Requires improvement

Camden and Islington NHS Foundation Trust

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

Quality Report

St Pancras Hospital
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Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
TAF72	Highgate Mental Health Centre	Amber, Jade, Opal, Sapphire and Topaz wards Coral Ward, Psychiatric Intensive Care Unit	N19 5JG
TAF01	St Pancras Hospital	Dunkley, Laffan, Jasper and Rosewood wards	NW1 0PE

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.

Overall rating for the service	Requires improvement 
Are services safe?	**Requires improvement** 
Are services effective?	**Requires improvement** 
Are services caring?	**Good** 
Are services responsive?	**Requires improvement** 
Are services well-led?	**Requires improvement** 

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

We rated acute wards for adults of working age and psychiatric intensive care units as requires improvement because:

- The trust delivered acute inpatient services over two sites, Highgate Mental Health Unit and St Pancras Hospital. We found extensive differences between the two environments. Wards at Highgate Mental Health Unit had recently been refurbished. The trust had not completed similar work at St Pancras Hospital, where wards remained in need of refurbishment and updating. Some patient care areas were unhygienic, for example on Laffan ward, we saw dust on surface areas and a ball of human hair on the nurses' office floor. We found items at St Pancras Hospital that posed a risk to patient safety. For example, plastic leaflet holders with sharp edges and a brick attached to a bench in an outside courtyard, which could be used as a weapon. We found damage to patient areas at both sites, which the trust had not repaired.
- There were multiple ligature points at St Pancras Hospital. A ligature is a fixed item to which a person could tie something for the purpose of self-strangulation. The trust had completed ligature risk assessments. However, these did not always contain plans for how staff could manage these risks. Wards on this site had multiple blind spots from where staff could not easily observe patients.
- At the Highgate Mental Health Unit, we found improvements to all patient care areas.
- The staff duty rotas showed high reliance upon the use of bank and agency staff. When bank or agency staff could not be booked, the wards were short of staff. Staff and patients told us this had a negative impact on patient care and access to outside space.
- Staff had not completed regular checks of emergency equipment on two wards. Staff could not be sure that the equipment was fit for use in an emergency. One ward had not replaced defibrillator pads following an incident.
- The trust operated a non-smoking policy. However, at the Highgate Mental Health Centre we found extensive evidence of patients smoking in the courtyard. We found a can of lighter fuel hidden in bushes and a strong smell of cigarette smoke in one of the bedroom corridors.
- The trust required staff to complete mandatory training and average compliance was low at 66%. A total of 26% of staff had completed safeguarding children training and 39% were compliant with training on the Mental Capacity Act (2005) (MCA). The Care Quality Commission had highlighted poor staff awareness and low compliance with training in the MCA in previous inspections, which the trust was required to address.
- The trust had a process for reporting safeguarding concerns but staff did not routinely raise concerns directly to the local authority and were unclear how this process would be actioned out of hours or at weekends.
- On the psychiatric intensive care unit, records showed that medical staff were not completing medical reviews for patients in seclusion in line with the revised Mental Health Act Code of Practice. We noted that the trust seclusion policy was dated December 2014, which pre-dated the revised code. The trust had not ensured that patients were provided with required safeguards in accordance with the MHA Code of Practice.
- The trust did not offer mandatory Mental Health Act or Code of Practice training for staff. Staff did not always inform patients of their rights under section 132 in a timely manner did not routinely refer or encourage patients to access independent mental health advocacy services. Staff did not always document patients' capacity to consent to treatment prior to first administration of medication and some capacity assessments contained contradictory information. Medical staff did not always fully complete patient leave forms to indicate terms of leave or to whom they had given copies.

Summary of findings

- The quality of care plans was variable. We found little evidence of patient involvement and many care plans did not include the full range of patients' problems and needs, or considered discharge planning.
- The trust provided data, which showed 53% of non-clinical staff had received an appraisal over the past 12 months. This was below the trust's overall achievement at 72%.
- The trust had no female psychiatric intensive care (PICU) beds. Female patients who required a PICU bed were admitted to beds outside of their local area. The trust also placed patients out of area when no local beds were available on the acute wards. This meant patients could potentially be placed far away from their local area, making contact with friends and family more difficult.

However:

- The trust had completed extensive refurbishment work at Highgate Mental Health Unit, which had improved the patient care areas and reduced ligature risks. Lines of sight were good and the environments were clean and airy. There were ample rooms available for care and treatment.
- The trust had recruited qualified staff to vacancies. The wards had a range of staff to deliver care and treatment to patients. The trust tried to ensure they used regular bank and agency staff to promote continuity of care for patients. When bank or agency staff could not be booked, the wards were short of staff. Staff and patients told us this had a negative impact on patient care and access to outside space.
- Practices were in place to ensure infection control and staff had access to protective personal equipment such as gloves and aprons.
- We observed good interaction between the ward staff and medical teams on the wards. Medical cover was available day and night and a psychiatrist could attend wards in an emergency.
- Staff were skilled in verbal de-escalation to manage disturbed behaviour. The training delivered reflected the Department of Health principals of Positive and Proactive Care (2014).
- Medical staff prescribed rapid tranquilisation in accordance with National Institute for Health and Care Excellent (NICE) guidelines.
- There were good medicines management processes and clinic rooms were clean and tidy. Good systems were in place for reporting and recording incidents and complaints.
- Staff were professional and respectful. Most patients told us staff were caring. Staff showed a good understanding of the care and treatment needs of patients and we observed good interactions between patients and staff.
- Staff reported being well supported by their managers and managers were visible on the wards.

Summary of findings

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

Are services safe?

Requires improvement

We rated safe as requires improvement because:

- We found items at St Pancras Hospital that posed a risk to patient safety, for example, plastic leaflet holders and a brick attached to a bench in an outside courtyard. We found damage to patient areas at both sites, which the trust had not repaired.
- There were multiple ligature points at St Pancras Hospital. The trust had completed ligature risk assessments. However, these did not always contain plans for how staff could manage these risks. Wards at St Pancras Hospital had multiple blind spots that obstructed patient observation. Wards were in need of refurbishment and some patient care areas were unhygienic. The trust had not completed urgent repairs on three wards, in a timely manner.
- One ward had not replaced the defibrillator pads following a recent incident. This was a risk to patient safety.
- The trust used bank or agency staff to fill vacancies. They tried to use regular bank and agency where possible to provide continuity. When bank or agency staff could not be booked, the wards were short of staff. Staff and patients told us this had a negative impact on patient care and access to outside space.
- Mandatory training compliance was below the trust's target, for example, compliance with safeguarding children training was 24% and Mental Capacity Act 39%.
- Staff were unclear how to make a safeguarding referral out of hours or at weekends.

However:

- The trust had completed extensive refurbishment at Highgate Mental Health Unit. Wards were bright and airy, with good lines of sight. There were ample rooms for care and treatment.
- The wards had a range of staff to deliver care and treatment to patients.
- The trust had been successful in recruiting qualified nursing staff and recruitment was ongoing.
- There were good processes for the storage, recording and dispensing of medication. Clinic rooms were clean and tidy. Emergency drugs were available and controlled drugs were appropriately stored and recorded in the register.
- Patients had individualised risk assessments with plans to manage risks.
- There were good systems for reporting, recording and reviewing incidents.

Summary of findings

- Staff reported their managers were supportive when incidents occurred and that debriefs were held quickly for the benefit of staff and patients following incidents.
- Appropriate arrangements were in place for children visiting.

Are services effective?

Requires improvement

We rated effective as requires improvement because:

- There were some discrepancies with MHA paperwork, for example, section 17 leave forms lacked information related to terms and conditions of leave.
- Staff completed care plans for patients. However, the quality was variable. Many care plans did not include the full range of patients' problems and needs, or consider discharge planning.
- Fifty-three per cent of non-clinical staff had received an appraisal.

However:

- Patients received regular monitoring of physical healthcare needs.
- Staff received regular supervision.
- Patients had access to psychological therapies.
- Staff were actively involved in clinical audit.

Are services caring?

Good

We rated caring as good because:

- All patients told us staff were kind and compassionate.
- Staff were responsive to patient needs, discreet and respectful.
- We observed good relationships between patients and staff on all wards. Staff were passionate and enthusiastic about providing care to patients with complex needs. They demonstrated good understanding of the care and treatment needs of patients.

However:

- Staff did not always involve patients in planning their care. Care plans did not always include the patients' views or show involvement of carers and family.

Are services responsive to people's needs?

Requires improvement

We rated responsive as requires improvement because:

Summary of findings

- The trust provided data for non-clinical bed moves (when patients were moved between wards, during an episode of care, not related to their clinical needs). The data showed varying amounts of patient movement between wards over an 11 month period to 25 February 2016. The highest recorded moves were January 2016 at 47 and the lowest was August 2015 at 5. The average monthly number of non-clinical bed moves for this period was 18.
- The trust had four learning disability beds. However, these beds were not protected for use exclusively by patients with a learning disability. Senior staff reported some delays in accessing appropriate beds for these patients. The trust does not employ any learning disability trained nurses on the inpatient wards.
- The trust has some wards on upper floors. Patients from these wards who required a nurse escort reported difficulties accessing outside space when wards were busy or staffing was low.
- Some wards at St Pancras had insufficient rooms for care and treatment.
- Several wards at Highgate Mental Health Unit had no cups or crockery for patient use. Patients reported having to ask staff to access drinks and snacks.
- The trust used out of area beds for patients when local beds were full. The trust had no female psychiatric intensive care (PICU) beds. Female patients who required a PICU bed could be placed away from their local area.

However:

- All wards had a varied range of activities available to patients.
- The trust had a bed management team. The team monitored admissions and discharges to ensure that beds were available for patient use as soon as possible.
- The trust had an effective system for recording and monitoring complaints.

Are services well-led?

Requires improvement

We rated well-led as requires improvement because:

- Staff compliance with mandatory training overall was 66%. Compliance with safeguarding children and Mental Capacity Act (MCA) 2005 training was particularly low. Staff's lack of understanding of the MCA had been identified in previous inspections. The trust was required to address this.

Summary of findings

- Not all staff had received an appraisal. The trust advised they moved to an open system with appraisals done throughout the year and not as one annual review. However, data provided showed recorded appraisal rates varied between 0% on Amber ward and 100% on Opal ward.
- Patients and staff reported difficulties in accessing leave, ward activities and outside space when extra staffing was not available.
- The trust did not have robust governance arrangements in relation to assessing, monitoring and mitigating risks of ligatures in the patient care areas. Whilst ligature risk assessments and action plans were in place, an unacceptable number of ligature risks remained at the St Pancras site.

However:

- Staff reported they were well supported by their managers and senior managers were visible on the wards.
- All clinical staff had access to clinical dashboards which provided close to real-time information about completion of clinical documentation such as care plans and risk assessments.
- Staff morale was good and we saw good evidence of team working and mutual support.

Summary of findings

Information about the service

The acute wards for adults of working age and the psychiatric intensive care unit (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 Hospital in Islington has five acute wards for adults of working age: Amber, Jade, Opal, Sapphire and Topaz wards. These wards accept males and females and have 16 beds on each ward. Coral ward is a Psychiatric Intensive Care Unit (PICU) and has 15 beds for males.

St Pancras Hospital in Camden has four acute wards for adults of working age: Dunkley, Laffan, Jasper and Rosewood wards. Dunkley and Laffan 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 and is for women only and Jasper has 12 beds and is for males.

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

The CQC completed a whole trust pilot comprehensive inspection in May 2014. We did not rate them for this inspection. We inspected some acute wards as unannounced inspections in August 2015. Of the services we have inspected some locations had previous and still outstanding non-compliance.

Our inspection team

Our inspection team was led by:

Chair: Prof. Heather Tierney-Moore, Chief Executive Officer, Lancashire Care NHS Foundation Trust

Team Leader: Julie Meikle, head of hospital inspection, mental health, CQC

Inspection Manager: Margaret Henderson, inspection manager, mental health hospitals, CQC

The team that inspected the acute wards for adults of working age and the psychiatric intensive care unit consisted of 14 people in total: six CQC inspectors, six specialist advisors (three consultant psychiatrists, two nurses and one social worker) and two Mental Health Act reviewers.

The team would like to thank all those who met and spoke with the team 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.

Why we carried out this inspection

We inspected this core service as part of our ongoing comprehensive mental health inspection programme

How we carried out this inspection

Before the inspection visit, we reviewed information that we held about these services, asked a range of other organisations for information and sought feedback from patients using the service.

During the inspection visit, the inspection team:

- visited all wards at the two hospital sites and looked at the quality of the ward environment and observed how staff were caring for patients.
- spoke with 26 patients who were using the service.
- interviewed ten managers (or acting managers) for each of the wards.

Summary of findings

- spoke with 55 other staff members individually, including doctors, nurses, student nurses, activity co-ordinators, psychologists, pharmacists, housekeepers, and support workers.
- reviewed 63 care and treatment records of patients.
- spoke with other professionals, including a senior service manager and a bed manager.
- attended and observed a multidisciplinary team meeting.
- carried out a specific check of the medication management on all wards.
- collected feedback from patients using comment cards.
- looked at a range of policies, procedures and other documents relating to the running of the service.
- completed three Mental Health Act reviews.

What people who use the provider's services say

All patients were positive about their care and treatment and felt that staff were compassionate and caring. Families and carers had the opportunity to be involved in care reviews. Patients told us they enjoyed the ward activities. Patients were aware of their rights, how to access advocacy and how to complain. Patients told us they felt safe on the wards.

Most patients we spoke with told us there were not always enough staff on duty to allow them to engage in ward activities or access outside space.

Patients' views about the food were variable. Some patients we spoke with enjoyed the food, while others told us portions were small and the food was overcooked.

Good practice

The trust had responded to lessons learned from serious untoward incidents. All wards now had showers and wet-rooms, the baths were removed following serious incidents.

Areas for improvement

Action the provider MUST take to improve

- The trust must take action to remove identified ligature risks and ensure that ligature risk assessments contain plans for staff to manage risks.
- The trust must mitigate where there are poor lines of sight.
- The trust must ensure that repairs to the patient care areas are completed in a timely manner.
- The trust must ensure there are sufficient experienced staff on duty at all times to provide care to meet patients' needs.
- The trust must ensure that clinical staff receive regular appraisals.
- The trust must ensure that staff receive mandatory training in line with trust targets.
- The trust must ensure that all staff are aware of the process for safeguarding referrals, including out of hours and at weekends.
- The trust must ensure that medical staff complete reviews for patients subject to seclusion, in accordance with the Mental Health Act (MHA) (1983) Code of Practice.
- The trust must ensure that staff record patients' capacity to consent to treatment in accordance with the MHA Code of Practice.

Summary of findings

Action the provider SHOULD take to improve

- The trust should ensure that patients' rights under section 132 MHA are repeated in accordance with the MHA Code of Practice.
- The trust should ensure that staff take positive steps to inform patients of their right to access advocacy and support patients in such access, particularly where patients may lack capacity to decide whether or not to obtain help from an Independent Mental Health Advocate (IMHA) in accordance with MHA Code of Practice, para 6.16).

Camden and Islington NHS Foundation Trust

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

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Amber, Jade, Opal, Sapphire, Topaz and Coral wards	Highgate Mental Health Unit
Dunkley, Laffan, Jasper and Rosewood wards	St Pancras Hospital

Mental Health Act responsibilities

We do not rate responsibilities under the Mental Health Act 1983. We use our findings as a determiner in reaching an overall judgement about the Provider.

- The trust did not deliver training in the Mental Health Act (MHA) or Code of Practice as part of the mandatory training programme. The trust ran a mental health law training programme, which was not mandatory. The trust recognised that this mental health law training was essential to the role of some staff and has an ongoing training plan in place.
- Staff completed most MHA paperwork correctly. There was administrative support to ensure paperwork was up to date and regular audits took place. Staff scanned MHA onto the electronic record for staff reference.
- Medical staff completed consent to treatment and capacity requirements. Staff attached copies to medication charts to ensure medication was administered in accordance with the MHA. However, staff did not always document patients' capacity to consent to treatment prior to the first administration of medication. The trust did not always record patients' capacity to consent to treatment in accordance with the Code of Practice.
- Staff read and recorded patients' rights under section 132 MHA in most records reviewed. However, we found examples where staff had not repeated patients' rights in accordance with the MHA code.
- Medical staff did not always complete details on patient leave authorisation forms, in accordance with the code.

Detailed findings

- Posters and leaflets detailing the Independent Mental Health Advocacy Service (IMHA) were visible on all wards and information was contained in the patients' admission packs. Staff were clear on how to access the service on behalf of patients. However, staff on the acute wards did not always inform patients of their right to access IMHA services or actively support patients to do so.

Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff compliance with Mental Capacity Act (MCA) 2005 training was 39%, against the trust target of 80%. The trust could not be sure that all staff were aware of their responsibilities under the Act.
- Staff we spoke with showed varying degrees of knowledge about the MCA and Deprivation of Liberty Safeguards (DoLS). None of the patients receiving care and treatment during our inspection was subject to a deprivation of liberty safeguard (DoLS).
- There was some evidence in clinical notes that the multidisciplinary team had considered capacity during care reviews. The trust had procedures for assessing capacity for significant decisions for patients who may lack capacity.

Requires improvement

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

Our findings

Acute Wards

Safe and clean environment

- At Highgate Mental Health unit, the nurses' offices were based in the centre of the wards, which enabled staff to observe patients in communal areas. Where staff observation was restricted, the trust lessened the risk by installing mirrors.
- At St Pancras Hospital the ward layout did not always enable staff to observe most parts of the ward. There were multiple blind spots where staff could not easily observe patients. For example, the external courtyard for Rosewood Ward had ligature risks, which could not be observed by staff or closed circuit television (CCTV) and the nurses' office on Jasper ward had no line of sight to the ward area. Not all wards had installed mirrors to aid staff observation and mitigate risks. Staff were aware of environmental risks to patients' safety and mitigated this through individual patient risk assessment and observations.
- Wards had ligature cutters available in the event of an emergency and staff new where these were located.
- The trust has completed extensive work at Highgate Mental Health Unit to address ligature risks. We found a significant reduction in the number of ligature risks across wards at this site, however, some ligature risks remained. For example, the trust had not replaced an internal door handle of a shower room with an anti-ligature handle. This room remained locked when not in use and the risk to patients was managed through assessments and observation levels.
- Patients' access to outside space was on the ground floor. For wards on upper floors, we found that the staircase handrails were not anti-ligature. All patients entering the stairwell area or other high-risk patient areas such as computer rooms were risk assessed or escorted by staff to maintain safety.
- At St Pancras Hospital, we found multiple ligature risks across all wards. These included an electrical box in a blind spot on Jasper Ward and window latches on Laffan ward. Rosewood ward had window latches that patients could access from inside the building and the outside courtyard area. To minimise the risks to patients, staff completed risk assessments and used observations. Staff also locked areas of the ward when not in use and increased staff presence in communal areas.
- The trust provided ligature risk assessments for all wards at St Pancras Hospital. The trust had reviewed these between 2014 and 2016. The ligature assessment contained the trust view on assessing and recording ligature risks. Staff had not completed these assessments in accordance with trust guidelines. We saw the 'action' and 'by whom' sections were blank in many cases. The trust regarded the assessment as 'void' if staff did not complete these sections fully. The trust had identified numerous ligature points, however the audits contained no action or management plans to lessen these risks.
- Staff had identified actions for some ligatures, for example, an external drainpipe on Rosewood Ward had been actioned for boxing in 2014. The trust had not completed this work.
- On Dunkley ward, the ligature audit contained details of emails sent to senior managers requesting action for an identified ligature risk in May 2015 and a further request in January 2016. Staff had highlighted several risks on the assessment; however, no mitigation or action plan had been included. The trust could not be sure that they were addressing these risks in a timely manner. This posed a risk to patients.
- At St Pancras Hospital, patient bedroom doors were not anti-barricade (doors that could open both ways) and plastic bin bags were seen in bins in patient areas. The trust had experienced a serious incident prior to the inspection where these factors were significant. Senior staff were unable to tell us if the trust had plans to make changes, following lessons learned.
- At Highgate Mental Health Unit, all rooms were single and had ensuite facilities. All doors were anti-barricade.

Requires improvement

Are services safe?

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

Mixed sex wards complied with mixed sex guidelines. Females had access to a female only lounge, which provided a safe space for women who preferred a female only environment.

- At St Pancras Hospital, the majority of patient bedrooms were single and some had ensuite facilities. A few rooms on each ward did not have ensuite facilities but had access to a separate gender specific shower room and toilet facilities. These rooms were in need of refurbishment, for example the shower trays on Jasper ward were mouldy and in need of fresh sealant. Dunkley ward had shared bedrooms, with privacy curtains dividing individual bed spaces. Patients told us that curtains often fell down. This would affect the privacy and dignity of patients. We reported this to senior staff.
- On Jasper ward, staff could lock patient bedrooms with a master key, at patient request, and patients could lock themselves into their rooms from the inside. The lock to one bedroom door had been replaced and needed a separate key to other bedrooms on the ward. Staff only had access to two keys for this lock. Urgent access to this room could be delayed as a result. Staff informed us they reduced this risk by only placing the most settled patients in this bedroom.
- All wards had fully equipped clinic rooms but clinic rooms did not contain couches for examining patients. Staff stored resuscitation equipment in nurses' offices on some wards, for example, Topaz and Jasper wards. Staff reported this was for ease of access in an emergency.
- Staff completed regular checks of emergency equipment, however on Jasper and Rosewood wards records were either not found, or had gaps in monitoring. Staff could not be sure that equipment was in date or regularly checked. On Jasper ward, there were no defibrillation pads available. Staff replaced these during our visit. Emergency drugs were available and regularly checked.
- On Topaz ward, we found a cleaning cupboard left unlocked. There was a cleaning product, a detergent, labelled as corrosive, left unsecured. This was not stored in line with COSHH regulations and could present a risk to patients if ingested. We drew this to the attention of a member of staff, who secured the room.
- There were no seclusion facilities available on the acute wards. Seclusion is defined as "the supervised confinement of a patient in a room, which may be locked. Its sole aim is to contain severely disturbed behaviour which is likely to cause harm to others". Staff referred patients who required seclusion to Coral ward, the psychiatric intensive care unit (PICU).
- The wards at Highgate Mental Health Unit were clean with good furnishings. There were adequate rooms for care and treatment. Overall, the wards were well maintained. However, on Topaz ward an external fire door had been damaged. The trust had made a temporary repair with hardwood that had since cracked and broken. Staff told us a final repair had been expected for some time. On Jade ward, a ceiling panel had been broken and was hanging down into the corridor. This posed a risk to patients and staff. We drew these concerns to the attention of senior staff.
- The trust has a no smoking policy across all sites. However, we saw cigarette ends and multiple cigarette packets in the courtyard areas at the Highgate Mental Health Unit. We also found a can of lighter fuel in the courtyard area. On one ward, there was a strong smell of cigarette smoke in a bedroom corridor. This posed a risk to patients and staff.
- The ward environments at St Pancras Hospital were in need of refurbishment in most areas. On Jasper ward, a patient had damaged the plasterwork in a bedroom ten days prior to our visit. Staff had reported this but no date for repair had been given. There was a wooden wall mounted rack, which contained patient information leaflets. This was damaged and contained plastic holders. We found these could be easily removed and, if broken, would have sharp edges. This posed a risk to both patients and staff. Senior staff were informed and these were removed on the day of our visit. On Rosewood ward, furniture and walls were stained. On Laffan ward, some bedrooms and the nurses' office were dirty. Rosewood ward had direct access to outside space, where we found a loose brick that was attached to a bench by a chain. This posed an immediate risk to patient safety. We drew this to the attention of senior staff.
- The latest patient led assessment of the care environment audit (PLACE) showed 95% patient

Requires improvement

Are services safe?

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

satisfaction in relation to cleanliness and 80% for general appearance and maintenance. The trust scored lower than the England average at 97% and 90% respectively.

- Practices were in place to ensure infection control policies were followed and staff had access to protective personal equipment such as gloves and aprons.
- Staff completed regular cleaning checks and clean stickers were visible and in date in most areas. However, on Jasper ward we found three commodes in the shower room without clean stickers visible. Senior staff were unsure why they were there.
- The wards had locks on the main entrances with entry and exit controlled by staff. Wards had posters to advise informal patients of their right to leave and informal patients we spoke with were aware of their rights. On Jasper ward, the poster was not visible and staff told us a patient had recently torn this down. Staff were able to identify actions they should take if they were concerned about the safety of an informal patient who wished to leave the ward.
- Staff carried personal alarms and there were alarms for patients' use in bedrooms and bathrooms. The trust had extra alarms available for visitors use.

Safe staffing

- The trust advised recruitment to vacant positions was ongoing and a significant number of newly qualified nurses had recently been employed. The trust supplied data related to staff establishment and vacancies between July and September 2015. The total establishment of registered nurses for the service was 95 and there were no vacancies. The total establishment of support workers was 76, with 19 vacancies. Opal ward reported the highest vacancy rate for support workers at 50% of posts filled.
- Dunkley ward had four beds for patients who also had a diagnosis of a learning disability. Patients' needs were assessed and managed by a learning disability consultant psychiatrist; however, the trust did not employ nursing staff trained in learning disability on the ward. Staff reported that patients maintained contact with the learning disability community team during their admission.
- Topaz and Jade ward did not have a permanent ward manager in post. However, the charge nurses reported being supernumerary to staffing numbers and well supported by the matron to run the wards.
- The trust utilised acuity tools to assess and monitor effective staffing levels and senior staff advised that there had been two recent reviews to establish whether current staffing levels were meeting the needs of patients. We did not have access to the findings.
- Ward managers advised that senior staff were supportive when increases to staffing were required.
- On all wards we visited, staff and patients informed us that there was often a shortage of permanent staff on duty to meet the needs of patients. The trust used bank and agency staff to fill vacant shifts. Where possible, the trust employed regular bank and agency staff to provide continuity of care to patients. However, bank or agency staff were not always available. When bank or agency staff could not be booked, the wards were short of staff. Staff and patients told us this had a negative impact on patient care and access to outside space.
- Between July and September 2015, the service reported 2201 shifts filled by bank or agency staff. Of these, the highest use was on Amber ward at 310 and the lowest on Sapphire ward at 191. The wards were unable to fill 285 shifts; the majority of which were on Opal ward who reported 44 shifts uncovered. On Topaz ward, there were 50 uncovered shifts between 25 December and 22 February. This meant that there was a high reliance on the use of bank and agency staff and, on occasion, wards operated short of staff. In most cases, extra staffing was required to cover staff sickness or manage higher levels of observations for patients. Senior staff informed us that staffing difficulties arose from a combination of staff sickness, difficulties with recruitment and retention and increased observation needs of patients. Wards could book extra staffing ahead for planned patient activities, for example home leave or medical appointments.
- Staff and patients told us that nurses were not always able to facilitate leave off the ward due to insufficient staffing. We were told this was particularly common at weekends and contributed to the tensions many patients on the ward experienced.

Requires improvement

Are services safe?

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

- A team of qualified and unqualified staff acted as a 'floating team'. These staff could be available to cover shortfalls in staffing across the wards. However, a senior staff member told us that maintaining staff on this team had proved difficult and resulted in having three qualified staff to provide cover.
- The total number of substantive staff leavers for acute service was 29, eight of which were on Laffan Ward. This represented a 44% turnover of staff on Laffan Ward over a 12 month period. The lowest turnover was reported on Sapphire ward at 11%."
- The trust provided data that showed the average staff sickness between October 2014 and September 2015 was 6%. This was higher than the average sickness absence for the NHS in England at 4%. Laffan ward reported the highest levels at 10% with the lowest being 3% on Jade ward. Processes were in place to manage staff sickness, to include the involvement of the human resources and occupational health departments.
- Permanent staff completed training in the management of violence and aggression to promote the safe use of physical interventions (restraint). The trust provided data, which showed 79% of staff were compliant with this training. However, bank and agency staff were not always trained in physical interventions. Senior staff explained that ward managers reviewed the skill mix on their wards to ensure there was always sufficient staff, trained in the management of violence and aggression, for safe care and treatment. We were concerned that newly appointed junior doctors were working on night shifts, prior to completing their breakaway training. This was a risk to staff safety.
- Medical cover was available day and night and a psychiatrist could attend wards in an emergency. We observed good interaction between the ward staff and medical teams on the wards.
- The trust supplied data on training compliance for the period October 2014 to October 2015. Overall, the average compliance with nine mandatory training courses was 66%. The lowest attendance was safeguarding children (26%) and the highest compliance was equality and diversity (86%) and manual handling (82%). The trust told us they continued to work towards 80% compliance with Mental Capacity Act (2005) training and currently 39% of staff were compliant. The Care Quality Commission identified staff's lack of understanding of the Mental Capacity Act during previous inspections. The trust was required to address this.

Assessing and managing risk to patients and staff

- The trust provided data between May and October 2015, which confirmed there had been four episodes of seclusion across the acute service. The trust reported no incidents of long-term segregation.
- All staff utilised verbal de-escalation to manage disturbed behaviour. The training delivered reflected the Department of Health principals of Positive and Proactive Care (2014).
- The trust provided data that showed there were 129 incidents of physical restraint across the acute service between May and October 2015. Forty-three restraints (33%) resulted in the use of 'prone' (face down) position. The highest was Sapphire ward that recorded 24 incidents of restraint involving 21 patients, of which 13 (54%) were in the prone position. 81% of all prone restraints resulted in administration of rapid tranquilisation. All staff spoken with confirmed that following administration of rapid tranquilisation, staff placed patients into the supine (face up) position and care records confirmed this. We noted minimal use of rapid tranquilisation in the records we reviewed. Staff were aware of the guidance contained in the Department of Health document, Positive and Proactive Care (2014) relating to the use of prone restraint.
- We reviewed 57 care and treatment records for patients. Staff completed individualised risk assessments for patients. Risk assessments contained plans to manage risks, for example, staff could increase the level and frequency of observations of patients. Overall, the individualised risk assessments we reviewed were detailed and staff had taken into account the patient's previous history as well as their current mental state. However, some assessments contained a great deal of information on historical risks, but current risks were less easy to identify. Staff told us a recent change over between electronic databases had caused large amounts of data to migrate over. This had made risk assessments difficult to read in some cases. Staff updated assessments at care planning meetings or after an incident.

Requires improvement

Are services safe?

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

- The trust had good policies and procedures for use of observation and searching patients.
- 79% of staff had completed safeguarding vulnerable adults training and 26% of staff had safeguarding vulnerable children training. Staff made safeguarding referrals via the electronic database and these were co-ordinated by the trust's safeguarding lead and actioned by the community teams. Staff were unclear of the process for raising an urgent safeguarding alert out of hours. The trust could not be sure that safeguarding alerts would be actioned in a timely manner out of hours. Staff told us strategy meetings were held to formulate action plans following concerns being raised.
- A pharmacy inspector carried out a review of treatment cards. Medical staff prescribed rapid tranquilisation in accordance with National Institute for Health and Care Excellent (NICE) guidelines. We found little evidence of the use of rapid tranquilisation in the patient treatment records. However, on Opal ward one person had received intramuscular lorazepam on three occasions. Staff had not completed a record in the patient's care notes, or documented whether any physical observations had been completed. Patients prescribed high dose anti-psychotic medication had received input from the pharmacy team and staff attached the appropriate monitoring forms to the treatment cards.
- There were robust processes for the storage, recording and dispensing of medication. Clinic rooms were clean and tidy. Staff recorded fridge and room temperatures daily and these were within required range. This ensured that medicines were stored appropriately to ensure their quality. Medicines, including controlled drugs, were stored securely. Controlled drugs are medicines that are stored in a special cupboard and their use recorded in a special register. Emergency drugs were available and checked regularly.
- Pharmacists visited all wards throughout the week to ensure medicines were available for patient use. Pharmacists attended patients' care planning reviews to offer advice on medication prescribing. On Dunkley ward there was a separate ward round for people with learning disabilities, attended by a learning disability specialist pharmacist.
- On Jade ward, we found an illicit substance in the controlled drug cupboard. The trust had a policy for handling illicit drugs, which was included in the trust's controlled drugs policy. Staff should have completed an incident form but there was no record this had been completed. On Jade ward, we found two older entries for illicit substances in the controlled drug register. Staff had not recorded how or when these substances were removed.
- The wards had appropriate policies for children visiting and visits were risk assessed as appropriate.

Track record on safety

- Trust information stated there were 15 serious incidents reported from the acute and PICU wards. This represented 18% of the serious incidents for the trust as a whole.
- Following two serious incidents on the acute wards and subsequent recommendations from investigations, the trust removed all baths and replaced these with wet rooms.
- The trust completed safety improvements to the patient care areas at Highgate Mental Health Unit in February of this year. Staff were unclear whether the trust had similar improvement plans for St Pancras Hospital. Wards at St Pancras Hospital continued to have unacceptable amounts of ligatures and poor lines of sight.

Reporting incidents and learning from when things go wrong

- Staff described the electronic system used to report incidents and their role in the reporting process. We saw each ward had access to the online electronic system. Managers reviewed reports and conducted investigations at both local and senior management level.
- Ward managers and clinical leads attended a monthly acute forum where incidents and lessons learned were discussed. Ward managers passed on outcomes of investigations in their ward team meetings. We saw outcome of investigations was an agenda item for team meetings. Staff also received information, outcomes and actions via monthly bulletins and safety alerts on the trust intranet site. Some staff told us that learning from

serious incidents was not always shared promptly with ward staff or across different wards and reported that, on occasions, wards worked in isolation from each other.

- Staff reported their managers and senior managers were supportive when incidents occurred and debriefs were held quickly for the benefit of staff and patients following incidents. Staff on Jasper ward told us their manager had been supportive following a recent serious incident and we observed evidence of this.

Psychiatric Intensive Care Unit - Coral Ward

Safe and clean environment

- Coral ward was a Psychiatric Intensive Care Unit (PICU). The unit had 15 beds and was for males only. All rooms had ensuite facilities.
- Ward layout enabled staff to observe most parts of the ward. We saw the ward had an updated ligature risk assessment. The ward had undergone extensive refurbishment, but where ligature points remained, we saw control measures in place to minimise the risk to patients. These included patient risk assessments and observations. Staff increased supervision of environmental areas and locked the relevant room when not in use.
- Ward doors were anti-barricade and fitted with anti-ligature hinges.
- The nurses' office was situated in the centre of the ward and provided staff with good visibility of the communal ward areas. Closed circuit television (CCTV) provided cover of the corridor areas.
- The ward had a fully equipped clinic room. However, there was no couch available for staff to examine patients. Ligature cutters were available for staff use in an emergency. Staff stored emergency resuscitation equipment in the nurses' office. Staff advised this was to allow quick access in an emergency. Staff checked emergency equipment weekly and kept up to date records.
- The ward had one seclusion room, which was fit for purpose. Staff could observe patients through observation panels and the main door. Staff could view CCTV from the nurses' office and a two-way communication intercom was available. Staff could control the temperature of the room. Patients in seclusion had access to a toilet and hand basin. A clock was prominently displayed.
- All areas of the ward were clean and in good decorative order. Furnishings were well maintained, comfortable and suitable for the environment. One bedroom had no ensuite bathroom door. Staff advised a patient had damaged the door and a replacement was needed. A portion of floor covering had been torn in the corridor. Staff had reported this damage.
- Practices were in place to ensure the infection control policy was followed. Staff had access to protective personal equipment such as gloves and aprons.
- Staff carried personal alarms and there were alarms for bank or agency staff and visitors.

Safe staffing

- Data provided by the trust showed that Coral ward had an establishment of 15 qualified staff and 11 support workers. Between July and September 2015, the ward had a full establishment of qualified staff, but had five support worker vacancies. Bank and agency staff had covered 362 shifts, but 26 shifts had not been filled. This meant that there was a high reliance on the use of bank and agency staff and, on occasion, the ward operated short of staff. Staff and patients we spoke with confirmed this.
- The ward manager stated that, where possible, regular bank and agency staff were booked to cover shifts to provide continuity of care for patients.
- Staff told us, and the duty rotas we saw confirmed, there was always an experienced member of staff on duty on the ward. Most patients told us that there was generally enough staff on duty; however, staff had cancelled Section 17 leave due to a shortage of staff on occasions.
- There had been eight staff leavers between October 2014 and September 2015. This represents 38% of the total staffing establishment. The trust reported staff sickness over the same period as 3%. This was below the England average for the NHS at 4%.
- Permanent staff completed training in the management of violence and aggression to promote the safe use of physical interventions (restraint). However, bank and

Requires improvement

Are services safe?

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

agency staff were often not qualified to participate. Senior staff explained that staff skill mix on the wards was always considered to ensure there were sufficiently trained staff for safe care and treatment.

- Medical cover was available day and night and a psychiatrist could attend wards in an emergency. We observed good interaction between the ward staff and medical teams on the wards.
- The trust supplied data on their compliance with mandatory training that showed between October 2014 and October 2015, the average compliance with nine mandatory training courses for staff working on the PICU was 51%. The lowest attendance was safeguarding children (4%). The highest compliance was equality and diversity (91%) and prevention and management of violence and aggression (82%). The trust advised they continue to work towards 80% compliance with Mental Capacity Act (2005) training and currently 23% of staff were compliant. The Care Quality Commission identified a lack of staff understanding of the Mental Capacity Act in previous inspections. The trust was required to address this.

Assessing and managing risk to patients and staff

- Coral ward has the only seclusion room in the trust. The trust reported 40 incidents of seclusion in the six-month period to October 2015. 36 incidents of seclusion were on Coral ward.
- Coral ward recorded 43 incidents of patient restraint, involving 19 patients, between July and September 2015. Twenty-four (55%) of restraints were in the prone (face down) position and 16 (66%) of prone restraints resulted in the administration of rapid tranquilisation. All staff spoken with confirmed incidents of prone restraint were for the briefest period possible to maintain a safe environment and records confirmed this. Staff were aware of the guidance contained in in the Department of Health document, Positive and Proactive Care (2014) relating to reducing the use of prone restraint.
- Medical staff prescribed rapid tranquilisation in accordance with National Institute for Health and Care Excellent (NICE) guidelines.
- We noted from trust audits that improvements had been made to ensure staff completed physical observations after people received medicines for rapid tranquillisation. The trust's last audit showed that observations were recorded in 50% of cases. The trust had shown improvement from 2013, however further improvements were needed. Staff did not monitor how often they administered rapid tranquilisation. The trust cannot be sure that the appropriateness and frequency of use was being monitored.
- Patients had individualised risk assessments with plans to manage risks. For example, staff could increase the level and frequency of patient observations. Overall, the individualised risk assessments we reviewed were detailed and staff had taken into account the patient's previous history as well as their current mental state. Staff updated assessments at care planning meetings or after an incident.
- The trust had good policies and procedures for use of observation and searching patients. Staff observed patients in accordance with individualised risk assessments and environmental factors. Staff searched all patients on return from leave and used a metal detector to search patients and visitors, when required.
- All staff utilised verbal de-escalation to manage disturbed behaviour. Staff had received extra training in de-escalation techniques, delivered by the practice development nurse and incidents of restraint had reduced since December 2015.The training delivered reflected the Department of Health principals of Positive and Proactive Care (2014).
- The trust had an operational policy for the use of seclusion. Staff were unable to show inspectors the seclusion monitoring records. Staff completed all seclusion records directly onto patients' electronic care records and, therefore, these were difficult to collate. However, records reviewed showed that medical staff were not completing medical reviews in line with the revised Mental Health Act Code of Practice 26.116. We noted that the trust policy pre-dated the revised code. Medical staff and senior nursing staff were not aware of this requirement. The trust had not ensured that patients were provided with required safeguards in accordance with the MHA Code of Practice.
- 56% of staff had completed safeguarding vulnerable adults training and 4% of staff had safeguarding vulnerable children training. Staff were able to identify

Requires improvement

Are services safe?

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abuse but did not directly make safeguarding referrals to the local authority. Staff completed referrals via the electronic database for action by the community teams. Staff were unclear of the process for raising an urgent safeguarding alert out of hours but told us strategy meetings were held following a referral being made to formulate action plans.

- Medicines were stored at suitable temperatures to maintain their quality. Medicines, including controlled drugs, were stored securely. Controlled drugs are medicines, which are stored in a special cupboard, and their use recorded in a special register. Fridge temperatures were recorded daily and were within required range.
- A pharmacist visited the ward during the week to ensure medicines were available for patients' use. Pharmacists attended care planning meetings to offer advice on medication prescribing.
- The ward had appropriate policies for children visiting and visits were risk assessed as appropriate.

Track record on safety

- The trust reported no serious incidents on the psychiatric intensive care unit (PICU) between October 2014 and September 2015.
- Senior staff told us that, following a recent series of violent incidents, staff meetings had been increased to weekly to assist team members with communication skills and identifying triggers (indicators of aggression or distress) in their patients.

Reporting incidents and learning from when things go wrong

- The ward manager had utilised the 'releasing time to care' initiative and completed 'safety crosses' to audit incidents on the ward, for example, self-harm and violence and aggression. Staff completed these documents for audit by the manager. We reviewed these audits and saw incidents were decreasing.
- Staff we spoke with were able to describe the electronic system to report incidents and their role in the reporting process. The ward manager reviewed all incidents and forwarded information to the clinical governance team for the trust. Senior managers were alerted to incidents promptly and could monitor the investigation and outcomes. The ward manager was confident that staff knew what to report.
- Staff discussed trust-wide incidents at weekly team meetings. There were weekly multi-disciplinary meetings, which included a discussion of potential risks relating to patients.
- The ward manager told us feedback on learning from incidents was provided to the team via team meetings and electronic bulletins.
- The trust had completed extensive work to ensure the environment was safe for patients, following feedback from previous Care Quality Commission inspections. Staff were able to demonstrate what changes had been made to improve the clinical environment.
- Staff reported that managers and senior managers were supportive when incidents occurred and that debriefs were held quickly for the benefit of staff and patients following incidents.

Are services effective?

Requires improvement

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.

Our findings

Acute Wards

Assessment of needs and planning of care

- We reviewed 57 care records for patients receiving care and treatment in the acute wards and found staff assessed patient need and delivered care in line with individualised care plans. However, The quality of care plans was variable. Most patients had signed and received a copy of their care plan. Ten care plans were not holistic, for example, they did not include the full range of patients' problems and needs. Two patients on Opal ward did not have care plans to address their nutritional needs, despite the fact that staff had identified those needs. One plan used negative wording to describe a patient's behaviour although there was no explanation as to what types of behaviour this referred. On Topaz ward, staff had not updated a care plan for a patient whose legal status had changed. On Sapphire ward, care plans were generic and did not consider discharge planning. The care plans examined were brief in nature. Staff had not updated the risk assessment for one patient following their detention under the Mental Health Act (MHA).
- The trust had recently changed the electronic care records system. Staff had experienced some difficulties with this change and data transferring between the two systems had proved difficult. For example, we found that patients' care plans contained vast amounts of historical risk information. Staff told us patients found the care plan difficult and, in some cases, distressing to read. Some teams were able to print off copies of care plans for patients with reduced content. We saw examples of these on Jasper ward and noted that bank and agency staff could refer to paper copies held in the nurses' office if they did not have access to the electronic system.
- Staff completed and recorded physical health examinations and assessments on admission. Staff monitored physical observations and physical health problems. Staff discussed physical health needs at weekly multi-disciplinary team meetings and physical health was considered in care plans.

Best practice in treatment and care

- We reviewed the medication administration records for all patients. Medical staff prescribed medicines in accordance with the National Institute for Health and Care Excellence (NICE) guidelines. However, on Opal ward, we reviewed the records of two patients prescribed clozapine (an anti-psychotic drug with specific prescribing and monitoring guidelines). Staff did not complete formal medicines side effect monitoring in accordance with guidelines. Staff could not be sure that patients were tolerating their medication.
- The trust had four psychologists working in the acute division. Psychologists would attend multi-disciplinary care planning meetings on the ward and offered advice to staff on completing behavioural support plans for patients. Psychologists also organised groups for patients on goal setting and relapse prevention and worked with patients individually. Psychologists also offered support to staff affected by incidents related to their work, for example violent assault by patients.
- Staff made referrals for assessment and treatment for physical healthcare needs to the local acute hospital. Patients could access a weekly surgery provided at the Highgate Mental Health Unit by the local acute trust.
- Specialist staff were available for advice relating to specific physical health issues, including smoking cessation, diabetes and sexual health.
- Staff completed a health of the nation outcome scales (HoNOS) which was filed in patient records. Staff used HoNOS scores to allocate patients to pathways of care, known as 'clusters', based on groups of patients with similar diagnosis and individual needs. The trust monitored clustering compliance at divisional performance meetings and teams could view live clustering status for their caseloads via clinical dashboards.
- The trust monitored and audited other outcomes for patients using the services including key performance indicators such as length of stay, out of area placements, the use of control and restraint, episodes of seclusion and rapid tranquilisation. Staff participated in clinical audit on either a weekly or a monthly basis. We saw examples of audits for infection control, medication and physical health checks.

Skilled staff to deliver care

Are services effective?

Requires improvement

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.

- Ward staff consisted of nurses, consultants, doctors, occupational therapists, health care support workers, activity co-ordinators, pharmacists and psychologists. This meant that patients had access to a variety of skills and experience for care and treatment.
- New staff underwent a formal induction period to teach them about the ward and trust policies. The induction included a period of shadowing experienced staff before working independently. Newly qualified nurses told us they felt supported and engaged in a well-structured and in-depth preceptorship programme. A student nurse reported feeling well supported and enthusiastic about the placement.
- Bank and agency staff underwent a basic induction including orientation to the ward, emergency procedures and a handover about patients and their current risks.
- The trust had plans to ensure that support workers undertake the care certificate. The care certificate is a set of standards aimed to equip health and social care support workers with the knowledge and skills they need to provide safe, compassionate care. This work was ongoing as the trust reported difficulties in gaining places on courses for their staff.
- Ward staff participated in regular supervision. Wards operated a 'supervision tree' arrangement, whereby senior staff supervised their junior colleagues. Staff advised that informal supervision took place also, however this was not documented.
- Not all staff had received an appraisal. Appraisal is a method by which the job performance of an employee is documented and evaluated The trust provided data, which showed 53% of non-clinical staff had received an appraisal over the past 12 months. This was below the trust's overall achievement at 72%. The trust advised they moved to an open system with appraisals done throughout the year and not as one annual review. However, data provided showed recorded appraisal rates varied between 0% on Amber ward and 100% on Opal ward.

Multi-disciplinary and inter-agency team work

- Staff attended multi-disciplinary meetings on the wards. We attended a multi-disciplinary team meeting on Topaz ward and observed this was effective in enabling staff to share information about patients and review their progress. Different professionals worked together effectively to assess and plan patients' care and treatment.
- Occupational therapists and psychologists worked across all wards and we saw that they worked effectively with patients and the multi-disciplinary team.
- Wards held comprehensive handovers between shifts, highlighting specific information where staff attention was required, for example patients with diabetes. Staff kept records of handovers for staff reference.
- Staff received detailed handovers from community teams when patients were admitted to the wards. We observed a handover of care for a patient admitted to Jasper ward and found this to be detailed and structured.
- Staff reported effective links with outside agencies to support patient care. For example, local authority representatives attended strategy meetings related to safeguarding referrals and local housing officers attended the hospital sites to assist with housing needs for patients prior to discharge.

Adherence to the Mental Health Act and the Mental Health Act Code of Practice

- The trust did not deliver training in the Mental Health Act (MHA) or Code of Practice as part of the mandatory training programme. On Rosewood, the ward manager had a brief guide for the staff, on the five key changes to the Code of Practice; however, we did not observe this on other wards.
- The trust ran a mental health law training programme. The trust did not consider this mandatory, however recognised that this training was essential to the role of some staff and had a training plan in place, which was ongoing.
- Staff completed most MHA paperwork correctly. There was administrative support to ensure paperwork was up to date and regular audits took place. There was a clear process for checking the receipt of MHA paperwork. Overall, MHA record keeping and scrutiny was satisfactory. MHA paperwork was scanned onto the electronic record for staff reference.

Are services effective?

Requires improvement

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.

- Medical staff completed consent to treatment and capacity requirement forms, either a T2 or T3 certificate; the first for a patient detained under the MHA who was consenting to treatment, and the second for a patient detained under the MHA who was not consenting to treatment. Staff attached copies to medication charts to ensure medication was administered in accordance with the MHA. However, care note entries relating to capacity were contradictory in some records reviewed. In the records of one patient on Jasper ward, being treated under the authority of a T2 certificate, a subsequent ward review noted that the patient lacked capacity to treatment/hospital stay. In the notes of another patient, treated under the authority of a T3 certificate, a progress note completed by a ward doctor stated that the patient had capacity to consent to medication. A ward review note completed on the same day stated that the same patient lacked capacity to consent to medication and had poor insight.
- Staff did not always document patients' capacity to consent to treatment prior to the first administration of medication. In the records of two patients on Sapphire ward, we were unable to locate an assessment of the patient's capacity to consent to treatment following their detention under section 2 of the MHA. Patients' capacity to consent to treatment in accordance with the Code of Practice was not always recorded.
- Staff read and recorded patients' rights under section 132 MHA in most records reviewed. However, on Jasper ward we were unable to locate evidence in the records of two patients that a discussion of rights had been completed following the renewal of the patient's detention under section 3 of the MHA. Staff had recorded that one patient had not understood their rights on admission; however, there was a 12 day delay before a discussion of rights was repeated. On Sapphire ward we found delays in reading patients' rights for one patient, no record of a patient's understanding of rights for another and no record of reading of rights for a third. Staff on Topaz ward were not repeating all patients' rights under section 132 at timely intervals, in accordance with the MHA Code of Practice.
- Staff did not always inform patients of their right to access the Independent Mental Health Advocacy Service (IMHA). On Jasper and Sapphire wards there was no evidence of discussion of IMHA in the care records of eight patients. Six records were reviewed on Topaz ward. Staff had not recorded, where applicable, that patients were being actively supported to access the IMHA service if they lacked capacity. However, posters and leaflets detailing this service were visible on all wards and information was contained in patients' admission packs. Staff were clear on how to access the service on behalf of patients.
- Medical staff did not always complete all details on patient leave authorisation forms. On Topaz ward some of these leave forms had not been completed in full to indicate to whom copies had been given. Forms lacked details in relation to terms and conditions, where applicable.

Good practice in applying the Mental Capacity Act

- The trust provided mandatory Mental Capacity Act (MCA) training. Data provided for October 2015 showed 39% of staff had received this training against the trust target of 80%. This does not reflect the recommendations made by the Department of Health, Positive and Proactive Care (2014) which states staff required to undertake physical interventions should also have training in the MCA. The trust could not be sure that all staff were aware of their responsibilities under the Act.
- When we spoke with staff there was varying degrees of knowledge about the MCA and Deprivation of Liberty Safeguards (DoLS). None of the patients receiving care and treatment during our inspection was subject to a deprivation of liberty safeguard (DoLS).
- There was some evidence in clinical notes that the multidisciplinary team had considered capacity during care reviews. Staff had completed assessment of capacity in 43 care records viewed. However, ten of the 43 care records had a poor level of documentation with little evidence of the mental capacity of the patient having been assessed. The trust had procedures for assessing capacity for significant decisions for patients who may lack capacity. We saw evidence of this in the notes for one patient on Topaz ward.

Psychiatric Intensive Care Unit - Coral Ward

Assessment of needs and planning of care

Are services effective?

Requires improvement

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.

- We reviewed six care records for patients receiving care and treatment on the psychiatric intensive care unit (PICU).
- Staff assessed patient needs and delivered care in line with individualised care plans.
- Staff completed physical health examinations and assessments on admission and recorded these in patient care records. Staff monitored physical observations and physical health problems. Patients spoken with told us, and records sampled showed, that patients' physical health care needs were being met.
- Staff completed and regularly updated care plans for patients. However, four care plans were not holistic or recovery focused. They did not include the full range of patients' problems and needs or include recovery options that built on patients' strengths and goals.
- Senior staff told us that the trust's electronic care records system had recently been changed.

Best practice in treatment and care

- We reviewed the medication administration records for all patients. Medical staff prescribed medicines in accordance with the National Institute for Health and Care Excellence (NICE) guidelines. The ward pharmacist attends the weekly MDT meeting to discuss people's treatment plans.
- The trust had four psychologists working in the acute division. Psychologists attended multi-disciplinary care planning meetings on the ward and offered advice to staff on completing behavioural support plans for patients. Psychologists also organised groups for patients on goal setting and relapse prevention and worked with patients individually. Psychologists also offered support to staff affected by incidents related to their work, for example violent assault by patients.
- Staff made referrals for assessment and treatment for physical healthcare needs to the local acute hospital. Patients could access a weekly surgery provided at the Highgate Mental Health Unit by the local acute trust. One patient with a diabetes plan in place had attended the diabetes clinic.
- Staff completed health of the nation outcome scales (HoNOS) and we saw evidence of these in patient records. Staff used HoNOS scores to allocate patients to pathways of care, known as 'clusters', based on groups of patients with similar diagnosis and individual needs. The trust monitors clustering compliance at divisional performance meetings and teams can view live clustering status for their caseloads via clinical dashboards.
- The trust monitored and audited other o Staff participated in clinical audit on a weekly or monthly basis. We saw examples of audits for infection control, medication and physical health checks. We noted from trust audits that improvements had been made to ensuring physical observations were carried out after people received medicines for rapid tranquillisation.

Skilled staff to deliver care

- Ward staff consisted of nurses, consultants, doctors, occupational therapists, health care support workers, activity co-ordinators, pharmacists and psychologists. This meant that patients had access to a variety of skills and experience for care and treatment.
- New staff underwent a formal induction period, which involved learning about the ward, and trust policies with a period of shadowing existing staff before working alone. Newly qualified nurses told us a well-structured and in-depth preceptorship programme was in place.
- Bank and agency staff underwent a basic induction including orientation to the ward. This included emergency procedures such as fire and a handover about patients and current risks.
- The trust had plans to put support workers through the care certificate. The care certificate is a set of standards aimed to equip health and social care support workers with the knowledge and skills they need to provide safe, compassionate care. This work was ongoing as there were difficulties in gaining places on courses for their staff.
- We saw evidence of ward timetables for supervision of staff but noted that some staff had not received supervision regularly. The ward manager had plans to address this. Staff advised that informal supervision took place, but was not documented.
- Not all staff had received an appraisal. The trust advised they moved to an open system with appraisals done throughout the year and not as one annual review.

Are services effective?

Requires improvement

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.

However, the trust provided data which showed 41% of non-clinical staff had received an appraisal over the past 12 months, which was below the trust's overall achievement at 72%.

Multi-disciplinary and inter-agency team work

- Staff attended m meetings on the ward to share information about patients and review their progress. We were told that different professionals worked together effectively to assess and plan patients' care and treatment. We saw evidence of this recorded in patient care records.
- Occupational therapists and psychologists worked closely with patients as part of the ward team.
- The ward held comprehensive handovers between shifts. Staff kept records of handovers for staff reference.
- Staff received detailed handovers from other teams when patients were admitted to the ward. Staff assessed the needs of patients requiring admission to the psychiatric intensive care unit, prior to admission. Staff from the PICU offered advice to the acute wards on the safe management of patients, when patients' needs did not indicate admission to the PICU.
- Staff reported effective links with outside agencies to support patient care. Local authority representatives attended strategy meetings related to safeguarding referrals, and local housing officers attended the hospital sites to assist with housing needs for patients prior to discharge.

Adherence to the Mental Health Act and the Mental Health Act Code of Practice

- The trust did not deliver training in the Mental Health Act (MHA) or Code of Practice as part of the mandatory training programme.
- The trust ran a mental health law training programme, which the trust did not consider mandatory. However, the trust recognised that this training was essential to the role of some staff and had a training plan in place, which was ongoing.
- Staff completed MHA paperwork correctly. There was administrative support to ensure paperwork was up to date and regular audits took place. There was a clear process for checking the receipt of MHA paperwork. Overall, MHA record keeping was satisfactory. Staff scanned MHA paperwork onto the electronic record for staff reference.
- Medical staff completed consent to treatment and capacity requirements. Staff attached copies to medication charts to ensure medication was administered in accordance with the MHA.
- Patients had access to independent mental health advocacy. Staff made referrals to the service and recorded this in patients' care records. The ward had posters and leaflets detailing this service and information were contained in the patients' admission packs. Staff were clear on how to access the service on behalf of patients.

Good practice in applying the Mental Capacity Act

- The trust provided mandatory MCA training. Data provided for October 2015 showed 22% of staff had received this training against the trust target of 80%. The trust could not be sure that all staff were aware of their responsibilities under the Act.
- Staff had varying degrees of knowledge about the MCA and Deprivation of Liberty Safeguards (DoLS).
- None of the patients receiving care and treatment during our inspection was under a deprivation of liberty safeguard (DoLS).
- There was evidence in clinical notes that the multidisciplinary team had considered capacity during care reviews. Staff had completed assessment of capacity in all care records viewed.

Good

Are services caring?

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

Our findings

Acute Wards

Kindness, dignity, respect and support

- We spoke with 23 patients receiving care and treatment on the acute ward and observed how staff cared for patients. All patients told us staff were kind and compassionate.
- We observed staff interactions with patients. Staff were responsive to patient needs, discreet and respectful. We observed good relationships between patients and staff on all wards.
- Staff were passionate and enthusiastic about providing care to patients with complex needs. They showed a good understanding of the care and treatment needs of patients, for example, re-directing patients towards meaningful activity during periods of agitation, and distracting patients away from situations that were stressful to them.
- We saw staff working with patients to reduce their anxiety and behavioural disturbance, for example, managing a distressed and agitated patient on Topaz ward.
- All wards had a calm and relaxing atmosphere.
- Staff had an understanding of the personal, cultural and religious needs of patients who used the service and we saw examples of actions taken to meet these needs.
- The latest patient led assessment of the care environment audit (PLACE) showed 91% satisfaction for privacy, dignity and wellbeing for wards at St Pancras Hospital. The trust scored higher than the England average for 2015, which was 86%.

The involvement of people in the care that they receive

- All wards had a patient admission pack that included important information about the ward environments, for example, information on the ward philosophy, the staff working on the ward; ward activities, Mental Health Act information and how to complain.
- Staff discussed patients' needs in their care planning meetings and records showed this. However, overall, 18 care plans contained little evidence of patient involvement with the care planning process. For example, care plans did not contain patients' views. On Topaz, Sapphire and Jasper wards, there was inconsistent evidence to demonstrate that patients were actively encouraged to participate and contribute in their care planning process.
- The majority of patients had received, or had been offered, a copy of their care plan.
- We received mixed feedback from patients about involvement with advocacy services. Most patients were aware of advocacy but not all had used the service. Posters containing advocacy information and contact details were visible on wards.
- Staff invited patients to the multi-disciplinary reviews, along with their family where appropriate. One carer told us they were impressed with the quality of the care planning reviews and the different professionals that attended.
- All patients we spoke with told us they had opportunities to keep in contact with their family where appropriate. There were dedicated areas for patients to see their visitors.
- Patients were actively involved in the running of the ward through a weekly community meeting. Staff recorded minutes of community meetings and placed these on ward notice boards for patients to refer to.

Psychiatric Intensive Care Unit - Coral Ward

Kindness, dignity, respect and support

- We spoke with three patients receiving care and treatment on the psychiatric intensive care unit (PICU) and observed how staff cared for patients. All patients told us staff were kind and compassionate.
- We observed staff interactions with patients. Staff were responsive to patient needs, discreet and respectful. We observed good relationships between patients and staff.
- Staff were passionate and enthusiastic about providing care to patients with complex needs. They showed a good understanding of the care and treatment needs of patients, for example, re-directing patients towards meaningful activity during periods of agitation and distracting patients away from situations that were stressful to them.

Good

Are services caring?

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

- The ward had a calm and relaxing atmosphere.
- Staff understood the personal, cultural and religious needs of patients who used the service and we saw examples of actions taken to meet these needs.

The involvement of people in the care that they receive

- The ward had a patient admission pack that included important information about the ward environments, for example, information on the ward philosophy, the staff present on the ward, ward activities, Mental Health Act information and how to complain.
- Staff discussed patients' needs in their care planning meetings and records showed this.
- We reviewed six care and treatment records. Staff completed personalised care plans. Patient views on their care and treatment were recorded in their own words. However, in the records of three patients, there was no evidence that a copy of the care plan had been given to the patient.
- Patients were aware of the advocacy services. Posters containing advocacy information and contact details were visible on wards.
- Staff invited patients to the multi-disciplinary reviews, along with their family where appropriate.
- All patients we spoke with told us they had opportunities to keep in contact with their family where appropriate. There were dedicated areas for patients to see their visitors.
- Patients were actively involved in the running of the ward through a weekly community meeting. Staff recorded minutes of community meetings and placed these on ward notice boards for patients to refer to.

Are services responsive to people's needs?

Requires improvement

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

Our findings

Acute Wards

Access and discharge

- Between May and October 2015, the trust reported average bed occupancy rates across the acute service at 97%. The highest bed occupancy rate for the acute service was Jade ward at 101% and the lowest Dunkley ward at 94%. Staff confirmed that most patients who left the wards on overnight leave would return for assessment and go back home on further periods of leave. The trust made every effort not to use patient leave beds, wherever possible.
- The trust had four beds for patients who also had a diagnosis of a learning disability on Dunkley ward. Although these beds were not protected for use exclusively by patients with a learning disability, there was a commitment to moving patients to these beds at the first opportunity after admission and the requirement for a learning disability bed was always escalated via the bed managers. These patients were supported through the learning disabilities multidisciplinary team. Senior staff advised there had been delays in accessing these beds, on occasions; however, this had improved recently.
- The trust had a bed management team working 24 hours. This team maintained daily contact with the wards to co-ordinate admissions and discharges. Staff completed a daily bed state and midnight report for information on admissions, discharges, incidents and patients absent without leave. The trust ensured it was aware of available beds in advance to admit patients.
- The trust reported figures above the England average for admissions gate kept by the crisis resolution and home treatment team over the past year, the last quarter being 96% against the England target of 95%.
- The trust had secured 16 out of area beds via a contracted arrangement with a neighbouring NHS trust. Senior staff advised that these beds were considered as trust beds. However, the bed management team considered which patients would be most suitable to use them. For example, patients under community treatment orders or requiring admission for very short periods were not admitted to these beds.
- The trust secured extra beds in the independent sector when needed. These beds could be some distance from the patient's local area, for example, Hertfordshire, Surrey and Hampshire. Patients might experience difficulty in maintaining contact with friends and family when this occurred. The trust reported 51 out of area placements for the acute service between June and December 2015. When local beds became available, patients would transfer back to continue their care and treatment.
- The trust provided data for non-clinical bed moves (when patients were moved between wards, during an episode of care, not related to their clinical needs). The data showed varying amounts of patient movement between wards over an 11 month period to 25 February 2016. The highest recorded moves were January 2016 at 47 and the lowest was August 2015 at 5. The average monthly number of non-clinical bed moves for this period was 18.
- The trust had one psychiatric intensive care unit (PICU) which only accepted males. Staff could refer patients to senior PICU staff for assessment for admission, as required.
- The trust data showed there had been five delayed discharges since June 2015 because patients had been waiting for appropriate housing allocation.
- The trust data showed the average length of stay for patients between November 2014 and December 2015 was 57 days. Rosewood ward had the longest length of stay at 151 and Sapphire the shortest at 13 days.
- The trust recorded the number of patients readmitted to hospital within 90 days of discharge. Between May and October 2015, 86 patients were re-admitted. The greatest number of readmissions occurred on Sapphire ward, the admission ward, at 22. Rosewood ward had the lowest re-admissions within this period, at three.

The facilities promote recovery, comfort, dignity and confidentiality

- The Highgate Mental Health Unit had multiple rooms for care and treatment, to include activity rooms, clinic rooms and rooms where patients could meet visitors or staff in private. However, St Pancras Hospital had fewer

Are services responsive to people's needs?

Requires improvement

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

rooms available. For example, on Jasper ward staff used rooms for multiple functions. The dining room was also used for activities and the staff room used to hold multi-disciplinary and care review meetings.

- The trust provided payphones on each ward where patients could make a phone call in private. Patients could also use their own mobile phones, following a risk assessment.
- Patients had access to outside space. However, on wards placed on upper floors, there was no direct access. Staff were needed to escort some patients to access outside space, which restricted how often, and for how long, patients could remain outside. Wards situated on the ground floor had access to outside areas for patient use with fewer restrictions, due to location and ease of staff observation.
- The patient led assessments of the care environment (PLACE) scored 88% for ward food at St Pancras Hospital. This was slightly lower than the England average for 2015 at 89%.
- Patients' views on the quality of the food were variable. Some patients told us the food was of good quality. However, some patients thought the potions were small and the vegetables were overcooked. One patient on Topaz ward told us patients often ordered take-away meals, as they either did not like the food or remained hungry after meals.
- Patients were able to personalise their bedrooms. We saw patients had photographs and artwork displayed in their rooms.
- Patients had secure areas to store their possessions. Staff locked patient bedrooms, at their request, or valuables were stored in ward safes.
- Patients had access to hot drinks and snacks 24 hours per day. However, on most wards patients would need to request snacks from staff and on Jade and Opal wards there were no crockery or cups available for patient use. This meant patients needed to ask staff to find cups before they could make drinks.
- All wards ran activity programmes, including at weekends. These programmes included a range of activities such as creative crafts, relaxation and community meetings. Staff placed activity timetables on patient notice boards and the majority of patients were happy with the activities on offer. However, staff and patients told us that activities were sometimes cancelled at weekends, due to staffing numbers.

Meeting the needs of all people who use the service

- Wards had facilities to meet the needs of patients with disabilities. For example, assisted bathrooms.
- Patient information leaflets were visible on all wards and covered a range of subjects including local services, advocacy and how to complain. Staff could access information in other languages when needed.
- Staff told us that interpreters were available using a local interpreting service or language line. Staff could access these services to assist in assessing patients' needs and explaining their care and treatment.
- We saw there was a range of choices provided in the menu that catered for patients dietary, religious and cultural needs.
- Spiritual support was available to patients for a range of faiths. Information was visible to staff in nurses' offices and some patients used this service.

Listening to and learning from concerns and complaints

- The trust had a system for recording and investigating complaints. Between November 2014 and November 2015 there were 29 complaints received for the acute services, the highest being on Sapphire ward with eight. Overall, three were fully upheld and 15 partially upheld. No complaints were forwarded to the parliamentary ombudsmen.
- Information about the complaints process was available on notice boards and contained in patient welcome packs. Patients we spoke with knew how to make a complaint. Staff confirmed they knew how to support patients to make a complaint.
- Staff recorded complaints using the trust's computerised incident reporting system. The ward managers told us they shared learning amongst their staff via staff meetings and communications.
- The trust recorded three compliments over the same time involving Opal, Jade and Rosewood wards.

Are services responsive to people's needs?

Requires improvement

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

Psychiatric Intensive Care Unit - Coral Ward

Access and discharge

- The trust had one psychiatric intensive care unit (PICU) for males only. The trust data showed average bed occupancy of 92% over the past six months.
- The trust does not have any female PICU beds. Senior staff advised that the trust had two contracted female PICU beds available elsewhere. When further male or female PICU beds were required, these were sourced in the independent sector. The trust data showed between June 2015 and December 2015, 39 patients were transferred out of area to receive care and treatment. This meant male and female patients could be admitted to hospitals some distance from their local area, for example, Essex and West Sussex. This might make maintaining contact with family and friends more difficult.
- Acute staff reported access to PICU beds was made by referral to the PICU team. Staff reported quick responses to these referrals and, in most cases, access to PICU beds was facilitated in a timely manner.
- The trust data showed the average length of stay for patients admitted to the PICU between December 2014 and December 2015 was 151 days.

The facilities promote recovery, comfort, dignity and confidentiality

- The ward had locks on the main entrances with entry and exit controlled by staff. An air lock system operated, where one door could not be opened until the previous door was securely closed.
- The ward had a range of rooms for care and treatment including quiet rooms, an activity room and a clinic room. The ward had rooms where patients could meet visitors in private.
- Payphones were provided where patients could make a phone call in private. Patients could use mobile phones, following a risk assessment.
- Patients had access to drinks and snacks 24 hours per day, which staff facilitated.
- Patients had their own sleeping accommodation with ensuite facilities.We saw patients' bedrooms were unlocked, meaning patients could access their bedroom at any time.
- Patients could store their personal possessions in their bedroom, which staff locked on request.
- Patients told us the food was of good quality.
- We saw the ward had an activity programme, which covered weekends, including activities such as Wii sports, relaxation and community meetings. A pool table was available for patient use, with staff supervision.
- The ward had direct access to a garden area in which patients could enjoy fresh air.

Meeting the needs of all people who use the service

- The ward had facilities to meet the needs of patients with disabilities. For example an assisted bathroom.
- Patient information leaflets about local services, advocacy and how to complain were available. Staff could access information in other languages when needed.
- Staff told us that interpreters were available using a local interpreting service or language line. Staff could access these services to assist in assessing patients' needs and explaining their care and treatment.
- Spiritual support was available to patients for a range of faiths. Information was visible to staff in nurses' offices and some patients used this service.
- We saw there was a range of choices provided in the menu that catered for patients dietary, religious and cultural needs.

Listening to and learning from concerns and complaints

- The trust had a system for recording and investigating complaints. Between November 2014 and November 2015 there was one complaint received. No complaints were forwarded to the parliamentary ombudsmen.

Are services responsive to people's needs?

Requires improvement

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

- Information about the complaints process was available on notice boards and contained in patient welcome packs. Patients we spoke with knew how to make a complaint. Staff confirmed they knew how to support patients to make a complaint.
- Senior staff told us complaints were an agenda item for staff meetings. Minutes detailed how the issues were investigated, the outcomes and lessons learnt.
- Staff recorded complaints using the trust's computerised incident reporting system. We saw it evidenced how the issues were investigated, the outcomes and any lessons learnt.

Are services well-led?

Requires improvement

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.

Our findings

Acute Wards

Vision and values

- Staff we spoke with were aware of the trust vision and values and these were available on the trust's intranet system.
- Staff were able to tell us who the most senior managers in the trust were, and said they had visited the wards.

Good governance

- The arrangements for governance did not always operate effectively. This meant issues which needed addressing had not been identified. For example, Mental Health Act monitoring regarding consent and staff not being aware of the safeguarding procedures.
- The trust supplied data related to compliance with training over a 12 month period that showed the average compliance with mandatory training courses was low at 66%. The lowest attendance was safeguarding children (26%) and Mental Capacity Act (MCA) (39%).
- The trust had procedures for raising safeguarding concerns for patients. However, staff were unsure of procedures for referrals out of hours.
- The trust had procedures for implementing, recording, storing and auditing Mental Health Act paperwork but issues had not been picked up.
- The trust supports supervision for staff. The trust advised they moved to an open system with appraisals done throughout the year and not as one annual review. However, only 53% of staff had received an appraisal over the past 12 months.
- The trust used acuity tools to determine safe staffing levels. However, wards employed high numbers of bank and agency staff to fill shifts when regular staff were unavailable to cover higher levels of patient need. There was a high reliance on the use of bank and agency staff and, on occasion, wards operated short of staff when bank or agency staff were not available.
- The trust did not have robust governance arrangements in relation to assessing, monitoring and mitigating risks of ligatures in the patient care areas. Whilst ligature risk assessments and action plans were in place, an unacceptable number of ligature risks remained at the St Pancras site.
- Staff participated in clinical audit and had access to clinical dashboards, which provided information about completion of clinical documentation such as care plans and risk assessments.
- The ward managers confirmed they felt supported by their managers.

Leadership, morale and staff engagement

- The trust data showed average sickness across the acute wards was 6%.
- On a day-to-day basis, the wards appeared to be well managed. Staff told us that the ward managers were highly visible on the wards, approachable and supportive. Staff morale was high and we found the teams were cohesive and enthusiastic.
- Staff told us that they felt part of a team and received support from each other. Staff were well supported by their immediate managers and felt they valued their work.
- The ward managers on all wards confirmed that there were no current cases of bullying and harassment involving the staff.
- Staff we spoke with confirmed they understood the whistleblowing process and would feel confident to use it.
- Staff we spoke with were aware of their responsibilities to be open and honest with patients and families when things went wrong.
- Staff participated in staff surveys.

Commitment to quality improvement and innovation

- The trust was applying to the Accreditation for Inpatient Mental Health Services (AIMS) schemes and the Psychiatric Liaison Accreditation Network (PLAN).

Psychiatric Intensive Care Unit - Coral Ward

Vision and values

Are services well-led?

Requires improvement

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.

- Staff we spoke with were aware of the trust vision and values and these were available on the trust's intranet system.
- Staff we spoke with were able to tell us who the most senior managers in the trust were, and that they had visited the wards.

Good governance

- The arrangements for governance did not always operate effectively. This meant issues which needed addressing had not been identified. For example, Mental Health Act monitoring regarding consent and staff not being aware of the safeguarding procedures.
- The trust supplied data related to compliance with mandatory training between October 2014 and October 2015. Overall, the average compliance with nine mandatory training courses for staff working on the PICU was low at 51%. The lowest attendance was safeguarding children (4%) and Mental Capacity Act (2005) at 23%. The Care Quality Commission identified a lack of staff training and understanding of the Mental Capacity Act in previous inspections. The trust was required to address this.
- The trust had procedures for raising safeguarding concerns for patients. However, staff were unsure of procedures for referrals out of hours.
- The trust has procedures for implementing, recording, storing and auditing Mental Health Act paperwork. Overall, MHA paperwork was completed correctly. However we found that medical reviews for seclusion were not being completed in accordance with the code.
- Staff participated in supervision. However, not all staff had received an appraisal. The trust advised they moved to an open system with appraisals done throughout the year and not as one annual review. Data provided showed 41% of non-clinical staff had received an appraisal over the 12 months to November 2015.
- The trust used acuity tools to determine safe staffing levels. However, the ward employed high numbers of bank and agency staff to fill shifts when regular staff were unavailable or to cover higher levels of patient need. However, on occasions when extra staffing could not be secured, wards operated short of staff.
- Staff participated in clinical audit and had access to clinical dashboards, which provided information about completion of clinical documentation such as care plans and risk assessments.

Leadership, morale and staff engagement

- The trust data showed average sickness on the psychiatric intensive care unit (PICU) as 3%. This was lower than the NHS England average at 4%.
- On a day-to-day basis, the ward appeared to be well managed. Staff told us that the ward manager was highly visible on the ward, approachable and supportive, and staff morale was good.
- Staff told us that they felt part of a team and received support from each other. They were well supported by their immediate manager and felt they valued their work.
- Senior staff confirmed that there were no current cases of bullying and harassment involving the staff.
- Staff we spoke with confirmed they understood the whistleblowing process and would feel confident to use it.
- Staff we spoke with were aware of their responsibilities to be open and honest with patients and families when things go wrong.

Commitment to quality improvement and innovation

- The trust was currently applying to the Accreditation for Inpatient Mental Health Services (AIMS) schemes and the Psychiatric Liaison Accreditation Network (PLAN).

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 were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care Care plans were not always personalised and did not include patients' views, nor were they recovery orientated, for example, they did not always include the patients' strengths and goals. This was a breach of Regulation: 9(1)(a)(b)(c), 9(3)(a)(b)(c)(d) and 9(3)(f).

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent The trust had not ensured that all patients' capacity to consent to treatment had been assessed and recorded in accordance with the Mental Health Act (1983) Code of Practice. This was a breach of Regulation 11(4).

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Wards and courtyard areas had potential ligature points that had not been fully managed, mitigated, or addressed. Some wards had poor lines of sight. Staff could not easily observe patients. One courtyard had a loose brick attached to a bench by a chain and another had plastic leaflet holders that could pose a risk to patients and staff if broken. This posed risks to patient safety.

This section is primarily information for the provider

Requirement notices

One ward had a defibrillator with no defibrillation pads available. Staff had not regularly completed emergency equipment checks on two wards. This posed a risk to patient safety in an emergency.

Medical staff were not completing medical reviews for patients, subject to periods of seclusion, in accordance with the Mental Health Act Code of Practice.

This was a breach of Regulation 12 (1)(2) (a)(b)(d)(e)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment The trust had not ensured that all staff were aware of the process for making safeguarding referrals out of hours or at weekends. This was a breach of Regulation 13(3)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment The trust had not completed essential repairs to patient care environments in a timely manner. Broken windowpanes within an external fire door had not been replaced and the quality of temporary repairs was poor. Some ward areas were not hygienic. For example, dust on surfaces and human hair on the floor. This was a breach of Regulation 15 (1)(e)(2)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The systems to assess, monitor and mitigate the risks relating to the health, safety and welfare of patients who may be at risk which arise from the carrying on of the regulated activity were not effective.

This section is primarily information for the provider

Requirement notices

Systems were in place to identify and manage ligature risks in the patient care areas, for example, we saw evidence of ligature risk assessments and action plans. However, some risks were highlighted in May 2015 and the trust had not completed this work.

We noted that the trust policy pre-dated the revised MHA code of practice. The trust had not ensured that patients were provided with required safeguards in accordance with the MHA Code of Practice. MHA monitoring had not picked these issues up.

This was a breach of Regulations 17(1), 17(2)(a)(b)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing There was a high reliance on bank and agency staff across all of the acute wards. Staff were not receiving regular appraisals. Staff were not receiving all required mandatory training. Compliance with safeguarding children and Mental Capacity Act (2005) was particularly low. The trust could not be sure staff had received sufficient training for their role. This was a breach of Regulation 18(1)(2)(a).