Care Quality Commission

Camden and Islington NHS Foundation Trust

Services for people with learning disabilities or autism

Quality Report

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Locations inspected

Name of CQC registered location	Location ID	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
St Pancras Hospital	TAF01	Dunkley Ward	NW1 0PE
St Pancras Hospital	TAF01	Camden Learning Disabilities Service	WC1H 9JE
Highgate Mental Health Centre	TAF72	Islington Learning Disabilities Partnership	N5 1NS

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

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

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

Summary of findings

Ratings

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

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

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

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

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

Summary of findings

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Summary of findings

Overall summary

Camden and Islington NHS Foundation Trust provides learning disabilities through its two community teams: Camden learning disabilities service (CLDS) and the Islington learning disabilities partnership (ILDP). There are also four nominal beds on Dunkley Ward at St Pancras Hospital. This is a 16-bed ward for people with a mental illness. However, if a bed is not available on Dunkley Ward, then the person will be admitted to another acute inpatient ward in the trust. This report specifically looks at the care of people with learning disabilities. Other issues relating to the acute ward are addressed in the report for acute admission wards.

We found that the services for people with a learning disability and autism were good.

Treatment and support was provided in the community by multidisciplinary teams that were integrated between health and social services. This meant that staff had effective working relationships, which benefited people using the service. There was a single point of referral to the community teams. After referral, staff completed an assessment and developed a care plan for each person.

People who needed hospital treatment were admitted to an acute mental health ward. In order to promote continuity of care, one ward (Dunkley Ward) was nominated to admit people with a learning disability. However, people were also sent to other wards in the hospital and were moved between wards. Although hospital staff had received little formal training, we saw that they understood about working with people with a learning disability. Staff from the community teams continued to provide treatment and support to people when they were in hospital.

Staff were person-centred, and discussed and reviewed people's care and treatment with them. Information was discussed with, and provided to, people in an accessible way. This included the use of pictures and easy-to-read materials.

Summary of findings

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

Are services safe?
The trust provided a safe service for people with learning disabilities or autism.

There were also systems for reporting and managing incidents, and identifying and reporting safeguarding concerns in place.

Are services effective?
The trust provided an effective service for people with learning disabilities or autism. The community teams were integrated between health and social services. This meant that staff had good working relationships, which benefited people using the service.

There was a single point of referral to the community teams. After referral staff completed an assessment and developed a care plan for each person.

People who were admitted to hospital were cared for by ward staff who had little formal training in working with people with a learning disability. However, staff from the community teams continued to provide treatment and support to people on the ward.

Are services caring?
The trust provided a caring service was provided for people with learning disabilities or autism. Staff were person-centred, and discussed and reviewed people's care and treatment with them. Information was discussed with, and provided to people, in an accessible format. This included the use of pictures and easy-to-read materials.

Are services responsive to people's needs?
Services were responsive to people's needs. Treatment and support was provided in the community by multidisciplinary teams that were integrated across health and social services.

The teams aimed to support people in the community as much as possible, but people were admitted to hospital when it was needed.

To provide continuity of care, the trust tried to always admit people with a learning disability to Dunkley Ward. However, this was not always possible, and people were admitted to and moved to different wards for both clinical and bed management reasons.

Are services well-led?
We found that the service for people with learning disabilities or autism was well led.

Summary of findings

The care records showed that a person's diagnosis was recorded, which included if a person had a learning disability. This meant that the information could be searched so that the Trust could identify when a person with a learning disability had been admitted, and track their care.

The two community learning disability teams were fully integrated between health and social services, and were hosted by the local authority in each borough. The funding for learning disability services was pooled between health and social care. The inpatient ward was within the trust's governance and monitoring procedures. The community team was hosted by the local authorities, and worked within their policies and procedures, with links into the trust.

Summary of findings

Background to the service

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

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

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

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

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

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

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

There are no dedicated inpatient wards for people with a learning disability in Camden and Islington. There are four nominal beds on Dunkley Ward at St Pancras Hospital. This is a 16-bed ward for people with a mental illness. If a bed is not available on Dunkley Ward, then the person will be admitted to another acute inpatient ward in the trust. Only a small number of people with a learning disability have been admitted to one of the trust's hospitals in the last year.

Nursing care on the ward is provided by mental health nurses and support workers. Other health and social care is provided by staff from the community learning disability teams in Camden and in Islington. This includes consultant psychiatrists, psychology, occupational therapy, speech and language therapy, and community nurses and social workers.

There are two community learning disability services: the Camden learning disabilities service (CLDS) and the Islington learning disabilities partnership (ILDP). Both teams are fully integrated between health and social services, and are 'hosted' or provided by the local authorities in Camden and in Islington. Most healthcare staff are employed by Camden and Islington NHS Foundation Trust, and seconded to work in the community teams.

Our inspection team

Our inspection team was led by:

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

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

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

Summary of findings

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

Why we carried out this inspection

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

How we carried out this inspection

To get to the heart of people who use services' experiences of care, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

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

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

Before visiting, we reviewed a range of information we hold about the provider and asked other organisations to share what they knew about the provider.

Before the inspection visit took place we met with five different groups of people who use the services provided by the trust across the boroughs of Camden and Islington. We also met with two carers groups from the two boroughs. They shared their views and experiences of receiving services from the provider.

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

During our visit the team:

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

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

Summary of findings

What people who use the provider's services say

We were only able to speak with and observe the care of a limited number of people using the service, and these were from the inpatient ward. One person told us they felt able to approach the staff, and had been involved in their discharge planning. We saw that people had easy-to-read care plans and information about their care, and were involved in meetings about their care and treatment.

We visited both the community learning disability team offices, where people using the service can meet with staff, but there were no people or their carers there to speak with us. However, we did see that the areas were clean, private and accessible, and that there was easy-to-read information available about different aspects of the service, and how they could complain or comment on the service they received.

Good practice

- The community learning disabilities teams were integrated between health and social care staff, and provided in-reach services to the inpatient wards. People on the ward had continuity of care as they continued to receive the support they had had in the community. The integrated team and shared team office had the effect of making health and social care professionals easily accessible to one another for advice and support.
- The availability of easy-to-read information for people with a learning disability. This included standard hospital care plans, information on medicines, and how to raise concerns.

Areas for improvement

Action the provider MUST or SHOULD take to improve

Action the provider SHOULD take to improve

- Staff supporting people with a learning disability while they are inpatients should have training to enable them to deliver a high standard of care.
- Access to electronic records should be improved for people working in the community teams. The community teams were integrated between two councils, the mental health trust, and an acute health trust (for the speech and language therapists). Each of these organisations had their own separate electronic record system, which staff found frustrating and time consuming. Some staff could only access one of the systems, and would have to ask colleagues for information on other systems. Other staff had to enter the same information into both a health and a social care record.
- Care plans for people with learning disabilities in inpatient services should be comprehensive and reflect their need. For example, there were no health actions plans or positive behaviour plans, and gaps in the communication plans.

Summary of findings

- The trust should follow through the recommendations made in the report produced by the Royal College of Psychiatrists, January 2014, reviewing learning disability services.

Detailed findings

Camden and Islington NHS Foundation Trust

Services for people with learning disabilities or autism

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Dunkley Ward	St Pancras Hospital
Camden Learning Disabilities Service	St Pancras Hospital
Islington Learning Disabilities Partnership	Highgate Mental Health Centre

Mental Health Act responsibilities

The use of the Mental Health Act (MHA) 1983 was mostly good in acute admission wards. Mental health documentation reviewed was mostly found to be compliant with the Act and the MHA Code of Practice in the records of people detained under the Act.

Mental Capacity Act and Deprivation of Liberty Safeguards

There were no people subject to Deprivation of Liberty Safeguards (DoLS) in the areas we visited. There had been a best interest meeting, under the Mental Capacity Act, for a person who had been on the inpatient ward, and this was documented in their care records.

An assessment of people's capacity was routinely incorporated into assessments and reviews of people's care. Staff in the community teams described situations where they had worked with people about their capacity to consent to complex decisions. There were also staff in the community teams who were trained as Best Interest Assessors (BIAs) under the Mental Capacity Act.

Are services safe?

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

* People are protected from physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse

Summary of findings

The trust provided a safe service for people with learning disabilities or autism.

There were also systems for reporting and managing incidents, and identifying and reporting safeguarding concerns in place.

Our findings

Inpatient services

Track record on safety

Staff we spoke with on acute wards knew how to recognise and report incidents on the trust's electronic incident recording system. All incidents were reviewed by the ward manager and forwarded to the clinical governance team for the trust, who maintained oversight.

The staff we spoke with told us there had been no incidents involving people with a learning disability, which included restraint. However, an incident occurred during the course of the inspection. It was not reported during the shift it occurred on, but staff told us that it would be reported.

Learning from incidents and improving safety standards

The trust's quarterly performance report (dated May 2014) did not include any indicators specifically related to learning disability services. The admission of people with a learning disability and their care is under the acute care pathway recording for incidents and complaints.

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

The trust had safeguarding procedures, and staff knew how to make a referral. The staff we spoke with described their understanding of safeguarding, and the action they would take to report this. Staff told us they had received safeguarding training, and this was also included as part of the induction for new staff. Most staff said they would discuss any safeguarding concerns with the nurse in charge, the ward manager, or the safeguarding lead, and that an online form was used to make a safeguarding referral. One member of staff told us that they knew how to make a referral, but they didn't know what happened after that. Most of the staff we spoke with said they had not needed to make a safeguarding referral.

One of the staff on the ward was a safeguarding lead, and had completed additional safeguarding training. They explained the process for making safeguarding referrals and seeking advice within the Trust. They said that the different local authorities had different processes for managing safeguarding, but the referral method for ward staff was the same.

Assessing and monitoring safety and risk

The risk register in the trust's quarterly performance report (May 2014) included one item specifically related to learning disability services. This was about the review of the formal agreement between the local authority and the trust relating to the provision of health and social care services. This was identified as a risk, but had all necessary actions completed or on target.

People with a learning disability received nursing care from the same staff as people with a mental illness on the ward. Staff told us that although the staffing levels were the same as for other acute wards in the trust, they thought they should be increased as people with a learning disability tended to need extra time with staff.

The care records we looked at included an assessment of risk for the person, and care plans to reduce these risks.

Community-based services

Track record on safety

The community teams followed the local authority policies for reporting and managing incidents.

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

Staff were familiar with the safeguarding procedures for the authority they worked in, and had raised, investigated, or chaired safeguarding meetings. The staff we spoke with were clear about how they identified and reported safeguarding concerns, and described examples of when this happened. In the community teams, safeguarding concerns were recorded through the electronic database, reviewed by a manager and then followed through the local authority processes. One member of staff explained

Are services safe?

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

how "low level" concerns could be logged on the electronic record system, without a full safeguarding investigation being instigated. This enabled them to keep track of possible problems that may otherwise be missed.

There were staff in the team who took on the role of investigating and taking action when safeguarding concerns had been raised. Many of the managers were trained Safeguarding Adults Managers (SAMs) who investigated the concerns, and most were social workers. Staff told us they followed the pan-London protocol for safeguarding.

Assessing and monitoring safety and risk

The community teams consisted of health and social care staff, who worked from one building in each of the local authorities (Camden and Islington). Staff told us that being able to meet with other colleagues directly both formally and informally, made it easier to discuss their concerns and share information and expertise. Staff believed this helped improve the service people received.

There were only a small number of vacancies in each of the community teams. There were waiting lists to see some professionals, such as psychologists and occupational therapists.

Staff told us that integrated community team working contributed to the success of the service in working with people who had complex and high risk behaviours. This included supporting, teaching and working with families and care workers to enable them to work effectively with the person. Each of the boroughs had a specialist outreach or support team that was set up to work specifically with people who were difficult to engage with or had complex behavioural and physical needs.

Understanding and management of foreseeable risks

The Camden and the Islington community teams both had a dedicated space for people using the service to visit for appointments or meetings. The areas for people using the service were clean and well maintained in both buildings. Each service had a medical room where people had basic physical health checks carried out, and routine injections administered in privacy.

Are services effective?

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

Summary of findings

The trust provided an effective service for people with learning disabilities or autism. The community teams were integrated between health and social services. This meant that staff had good working relationships, which benefited people using the service.

There was a single point of referral to the community teams. After referral staff completed an assessment and developed a care plan for each person.

People who were admitted to hospital were cared for by ward staff who had little formal training in working with people with a learning disability. However, staff from the community teams continued to provide treatment and support to people on the ward.

Our findings

Inpatient services

Assessment and delivery of care and treatment

People's specific healthcare needs were met by staff from the community learning disability teams. A junior doctor saw people on the ward four days per week, and a weekly ward round was held with the consultant psychiatrist and other members of the multidisciplinary team such as psychologists, occupational therapists and social workers. If a person was on a ward other than Dunkley Ward, they would still be reviewed but at different times. Staff told us that if a person had been receiving treatment or support in the community, then this would continue as much as possible whilst they were on the ward. For example if a person had sessions with a psychologist, or went out with a community support worker.

We looked at a sample of care records of people with a learning disability admitted to Dunkley Ward. They showed that people had had their needs assessed and care plans developed in response to these. Staff told us that most information about a person's needs was passed on through the nursing handover. People had had their care reviewed, and they were seen by the medical and multidisciplinary team regularly.

The care records showed that each person's physical healthcare needs had been assessed. Care plans had been developed from these, for example for epilepsy. However, the care records did not include health action plans or positive behaviour support plans, which include detailed information about a person's needs. Staff in the community team told us that positive behavioural support plans had not been implemented, but there were plans to do so in the future. One of the records included detailed communication plans, which had been provided by the community team, but another did not.

We reviewed a sample of medication charts of people with a learning disability admitted to Dunkley Ward. They included basic information including allergies, and had been checked by the Trust's pharmacist. We noted that there had been several occasions when a person had refused medication, including for physical health conditions. Staff explained to us what had happened on these occasions, and the action that had been taken. We saw that medication was reviewed by the consultant psychiatrist in the weekly multi-disciplinary team meeting, which was also attended by a pharmacist who provided advice.

Staff told us that when a person was admitted the junior doctor would assess their capacity, and this would be reassessed each week in the ward round. This was confirmed in the care records. Staff were able to tell us about the capacity of the people with a learning disability on the ward, and how they protected their safety and legal rights. For example, about the choices they made, and if they wanted to leave the ward. A person we spoke with confirmed they went out when they wished, and they were able to make choices about what they wanted to do. We saw that a best interest meeting had been held where a person was assessed as not having the capacity to make a decision about where they lived.

Outcomes for people using services

The trust had taken part in the Royal College of Psychiatrists' national audit of learning disability services with a report produced in January 2014. This identified a number of areas where the services provided by the trust could improve. These need to be followed through.

Staff, equipment and facilities

Most of the staff we spoke with told us they had not had training in working with a person with a learning disability. This was consistent with the National Audit for Learning Disabilities report in January 2014. Staff told us that information about working with people with a learning disability was not included as part of the induction for new

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staff. Staff told us that information about working with people with a learning disability was provided by other staff on the ward, the community learning disability team, and care records. However, the staff we spoke with did have an understanding of the needs of the people on the ward. For example, staff told us that when a person used certain words or phrases this meant they were in pain, or they were responding to auditory hallucinations. They also said they use communication tools with some people, for example the use of pictures or easy to read care plans.

Staff told us that although they received supervision, they did not have specific clinical support for working with people with a learning disability. However, they told us that if they needed advice they would speak with a member of the community learning disability team.

The ward had a part-time occupational therapist and a part-time activity coordinator. There were no activities specifically for people with a learning disability, although staff said they would provide one-to-one activities if necessary. One member of staff told us that there was a one-to-one activity box for people with a learning disability. There was a list of activities on the noticeboard, which included religious activities, minutes of community meetings, mealtimes and computer access. There was a computer room and a pool table on the ward. A person we spoke with said they had got involved in some activities on the ward such as pottery and music.

Multidisciplinary working

People's care was reviewed regularly, which included by the consultant psychiatrist and the rest of the multidisciplinary team once a week. This included psychologists, occupational therapists, community nurses, social workers and a pharmacist.

There was a junior doctor, who changed every six months, in each of the community learning disability teams. They each attended the ward two days per week, and reviewed and met with all the people with a learning disability. This meant that people with a learning disability were seen by a member of staff from the community team most weekdays. In addition, they saw people on the ward who did not have a learning disability when necessary. For example, the ward doctor was on nights so the doctor from the learning disability team provided cover for them during the day.

Staff from the community team continued to provide support for people when they were on the ward. For example, one of the people on the ward at the time of our inspection continued to be seen by the speech and language therapist. Staff told us that the care coordinator of one of the people with a learning disability had brought in a profile of the person, which included activities they liked, and words they responded to. However, they said this didn't happen with all the people who were admitted.

Mental Health Act (MHA) 1983

There was only one person with a learning disability who was an inpatient in the trust who was detained under the MHA. The correct procedures had been followed.

Community-based services

Assessment and delivery of care and treatment

There was a 'medical room' in each of the community learning disability offices. Staff told us this was where simple physical health checks were carried out and routine injections were administered. One of the people we spoke with told us that they could take their own medication, but they needed support with this which they received from a member of the learning disability team.

There was a process for assessing people referred to the service. Each community team had a single point of referral, and a weekly meeting where any new referrals were discussed. People were assessed by one or more staff from the team. Staff told us this included a comprehensive assessment of the person's needs, and this was used to determine the treatment and support they needed from the team.

Staff told us that when a person was allocated to a member of the team, more detailed assessments would be carried out. For example, an occupational therapist would do functional skills assessments and identify people's support needs. They may also work with the person and a speech and language therapist to assess their needs regarding eating and drinking.

The staff we spoke with had an understanding of capacity. Staff told us that when a person was first referred to the service, they were presumed to have capacity to make decisions until this was assessed as otherwise. For people who are known to the service, their capacity will be regularly assessed, and in response to any decisions they need to make. Staff told us that many members of the team were able to assess capacity, but a psychologist may carry out an assessment if a person had fluctuating capacity, and the decision was complex.

Are services effective?

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

Staff described examples of how complex decisions had been made where a person lacked capacity. This involved following best interest processes, and supporting the person to understand their choices, so that they could be involved in the decision making process. For example, regarding where a person lived, or to manage a person's financial affairs.

There were staff in the community teams who were trained as Best Interest Assessors (BIA). However, they carried out best interest assessments of services other than their own, and similarly BIAs from other services in the borough would tend to do assessments for the learning disability service, to promote an independent perspective.

Staff in both boroughs told us there were no Deprivation of Liberty Safeguards (DoLS) currently in place for people the team worked with. They said that any applications to restrict people using the DoLS would go to the DoLS office within the local authority.

Staff in both of the community learning disability teams, told us that they had reviewed all the people that were placed in out of borough placements, in accordance with national government policy following the investigation into Winterbourne View care home. Staff told us there was a detailed plan in place for the remaining people who needed to be moved elsewhere, which was less than ten people across both teams. There were no current inpatients who had been there for extended periods (over 12 months) or who did not have a discharge plan, or actions being taken to achieve this.

Staff, equipment and facilities

There was a structure for line management, clinical supervision, and appraisal. The staff we spoke with had supervision and appraisal, and many of the staff we spoke with had clinical supervision provided for them outside the trust. They found this supportive and helpful for their practice. Many of the allied health professionals, such as psychologists and occupational therapists, were part of practice and development groups with their colleagues in other parts of the trust. The staff we spoke with were positive about the support they received from having a mix of professionals available through the integrated team working. Staff told us they had completed mandatory training through the local authority or through the trust.

Multidisciplinary working

The community learning disability teams were fully integrated between health and social services, and worked effectively together. The integrated community teams worked only with people with a learning disability, so all staff specialised in this area. The nursing staff were a deliberate mix of mental health and learning disability trained. The staff we spoke with were positive about the integrated teams, and told us they found it beneficial to be able to easily contact each other for formal and informal advice and support.

Both of the integrated teams included a mixture of social and healthcare professionals, and directly employed the social workers. The trust employed and seconded the medical staff (consultant psychiatrists, specialist registrar, and junior doctors), psychologists, occupational therapists, and nurses. In each of the teams there were community support teams, and some other staff such as a counsellor, and brokerage workers (who provide specialist housing advice). Other community learning disability staff work within the trust's areas but are employed by other acute trusts. For example the speech and language therapist, transition nurse (from child to adult services), and liaison nurses at A&E departments. There is also a specialist physiotherapy service.

Allied health professionals, such as psychologists and occupational therapists, had managerial responsibilities and attended professional and governance groups across the trust and local authority. For example, the head of service at Camden learning disability service was also the head of psychology for both the Camden and Islington community learning disability teams. The occupational therapists had links with occupational therapists in other services, which they used if people needed special equipment or adaptations to where they lived. Staff told us they had good links with the council and adult social services, and this was helpful for accessing 'mainstream' social services that some people with a learning disability needed to access.

Each of the community teams had several meetings each week where the multidisciplinary team could book in sessions to discuss people with complex care needs, where urgent or immediate concerns could be discussed, and also a referrals meeting for people who had recently been referred to the service.

Are services effective?

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

The staff we spoke with were positive about the service they provided, and said they worked well together. However, they felt the incompatibility of the IT systems created additional work and did not support the joint working arrangements. The trust used a healthcare record system (RiO), and each of the community teams had a different local authority record system (Camden and Islington councils both have different IT systems). There were RiO terminals in the community teams that some health staff could access, but no local authority system access in the hospital. Staff told us that they "worked around" this but it did result in information being entered twice, or in information being recorded in one system but not the other.

Mental Health Act (MHA) 1983

Some of the staff in the community teams were Approved Mental Health Practitioners (AMHPs). They were part of the borough-wide AMHP rota, so carried out MHA assessments of all people who required them, not just people with a learning disability. Staff told us that they worked with the AMHPs service if a person with a learning disability needed to be assessed under the MHA. They told us that this did not happen often, but when it did the consultant psychiatrists in the team would try and to also assess the person. Staff told us that most people were supported and cared for in the community.

Are services caring?

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

Summary of findings

The trust provided a caring service was provided for people with learning disabilities or autism. Staff were person-centred and discussed and reviewed people's care and treatment with them. Information was discussed with, and provided to people, in an accessible format. This included the use of pictures and easy-to-read materials.

Our findings

Inpatient services

Kindness, dignity and respect

Women who were admitted to Dunkley Ward had their own bedroom, on a women-only corridor that had restricted entry. Many of the staff we spoke with said that when working with people with a learning disability more time and patience was needed than with the other people on the ward. They said that they tried to provide this, but it could be difficult as the ward was often busy. A person we spoke with had mixed opinions about being on the ward but told us "I feel comfortable here" and that there were "some good staff".

People using services involvement

When people were admitted to hospital they had a 'Hospital Care Plan' in an easy-to-read format that explained what was happening. Staff told us they went through this with the person, and we saw that people had signed it to say they understood. There was a noticeboard with lots of information leaflets about different services which included advocacy. Some of the information was in an easy to read format. On Dunkley Ward there was a folder of information for people with a learning disability in an easy to read format. This included information about medication, and told them they could raise a safeguarding concern or make a complaint. Staff told us that each person was given their own folder, with this information in, that staff went through with the person. Staff told us this was not available if people were admitted to other wards, and Dunkley Ward didn't have links to people with a learning disability who were admitted to other wards.

The inpatient care records we looked at did not include the person centred plans. Staff showed us a paper copy of the plan, and said they had yet to be uploaded onto the system. One of the people on the ward had limited verbal communication, and had a detailed communication plan which informed staff how they could communicate effectively with the person.

We attended a multidisciplinary team meeting on the ward, which included a care programme approach (CPA) meeting. This was attended by staff from the community learning disability teams, which included a consultant psychiatrist, psychologist, pharmacist, occupational therapist, charge nurse from the ward, two junior doctors, the specialist registrar, and a speech and language therapist. Relatives and advocates were invited, and the service user and an advocate attended the meeting. Accessible CPA documents were used, and for one service user some of the staff left the room so it would be more comfortable for them. One person was given a copy of their CPA or discharge plan. Aspects of care were discussed with people, and their views taken account of. Medication was discussed with one person by using pictures. We saw that the use of the Mental Health Act and DoLS were discussed where applicable. We saw that capacity was assessed, and discharge plans including future support were discussed with the person.

Emotional support for care and treatment

The care records included information about the people's relatives and carers. They showed that staff had been in contact with relatives, and that they were invited to meetings about their relative's care. We observed a ward round during our inspection, and although no relatives attended, we saw that they had been invited.

Community-based services

Kindness, dignity and respect

During our inspection we were not able to speak with people using the community services. The staff we met in the community teams spoke about the people using the service in a positive and person centred way that focused on supporting and enabling people and their carers as far as possible.

People using services involvement

In the community mental health teams there was lots of information on display, and in leaflets, for people in an easy to read format. Staff in the Camden community learning disability team told us that they had a dedicated member of staff who researched and developed the materials.

Are services caring?

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

Staff told us there was a weekly multidisciplinary meeting where they discussed the care of people who may have complex care needs. This may be attended by professionals outside the service and by the person themselves.

Staff spoke about people using the service in a person-centred way. Some of the staff we spoke with identified the power imbalance between staff and people using the services, and said they tried to work with people to empower them. For example, one member of staff said they were mindful that a person had often been referred to the service by other people, such as relatives and care staff. The staff would discuss this with the person, and how they felt about it, and ask them about their experience and expectations of services. The psychologist stated that if a person had a more severe learning disability and no capacity, then the work would focus on keeping them at the centre of their care, and this may include following processes for working in their best interest.

Emotional support for care and treatment

Staff told us that a person's care coordinator usually carried out an assessment of the carer's needs. Staff told us that in addition to working with a person with a learning disability directly, they also supported the family and other staff who provided direct care to them. One member of staff said "we support the carers to support the person". For example, a psychologist may work with a person's family to identify what triggered specific behaviour, or appropriate responses to the person's needs.

Are services responsive to people's needs?

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

Summary of findings

Services were responsive to people's needs. Treatment and support was provided in the community by multidisciplinary teams that were integrated across health and social services.

The teams aimed to support people in the community as much as possible, but people were admitted to hospital when it was needed.

To provide continuity of care, the trust tried to always admit people with a learning disability to Dunkley Ward. However, this was not always possible, and people were admitted to and moved to different wards for both clinical and bed management reasons.

Our findings

Inpatient services

Planning and delivering services

The trust had four nominal inpatient beds for people with a learning disability. Staff in both community teams told us that there were people in out of borough placements, but these were not people who would have been admitted to the mental health ward. Many of the staff we spoke with, both on the ward and in the community teams, had mixed views about the success of having people with a learning disability on a mental health ward. One member of staff said they thought the ward worked well for people with a learning disability who were more able and had a definable mental illness. The community staff agreed that they tried to support people in the community for as long as possible. However, when people were admitted the community team continued to provide support.

There were no current inpatients who had been there for an extended period (over 12 months) or who did not have a discharge plan, or actions being taken to achieve this.

Right care at the right time

Staff told us that if a person with a learning disability needed to be admitted to hospital a bed would be available. However, because of the demand for acute inpatient beds, a person wouldn't always be admitted to the allocated ward (Dunkley Ward) and may get moved around wards within the hospital.

Staff told us that when a person was admitted they had usually been assessed by the community learning disability team, who had identified their needs. The community team staff determine if a person needs to be admitted to hospital, or if they can be supported in the community. Staff told us that although people's needs are discussed by the multidisciplinary team, the consultant psychiatrist ultimately decides whether a person requires admission.

Staff told us that the number of people on the ward with a learning disability varied. The trust provided information of the people with a learning disability who had been admitted to one of the trust's two hospitals. Although this information was not consistent regarding the current inpatients, it stated that that 12 people with a learning disability had been admitted since October 2012. Two of these had been admitted more than once. Four people had moved wards at least once, and one person had been on five wards during their admission. Some of these moves were for 'clinical' reasons. However, we saw that a person had been on one ward for three days, moved to a second to "sleep out" overnight, and then returned to a third ward the following day.

A consultant psychiatrist told us that they would not usually admit people with autism or a severe learning disability to the hospital, as it was not a suitable environment for them. They told us that if this was necessary then people would usually be found a placement elsewhere.

The care records showed that discharge plans were in place for the people with a learning disability on Dunkley Ward. Staff from the community teams told us they provided an in-reach service to the ward, which included discharge planning and relapse prevention. This was confirmed by the care records. A person we spoke with told us they had been involved in the development of their discharge plans.

Care pathway

The care records included details of people's ethnicity, religion and other information. We saw that people's needs and wishes were included in the discharge and transition process. All the women's rooms on Dunkley Ward were single, and on a separate corridor that had key code access. The men were in double or single rooms. All the bathroom facilities were single sex.

Are services responsive to people's needs?

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

Learning from concerns and complaints

The trust provided a summary of complaints, which showed that they had not received any specific complaints from or about the care of people using the learning disability service.

Community-based services

Planning and delivering services

Both the community teams were integrated between health and social care staff and provided treatment and support for people with a learning disability. There was a single point of referral to each borough's community learning disability team, and people were allocated the necessary staff to manage and provide their care. People using the service have a broad range of needs that may also include physical and mental health problems. Each of the teams was structured differently, but included psychiatrists, nurses, social workers, psychologists, occupational therapists, speech and language therapists, and community support workers. The services are predominantly borough-based, but there was some cross-working.

Right care at the right time

There was a process for assessing people referred to the service. Both community teams said there were typically about 50 new people added to the teams each year. This included people who had been supported by the children's learning disability service but were getting older, people who had moved into the area, and some people who had not been in contact with services before. Each community team had a single point of referral, and a weekly meeting where any new referrals were discussed. People were assessed, and if necessary allocated to a member of the team, or to the duty system, depending on their needs. Staff told us there was a waiting list for occupational therapy and psychology services, but not for the allocation of a nurse or social worker.

Learning from concerns and complaints

Complaints in the community learning disability services were handled through the local authority complaints processes. There was information in the community learning disability offices that explained what people should do if they wanted to complain, or were unhappy about the service. This was in an easy to read format.

Are services well-led?

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

Summary of findings

We found that the service for people with learning disabilities or autism was well led.

The care records showed that a person's diagnosis was recorded, which included if a person had a learning disability. This meant that the information could be searched so that the Trust could identify when a person with a learning disability had been admitted, and track their care.

The two community learning disability teams were fully integrated between health and social services, and were hosted by the local authority in each borough. The funding for learning disability services was pooled between health and social care. The inpatient ward was within the Trust's governance and monitoring procedures. The community team was hosted by the local authorities, and worked within their policies and procedures, with links into the trust.

Our findings

Inpatient services

Vision and strategy

The trust's vision is that "people who use Camden and Islington services will have the best possible prospect of recovery within the resources we have available." Staff confirmed that the purpose of caring for people with a learning disability on a mental health ward was to integrate them into mainstream healthcare services.

Responsible governance

The care records showed that a person's diagnosis was recorded, which included if a person had a learning disability. This meant that the information could be searched so that the trust could identify when a person with a learning disability had been admitted, and track their care.

Engagement

There was information about how to contact an advocacy service, although this was not a specific service for people with a learning disability. However, an advocate from a learning disability organisation did attend a meeting with a person on the ward. Some of the information on the noticeboards was in an easy to read format. The staff we spoke with told us they felt able to raise their concerns.

Performance improvement

The funding for learning disability services was pooled between health and social care, which included the inpatient service on Dunkley Ward, and the in-reach service provided by the community learning disability teams. The respective Clinical Commissioning Groups (CCGs) monitored the service within each borough.

Community-based services

Vision and strategy

The community learning disability teams were fully integrated between health and social services. The staff we spoke with were positive about the service, and that their aim was to put people at the centre of the service they provided. Several staff told us they thought they did well at working with the voluntary sector and 'mainstreaming' (supporting people to access mainstream health and social care services), but thought they could do better at supporting people with employment.

There were structures in place to review and develop learning disability services for people living within Camden and Islington. These impacted on the services the trust provide as it runs the inpatient service, and healthcare is provided by its staff who work in the integrated teams.

Leadership and culture

The community teams were fully integrated between health and social services, and were hosted by the local authority. The staff we spoke with were positive about the service they provided, and said they worked well together.

Many of the managerial leads also carried a reduced caseload in addition to their management responsibilities. Most staff told us they found this positive as it kept them in touch with people using the service, and kept them up to date with current practice. However, it could be difficult to balance both roles at times. Staff also told us that it could be difficult to manage staff from different organisations. In addition to the electronic record system, staff had different managerial and clinical leads, so it wasn't always clear which organisations policies needed to be followed.

Engagement

Staff told us that people were asked for their views about the service, when their care was provided and reviewed.

Are services well-led?

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

There was information in the community teams that provided information about the service, and asked people what they thought of it. This included easy to read information leaflets that asked people to tell the service if there was anything they didn't like, or if they had any ideas about how it would work better. Some of the staff, such as the speech and language therapists, used easy to read feedback forms to get feedback from people using the service and their relatives and carers.

All the staff we spoke with were mostly positive about the service. They thought the integrated community teams worked well, and believed that people experienced a good service. Staff expressed mixed views about the workload. Some thought it was manageable, but others acknowledged that there were waiting lists and it could be difficult at times to manage competing priorities. Although staff were positive about working within the integrated teams, there were frustrated with some of the organisational difficulties this created. For example, the multiple computer systems for accessing care records, and each organisations policies and information.