trust had reviewed its governance processes. This had highlighted the need to make good use of soft information and the importance of visits to services.
- The trust had systems in place for escalating and gaining assurance on risk. This included the corporate risk register and board assurance framework. The board assurance framework was used actively by the board. The trust had appropriate arrangements in place to oversee the application of the Mental Health Act and Safeguarding. Suitable governance arrangements were in place for financial governance. There was clarity about the cost improvement programmes (CIPs) and how these would be achieved.
- The trust collected, analysed, managed and used information well to support all its activities. Since the last inspection, the trust had improved its business information including its presentation. Data was available and accessible to all levels of staff. This same information informed the board on the performance of the trust.
- The trust was making good use of data as part of its programme of change, for example, to understand the demand and capacity issues facing services. The trust was also making increasing use of digital technology to support the delivery of services, such as by providing equipment to promote mobile working.
- The trust engaged positively with patients, carers and staff. This included a wide range of co-production work. The trust was also extending the number of peer support workers. Plans were in place to develop a trust strategy for user involvement and to ensure this was embedded throughout the organisation. The trust was working to improve staff health and well-being, for which it had produced a strategy. This included understanding what would make a difference for staff and delivering a programme of activities.
- Staff had been engaged in various ways to learn, improve and innovate and were given time to do this in their day to day roles. The trust was committed to delivering a Quality Improvement (QI) programme and had invested in this across the organisation. The QI programme had flourished since the last inspection and was well embedded across the trust. Funding had been approved to have a larger permanent team to support the work and develop a micro-site so good practice could be shared more easily. The trust continued to be involved in research and worked in partnership with other organisations. Trust staff had undertaken research that benefitted patients.

However:

Summary of findings

- There were a few areas identified during the well-led review where the trust's momentum of change had not been timely enough. It was recognised that this was probably associated with the challenges of the previous year.
- The trust operated in very diverse boroughs and had started work to meet the needs of staff and patients with protected characteristics. However, this needed ongoing work. For example, staff networks were in place but required strengthening. This work needed further promotion so that the trust could become a beacon of good practice. The trust also needed to undertake further work to improve its performance against the Workforce Race Equality Standards, Workforce Disability Equality Standards and the Accessible Information Standard.
- The trust was completing serious incident investigations appropriately, but it was continuing to miss the timescales. Whilst the senior leaders were aware of this and plans were being considered to establish a central team to undertake this work as part of the alliance, these improvements were not yet taking place.
- Significant numbers of staff continued to express frustration about the difficulties of being able to connect to the internet and the time taken for patient record systems to load. The trust had plans in place to address this in the next 3-5 months. Staff contacting the trust helpdesk for assistance with IT largely reported a positive experience.
- The trust had completed disclosure barring checks as required, but these were not at the appropriate level for people meeting patients and having access to confidential information for all members of the Board.

Ratings tables

The ratings tables show the ratings overall and for each key question, for each service and for the whole trust. They also show the current ratings for services or parts of them not inspected this time. We took all ratings into account in deciding overall ratings. Our decisions on overall ratings also took into account factors including the relative size of services and we used our professional judgement to reach fair and balanced ratings.

Outstanding practice

We found examples of outstanding practice in two of the four services we inspected:

•Long stay/rehabilitation mental health wards for working age adults

•Community-based mental health services for adults of working age

For more information see the Outstanding practice section of this report.

Areas for improvement

We found areas for improvement including breaches of four regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 that the trust must put right: Regulation 10 Dignity and respect, Regulation 12 Safe care and treatment, Regulation 17 Good Governance and Regulation 18 Staffing.

There were six things the trust must put right in relation to breaches of these two regulations. In addition, we found 28 things that the trust should improve to comply with a minor breach that did not justify regulatory action, to prevent breaching a legal requirement, or to improve service quality.

For more information see the areas for improvement section of this report.

Action we have taken

We issued requirement notices in respect of the two regulations that had been breached within one specialist service.

For more information on action we have taken, see the sections on Areas for improvement and Regulatory action.

Summary of findings

What happens next

We will check that the trust takes the necessary action to improve its services. We will continue to monitor the safety and quality of services through our continuing relationship with the trust and our regular inspections.

Outstanding practice

Long stay/rehabilitation mental health wards for working age adults

- At Aberdeen Park and Highview, staff visited patients for three months after their discharge to help them settle into their new accommodation.
- On Malachite Ward, staff had carried out a quality improvement project to make care plans more relevant and easier for patients to understand.
- Staff had supported one patient to travel to Scotland to see their family. This had led to plans for the patient to move to be nearer their family when they left the service.

Community-based mental health services for adults of working age

- The trust had established locality-based teams, such as the Camden primary care in mental health network, to support patients cared for in the primary care. These teams meant that access specialist support more easily whilst being cared for in primary care services.

Areas for improvement

Action the trust MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is to comply with a minor breach that did not justify regulatory action, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the trust MUST take to improve

We told the trust that it must take action to bring services into line with legal requirements. These six actions related to two core services and trust-wide.

Trust-wide

- The trust must continue and embed the work it has started to improve its performance against the workforce race equality standards. **Regulation 17 Good Governance (1)**

Acute wards for adults of working age and psychiatric intensive care units

- The trust must ensure that patients are accommodated in bedrooms that are designed to support their privacy and dignity. **Regulation 10 Dignity and respect (1)(2) (a)**
- The trust must ensure that staff take all reasonable steps to ensure that physical health checks are carried out and recorded after patients receive rapid tranquilisation, including when a patient refuses to have their vital signs taken. **Regulation 12 Safe Care and treatment (1)(2) (a)(b)**

Mental health crisis services and health-based places of safety

- The trust must ensure that the Crisis resolution and home treatment teams monitor stock medicines, so they can identify quickly if any go missing. **Regulation 12 Safe care and treatment 12(1)(2) (g)**

Summary of findings

Community-based mental health services for adults of working age

- The trust must continue to work with the police and partners to ensure that patients identified as requiring assessment under the Mental Health Act are assessed promptly. **Regulation 12 Safe Care and treatment (1)(2)(a)(b)(i)**
- The trust must ensure caseloads for members of staff in the Complex depression, anxiety and trauma team and the Camden early intervention service are low enough for them to offer care that meets the needs of patient. **Regulation 18 staffing (1)**

Action the trust SHOULD take to improve

We told the trust that it should take action to comply with minor breaches that did not justify regulatory action, to prevent breaching a legal requirement in future or to improve service quality. These are the 28 actions related to the whole trust and four core services.

Trust-wide

- The trust should ensure that it continues work to improve IT systems so that staff can access information promptly at all times.
- The trust should ensure that all members of the Board complete disclosure barring checks at the appropriate level for people meeting patients and having access to confidential information.
- The trust should ensure that serious incidents are investigated within timescales.
- The trust should continue to support and embed the work of its staff networks.

Acute wards for adults of working age and psychiatric intensive care units

- The trust should ensure that staff on Coral psychiatric intensive care unit understand the ward's fire evacuation procedures to ensure staff and patients can be safely evacuated in case of an emergency.
- The trust should ensure that staff identify blind spots on the wards and safely mitigate any risks.
- The trust should work towards eliminating the two shared bedrooms on Dunkley Ward to promote privacy and dignity for patients.
- The trust should ensure that staff regularly check items for clinical use are within their expiry date and are fit for purpose.
- The trust should ensure that repairs to equipment are carried out promptly.
- The trust should continue to that systems are in place to ensure staff regularly calibrate all medical equipment to ensure accurate results.
- The trust should review whether examination couches can be accommodated in its clinic rooms.
- The trust should continue work on recruitment and retention to ensure that it employs sufficient staff to ensure that the shifts are covered.
- The service should ensure that appropriate treatments for patients, including psychology.
- The trust should ensure that all staff receive regular one-to-one clinical supervision to support them with carrying out their duties.
- The trust should ensure that there is an effective system in place for staff to record checks of the ward's emergency equipment to provide assurance on the quality and safety.

Summary of findings

- The trust should ensure that there are formal systems in place so that families and carers are able to give feedback on the service they receive.

Long stay/rehabilitation mental health wards for working age adults

- The trust should ensure that it completes the installation of air conditioning units to ensure temperatures in the clinic rooms at Aberdeen Park and Highview do not rise above the maximum recommended temperatures for storing medicines.
- The trust should ensure that informal patients on Montague Ward are aware they can leave the ward.
- The trust should ensure that all care plans are up to date and do not include information that is no longer relevant. The trust should also ensure that patients have a copy of their care plan.
- The trust should ensure that information technology works well and enables staff to access information without unnecessary delays. The trust should also ensure that systems for providing managers with essential information work effectively.
- The trust should ensure that sufficient psychology is provided for patients at all the services.
- The trust should ensure that staff record their consideration of patients' wishes, feelings, culture and history when they are assessing the patient's best interests.
- The trust should ensure that, where appropriate, patients at all the services can have a key to their bedroom.
- The trust should ensure that staff have up-to-date information about significant changes to services.

Mental health crisis services and health-based places of safety

- The trust should ensure that all patients are offered a copy of their care plan.
- The trust should review the effectiveness of its training on lone working procedures and, in particular, the use of new personal alarms.
- The trust should continue its work to address staff vacancy rates and high turnover across the CRHTs.

Is this organisation well-led?

Our comprehensive inspections of NHS trusts have shown a strong link between the quality of overall management of a trust and the quality of its services. For that reason, we look at the quality of leadership at every level. We also look at how well a trust manages the governance of its services – in other words, how well leaders continually improve the quality of services and safeguard high standards of care by creating an environment for excellence in clinical care to flourish.

Our rating of well-led stayed the same. We rated it as good because:

The trust had a capable and experienced leadership team. The previous year had been very challenging due to a number of unexpected changes in both the executive and non-executive members of the board. However, the chair, chief executive and other senior leaders across the trust had worked together to provide continuity. Members of the leadership team were open about the challenges and believed they were now through this difficult period. New members of the team were settling into their roles and felt well supported by longer standing colleagues.

Summary of findings

The trust provided strong leadership following a serious incident of an alleged homicide on Coral ward. Managers took immediate actions to keep patients and staff safe, and longer-term work to investigate and learn from the incident had taken place. During the inspection, we found that nursing leadership had been increased at night. Leaders had been very mindful about the psychological well-being of patients, carers and staff.

The leadership team recognised the importance of being visible and approachable and had sought to increase their accessibility to staff. Board members had well-structured arrangements to visit services across the geographical area served by the trust.

The board and senior leadership team had set a clear strategy and staff were aware of what it was. Since the last inspection, they had refreshed their strategic priorities. They had added another priority which was to keep service users, carers and staff safe. Work was underway to refresh the clinical strategy. This was being done in partnership with the neighbouring trust to reflect the needs of the population across north-central London. Staff and patients were engaged in this work. The trust's strategic priorities were well embedded in its work.

The trust worked effectively in partnership with other stakeholders across north London. It had entered a formal alliance with Barnet, Enfield and Haringey NHS Mental Health Trust, which was progressing well. Suitable arrangements were in place to oversee this work. The trusts had identified 10 workstreams where working together provided benefits for patients and staff.

The trust was starting to review its internal structures to reflect the importance of delivering care in a place. This was being done in a thoughtful manner and senior leaders were engaged with the early work.

The trust supported staff to develop. Arrangements were in place to promote leadership development for staff across the organisation. The leadership development programme was being refreshed to provide leaders with the skills to carry out their roles.

The trust recognised the need to put improving culture at the centre of their work. To help guide this work, they were refreshing their cultural 'pillars'. The trust was also taking part in a 'culture collaborative' established by NHS Improvement. Throughout the inspection, most staff spoke positively about the culture of the trust and said they enjoyed working for the organisation. The trust promoted staff being able to 'speak up'. They had decided to change the arrangements for the Freedom to Speak Up Guardian, and this was starting in December 2019. There had been a period where the previous post-holder was not available, and the cover arrangements had not been very robust.

The trust had strengthened its governance structures and processes since the last inspection with an introduction of three programme boards sitting beneath the board sub-committees. This enabled senior staff from across the trust to look in more detail at specific areas before presenting papers to the sub-committees. Following the serious incident on Coral ward, the trust had reviewed its governance processes. This had highlighted the need to make good use of soft information and the importance of visits to services.

The trust had systems in place for escalating and gaining assurance on risk. This included the corporate risk register and board assurance framework. The board assurance framework was used actively by the board. The trust had appropriate arrangements in place to oversee the application of the Mental Health Act and Safeguarding. Suitable governance arrangements were in place for financial governance. There was clarity about the cost improvement programmes (CIPs) and how these would be achieved.

The trust collected, analysed, managed and used information well to support all its activities. Since the last inspection, the trust had improved its business information including its presentation. Data was available and accessible to all levels of staff. This same information informed the board on the performance of the trust.

The trust was making good use of data as part of its programme of change, for example, to understand the demand and capacity issues facing services. The trust was also making increasing use of digital technology to support the delivery of services, such as by providing equipment to promote mobile working.

Summary of findings

The trust engaged positively with patients, carers and staff. This included a wide range of co-production work. The trust was also extending the number of peer support workers. Plans were in place to develop a trust strategy for user involvement and to ensure this was embedded throughout the organisation. The trust was working to improve staff health and well-being, for which it had produced a strategy. This included understanding what would make a difference for staff and delivering a programme of activities.

Staff had been engaged in various ways to learn, improve and innovate and were given time to do this in their day to day roles. The trust was committed to delivering a Quality Improvement (QI) programme and had invested in this across the organisation. The QI programme had flourished since the last inspection and was well embedded across the trust. Funding had been approved to have a larger permanent team to support the work and develop a micro-site so good practice could be shared more easily. The trust continued to be involved in research and worked in partnership with other organisations. Trust staff had undertaken research that benefitted patients.

However:

There were a few areas identified during the well-led review where the trust's momentum of change had not been timely enough. It was recognised that this was probably associated with the challenges of the previous year.

The trust operated in very diverse boroughs and had started work to meet the needs of staff and patients with protected characteristics. However, this needed ongoing work. For example, staff networks were in place but required strengthening. This work needed further promotion so that the trust could become a beacon of good practice. The trust also needed to undertake further work to improve its performance against the Workforce Race Equality Standards, Workforce Disability Equality Standards and the Accessible Information Standard.

The trust was completing serious incident investigations appropriately, but it was continuing to miss the timescales. Whilst the senior leaders were aware of this and plans were being considered to establish a central team to undertake this work as part of the alliance, these improvements were not yet taking place.

Significant numbers of staff continued to express frustration about the difficulties of being able to connect to the internet and the time taken for patient record systems to load. The trust had plans in place to address this in the next 3-5 months. Staff contacting the trust helpdesk for assistance with IT largely reported a positive experience.

The trust had completed disclosure barring checks as required, but these were not at the appropriate level for people meeting patients and having access to confidential information for all members of the Board

Ratings tables

Key to tables					
Ratings	Not rated	Inadequate	Requires improvement	Good	Outstanding
Rating change since last inspection	Same	Up one rating	Up two ratings	Down one rating	Down two ratings
Symbol *	→←	↑	↑↑	↓	↓↓
Month Year = Date last rating published					

* Where there is no symbol showing how a rating has changed, it means either that:

- we have not inspected this aspect of the service before or
- we have not inspected it this time or
- changes to how we inspect make comparisons with a previous inspection unreliable.

Ratings for the whole trust

Safe	Effective	Caring	Responsive	Well-led	Overall
Requires improvement →← Jan 2020	Outstanding →← Jan 2020	Good →← Jan 2020	Good →← Jan 2020	Good →← Jan 2020	Good →← Jan 2020

The rating for well-led is based on our inspection at trust level, taking into account what we found in individual services. Ratings for other key questions are from combining ratings for services and using our professional judgement.

Ratings for mental health services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Acute wards for adults of working age and psychiatric intensive care units	Requires improvement → ← Jan 2020	Good → ← Jan 2020	Good → ← Jan 2020	Requires improvement ↓ Jan 2020	Good → ← Jan 2020	Requires improvement ↓ Jan 2020
Long-stay or rehabilitation mental health wards for working age adults	Good → ← Jan 2020	Good ↑ Jan 2020	Good → ← Jan 2020	Good → ← Jan 2020	Good → ← Jan 2020	Good → ← Jan 2020
Wards for older people with mental health problems	Good Mar 2018	Good Mar 2018	Good Mar 2018	Good Mar 2018	Good Mar 2018	Good Mar 2018
Community-based mental health services for adults of working age	Requires improvement ↓ Jan 2020	Outstanding Mar 2018	Good Mar 2018	Good Mar 2018	Good Mar 2018	Good → ← Jan 2020
Mental health crisis services and health-based places of safety	Requires improvement → ← Jan 2020	Good → ← Jan 2020	Good → ← Jan 2020	Good → ← Jan 2020	Good → ← Jan 2020	Good → ← Jan 2020
Community-based mental health services for older people	Good Mar 2018	Outstanding Mar 2018	Outstanding Mar 2018	Outstanding Mar 2018	Outstanding Mar 2018	Outstanding Mar 2018
Community mental health services for people with a learning disability or autism	Good Mar 2018	Outstanding Mar 2018	Good Mar 2018	Good Mar 2018	Good Mar 2018	Good Mar 2018
Substance misuse services	Good Mar 2018	Good Mar 2018	Outstanding Mar 2018	Outstanding Mar 2018	Outstanding Mar 2018	Outstanding Mar 2018

Overall ratings for mental health services are from combining ratings for services. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Long stay or rehabilitation mental health wards for working age adults

Good ➔➔

Key facts and figures

Aberdeen Park, which has 11 beds, and Highview, which has 15 beds, are community rehabilitation services for adults of working age in Islington. Number 154 Camden Road, which has 15 beds, is a community rehabilitation service for adults of working age in Camden. Montague ward, which has 14 beds, and Malachite ward, which has 16 beds, are high dependency inpatient rehabilitation wards based at St Pancras Hospital and Highgate Mental Health Centre respectively.

All these services admitted male and female patients who had severe and enduring mental health problems. Patients were admitted from acute wards, forensic wards and from the community.

During this inspection we visited five sites, including two inpatient wards and three community rehabilitation services.

At the last inspection, the rehabilitation services were rated as good in four domains (safe, caring, responsive and well-led) and requires improvement in effective. This inspection was not announced in advance, so staff did not know we were coming.

During the inspection, the inspection team:

- looked at the quality of the environment on all the wards and at the community residential settings
- observed how staff were caring for patients
- spoke with 26 patients
- interviewed 27 members of staff including ward managers, service managers, doctors, registered nurses, occupational therapists, psychologists and a pharmacist
- looked at 25 care records
- attended three handover meetings, two community meetings and a multidisciplinary team meeting
- looked at a small sample of medication charts, records of physical observations and statutory documents in relation to the Mental Health Act
- looked at other documents relating to the running of services including policies, supervision record, appraisal records, incident records, minutes of team meetings and safeguarding records.

Summary of this service

Our rating of this service stayed the same. We rated it as good because:

- The service provided safe care. The ward environments were safe and clean. The wards had enough nurses and doctors. Staff assessed and managed risk well. They minimised the use of restrictive practices, managed medicines safely and followed good practice with respect to safeguarding.
- Staff developed holistic, recovery-oriented care plans informed by a comprehensive assessment. They provided a range of treatments suitable to the needs of the patients cared for in a mental health rehabilitation ward and in line with national guidance about best practice. Staff engaged in clinical audit to evaluate the quality of care they provided.

Long stay or rehabilitation mental health wards for working age adults

- The ward teams included or had access to the specialists required to meet the needs of patients on the wards. Managers ensured that these staff received training, supervision and appraisal. The ward staff worked well together as a multidisciplinary team and with those outside the ward who would have a role in providing aftercare.
- Staff understood and discharged their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, and understood the individual needs of patients. They actively involved patients and families and carers in care decisions.
- Staff planned and managed discharge well and liaised well with services that would provide aftercare. As a result, discharge was rarely delayed for other than a clinical reason.
- The service worked to a recognised model of mental health rehabilitation. It was well led and the governance processes ensured that ward procedures ran smoothly.

Is the service safe?

Good 

Our rating of safe stayed the same. We rated it as good because:

- All wards were safe, clean, well equipped, well furnished, well maintained and fit for purpose.
- The service had enough nursing and medical staff, who knew the patients and received basic training to keep patients safe from avoidable harm
- Staff assessed and managed risks to patients and themselves well. They achieved the right balance between maintaining safety and providing the least restrictive environment possible in order to facilitate patients' recovery. Staff followed best practice in anticipating, de-escalating and managing challenging behaviour. As a result, they used restraint and seclusion only after attempts at de-escalation had failed. The ward staff participated in the provider's restrictive interventions reduction programme.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.
- The service used systems and processes to safely prescribe, administer, record and store medicines. Staff regularly reviewed the effects of medications on each patient's physical health. Temperatures in clinic rooms sometimes rose above maximum recommended temperatures, but the trust had plans to address this problem.
- The wards had a good track record on safety. The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

However,

- Staff found it difficult access clinical information on the electronic patient record. This meant it was difficult to maintain high quality records.

Long stay or rehabilitation mental health wards for working age adults

Is the service effective?

Good 

Our rating of effective improved. We rated it as good because:

- Staff assessed the physical and mental health of all patients on admission. They developed individual care plans, which they reviewed regularly through multidisciplinary discussion. Care plans reflected the assessed needs. On Malachite Ward, staff had carried out a quality improvement project to make care plans more relevant and easier for patients to understand. However, care plans were not always up-to-date. Many care plans included out-of-date objectives that were no longer relevant to the patient.
- Staff provided a range of care and treatment interventions suitable for the patient group and consistent with national guidance on best practice. Patients took part in meaningful occupation and could access support to develop their self-care and everyday living skills. Staff ensured that patients had good access to physical healthcare and supported patients to live healthier lives.
- Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives.
- The ward teams included or had access to the full range of specialists required to meet the needs of patients on the wards. Managers made sure they had staff with a range of skills needed to provide high quality care. They supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.
- Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. The ward teams had effective working relationships with other staff from services that would provide aftercare following the patient's discharge and engaged with them early in the patient's admission to plan discharge.
- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and discharged these well. Managers made sure that staff could explain patients' rights to them.
- Staff supported patients to make decisions on their care for themselves. They understood the provider's policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly for patients who might have impaired mental capacity.

However,

- Patients had very little direct access to psychological therapies. Some of the services did not have their full complement of weekly psychology hours.
- Records of discussions about the best interests of patients who may lack capacity to make decisions did not always demonstrate that staff considered patient's wishes, feelings, culture and history.

Is the service caring?

Good 

Our rating of caring stayed the same. We rated it as good because:

Long stay or rehabilitation mental health wards for working age adults

- Staff treated patients with compassion and kindness. They respected patients' privacy and dignity. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.
- Staff involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided. They ensured that patients had easy access to independent advocates.
- Staff informed and involved families and carers appropriately. On Montague Ward, staff had supported a patient to visit their family many miles away. This had led to plans for the patient to move to be close to their family when they were discharged.

Is the service responsive?

Good 

Our rating of responsive stayed the same. We rated it as good because:

- Staff planned and managed discharge well. They liaised well with services that would provide aftercare and were assertive in managing the discharge care pathway. As a result, patients did not have excessive lengths of stay and discharge was rarely delayed for other than a clinical reason. At Aberdeen Park and Highview, staff visited patients for three months after their discharge to help them settle into their new accommodation.
- The design, layout, and furnishings of the ward/service supported patients' treatment, privacy and dignity. Each patient had their own bedroom with an en-suite bathroom and patients at most services could keep their personal belongings safe. There were quiet areas for privacy.
- The food was of a good quality and patients could make hot drinks and snacks at any time.
- The wards met the needs of all patients who used the service – including those with a protected characteristic. Staff helped patients with communication, advocacy and cultural and spiritual support.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and the wider service.

However,

- Patients on Montague Ward did not have a key to their bedrooms. This meant that patients had to ask staff to lock and unlock their rooms to keep their belongings safe.

Is the service well-led?

Good 

Our rating of well-led stayed the same. We rated it as good because:

- Leaders had the skills, knowledge and experience to perform their roles, had a good understanding of the services they managed, and were visible in the service and approachable for patients and staff.
- Staff knew and understood the provider's vision and values and how they were applied in the work of their team.
- Staff felt respected, supported and valued. They reported that the provider promoted equality and diversity in its day-to-day work and in providing opportunities for career progression. They felt able to raise concerns without fear of retribution.

Long stay or rehabilitation mental health wards for working age adults

- Our findings from the other key questions demonstrated that governance processes operated effectively at ward level and that performance and risk were managed well.
- Ward teams had access to most information they needed to provide safe and effective care and used that information to good effect.
- Staff engaged actively in local and national quality improvement activities.

However,

- Systems for providing managers with information about the performance of their services did not always work effectively. For example, managers found it difficult to find accurate, up-to-date performance information on their electronic 'dashboards'.
- The trust did not ensure that staff received up-to-date information about changes to services that would have a significant impact on their employment. For example, managers had not provided staff at 154 Camden Road with up-to-date information about the re-tendering of this service. This had led to low staff morale.

Outstanding practice

We found an example of outstanding practice in this service:

- At Aberdeen Park and Highview, staff visited patients for three months after their discharge to help them settle into their new accommodation
- On Malachite Ward, staff had carried out a quality improvement project to make care plans more relevant and easier for patients to understand.
- Staff had supported one patient to travel to Scotland to see their family. This had led to plans for the patient to move to be nearer their family when they left the service.

Areas for improvement

Action the provider SHOULD take to improve:

- The trust should ensure that it completes the installation of air conditioning units to ensure temperatures in the clinic rooms at Aberdeen Park and Highview do not rise above the maximum recommended temperatures for storing medicines.
- The trust should ensure that informal patients on Montague Ward are aware they can leave the ward.
- The trust should ensure that all care plans are up to date and do not include information that is no longer relevant. The trust should also ensure that patients have a copy of their care plan.
- The trust should ensure that information technology works well and enables staff to access information without unnecessary delays. The trust should also ensure that systems for providing managers with essential information work effectively.
- The trust should ensure that sufficient psychology is provided for patients at all the services.
- The trust should ensure that staff record their consideration of patients' wishes, feelings, culture and history when they are assessing the patient's best interests.
- The trust should ensure that, where appropriate, patients at all the services can have a key to their bedroom.
- The trust should ensure that staff have up-to-date information about significant changes to services.

Acute wards for adults of working age and psychiatric intensive care units

Requires improvement 

Key facts and figures

The acute wards for adults of working age and psychiatric intensive care units (PICU) provided by Camden and Islington NHS Foundation Trust are part of the trust's acute division. The wards are situated on two sites, Highgate Mental Health Centre and St Pancras Hospital.

Highgate Mental Health Centre in Islington has six acute wards for adults of working age: Amber, Jade, Opal, Sapphire, Topaz and Emerald wards. These wards accept male and female patients. Each ward can accommodate up 16 beds patients. Amber, Jade and Opal have a 17th bed on the wards to accommodate out-of-area patients awaiting transfer to a trust in the area they are from. There is also a PICU, Coral, which has 12 beds for males.

The Huntley Centre at St Pancras Hospital has three acute wards for adults of working age. Dunkley and Laffan are mixed gender wards and have 16 beds each. Four beds on Dunkley Ward are for patients who also have a diagnosis of a learning disability. Rosewood has 12 beds for female patients. Ruby is a PICU for up to 11 female patients. Two weeks before the inspection, the trust changed Ruby PICU to a female acute treatment ward due to bed pressures. At the time of the inspection, it was actively planning its transition back to a PICU.

All wards accept informal patients and patients detained under the Mental Health Act.

The last comprehensive inspection of the service took place in December 2017. At that inspection, we rated acute wards for adults of working age and psychiatric intensive care units as good overall. We rated the safe domain as requires improvements, and effective, care, responsive and well-led as good.

During this inspection, we visited all acute and PICU wards on 8, 9 and 10 October 2019. In addition, we visited Highgate Mental Health Centre on 14 October 2019 to conduct a night-time inspection of Coral PICU and Sapphire, Emerald, Topaz and Opal wards.

During the inspection visits, the inspection team:

- visited all the acute and PICU wards at the two hospital sites on 8, 9, 10 and 14 October 2019. During these visits, we looked at the quality of the ward environment and observed how staff were interacting with patients.
- Spoke with 29 patients who were using the service
- Interviewed all ward managers, two matrons and a night-time senior manager for Highgate Mental Health Centre
- Spoke with 78 other staff members individually, including doctors, registered mental health nurses (day and night workers), clinical support workers, activity coordinators, occupational therapists and clinical psychologists
- Reviewed 41 care and treatment records
- Attended and observed two multidisciplinary team meetings, three community meetings, one patient safety huddle, three staff safety huddles, two shift handovers and one patient review meeting
- Carried out a specific review of medicines management on Coral PICU, Ruby PICU, Dunkley Ward, Rosewood Ward and Amber Wards. We also reviewed medicine administration charts across all the wards.
- Looked at a range of trust policies, procedures and other documents relating to the running of the service
- Completed a Mental Health Act review at Amber Ward.

Acute wards for adults of working age and psychiatric intensive care units

Summary of this service

Our rating of this service went down. We rated it as requires improvement because:

- Staff did not always take reasonable steps to ensure physical health checks had been carried out post rapid tranquilisation administration. Staff did not always demonstrate that non-contact physical health checks had been carried out if a patient refused contact physical health checks. This was an issue that we also identified in the last inspection in December 2017. The trust planned to revise the trust's rapid tranquilisation policy to include the need for staff to conduct non-contact physical health checks if a patient refuses. The ward managers had been instructed to closely monitor rapid tranquilisation and ensure staff followed best practice guidelines.
- The trust had some wards on which it found it hard to recruit permanent staff, which meant that they sometimes had gaps. The trust had continued with their recruitment drive and most wards had enough nursing and medical staff to keep patients safe. Coral PICU had high registered nurse vacancies and managers could not always fill shifts with bank staff. This meant that shifts did not always have the required number of registered nurses, there was high use of bank/agency staff, one-to-one clinical supervision for staff did not always happen, and permanent registered nurses reported feeling burnt-out.
- The trust was experiencing high demand for its acute wards for adults of working age and psychiatric intensive care units. When beds were not available, some patients had to be placed in beds in external hospitals in the private sector, which were sometimes out of the local area. Eight out of the eleven wards had bed occupancies rates ranging above 100% between June 2018 and May 2019. To manage high demand when local private sector beds were not available, the trust had decided that patients could be placed in temporary beds in quiet lounges on the wards. These rooms compromised patients' privacy and dignity. The rooms were not designed as bedrooms and did not have sinks. Some opened onto the main lounge. When patients were placed in the rooms, no quiet room was available on the ward. When the temporary beds were used, extra staff would be used to provide one-to-one observation and staff completed a risk assessment and care plan to ensure the patient's safety.
- Some wards did not provide good environments for supporting patients. The current wards at St Pancras hospital were limited in space and did not provide a therapeutic environment for patients. Some patients on Dunkley ward had to share bedrooms. However, staff hard worked hard to try and improve the decoration of the wards. The trust was planning to build a new hospital to replace the wards.
- Staff across the acute and PICU wards were not consistent in using the trust's audit tool to record checks of the ward's emergency equipment.
- Patients had limited access to clinical psychology input. The trust had limited clinical psychology resource. Five clinical psychologists worked across the inpatient and community teams, which meant only one to two patients per ward were able to be seen. This meant many patients did not have any psychological input, which was not in line with best practice. This was a recurring issue that we identified in the last inspection in December 2017.

However:

- The service provided safe care to most patients. The ward environments were clean and had good furnishings. Staff regularly assessed the risk within the care environment. Staff had worked hard on reducing restrictive practices, and most wards had taken part in the Safewards initiative, which looked at understanding conflict and resolution. Staff managed medicines safely, reported incidents and learned from them, and followed good practice with respect to safeguarding.

Acute wards for adults of working age and psychiatric intensive care units

- Staff assessed the physical and mental health of all patients promptly on admission. Most care plans were personalised, holistic and recovery-orientated. Staff ensured patients had access to good physical health care, including specialists as required.
- The ward teams included or had access to the full range of specialists required to meet the needs of patients on the wards. Managers ensured that these staff received training and appraisal. The ward staff worked well together as a multidisciplinary team and with those outside the ward who would have a role in providing aftercare.
- Staff understood and discharged their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, and understood the individual needs of patients. They actively involved patients in care decisions.
- Staff planned for patients' discharge, including good liaison with care managers/co-ordinators and plans for patients' discharges were discussed each at the multidisciplinary meetings. The trust worked with local stakeholders to review barriers to patients' discharges.
- Staff took account of patients' individual needs and were able to access interpreters and offer access to spiritual support. The wards were accessible to patients with physical disabilities and mobility issues.
- The service was well-led and governance processes mostly ensured the ward procedures ran smoothly. Leaders had the skills, knowledge and experience to perform their roles, had a good understanding of the services they managed and were visible in the service and approachable for patients and staff.
- All staff were committed to continually improving services and most wards were taking part in quality improvement projects to improve aspects of the quality of care they delivered. Some wards were taking part in national collaboratives, in reducing restrictive practices and improving sexual safety on inpatient wards.

Is the service safe?

Requires improvement 

Our rating of safe stayed the same. We rated it as requires improvement because:

- At the last inspection in December 2017, staff did not always complete physical health checks after administering rapid tranquilisation. At this inspection, although some wards ensured this was taking place, four wards did not demonstrate reasonable steps were taken to ensure physical health checks had been carried out post rapid tranquilisation administration. Staff did not always record or evidence that when a patient refused contact physical health observations, non-contact physical health observations had been completed or that there were repeat attempts to monitor vital signs. The trust acknowledged that this was an area that required improvement, and managers were revising the trust's policy to include the need for non-contact observations if a patient refused contact physical observations. In addition, the trust was planning to update the rapid tranquilisation recording document to include documentation of non-contact observations, if required. This was due to be implemented by January 2020.
- The current ward environments at St Pancras Hospital did not provide a good environment for patient care. The wards were limited in space and lacked a therapeutic environment for patients. Some patients had to share bedrooms. On Rosewood Ward, ledges at the edge of the lounge posed a risk to staff and patients. The trust had undertaken work to improve the safety of the wards, such as by installing anti-barricade doors, and had advanced plans to build a new hospital to replace the wards.

Acute wards for adults of working age and psychiatric intensive care units

- On some wards, there were delays in repairs being carried out. Trust managers were working with contractors to improve the speed of response to problems.
- Staff had not completed all safety checks of equipment. On some wards, staff had not recorded regular calibration checks of blood glucose monitoring machines. On Dunkley and Opal Wards, staff did not routinely record the fridge temperature of the fridge where patients stored their food. On Opal Ward, there were several out of date items in the store cupboard, which included mouth swabs that expired in 2003.
- Clinic rooms on the wards did not contain an examination couch for physical health examinations to take place. Staff told us they conducted physical health examinations in patients' bedrooms. However, on Coral PICU, we saw that staff conducted physical health examinations in communal lounge areas, which compromised privacy and dignity. The trust told us that clinic rooms were too small for examination couches and posed a health and safety risk. However, they proposed to complete a risk assessment and options review regarding this matter.
- Staffing remained an issue for some wards, although the trust had continued with their recruitment drive, and most wards had enough nursing and medical staff to keep patients safe. Coral PICU had high registered nurse vacancies and shifts could not always be filled with bank staff. This meant that shifts did not always have the required number of registered nurses, there was high use of bank/agency staff, one-to-one clinical supervision for staff did not always happen, and permanent registered nurses reported feelings of burnout.
- Although improvements had been made since the last inspection on recording comprehensive restraint records, on Topaz and Opal Wards, staff did not always record the names and roles of staff involved in a restraint.

However:

- All wards were clean and had good furnishings. Staff regularly assessed the risk within the care environment. This included fire safety checks and ligature risk assessments.
- The trust had worked hard on reducing restrictive interventions. Most wards had taken part in the Safewards initiative, which looked at understanding conflict and resolution. Coral PICU had a large focus on reducing restraint. They delivered a quality improvement project in violence and aggression, where they introduced patient-led safety huddles, staff safety huddles and increased the number of nurse-led activities on the wards. The ward had seen a reduction in violent incidents, alongside a decrease in incidents of prone restraint.
- The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Following an alleged homicide on Coral PICU in February 2019, senior managers had taken immediate steps to ensure the safety of patients, including the deployment of senior managers at night. The trust had also fully investigated what happened and shared learning across all the wards.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse, and they knew how to apply it.
- The service used systems and processes to safely prescribe, administer, record and store medicines. Staff regularly reviewed the effects of medications on each patient's physical health.
- Most staff had received and were up-to-date with appropriate mandatory training. However, not all bank NHSP registered nurses were trained in restraint or intermediate life support. This meant that some bank registered nurses were unable to carry out physical interventions or intermediate life support if required on the wards.
- Staff had easy access to clinical information, and it was easy for them to maintain high quality clinical records – whether paper-based or electronic.

Acute wards for adults of working age and psychiatric intensive care units

Is the service effective?

Good ➔➔

Our rating of effective stayed the same. We rated it as good because:

- On most wards, staff assessed the physical and mental health of patients promptly on admission. Most care plans were personalised, holistic and recovery orientated.
- Managers recruited volunteers when required and trained and supported them for the roles they undertook. On Coral PICU, peer debrief volunteers met with patients who had been restrained to provide a debrief and additional support.
- Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives (QI). Most wards were taking part in QI projects to try and improve specific issues pertinent to their wards.
- Staff from different disciplines worked together as a team to benefit patients. Staff held regular and effective multi-disciplinary team meetings, where patients' care and treatment were comprehensively discussed. Staff supported each other to make sure patients had no gaps in their care. The teams had effective working relationships with other relevant teams within the organisation and with relevant services outside of the organisation.
- Staff supported patients to live healthier lives. Staff supported patients with smoking cessation. Where appropriate, patients had access to a gym, yoga, walking groups, football and tennis activities. These activities promoted movement and exercise.
- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and discharged these well. Managers made sure that staff could explain patients' rights to them.

However:

- Patients had limited access to clinical psychology input. At the time of the inspection, four wards had not had access to a dedicated clinical psychologist since February 2019, although staff could refer patients to the trust's lead clinical psychologist. A clinical psychologist was due to start in October 2019 to provide dedicated input to these four wards. The trust had limited clinical psychology resource. Five clinical psychologists worked across the inpatient and community teams, which meant only one to two patients per ward were able to be seen. This meant many patients did not have any psychological input.
- Not all staff received regular one-to-one clinical supervision to support them with carrying out their duties. For example, on Opal Ward, the completion rate for supervision in August 2019 was 58%, and 41% for September 2019. On Coral PICU, due to a shortage of permanent registered band five nurses, some staff were offered group supervision as there was no resource to deliver one to one supervision. However, most staff that we spoke to across all wards said they were getting one to one clinical supervision.

Is the service caring?

Good ➔➔

Our rating of caring stayed the same. We rated it as good because:

- Staff treated patients, families and carers with compassion and kindness. Staff demonstrated a good understanding of patients' and carers' needs and interacted with them in a respectful and responsive way.

Acute wards for adults of working age and psychiatric intensive care units

- Staff supported patients to understand and manage their care, treatment or condition. Staff met with patients regularly on an individual basis each day, and through weekly multidisciplinary ward rounds to discuss their care and treatment with them.
- Staff actively sought feedback from patients on the quality of care provided. For example, on Coral PICU, patients were invited to attend patient 'huddles' to provide feedback on any concerns they had on the ward and how staff could better support them.

However:

- The wards did not use formal systems in place to gather feedback from families and carers. Staff said they would informally speak to families and carers when they visited the ward or spoke to them over the phone.

Is the service responsive?

Requires improvement 

Our rating of responsive went down. We rated it as requires improvement because:

- The trust was experiencing high demand for its acute wards for adults of working age and psychiatric intensive care units. When beds were not available, some patients had to be placed in beds in external hospitals in the private sector, which were sometimes out of the local area. Eight out of the eleven wards had bed occupancies rates ranging above 100% between June 2018 and May 2019. To manage high demand when local private sector beds were not available, the trust had decided that patients could be placed in temporary beds in quiet lounges on the wards. These rooms compromised patients' privacy and dignity. The rooms were not designed as bedrooms and did not have sinks. Some opened onto the main lounge. When patients were placed in the rooms, no quiet room was available on the ward. When the temporary beds were used, extra staff would be used to provide one-to-one observation and staff completed a risk assessment and care plan to ensure the patient's safety.
- The acute ward environments at the St Pancras Hospital site had limited space and did not provide a therapeutic environment for patients. However, Laffan Ward had worked with a charity and students from a local art college to improve the decoration of the ward. The acute wards were due to be re-located to a brand-new facility in Highgate.

However:

- Staff planned for patients' discharge, including good liaison with care managers/co-ordinators and plans for patients' discharges were discussed each at the multidisciplinary meetings. The trust attended multi-agency discharge events with local stakeholders to review patients with a barrier to discharge.
- Staff took account of patients' individual needs. Wards provided interpreters for patients whenever this was needed, to support patients at ward rounds and in other aspects of their care. Staff ensured patients had access to spiritual support. The wards were accessible to patients with physical disabilities and mobility issues. Staff could seek support from the trust's community learning disability consultant if a patient had a learning disability.
- The food was of mostly of a good quality and patients could make hot drinks and snacks at any time. Staff ensured patients had a choice of food to meet the dietary requirements of different religious, cultural and personal needs.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and the wider service.

Acute wards for adults of working age and psychiatric intensive care units

Is the service well-led?

Good ➔➔

Our rating of well-led stayed the same. We rated it as good because:

- Leaders had the skills, knowledge and experience to perform their roles, had a good understanding of the services they managed and were visible in the service and approachable for patients and staff.
- Staff felt respected, supported and valued by their immediate colleagues. Every member of staff we spoke with praised the teamwork on the ward. Staff we spoke with said they felt about to raise concerns without fear of retribution. Staff told us that the culture of the trust had improved since the last inspection in December 2017, and there was a more open and transparent culture.
- All staff were committed to continually improving services and had a good understanding of quality improvement (QI) methods. Leaders encouraged innovation and participation in research. Most wards were taking part in a QI project to improve specific aspects of quality delivered to patients.
- Staff were eager to learn from other acute and PICU wards outside of the trust. Coral PICU was part of the national collaborative QI project for reducing restrictive interventions. On Ruby PICU, staff were due to attend the sexual safety collaborative launch, to learn how they could improve sexual safety on the ward.
- Our findings from the other key questions demonstrated that governance processes generally operated effectively at ward level. Since the serious incident on Coral PICU in February 2019, the trust had reviewed its processes to ensure that it identified any potential concerns.

Areas for improvement

Action the provider MUST take to improve:

- The trust must ensure that staff take all reasonable steps to ensure that physical health checks are carried out and recorded after patients receive rapid tranquilisation, including when a patient refuses to have their vital signs taken. **Regulation 12 Safe Care and treatment (1)(2) (a)(b)**
- The trust must ensure that patients are accommodated in bedrooms that are designed to support their privacy and dignity. **Regulation 10 Dignity and respect (1)(2) (a)**

Action the provider SHOULD take to improve:

- The trust should ensure that staff on Coral psychiatric intensive care unit understand the ward's fire evacuation procedures to ensure staff and patients can be safely evacuated in case of an emergency.
- The trust should ensure that staff identify blind spots on the wards and safely mitigate any risks.
- The trust should work towards eliminating the two shared bedrooms on Dunkley Ward to promote privacy and dignity for patients.
- The trust should ensure that staff regularly check items for clinical use are within their expiry date and are fit for purpose.
- The trust should ensure that repairs to equipment are carried out promptly.
- The trust should continue to that systems are in place to ensure staff regularly calibrate all medical equipment to ensure accurate results.

Acute wards for adults of working age and psychiatric intensive care units

- The trust should review whether examination couches can be accommodated in its clinic rooms.
- The trust should continue work on recruitment and retention to ensure that it employs sufficient staff to ensure that the shifts are covered.
- The service should ensure that appropriate treatments for patients, including psychology.
- The trust should ensure that all staff receive regular one-to-one clinical supervision to support them with carrying out their duties.
- The trust should ensure that there is an effective system in place for staff to record checks of the ward's emergency equipment to provide assurance on the quality and safety.
- The trust should ensure that there are formal systems in place so that families and carers are able to give feedback on the service they receive.

Mental health crisis services and health-based places of safety

Good ➔➔

Key facts and figures

The team that inspected mental health crisis services consisted of a CQC inspector, two inspection managers and two specialist advisors: one was a senior nurse with experience of working in crisis services and one was a consultant psychiatrist.

Before the inspection, we reviewed information that we held and asked other organisations to share what they knew about the trust.

During the inspection visit, the inspection team:

- Spoke with four patients and reviewed 15 patient feedback forms
- Reviewed seven carer feedback forms
- Spoke with managers of each crisis resolution and home treatment team, one crisis house and the crisis call centre
- Spoke to the operational lead manager and director of community acute
- Spoke with a further 17 members of staff including, doctors, nurses, assistant practitioners, student nurses and social workers
- Observed care and treatment during an assessment meeting
- Observed care and treatment during two home visits
- Attended six staff handover meetings
- Looked at 22 patient records.

The crisis resolution and home treatment teams (CRHTs) provide initial assessment and home treatment for adults who present with a mental health need that requires a specialist mental health service. Their primary function is to undertake a comprehensive assessment of needs, whilst providing a range of short-term treatments / therapies aimed at a quicker recovery for people who do not need long term care and treatment and as an alternative to hospital admission. The teams support people who are discharged from hospital within their own homes and those staying in the crisis houses.

We inspected the trust's three CHRTs: Islington, South Camden and North Camden.

We inspected the Rivers Crisis House in South Camden. This house offers an alternative to hospital admission for people who need treatment for their mental health problem. Admission to the crisis house is on a short-term basis and patients must be able to give consent to accept treatment.

We inspected the crisis call centre at the Highgate Mental Health Centre in Islington, which offers a 24-hour crisis call line.

The trust provides health-based places of safety. A health-based place of safety is a place where someone who may be suffering from a mental health problem can be taken to be assessed by a team of mental health professionals. At the time of the inspection, the trust was in the process of building a new health-based place of safety for adults at Highgate Mental Health Centre to replace the current provision it was using in local acute hospital emergency departments. The trust aimed to open this provision in late 2019. We did not inspect the current provision during this inspection. We will inspect the new health-based place of safety when it opens.

Mental health crisis services and health-based places of safety

The Camden and Islington NHS Foundation Trust crisis services were last inspected in December 2017, when the overall rating for the service was good. Safe was rated as requires improvement, and effective, caring, responsive and well-led as good.

Summary of this service

Our rating of this service stayed the same. We rated it as good because:

- We rated effective, caring, responsive and well led as good. We rated safe as requires improvement.
- The service provided safe care. Clinical premises where patients were seen were safe and clean and the physical environment of crisis resolution and home treatment (CHRT) teams and Crisis House were fit for purpose. The number of patients on the caseload of the mental health crisis teams, and of individual members of staff, was not too high to prevent staff from giving each patient the time they needed. Staff assessed and managed risk well and followed good practice with respect to safeguarding.
- They provided a range of treatments that were informed by best-practice guidance and suitable to the needs of the patients. Staff engaged in clinical audit to evaluate the quality of care they provided.
- The mental health crisis teams included or had access to the full range of specialists required to meet the needs of the patients. Managers ensured that these staff received training, supervision and appraisal. Staff worked well together as a multidisciplinary team and with relevant services outside the organisation.
- Staff understood and discharged their roles and responsibilities under the Mental Health Act (1983) and the Mental Capacity Act (2005).
- Staff treated patients with compassion and kindness and understood the individual needs of patients. They actively involved patients and families and carers in care decisions.
- The mental health crisis service was easy to access. Those who required urgent care were taken onto the caseload of the crisis teams. Staff completed most initial assessments within two days. Staff and managers managed the caseloads of the mental health crisis teams well. The services did not exclude patients who would have benefitted from care.
- The service was well led, and the governance processes ensured that service procedures ran smoothly.

However:

- The Crisis resolution and home treatment teams did not have a robust system in place to keep an audit trail for medicines in stock. Staff did not always count and record the medicines the teams had received and dispensed, which meant they may not always have an accurate oversight of the medicines for which they were responsible.
- There were high levels of staff turnover and all the CRHT's had vacancies. However, there was ongoing work on recruitment and retention of staff and where needed temporary staff covered vacant posts.
- Staff working for the mental health crisis teams did not always provide copies of care plans for patients.
- Arrangements for safe lone working needed to be strengthened further. Staff were being provided with new personal alarms to call for help if needed during a home visit. However, staff were still receiving training to use this new equipment and were not yet confident. Other arrangements to ensure safe lone working were in place such as carrying out visits in pairs where needed and maintaining a calendar of staff visits.

Mental health crisis services and health-based places of safety

Is the service safe?

Requires improvement  

Our rating of safe stayed the same. We rated it as requires improvement because:

- The Crisis resolution and home treatment teams did not have a robust system in place to keep an audit trail for medicines in stock. Staff did not always count and record the medicines the teams had received and dispensed, which meant they may not always have an accurate oversight of the medicines for which they were responsible.
- There were high levels of staff turnover and all the CRHT's had vacancies. However, there was ongoing work on recruitment and retention of staff and where needed temporary staff covered vacant posts.
- Arrangements for safe lone working needed to be strengthened further. Staff were being provided with new personal alarms to call for help if needed during a home visit. However, staff were still receiving training to use this new equipment and were not yet confident. Other arrangements to ensure safe lone working were in place such as carrying out visits in pairs where needed and maintaining a calendar of staff visits.

However:

- All clinical premises where patients received care were safe, clean, well equipped, well furnished, well maintained and fit for purpose.
- The services had staff, who received basic training to keep patients safe from avoidable harm. The number of patients on the caseload of the mental health crisis teams and of individual members of staff, was not too high to prevent staff from giving each patient the time they needed.
- Staff assessed and managed risks to patients. They responded promptly to sudden deterioration in a patient's health.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse, and they knew how to apply it.
- Staff working for the mental health crisis teams kept records of patients' care and treatment and these were easily available to all staff providing care.
- The service used systems and processes to safely prescribe and administer medicines.
- The teams had a good track record on safety. The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

Is the service effective?

Good  

Our rating of effective stayed the same. We rated it as good because:

- Staff working for the mental health crisis teams provided a range of care and treatment interventions that were informed by best practice guidance and suitable for the patient group. They assessed the mental health needs of all patients and provided support based on their individual needs.

Mental health crisis services and health-based places of safety

- The mental health crisis teams included or had access to the full range of specialists required to meet the needs of patients under their care. Managers made sure that staff had a range of skills needed to provide high quality care. They supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.
- Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. The teams had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation. They participated in clinical audit, benchmarking and quality improvement initiatives.
- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice.
- Staff supported patients to make decisions on their care for themselves. They understood the provider's policy on the Mental Capacity Act 2005 and assessed and recorded capacity for patients who might have impaired mental capacity.

However:

- Staff working for the mental health crisis teams did not always develop individual care plans and did not always update them when needed.

Is the service caring?

Good ➔➔

Our rating of caring stayed the same. We rated it as good because:

- Staff treated patients with compassion and kindness. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.
- Staff in the mental health crisis teams involved patients in risk assessment and actively sought their feedback on the quality of care provided. They ensured that patients had easy access to advocates when needed.
- Staff informed and involved families and carers appropriately.

Is the service responsive?

Good ➔➔

Our rating of responsive stayed the same. We rated it as good because:

- The mental health crisis service was available 24-hours a day and was easy to access – including through a dedicated crisis telephone line. The referral criteria for the mental health crisis teams did not exclude patients who would have benefitted from care. Staff followed up patients who missed appointments.
- The services met the needs of all patients who use the service – including those with a protected characteristic. Staff helped patients with communication, advocacy and cultural support.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff.

Mental health crisis services and health-based places of safety

Is the service well-led?

Good 

Our rating of well-led stayed the same. We rated it as good because:

- Leaders had the skills, knowledge and experience to perform their roles, had a good understanding of the services they managed, and were visible in the service and approachable for patients and staff.
- Staff knew and understood the provider's vision and values and how they were applied in the work of their team.
- Most staff felt respected, supported and valued. They reported that the provider promoted equality and diversity in its day-to-day work and in providing opportunities for career progression. They felt able to raise concerns without fear of retribution.
- Our findings from the other key questions demonstrated that governance processes operated effectively at team level and that performance and risk were managed well.
- Teams had access to the information they needed to provide safe and effective care and used that information to good effect.
- Staff collected analysed data about outcomes and performance and engaged actively in local and national quality improvement activities.
- There were effective, multi-agency arrangements to agree and monitor the governance of the mental health crisis services. Managers of the service worked actively with partner agencies (including the police, ambulance service, primary care and local acute medical services) to ensure that people in the area received

Areas for improvement

Action the provide MUST take to improve

- The trust must ensure that the Crisis resolution and home treatment teams monitor stock medicines, so they can identify quickly if any go missing. **Regulation 12 Safe care and treatment 12(1)(2)g**

Action the provider SHOULD take to improve

- The trust should ensure that all patients are offered a copy of their care plan.
- The trust should review the effectiveness of its training on lone working procedures and, in particular, the use of new personal alarms.
- The trust should continue its work to address staff vacancy rates and high turnover across the CRHTs.

Community-based mental health services of adults of working age

Good 

Key facts and figures

Camden and Islington NHS foundation trust provides a range of community-based mental health services for adults of working age throughout the London boroughs of Camden and Islington. It also provides some psychology services in the borough of Kingston. Some adults receiving services may be subject to conditions under the Mental Health Act (1983).

This inspection was a short-term announced focused inspection. This meant staff knew we were coming the week before the inspection. The inspection took place at the same time as a wider inspection of the trust. In this inspection, we only inspected the Safe key question. We undertook this inspection due to concerns raised with us regarding the management of team caseloads.

During this inspection, we visited a sample of seven teams:

- South Camden recovery and rehabilitation team – provides support and interventions to patients in south Camden, who are over the age of 18 and with a primary diagnosis of psychosis.
- North Islington recovery and rehabilitation team – provides support and interventions to patients in north Islington, who are over the age of 18 and with a primary diagnosis of psychosis.
- Camden primary care mental health network – works in collaboration with the local authority and third sector providers to support patients under the care of primary care services.
- Islington assertive outreach team – provides interventions and support to patients in Islington aged 18 – 65 with a history of psychotic disorders and complex needs who may have had difficulty working with other teams.
- Camden early Intervention service – provides support and interventions to patients in Camden from the age of 14 upwards who are experiencing their first episode of psychosis. They provide support to patients for three years.
- Complex depression, anxiety and trauma team – provide assessments, support and interventions for patients with complex depression, anxiety and trauma from Camden and Islington that requires more specialist support than can be provided in primary care.
- Camden and Islington personality disorder service – provides support and interventions to patients from Camden and Islington that meet the diagnostic criteria for a personality disorder.

The last comprehensive inspection of this service was published in March 2018. We rated the service as good overall. We rated Safe, Caring, Responsive and Well-led as good. We rated Effective as outstanding.

The team that visited the community-based mental health services for adults of working age consisted of five members of CQC inspection staff and two specialist advisors, who were nurses by background.

Before the inspection visit, we reviewed information that we held about these services and information requested from the trust.

- visited seven teams providing community mental health services for adults of working age and looked at the quality of the environment in which patients were seen
- spoke to two divisional directors
- spoke to the service managers for each of the seven teams

Community-based mental health services of adults of working age

- spoke to eight team managers across the teams
- spoke to 31 other staff members including consultant psychiatrists, clinical psychologists, assistant psychologist, matrons, nurses, social workers, occupational therapists and students
- spoke to two patients
- looked at 22 patient care and treatment records
- checked 19 prescription charts
- attended and observed three handover meetings
- attended and observed one multi-disciplinary team
- looked at a range of policies, procedures and other documents relating to the running of the service.

Summary of this service

Our rating of this service stayed the same. We rated it as good because:

- Our overall aggregated rating did not change in this inspection because we did not inspect Effective, Caring, Responsive and Well-led. In these key questions, our ratings for from our previous inspection published in March 2018 remain unchanged. At that inspection, we rated the trust's community-based mental health services for adults of working age as good for caring, responsive and well-led. We rated it as outstanding for effective.

However, our rating of Safe went down. We rated Safe as requires improvement because:

- Patients identified as in need of a Mental Health Act (MHA) assessment were not always assessed promptly.
- The number of patients on the caseloads of some teams, and of individual members of staff in these teams, was too high to allow the staff to give each patient the time they needed.
- Nevertheless, the service provided safe care to most patients. Clinical premises where patients were seen were safe and clean. Staff managed most waiting lists well to ensure that patients who required urgent care were seen promptly. Staff assessed and managed risk well and followed good practice with respect to safeguarding.

Is the service safe?

Requires improvement 

Our rating of safe went down. We rated it as requires improvement because:

- Patients identified as in need of a Mental Health Act (MHA) assessment were not always assessed promptly. Staff did not complete some assessments for more than four weeks due to delays in obtaining a warrant and accessing support from the police. The police only provided limited time-slots to support assessments, which meant it was hard to staff to complete assessments promptly. Staff continued to monitor patients waiting for assessments and would offer more intensive support to patients where this was possible.

Community-based mental health services of adults of working age

- The number of patients on the caseloads of some teams, and of individual members of staff in these teams, was too high to allow the staff to give each patient the time they needed. The staff in the Camden early intervention service could not provide recommended interventions. Members of staff in the Complex depression, anxiety and trauma team felt they could not provide care that met the needs of their patients. The trust hoped to agree extra funding for the early intervention service and had already started work to review pathways to try and improve caseload size.

However:

- All clinical premises where patents received care were safe, clean, well equipped, well furnished, well maintained and fit for purpose.
- The service had enough staff, who knew the patients and received basic training to keep patients safe from avoidable harm.
- Staff assessed and managed risks to patients and themselves. They identified and responded promptly to sudden deteriorations in patients' health. When necessary, staff worked with patients and their families and carers to develop crisis plans. Staff in most teams monitored patients on waiting lists to detect and respond to increases in level of risk. Staff followed good personal safety protocols.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.
- Staff kept detailed records of patients' care and treatment. Records were clear, up to date and easily available to all staff providing care.
- The service used systems and processes to safely prescribe, administer, record and store medicines. Staff regularly reviewed the effects of medications on each patient's physical health.
- The teams had a good track record on safety. The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

Is the service effective?

Outstanding ☆

We did not inspect this key question as part of this focused inspection. The rating from the previous inspection published in March 2018 remains unchanged.

Is the service caring?

Good ●

We did not inspect this key question as part of this focused inspection. The rating from the previous inspection published in March 2018 remains unchanged.

Is the service responsive?

Good ●

Community-based mental health services of adults of working age

We did not inspect this key question as part of this focused inspection. The rating from the previous inspection published in March 2018 remains unchanged.

Is the service well-led?

Good

We did not inspect this key question as part of this focused inspection. The rating from the previous inspection published in March 2018 remains unchanged.

Outstanding practice

We found an example of outstanding practice in this service:

The trust had established locality-based teams, such as the Camden primary care in mental health network, to support patients cared for in the primary care. These teams meant that accessing specialist support was easier whilst being cared for in primary care services.

Areas for improvement

Action the provider MUST take to improve:

- The trust must continue to work with the police and partners to ensure that patients identified as requiring assessment under the Mental Health Act are assessed promptly. **Regulation 12 Safe care and treatment (1)(2)(a)(b)(i)**
- The trust must ensure caseloads for members of staff in the Complex depression, anxiety and trauma team and the Camden early intervention service are low enough for them to offer care that meets the needs of patient. **Regulation 18 Staffing (1)**

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that the service provider was not meeting. The provider must send CQC a report that says what action it is going to take to meet these requirements.

For more information on things the provider must improve, see the Areas for improvement section above.

Please note: Regulatory action relating to primary medical services and adult social care services we inspected appears in the separate reports on individual services (available on our website www.cqc.org.uk)

This guidance (see goo.gl/Y1dLhz) describes how providers and managers can meet the regulations. These include the fundamental standards – the standards below which care must never fall.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing

Our inspection team

Jane Ray, Head of Hospital Inspection at CQC, led this inspection.

An executive reviewer, Chrishni Waring, Trust Chair at Northamptonshire Healthcare NHS Foundation Trust, supported our inspection of well-led for the trust overall.

The team included14 further CQC inspection staff, 11 specialist advisers, and two experts by experience.

Executive reviewers are senior healthcare managers who support our inspections of the leadership of trusts. Specialist advisers are experts in their field who we do not directly employ. Experts by experience are people who have personal experience of using or caring for people who use health and social care services.