North London NHS Foundation Trust

Quality Report

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Core services inspected	CQC registered location	CQC location ID
Community-based mental health services for older people	Camden and Islington NHS Foundation Trust Headquarters	TAF
Long stay/rehabilitation mental health wards for working age adults	St Pancras Hospital Highgate Mental Health Centre	TAF01 TAF72
Acute wards for adults of working age and psychiatric intensive care unite	St Pancras Hospital Highgate Mental Health Centre	TAF01 TAF72
Wards for older people with mental health problems	Highgate Mental Health Centre	TAF72
Community-based mental health services for adults of working age	Camden and Islington NHS Foundation Trust Headquarters	TAF
Mental Health crisis services and health based places of safety	Camden and Islington NHS Foundation Trust Headquarters	TAF
Community mental health services for people with learning disabilities	Camden and Islington NHS Foundation Trust Headquarters	TAF
Substance misuse services	Camden and Islington NHS Foundation Trust Headquarters	TAF

This report describes our judgement of the quality of care at this provider. It is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from people who use services, the public and other organisations.

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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 services at this Provider	Requires improvement 
Are Mental Health Services safe?	**Requires improvement** 
Are Mental Health Services effective?	**Requires improvement** 
Are Mental Health Services caring?	**Good** 
Are Mental Health Services responsive?	**Requires improvement** 
Are Mental Health 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.

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Overall summary

When aggregating ratings, our inspection teams follow a set of principles to ensure consistent decisions. The principles will normally apply but will be balanced by inspection teams using their discretion and professional judgement in the light of all of the available evidence.

- It is our view that the trust needs to take steps to improve the quality of their services and we find that they were in breach of three regulations. We issued three requirement notices which outline the breaches and require the trust to take action to address. We will be working with them to agree an action plan to assist them in improving the standards of care and treatment.

We found that the trust was performing at a level which led to a rating of requires improvement because:

- We rated mental health crisis services and health based places of safety as inadequate. We rated acute wards for adults of working age and psychiatric intensive care units, long stay/rehabilitation mental health wards for working age adults, community-based mental health services for adults of working age, and substance misuse services as requires improvement. We rated wards for older people with mental health problems, community-based mental health services for older people, and community mental health services for people with a learning disability or autism as good overall.
- There were a number of concerns about environments. In the health based places of safety the environment was not suitable. Patients in the health based place of safety at the accident and emergency department in the Royal Free hospital had to walk past other cubicles to use the toilet. The premises did not meet the guidance in the Mental Health Act code of practice or from the Royal College of Psychiatrist's. The toilet also had ligature points in which could be used by a patient to self harm. The places of safety were housed in the acute hospital and were cleaned by their staff but the trust had not ensured the environment was clean and well maintained. Facilities at two of the three health based places of safety did not promote dignity, recovery, comfort or confidentiality for people using this service
- We received limited assurance about safety. For example we identified ligature points in wards which had not been removed or measures put in place to mitigate risks. In some wards staff could not see all parts of the ward, there were blind spots and no mirrors to mitigate risk. Three staff on Garnet ward did not know where the ligature cutters (equipment to cut safely through materials used to self harm) were kept, other wards did not have any ligature cutters. 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. At the Highgate Mental Health Unit, we found one ward had identified a new fitting as a ligature risk in an assessment, but other wards had not identified the same problem. Therefore, other wards had no plan in place to manage this risk and staff were unaware of it. The service had breached the eliminating mixed sex accommodation guidance at Highview, there were five bedrooms on the second floor, four used by females and one by a male, there was evidence that this male had used the female facilities on that floor. The trust had not completed urgent repairs on three wards, at St Pancras, in a timely manner.
- Safeguarding was not always given sufficient priority. Safeguarding referrals for other services within the trust was being processed through community based adult mental health teams. The safeguarding referrals were being sent to email addresses within the community based mental health teams where the service was operating nine to five office hours. This meant referrals made out of hours were not being seen until the next working day. Staff were unclear how to make a safeguarding referral out of hours or at weekends. Staff did not always record safeguarding information appropriately and clearly.
- Record keeping was disorganised in paper files which meant information was difficult to find and could lead to key information being missed. Confidentiality was breached in some teams where patient names on files in the office could be seen by others. Staff had not stored hard copy care plans and legal documents effectively. Some care plans were not person centred or holistic. Patients had not signed their care plans because care plans were completed electronically separately from the patient appointment. Staff did not

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always clearly document the level of involvement of patients in their care plan or reasons why patients had not been involved. Some patients had not signed their care plan to indicate agreement with it. There were gaps in records. In the learning disabilities service there were two electronic recording systems in operation in each team that did not link to each other at all, meaning that information may be entered twice on some occasions or being recorded on one system but not the other. In order to address this, the teams had a protocol that identified their social care system as their primary record where all information should routinely be stored, with defined information being up loaded to the trust system when the patient was in hospital or at risk of going into hospital.

- In some services compliance with mandatory training for the service was below the trust target of 80%. In community adult services staff mandatory training rate was low, especially for safeguarding children training, safeguarding adults training and Mental Capacity Act and Deprivation of Liberty Safeguards training. This meant there was a risk staff were not trained sufficiently.
- Compliance for Mental Health Act (MHA) and Mental Capacity Act (MCA) training were low with some staff not receiving any training at all in MHA or MCA. Some staff were not aware of their responsibilities under the MHA and MCA. The trust set a target of 80% for mandatory training.
- Waiting times in some services were long. The waiting time for psychological support with the complex depression, anxiety and trauma service (CDAT) was one year. The assessment and advice team had a waiting list for routine referrals to be seen for an initial assessment of five weeks. North Camden recovery team had a patient waiting list for therapy of nine months, the personality disorder service had a waiting list to be allocated to a care coordinator of 16 weeks and a 12 month wait for therapy.
- The arrangements for governance and performance management did not always operate effectively. The leadership, governance and culture did not always support the delivery of high quality person-centred care.

However:

- We observed staff interactions with service users and their families in a variety of settings, found that they were responsive, respectful, and provided appropriate practical and emotional support. Staff were committed to working in partnership with people to ensure that the service users felt supported and safe. Staff supported families and carers to be involved in the service users' care. Staff offered families and carers access to psychological therapies.
- Some wards were safe, visibly clean and well maintained. Clinical areas and ward environments were bright, airy and hygienic. Furnishings were of good quality and homely. Up to date cleaning records showed that the wards were cleaned regularly.Handrails helped patients to maintain their balance while walking around the wards. There were wheelchairs and bathing facilities specific to the needs of older frail people. The clinic rooms were fully equipped. Resuscitation equipment was accessible and regularly checked. Nurse call bells were in every bedroom, bathroom and communal area. Staff carried alarms to summon help.
- Some services managed risks to patients well. There were clear lines of sight from the nursing offices. Where there were blind spots, a convex mirror was used to help staff observe the ward. There was a robust policy on the use of patient observations in place. Environmental ligature points (fittings to which patients intent on self-injury might tie something to harm themselves) were mostly addressed and the trust was taking steps to mitigate the risks from these by using the guidance of the trust observation policy.
- Care plans in some services were personalised including patients' views and staff wrote them in a way which met the patients' needs. Patients had individualised risk assessments which had been commenced at the point of referral to the service and regularly updated thereafter. There were some good examples of crisis and contingency plans for each patient. Physical healthcare needs were identified and monitored during treatment. Staff used the 'Modified early warning signs' tool to monitor and assess physical health. Falls prevention plans were in place, all inpatient wards used the 'Fallstop' guidance. Pressure ulcer care was led by a tissue viability nurse.
- There was rapid access to a psychiatrist when needed, and teams included staff from different disciplines with varied skill bases. Guidelines from the National Institute for Health and Care Excellence (NICE) for

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prescribing were being followed in all teams. There was an audit programme to monitor adherence to NICE guidance. A range of nationally recognised outcome tools were used.

- Across the trust some teams used a balanced scorecard to monitor performance and quality of care. Some teams had a local risk register to identify and mitigate risks. Patients generally knew how to complain and complaints were logged. Learning from complaints was shared in team meetings in some teams.
- Staff said that they felt supported by senior managers. Ward managers said they had authority to make changes to the ward staffing levels when needed. Ward Managers engaged well with their staff. Staff said they felt supported to raise concerns without fear of victimisation and told us that morale and job satisfaction was good.

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

We always ask the following five questions of the services.

Are services safe?

Requires improvement 

We rated Camden and Islington NHS Foundation trust as requires improvement for safe because:

- There were a number of concerns about environments. In the health based places of safety the environment was not suitable. Patients in the health based place of safety at the accident and emergency department in the Royal Free hospital had to walk past other cubicles to use the toilet. The premises do not meet the guidance in the Mental Health Act code of practice or from the Royal College of Psychiatrist's. The toilet also had ligature points in which could be used by a patient to self harm. The places of safety were housed in the acute hospital and were cleaned by their staff but the trust had not ensured the environment was clean and well maintained. Facilities at two of the three health based places of safety did not promote dignity, recovery, comfort or confidentiality for people using this service.
- We received limited assurance about safety. For example we identified ligature points in wards which had not been removed or measures put in place to mitigate risks. In some wards staff could not see all parts of the ward, there were blind spots and no mirrors to mitigate risk. Three staff on Garnet ward did not know where the ligature cutters (equipment to cut safely through materials used to self harm) were kept, other wards did not have any ligature cutters. 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. At the Highgate Mental Health Unit, we found one ward had identified a new fitting as a ligature risk in an assessment, but other wards had not identified the same problem. Therefore, other wards had no plan in place to manage this risk and staff were unaware of it.
- The service had breached the eliminating mixed sex accommodation guidance at Highview, there were five bedrooms on the second floor, four used by females and one by a male, there was evidence that this male had used the female facilities on that floor. The trust had not completed urgent repairs on three wards, at St Pancras, in a timely manner.
- Some teams did not have a designated clinic or interview area for carrying out physical examinations or private consultations. We found essential emergency equipment was not present, or

was perished. Emergency equipment was not always checked to make sure it was clean and functioning. There was no emergency equipment available at any of the sites visited in the community based mental health services for adults of working age. We found some emergency equipment out of date. There was emergency equipment available in rehabilitation services but some of the equipment such as airways and syringes was out of date. Other equipment such as weighing scales had not been re-calibrated.

- Aspects of medicines management required improvement in four community services. Staff in some of the rehabilitation service administered medicines from a locked cupboard in the main office, which was neither private nor practical. Medicines storage temperatures were not monitored consistently in two areas, so there was no assurance that medicines were kept at the right temperature. In the community adult service, medicines were not transported safely as we saw staff transporting medication in their handbags. Prescribers in the substance misuse service did not see clients for formal medication reviews regularly. We found one example where a doctor last saw a client in 2013. Staff in substance misuse services did not always complete medication records in full including information about client allergies, pharmacy details and medical histories. Medicines records were not completed fully in the North Camden crisis team.
- Risk assessments were not always kept up to date and amended following a change in circumstances. Others lacked pertinent detail.
- Not all community staff had access to lone worker devices. Staff were not adhering to the trusts lone working policy, compromising staff safety.
- Safeguarding was not always given sufficient priority. Safeguarding referrals for other services within the trust was being processed through community based adult mental health teams. The safeguarding referrals were being sent to email addresses within the community based mental health teams where the service was operating nine to five office hours. This meant referrals made out of hours were not being seen until the next working day. Staff were unclear how to make a safeguarding referral out of hours or at weekends. Staff did not always record safeguarding information appropriately and clearly.

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- There were periods of understaffing. There was a high reliance on bank and agency staff in some teams, although the trust tried to ensure continuity of care. Caseloads were not monitored in all teams. Compliance with mandatory training did not meet the trust target of 80% in most teams.

However:

- We found some good examples of risk assessments, crisis and contingency plans. All patients in the rehabilitation teams had an up to date risk assessment.
- Staff knew what incidents needed to be reported and ensured that incident forms were completed and recorded. Staff in some teams received feedback from investigations of incidents both internal and external to the service in monthly team meetings and via email. Staff were able to describe their duty of candour as the need to be open and honest with patients when things go wrong. There were systems in place for tracking and learning from safeguarding and other reportable incidents.
- In substance misuse service 94% of staff had attended their mandatory training, 96% attended safeguarding training. Staff were able to describe what actions could amount to abuse and knew what action to take.
- Some teams were fully established with all vacancies filled. Ward managers were able to adjust staffing numbers depending on the patient need on a day to day basis. All services had rapid access to a consultant psychiatrist when required.
- 'Fallstop', a risk management tool for falls, was in use in all inpatient wards. Staff received regular training on the prevention of falls which was ongoing. A full time matron for falls and fractures prevention was in post. Assessments were in use to manage the risk of pressure ulcers. A tissue viability nurse was available to give specialist input to the management of pressure ulcers. There was access to specialist pressure ulcer prevention equipment when required.
- The trust had an up to date infection control policy. We found most areas were clean and tidy.

Are services effective?

Requires improvement

We rated Camden and Islington NHS Foundation trust as requires improvement for effective because:

- Record keeping was disorganised in paper files which meant information was difficult to find and could lead to key

information being missed. Confidentiality was breached in some teams where patient names on files in the office could be seen by others. Staff had not stored hard copy care plans and legal documents effectively.

- Some care plans were not person centred or holistic. Patients had not signed their care plans because care plans were completed electronically separately from the patient appointment. There were gaps in records. In the learning disabilities service there were two electronic recording systems in operation in each team that did not link to each other at all, meaning that information may be entered twice on some occasions or being recorded on one system but not the other. In order to address this, the teams had a protocol that identified their social care system as their primary record where all information should routinely be stored, with defined information being up loaded to the trust system when the patient was in hospital or at risk of going into hospital.
- Compliance for Mental Health Act (MHA) and Mental Capacity Act (MCA) training were low with some staff not receiving any training at all in MHA or MCA. Some staff were not aware of their responsibilities under the MHA and MCA.
- Section 17 leave papers, section 117 aftercare meeting papers and consent to treatment forms were missing from the electronic database and no hard copies were available. Section 17 leave forms lacked information related to terms and conditions of leave. Staff did not regularly inform patients of their rights under the MHA or record consent to treatment properly. Some patients were not told of their right to have an advocate. There was a lack of consistency in how patients' mental capacity was assessed and recorded.
- There was a trust system in place to identify patients who were prescribed high dose antipsychotics or lithium, and to carry out the necessary monitoring. However this was not being followed in the community-based mental health services for adults of working age, so these patients were not being effectively monitored.
- At North Camden recovery team, only one out of five patients had a record of physical health checks being carried out when they needed one.
- There were gaps in the management and support arrangements for staff, such as appraisal, supervision and professional development. Managers reported that staff received in house specialist training but some managers did not keep a record of

staff's attendance centrally. Compliance with appraisal was low across most teams. Staff on Montague ward and Amber ward had not received an annual appraisal. Although staff received supervision sufficient records were not always kept.

However:

- Patients' physical health needs were assessed and were monitored by most teams, apart from North Camden recovery team. Patients were able to access specialist care for physical health care problems. Staff in the older adults' teams assessed and recorded in case records capacity to consent for people who might have impaired capacity at every appointment. In the rehabilitation service care plans were holistic and up to date and created using resident's own life stories, likes, and dislikes. Residents received regular health checks and examinations when necessary from the local GP surgeries. We saw evidence of how staff had supported residents to access local GP's. Staff used the recovery approach to focus their treatment interventions.
- Staff followed guidelines from the National Institute for Health and Care Excellence (NICE) when prescribing medication. A range of nationally recognised outcome tools were used.
- A range of multi-disciplinary team (MDT) meetings took place on a regular basis. The MDT was made up of psychiatrists, activity co-ordinators, pharmacists, nurses and support workers. Staff from community teams attended the weekly inpatient ward round to ensure that patients that they were involved in discharge planning. Handovers between shifts were effective and included relevant information for staff. Wards had dedicated psychologist support that provided one to one as well as group sessions for patients.
- In the older adults' service 100% of staff received monthly clinical and managerial supervision and 93% of non-medical staff who had received an appraisal in the last 12 months.
- The trust had an audit programme and most staff were actively involved in clinical audit.

Are services caring?

Good

We rated Camden and Islington NHS Foundation trust as good for caring because:

- Staff treated patients with care, compassion and communicating effectively. They spoke with patients in a kind and respectful manner. Staff had a good understanding of the personal,

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cultural and religious needs of patients. Staff were passionate and enthusiastic about providing care to patients with complex needs. They demonstrated good understanding of the care and treatment needs of these patients.

- Most care records showed that patients had been involved in the planning of their care and treatment. Carers spoke highly of the care their relatives received.
- Staff in the older adults' community team offered families and carers access to psychological therapies. For example strategies for relatives of people living with dementia (START) and cognitive stimulation therapy (CST).
- Service users and families were able to give feedback on the care they receive by completing the family and friends test and satisfaction surveys.
- Advocacy services were provided.

However:

- Records did not consistently show patient involvement in care and treatment options. Care plans did not always include the patients' views. Staff did not always clearly document the level of involvement of patients in their care plan or reasons why patients had not been involved. Some patients had not signed their care plan to indicate agreement with it.
- Several at Aberdeen Park and Highview told us that they were not happy about the trust's blanket policy of not allowing people to have a bath without supervision. Staff advised us that this was trust policy following decisions taken after a serious untoward incident had occurred elsewhere in the trust.

Are services responsive to people's needs?

Requires improvement

We rated Camden and Islington NHS Foundation trust as requires improvement for responsive because:

- Waiting times in some services were long. The waiting time for psychological support with the complex depression, anxiety and trauma service (CDAT) was one year. The assessment and advice team had a waiting list for routine referrals to be seen for an initial assessment of five weeks. North Camden recovery team had a patient waiting list for therapy of nine months, the personality disorder service had a waiting list to be allocated to a care coordinator of 16 weeks and a 12 month wait for therapy.
- The trust is not commissioned to provide female psychiatric intensive care (PICU) beds. Female patients requiring a PICU bed were placed away from their local area.
- The trust had four learning disability beds 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. The requirement for a learning disabilities bed was escalated via the bed managers. These patients were supported through the learning disabilities multidisciplinary team. The trust did not employ any learning disability trained nurses on the inpatient wards.

- Staff in the rehabilitation service said that when patients went on leave their beds were sometimes used for patients from other wards. This meant that patients returning from leave would not have access to their room until a bed was found for the patient who was sleeping over. The four wards had a bed occupancy of more than 85% over the last six months.
- Some wards at St Pancras had insufficient rooms for care and treatment. Several wards at the 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 has some wards on upper floors. Patients requiring a nurse escort reported difficulties accessing outside space when wards were busy or staffing was low.
- There were limited information leaflets in languages other than English available most of the services inspected, although they were made available upon request.

However:

- Services took active steps to engage with patients reluctant to engage or who did not attend appointments.
- 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.
- Patients could make telephone calls in private. Patients had access to outside space, although this proved difficult for patients on the wards on the upper floors. Patients were able to personalise their bedrooms. A range of activities was provided in the inpatient areas throughout the week.
- There was disabled access for most buildings. The environment in older adults wards had been adapted to meet the needs of the patients, signage was easy to read and at eye level.
- In the learning disabilities service information was available in both easy to read and standard formats.
- Information about the complaints process, and feedback process, was available as an easy to read leaflet. Information about meeting spiritual needs, independent advocacy, access to

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interpreters, making a complaint and local services for carers was displayed in most areas. Patients said that they had access to appropriate spiritual support and were able to visit church or mosque and see the Iman.

- There was a robust and effective complaints process. Patients and carers in all services knew how to make a complaint. Staff tried to resolve complaints at a local level. If unable to they became formal complaints that were referred to the trust complaints team. Staff knew how to respond to complaints and said that outcomes of investigations were discussed at the weekly ward business meeting.

Are services well-led?

Requires improvement

We rated Camden and Islington NHS Foundation trust as requires improvement for well-led because:

- The leadership, governance and culture did not always support the delivery of high quality person-centred care.
- The health based places of safety breached guidance and were not fit for purpose. This had not been resolved with the acute trusts that managed the estate where these were situated. The trust was not providing a service that was safe in those areas. This was not on the trust's risk register.
- Most staff told us that they felt that trust senior management were remote and seldom seen on the wards. Staff knew who the senior managers were locally. However, they had not met nor knew who the executive and non-executive directors were.
- 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, they did not address all ligature risks and an unacceptable number of ligature risks remained at the St Pancras site. Monitoring systems were inconsistent across the trust. There was no standardised system to record supervision and appraisals. There was a lack of consistency in the quality, storage and format of supervision. Supervision records lacked clear staff objectives.
- The trust was reliant on the use of bank and agency nurses to fill vacant shifts. Patients and staff reported difficulties in accessing leave, ward activities and outside space when extra staffing was not available.
- The trust did not ensure that staff met 80% compliance rate for mandatory training across the services. 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. Staff on Montague and Amber ward had not had an annual appraisal and appraisal compliance rates in other areas were below the trust standard. The trust could not be sure that performance issues or development opportunities were discussed with staff working in the acute services.
- There was no team leader in place at Islington early intervention service and a lack of management input. Staff morale was low in this team.
- Staff in some teams were not able to submit items to the trust risk register, this was completed at divisional level with no local or team risk registers. The trust had not addressed the issues with the electronic case records in a timely way and there was no plan in place to resolve this.

However:

- Most staff were aware of the visions and values of the trust. Senior nurses and managers in some teams were highly visible, approachable and supportive.
- The provider used balance score cards to gauge performance of teams. The scorecards were presented in an accessible format. Not all teams were using these.
- Staff said they felt supported to raise concerns without fear of victimisation. Staff told us morale and job satisfaction was good.
- Staff were committed to improving the service by participating in research. They had been innovative in implementing a 'Brain food' group that was making a positive difference to service users.
- Some wards were using the 'Productive Ward – Releasing Time to Care' materials. The 'Productive Ward' initiative encouraged staff to think about how time may be wasted so they can spend more time with patients.
- Ward managers had sufficient authority to run the ward and administration support to help them. Staff were provided with opportunities for leadership training at ward management level
- Staff knew how to use the whistle-blowing process and said they felt able to raise concerns without fear of victimisation. Staff said that they felt supported by senior managers.

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Our inspection team

Our inspection team was led by:

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

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

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

The team included four inspection managers, twelve inspectors, six Mental Health Act reviewers, a pharmacy inspector, support staff and a variety of specialists. The specialists included consultant psychiatrists, specialist nurses in mental health, substance misuse and learning disabilities, psychologists, occupational therapists and social workers.

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

When we inspect, we always ask the following five questions of every service and provider:

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

Before visiting, we reviewed a range of information we hold about Camden and Islington NHS Foundation Trust and asked other organisations to share what they knew. We spoke with commissioners, local Healthwatch and local service user groups. We looked at information received from service users and carers and members of the public who had contacted the CQC about this trust.

We carried out an announced visit between 21 and 25 February 2016.

Prior to and during the visit the team:

- Held focus groups with ten different staff groups.
- Spoke with 115 patients and 20 carers and family members and collected feedback using comment cards.
- Attended six multidisciplinary meetings.
- Attended seven community treatment appointments, and six home visits.
- Looked at the personal care or treatment records of 247 patients and service users, including medication cards.
- Looked at patients' legal documentation including the records of people subject to community treatment.
- Observed how staff were caring for people.
- Observed six patient group meetings.
- Interviewed more than 300 staff members at all levels.
- Looked at 54 staff records.
- Reviewed information we had asked the trust to provide.

We visited all of the trust's hospital locations and community mental health services.

We inspected all wards across the trust including adult acute services, the psychiatric intensive care unit (PICU), rehabilitation wards and older people's wards. We looked at the trust's places of safety under section 136 of the

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Mental Health Act. We inspected learning disability and older people's community services and the trust's crisis services. We visited a sample of adult community and substance misuse services.

Information about the provider

Camden and Islington NHS Foundation Trust provide mental health services across the boroughs of Camden and Islington, to a population of around 431,000. The trust has 120 beds.

In addition the trust provides substance misuse services in Westminster, and a substance misuse and psychological therapies service to people living in Kingston. Camden and Islington NHS FT Trust provides services to adults of working age, adults with learning difficulties and older people. There are no children's mental health services provided. Early intervention services are provided from age 14. There is a high mobile population consisting of students and people moving in and out of the area. The population is very diverse with over 200 languages spoken.

It provides the following core services:

- Community-based mental health services for older people
- Long stay/rehabilitation mental health wards for working age adults
- Acute wards for adults of working age and psychiatric intensive care unite
- Wards for older people with mental health problems
- Community-based mental health services for adults of working age
- Mental Health crisis services and health based places of safety
- Community mental health services for people with learning disabilities
- Substance misuse services

Camden and Islington NHS Foundation Trust has a total of three registered locations: Highgate Mental Health Centre; St Pancras Hospital and Stacey Street Nursing Home (the latter of which falls under adult social care).

Camden and Islington NHS Foundation Trust was formed in April 2002 and became a foundation trust in 2008. It now has an income of about £141 million and employs approximately 1700 staff.

Camden and Islington NHS Foundation Trust has been inspected nine times across their three sites since registration. Out of these, there have been five inspections covering the two locations which are registered for mental health conditions.

Camden and Islington NHS Foundation Trust was inspected as a whole trust pilot comprehensive inspection in May 2014. We did not rate them for this inspection. We inspected some acute wards and community services as unannounced inspections in August 2015.

Of the services we have inspected there are some locations which have previous and still outstanding, non-compliance. They include action to improve recruitment to vacancies, management of medicines, provision of psychological therapies, and the use of the Mental Capacity Act and Deprivation of Liberty Safeguards.

There have been 19 Mental Health Act reviewer visits between 7 March 2014 and 6 October 2015 which raised 84 issues in total. We require providers to produce a statement of the actions that they will take as a result of a monitoring visit.

What people who use the provider's services say

We spoke with 115 patients and 20 carers.

- We received positive feedback about the services. Patients told us that they had good relationships with staff and felt well supported by them. Comments highlighted that staff understood individual needs, they were helpful and supportive and that they could not do enough for the service users. Patients told us staff treated them with respect and dignity. Patients told us they knew how to make a complaint or compliment about the service.

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- Carers in the older adults' services spoke highly of the care and treatment their relative received. Carers on both wards said they had been involved when appropriate in creating care plans with the patient and multi-disciplinary team. Carers said they were welcomed onto the ward and kept appropriately informed about the patient. Carers said they felt confident to raise concerns with staff.
- Other carers told us their relative or friend was supported by the team and support was also available for them. One patient told us that their family member had completed a carer's assessment with staff and were able to receive additional support.

Good practice

- The Islington learning disabilities service had set-up and were running, twice a month, a "health hub" from their premises. The health hub related to the physical health of patients using the service. Staff would speak with patients about their physical health and support patients to have a health check. Information was also provided for patients to make choices about their physical health care. We saw a range of information was available in easy to read format, which covered topics such as medicines, eating healthy, staying healthy in the community, sexual health and health appointments. The team was proud of the health hub and we found this to be good practice.
- A lead practitioner at the Camden Memory service set up a 'brain food' group for service users. The group offered five 90-minute sessions over a three months period. The group was based on research that a Mediterranean diet provides high quality nutrients that positively affects energy levels and the ability to think clearly. The group is in its infancy but staff explained that feedback is encouraging and there has been some improvement in service users' mini mental state examinations scores. Staff had applied for a funding grant in order to complete a research paper and continue this piece of work.
- In the older adults community service staff offered families and carers' access to psychological therapies. One therapy offered was a strategy for relatives of people living with dementia (START programme). Staff offered cognitive stimulation therapy to families and carers if the service user did not want to engage in the programme. This enabled them to try the activities at home to improve the well-being of the service user
- The older adult inpatient wards had implemented a robust action plan to reduce the number of patient falls. 'Fallstop' initiatives led by the matron for the prevention of falls and fractures were in use across wards. The older adults wards had seen a reduction of 20% in the number of falls since implementing the Fallstop guidance.
- We saw good working practise within the partnerships in care (PIC) team which was commissioned as part of the services for people diagnosed with a personality disorder. The PIC offered consultation, joint working and training and did not hold a caseload of patients. The aim of PIC was to upskill staff and provide advice where appropriate on referral to specialist mental health services.
- Camden and Islington NHS Foundation Trust substance misuse services provided a specialist service for people addicted to 'club drugs' and stimulants. Clients accessed the service via the Grip Clinic in response to the increasing use of these drugs in the local area. The service supports people to understand the psychological and physical effects of these drugs and helps people make decisions about safer use, reducing harm and making changes.

Areas for improvement

Action the provider MUST take to improve

- The trust must take action to ensure the environment is safe and remove identified ligature risks and ensure that ligature risk assessments contain plans for staff to manage risks, including mitigation for obstructed lines of sight. The trust must address the identified safety concerns in the health-based places of safety.

Summary of findings

- The trust must ensure that repairs to the patient care areas are completed in a timely manner.
- The trust must ensure there are robust and effective governance systems to monitor the quality, performance and risk management of services including the following: record keeping - risk assessments are fully completed and updated, safeguarding information is recorded appropriately and clearly, medication reviews take place in line with guidance and are fully recorded, that MHA documentation is correctly stored and completed, that all electronic records are fully completed; individual practitioner caseloads, that staff training records includes specialised training, and that supervision records are fully completed.
- The trust must ensure that all medical equipment is checked regularly, that stickers are placed on the equipment stating date of inspection and staff update the inspection register regularly.
- The trust must ensure that the clinic and medication storage fridge temperatures are regularly recorded.
- The trust must ensure that patients' rights under section 132 MHA are repeated in accordance with the MHA Code of Practice (2015), including that patients are informed of their right to access the Independent Mental Health Advocacy Service.
- The trust must ensure that that all staff receive an annual appraisal.
- The trust must ensure that that all staff receive an annual appraisal.

Action the provider SHOULD take to improve

- The trust should ensure that patients are allocated a care coordinator where appropriate.
- The trust should ensure signs are clearly displayed to inform people who are using the service that closed circuit television is in operation.

North London NHS Foundation Trust

Detailed findings

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 ran a Mental Health Law (MHL) Training Programme (which included both Mental Health Act and Mental Capacity Act training). They stated that none of the MHL training courses was considered mandatory, therefore compliance rates were not provided but this training was seen as essential for certain categories of staff. Receipt and acceptance of statutory documents is an essential role for all receiving officers as per the trust scheme of delegation, including MHA officers and band 6 duty nurses. This training plan was agreed in the MHL training meeting and ratified by the MHL Committee. The trust provided details of their MHL Training Plan 2015-16.
- Compliance for Mental Health Act (MHA) and Mental Capacity Act (MCA) training was low with some staff not receiving any training at all in MHA or MCA. Some staff were not aware of their responsibilities under the MHA and MCA. The trust set a target of 80% for mandatory training.
- Section 17 leave papers, section 117 aftercare meeting papers and consent to treatment forms were missing from the electronic database and no hard copies were available. Section 17 leave forms lacked information related to terms and conditions of leave. Staff did not regularly inform patients of their rights under the MHA or record consent to treatment properly.
- The trust's policy on MHA was available for staff to access and staff could seek advice when needed.
- Independent mental health advocacy services were available for patients but not all were aware of this.
- There were 19 MHA review visits between March 2014 and September 2015 which highlighted issues for the trust to learn from and action. The top 3 issues were as follows: issues with evidence of patient capacity to treatment (16 issues), missing or insufficiently filled out care plans (16 issues) and poor management of discussion of rights on admission (13 issues).
- Issues around capacity to consent and management of section 132 rights had been picked up in audits on the use of the MHA.

Mental Capacity Act and Deprivation of Liberty Safeguards

The CQC have made a public commitment to reviewing provider adherence to MCA and DoLS.

- There was a lack of consistency in how patients' mental capacity was assessed and recorded. Staff's lack of understanding of the MCA had been identified in previous inspections. The trust reported the training completion rate for the Mental Capacity Act and DoLS from October 2014 to October 2015 was 26%. Training had been completed by 336 of the 1417 staff eligible. This was an annual training course.
- The trust's policy on MCA and DoLS was available for staff to access and staff could seek advice when needed. The trust had recently appointed a MCA manager.

Detailed findings

- Between May and October 2015 the trust listed that four Mental Health Deprivation of Liberty Standards applications had been made relating to mental health services. Three of the four related to acute/adult psychiatric intensive care and one in the older adult ward, Pearl ward.
- The risk register reflected a risk around MCA. The trust recognised a risk of not having suitable arrangements in place for ensuring staff have appropriate knowledge (of MCA or DoLS). This meant that decisions were being made that might not take into account people's human rights.

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

Summary of findings

We rated Camden and Islington NHS Foundation trust as requires improvement for safe because:

- There were a number of concerns about environments. In the health based places of safety the environment was not suitable. Patients in the health based place of safety at the accident and emergency department in the Royal Free hospital had to walk past other cubicles to use the toilet. The premises do not meet the guidance in the Mental Health Act code of practice or from the Royal College of Psychiatrist's. The toilet also had ligature points in which could be used by a patient to self harm. The places of safety were housed in the acute hospital and were cleaned by their staff but the trust had not ensured the environment was clean and well maintained. Facilities at two of the three health based places of safety did not promote dignity, recovery, comfort or confidentiality for people using this service.
- We received limited assurance about safety. For example we identified ligature points in wards which had not been removed or measures put in place to mitigate risks. In some wards staff could not see all parts of the ward, there were blind spots and no mirrors to mitigate risk. Three staff on Garnet ward did not know where the ligature cutters (equipment to cut safely through materials used to self harm) were kept, other wards did not have any ligature cutters. 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. At the Highgate Mental Health Unit, we found one ward had identified a new fitting as a ligature risk in an assessment, but other wards had not identified the same problem. Therefore, other wards had no plan in place to manage this risk and staff were unaware of it.
- The service had breached the eliminating mixed sex accommodation guidance at Highview, there were five bedrooms on the second floor, four used by females and one by a male, there was evidence that this male had used the female facilities on that floor. The trust had not completed urgent repairs on three wards, at St Pancras, in a timely manner.
- Some teams did not have a designated clinic or interview area for carrying out physical examinations or private consultations. We found essential emergency equipment was not present, or was perished. Emergency equipment was not always checked to make sure it was clean and functioning. There was no emergency equipment available at any of the sites visited in the community based mental health services for adults of working age. We found some emergency equipment out of date. There was emergency equipment available in rehabilitation services but some of the equipment such as airways and syringes was out of date. Other equipment such as weighing scales had not been re-calibrated.
- Aspects of medicines management required improvement in four community services. Staff in some of the rehabilitation service administered medicines from a locked cupboard in the main office, which was neither private nor practical. Medicines storage temperatures were not monitored consistently in two areas, so there was no assurance that medicines were kept at the right temperature. In the community adult service, medicines were not transported safely as we saw staff transporting medication in their handbags. Prescribers in the substance misuse service did not see clients for formal medication reviews regularly. We found one example where a doctor last saw a client in 2013. Staff in substance misuse services did not always complete medication records in full including information about client allergies, pharmacy details and medical histories. Medicines records were not completed fully in the North Camden crisis team.

Requires improvement

Are services safe?

- Risk assessments were not always kept up to date and amended following a change in circumstances. Others lacked pertinent detail.
- Not all community staff had access to lone worker devices. Staff were not adhering to the trusts lone working policy, compromising staff safety.
- Safeguarding was not always given sufficient priority. Safeguarding referrals for other services within the trust was being processed through community based adult mental health teams. The safeguarding referrals were being sent to email addresses within the community based mental health teams where the service was operating nine to five office hours. This meant referrals made out of hours were not being seen until the next working day. Staff were unclear how to make a safeguarding referral out of hours or at weekends. Staff did not always record safeguarding information appropriately and clearly.
- There were periods of understaffing. There was a high reliance on bank and agency staff in some teams, although the trust tried to ensure continuity of care. Caseloads were not monitored in all teams. Compliance with mandatory training did not meet the trust target of 80% in most teams.

However:

- We found some good examples of risk assessments, crisis and contingency plans. All patients in the rehabilitation teams had an up to date risk assessment.
- Staff knew what incidents needed to be reported and ensured that incident forms were completed and recorded. Staff in some teams received feedback from investigations of incidents both internal and external to the service in monthly team meetings and via email. Staff were able to describe their duty of candour as the need to be open and honest with patients when things go wrong. There were systems in place for tracking and learning from safeguarding and other reportable incidents.
- In substance misuse service 94% of staff had attended their mandatory training, 96% attended safeguarding training. Staff were able to describe what actions could amount to abuse and knew what action to take.
- Some teams were fully established with all vacancies filled. Ward managers were able to adjust staffing numbers depending on the patient need on a day to day basis. All services had rapid access to a consultant psychiatrist when required.
- 'Fallstop', a risk management tool for falls, was in use in all inpatient wards. Staff received regular training on the prevention of falls which was ongoing. A full time matron for falls and fractures prevention was in post. Assessments were in use to manage the risk of pressure ulcers. A tissue viability nurse was available to give specialist input to the management of pressure ulcers. There was access to specialist pressure ulcer prevention equipment when required.
- The trust had an up to date infection control policy. We found most areas were clean and tidy.

Our findings

Safe and clean environment

- The trust had an estates strategy to cover 2014 to 2019. The trust undertook a programme of environmental health and safety checks. Ligature risk assessments were reviewed as part of this programme. The trust had completed a programme to reduce the number of ligature points at Highgate mental health unit. We found many ligature points and blind spots at St Pancras acute wards and in the rehabilitation services, Malachite and Aberdeen Park. There were no ligature cutters (equipment to cut safely through materials used to self harm) available at Malachite and Aberdeen Park. Three nursing staff on Garnet ward did not know where the ligature cutters were kept. Staff identified ligature points using the ligature audits but did not always detail plans for how staff could manage these risks.
- During inspection environmental risks were identified in two of the three health based places of safety used for adults. This included potential ligature points and limited ability to observe people who were detained under section 136 of the Mental Health Act. To access bathrooms, patients had to be escorted across the A&E department at the Royal Free health based place of safety. This was a risk to other patients who may be

very ill and also a potential absconsion risk. The environment was not clean or well maintained and did not meet required standards as laid down in the Mental Health Act Code of Practice.

- Generally staff were aware of the risks to patients' safety caused by the environment and had assessed patients' individual risks and increased their observation level as needed. 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.
- Emergency equipment checks were not available in all areas to look at what staff checked and how often. We found essential emergency equipment was not present, or was perished. Staff in the health based places of safety told us they checked the defibrillator was present, but did not check that it was functional. Staff on one acute ward had not replaced the defibrillator pads following a recent incident, this was a risk to patient safety. There was no emergency equipment available at any of the sites visited in the community based mental health services for adults of working age. There was emergency equipment available in rehabilitation services but some of the equipment such as airways and syringes was out of date. Scales had not been re-calibrated in some teams.
- The rehabilitation service at Highview had breached the eliminating mixed sex accommodation guidance, there were five bedrooms on the second floor, four used by females and one by a male, there was evidence that this male had used the female facilities on that floor.
- The four beds for people with a diagnosis of learning disabilities on Dunkley ward were in the same room and the beds were only separated by curtains. This did not promote privacy and dignity.
- Fire procedures and equipment were in place at all services. Staff had received fire safety training and were aware of what to do in an emergency.
- The trust had an infection control committee that oversaw a programme of audit for this work. Hand hygiene and infection control audits were regularly undertaken across services and showed that staff demonstrated good hand hygiene. Staff received infection control practice as part of mandatory training. Staff followed infection control procedures. Hand gels and other equipment was readily available and in use. Inpatient services had hand-washing facilities readily available.
- All clinic rooms we visited appeared clean and most were fit for purpose. However, we were concerned there was no designated clinic or interview area for carrying out physical examinations or private consultations at Highview and Aberdeen Park. The clinic room fridge temperature at North Camden recovery team was not being recorded regularly, meaning that staff would not know if the fridge temperature had gone over the optimum range, this meant that medication that should have been disposed of may have still been used. On Pearl ward the clinic room and fridge temperature records showed gaps in recording, the worst being a week of no monitoring between 15 February 2016 and 22 February 2016.
- Patients had access to appropriate nurse call systems on most wards. However, in Aberdeen Park and Highview there were no alarms fitted to either bathrooms or bedrooms, so people requiring urgent assistance in these private areas would not be able to access help easily. Staff carried personal alarms when appropriate. Not all community staff had access to lone worker devices. Staff were not adhering to the trusts lone working policy, compromising staff safety.
- In the 2015 patient-led assessments of the care environment (PLACE)the trust scored higher than the England average compared to other mental health or community health service trusts for cleanliness, food, organisation food and privacy, dignity and wellbeing. The trust scored lower than the England average for condition, appearance and maintenance and dementia friendly environment. Camden Road rehabilitation service scored lower than the England average for all areas.

Safe staffing

The board reviewed overall staffing levels on a monthly basis. The trust used a safe staffing toolkit to review staffing levels in 2015. The following was the situation in September 2015:

- Total number of substantive staff 1,541
- Total number of substantive staff leavers in the last 12 months 287
- Total % vacancies overall (excluding seconded staff) 9.2%

Requires improvement

Are services safe?

- Total % permanent staff sickness overall 3.2%
- Establishment levels qualified nurses (WTE) 415
- Establishment levels nursing assistants (WTE) 288
- Number of WTE vacancies qualified nurses 5.5
- Number of WTE vacancies nursing assistants 86
- Number of shifts filled by bank or agency staff to cover sickness, absence or vacancies 7309
- Number of shifts not filled by bank or agency staff where there is sickness, absence or vacancies 471 (6%)
- The crisis and place of safety core service had the highest vacancy rate of 21.7% for qualified nurses, vacancies not specified to a core service had a rate of 21.6%.
- At 30 September 2015 the staff sickness rate for the previous 12 months was 3.2%. The highest of these were the Camden Assessment Team at St. Pancras Hospital and the team at 154 Camden Road which both had a sickness rate of 12%. The trust's sickness rate of 3.2% (at 30 Sept 2015) is below the most recent national data show that the average sickness rate for mental health and learning disability trusts was 4.6% as at August 2015.
- The overall trust turnover rate was 19% for October 2014 to September 2015. The psychology staff at St. Pancras Hospital had the highest turnover rate, for a team with five or more staff with 75%. The trust informed the CQC that the high turnover rate was an artefact of a number of temporary contracts given during the period. This was a planned approach to maintain service provision during a renegotiation of the service provision with Whittington Health. The service in its new form will be in place from 1 April 2016.
- The trust stated they had spent 13% of their total pay bill on temporary staffing last year. There were targets set by Monitor that the trust works to adhere to, as well as their internal financial target to reduce agency/ bank staffing by year end alongside an active recruitment campaign. In 2014/15, the trust spent £12,020 in total on temporary staff, of which £6,135 was on agency/ contract staff. The balance was on bank staff from NHS Professionals. The trust stated it had met the Monitor cap and had not been in breach since its commencement in October 2015.
- The trust acknowledged challenges regarding recruitment and retention but told us that they are working hard to address this issue. We saw a recruitment strategy, action plans and positive information about recruitment initiatives.
- Ward managers indicated that they were able to request additional staff to undertake observations. When necessary, regular bank and agency staff were used who knew the ward and patient group. There was a high reliance on bank and agency staff in the acute wards.
- Consultant psychiatrists and junior doctors were accessible within the services. When they were not immediately available, they were contactable by telephone.
- In some services compliance with mandatory training for the service was below the trust target of 80%. In older adults community compliance was 71%. For community based mental health services, with the exception of North Camden recovery team who had a 100% compliance rate for Mental Capacity Act and DoLS training, 32% of staff had completed safeguarding children training,65% of staff had completed adult safeguarding training, 25% of staff had completed mental capacity act and DoLS training, 70% of staff had completed information governance training, 74% of staff had completed infection control training and 74% of staff had completed manual handling. Compliance figures submitted for equality and diversity training and fire and safety awareness training showed that over 75% of staff were compliant. In the acute wards overall staff compliance with mandatory training was 66%. However in the learning disabilities service compliance with mandatory training was at 94%. In the NHS staff survey 2014 the trust scored about the same as other mental health trusts for questions relating to the percentage of staff receiving job relevant training and health and safety training.
- Caseloads were not monitored in all community teams. Staffing levels at North Camden Drug Service (NCDS) meant that the recovery practitioner held the caseload of 184 clients. Six out of 15 patients at 154 Camden Road did not have a nominated community care coordinator.

Assessing and managing risk to patients and staff

- We looked at the quality of individual risk assessments. Usually these addressed risks in most inpatient and community mental health services. However, there was a lack of detail in risk formulation and management plans at Islington early intervention service, South Islington recovery team, and Islington assertive outreach team. Not all teams made sure risk assessments were

updated following an incident or change in circumstances. For example in the substance misuse teams risk assessments were not updated following medication reviews.

- There were 40 incidents of seclusion and 179 incidents of restraint in the preceding six months. The vast majority of these took place in the adult / PICU wards, with Coral Ward showing the highest number of incidents, with 36 seclusions and 43 restraints. Sapphire Ward showed the second highest restraints with 24. Coral Ward is a PICU ward and has a different function to other acute wards. It is the only ward with a seclusion facility. Sapphire Ward is an assessment ward. The 179 incidents of restraint involved 111 patients.
- Of the 179 incidents 67 resulted in the patient being in the prone position, which means they were lying on their front, 51 of these resulted in rapid tranquilisation where the patient was given medication to help calm them down quickly. The trust was working towards reducing the use of restraint, particularly prone restraint as recommended in the Department of health guidance: Positive and Proactive Care: reducing the need for restrictive interventions (2014).
- Policies and procedures were in place and had been updated covering the management of aggression, physical intervention, seclusion and segregation. These policies had been reviewed to reflect latest guidance regarding the safe management of patients in a prone position and addressed the specialist needs of children or people with a learning disability, autism or a physical condition. However, we noted that the trust seclusion policy was dated December 2014, which pre-dated the revised Mental Health Act code of practice.
- Most patients were not subject to blanket restrictions. However, several patients in the rehabilitation services told us that they were not happy about the trust's blanket policy of not allowing people to have a bath without supervision. Staff advised us that this was trust policy following decisions taken after a serious untoward incident had occurred elsewhere in the trust.
- At our inspection in May 2014, we noted that improvements were needed to transportation and recording of medicines in the crisis resolution and home treatment teams, the recording of physical observations after people received medicines for rapid tranquilisation, and action was needed on the areas of risk identified in the medicines risk register.
- At this inspection, we saw that improvements had been made, and medicines were managed well in some of the core services; however we found continuing issues with recording in one crisis team and issues with a few aspects of medicines management in three community services.
- A pharmacy inspector reviewed treatment records. Medicines were prescribed in line with trust policy and current national guidance.
- When people were detained under the Mental Health Act, the appropriate legal authorities were in place for medicines to be administered, and were kept with people's prescription charts. When we checked a sample of prescription charts in each of the areas of the trust we inspected, we saw that these were completed fully in all areas providing evidence that people were receiving their medicines safely and as prescribed, except for two community teams, the substance misuse service and the North Camden crisis team, where records were not complete.
- Medicines were stored securely, and access to medicines was controlled appropriately, except in the community adult service where medicines were not being transported safely. Temperature monitoring of medicines storage areas was carried out regularly in all areas we inspected, providing assurance that medicines were stored at the correct temperatures to remain safe and effective, except in two areas, Pearl Ward and the North Camden recovery team.
- There were safe and effective processes for controlled drugs. In the services we inspected, there were suitable cupboards to store controlled drugs, and accurate records kept. Incidents involving controlled and illicit drugs were reported via the incident reporting system and stocks were checked regularly by ward and pharmacy staff. There was a process for handling illicit drugs found on the wards. The process did not require staff to record illicit drugs in the CD register although we were told it was common practise to do so, and we found illicit drugs in the CD cupboard on Jade Ward which hadn't been recorded in the CD register.
- Arrangements for the supply of medicines were good. Patients and staff in all of the locations we inspected told us that they did not experience any delays in receiving their medicines, both on the wards and on discharge from the trust. The pharmacy department at Highgate Mental Health Centre supplied medicines for the trust, with a satellite dispensary at St Pancras. There

was an agreement with the Whittington Hospital to provide out-of- hours advice and medicines. Staff told us that discharge from the wards was not delayed due to waiting for medicines for people to take home, as these were pre-ordered and held on in-patient wards.

- The trust has worked to improve medicines safety since the last trust inspection, including the appointment of a medicines safety officer although the person had recently left the post, and a replacement was lined up for April 2016. We saw that medicines incident reporting had improved; incidents were investigated by the medicines safety officer and discussed at governance meetings. There was evidence of shared learning and changes to processes after medicines incidents, including a medicines safety bulletin. The trust provided a good clinical pharmacy service to all in-patient areas, making clinical interventions with medicines to improve patient safety.
- There was a trust high dose antipsychotic (HDA) policy. People prescribed HDA medicines were identified by the pharmacy team, the reason for prescribing over the recommended dose was recorded in people's notes, and HDA monitoring forms were used to record that the necessary physical monitoring had been carried out or offered. This process was in place in all areas except for the community-based service for adults.
- There were convenient arrangements in place for community patients on clozapine. Clozapine clinics were on-site, located next to the pharmacy, where people were able to have blood tests, receive their results straight away and have their medicines dispensed at the same time without delays. To assist with the clinics, one of the pharmacists is a non-medical prescriber.
- The medicines management policy had been updated in September 2015 and was supported by all necessary procedures, including procedures for self-administration, covert administration, off licence medicines and the use of patient-own medicines. Although medicines training was not mandatory, there was a medicines training programme, and plans to begin medicines e-learning for both nursing and non-nursing staff. Pharmacy staff facilitated medicines education groups and 1:1 patient counselling.
- There was a more extensive medicines auditing programme compared to at our last inspection, including audits of safe storage, controlled drugs, medicine reconciliation, and a number of prescribing audits led by the lead mental health trust pharmacist, such as audits of high dose anti psychotics and hypnotics. The results of these audits were discussed at the drugs and therapeutics committee meetings and we were shown evidence that improvements have been made following on from these audits. The most recent rapid tranquilisation audit from 2015 showed that the recording of physical observations after people received rapid tranquilisation had improved from 2014 however it was still lower than expected. There was very little or no use of rapid tranquilisation on all of the wards we inspected. Trust audits showed that the pharmacy team were completing the target percentage of medicines reconciliation during the patient's hospital stay. Medicines reconciliation is a formal process of obtaining and verifying a complete and accurate list of each patient's current .
- Information about medicines was available in all areas, although people self-administering their medicines in the rehabilitation service told us that they did not fully understand their medicines and what side effects to look for. There was little recorded evidence that the side effects of medicines was monitored, however the chief pharmacist told us that there was a trust project looking into the monitoring of medicines.
- Processes for medicines administration were safe and respected people's privacy, except in two areas. In Aberdeen Park and Highview, staff administered medicines from a locked cupboard in the main office, which was neither private nor practical. On one inpatient ward for older people, Garnet ward, appropriate agreements were in place for covert administration and crushing medicines for people with swallowing difficulties, however the same tablet crusher was being used for several patients, and contained medication powder residue from previous medications, which was a potential safety issue. The manager immediately ordered four more sets of tablet crushers.
- There was very low use of anti-psychotic and sedating medicines for older people and risks due to medicines were now considered as part of people's falls risk assessments.
- All inpatient ward staff used 'Fallstop', a risk management tool for falls. Prevention of fall training was regular and ongoing. A full time matron for falls and fractures prevention was in post. Assessments were in use to manage the risk of pressure ulcers.

Requires improvement

Are services safe?

- The trust provided a copy of their trust risk register for the quarter July to September 2015.This detailed 42 risks which scored at 12 or higher. Three had a risk rating of 20, 11 had a risk rating of 16, three had a risk rating of 15 and the remaining 25 had a risk rating of 12.

The three items with a risk rating of 20 are summarised below:

1. Pressure and demand on acute beds impacting on quality of care, and resulting in increased clinical risk for service users who are experiencing delays to admission. In addition significant financial overspend. This risk was added to the risk register on 24 September 2013 and was last reviewed on 25 September 2015. The blockages to progress for this risk were listed as funding and estate for bed capacity. The trust has noted that since mid-July 2015 there were three female PICU service users in private acute beds as at 25 September 2015. There were no acute and no male PICU patients in private beds. The trust's significant anti ligature programme required closure of an entire ward for over one year. This ligature programme allowed the trust to make improvements to the safety of the environment, following feedback from the last CQC inspection.
2. Lack of trust-wide clinical risk assessment training and risk management approach. This risk was added to the risk register on 30 May 2014 and was last reviewed on 24 September 2015. There was one action overdue on the action plan for this risk which related to the trust's capacity to deliver training against the demand. The trust stated that by the end of 2015 they will have trained 150 staff and this includes all the newly qualified nurses that had been recently recruited. The latest trust risk register for July to September 2015 showed 121 staff had received risk training.Potential risk to trust staff and contracted staff from exposure to asbestos containing materials recently found in the boiler house, service tunnels and south wing plant room at the St Pancras site. Potential reputational damage to the trust as the buildings had previously been certified asbestos free. This risk was added to the risk register on 22 September 2015. The gaps in control and assurance for this risk were that no one in the trust was trained in asbestos management. The trust is legally required to have a competent person with the qualification 406 Managing Asbestos in Buildings. The trust identified and trained a member of staff to fulfil this role by the time of our inspection. The trust provided the action plan for the management of the asbestos and removal where possible.There was a risk around quality and reputational risks arising from coronial inquests listed on the trust's risk register (risk ID NR164). This risk was added on 13 September 2013 and was last reviewed on 24 September 2015. The seven gaps in control / assurance were as follows:
3. Unpredictable nature of inquests meant it was difficult to predict press coverage, and there was a lack of resource in the communications department.

- The trust had not yet built a strong relationship with the new Coroner at St Pancras Court.
- Tight timescales for disclosure of statements and other relevant documents. Coroners can impose a fine of up to £1000 for not meeting deadlines.
- Trust had no legal services manager and limited capacity within current governance structure to support timely management of inquest process. A legal services manager has since been appointed.
- Lack of capacity within service to deliver timely serious incident investigations and implement recommendations.
- Trust had received 13 Prevention of Future Death Reports. All actions the trust has in place are either complete or on target.
- There had been no safeguarding alerts raised with CQC. There were four safeguarding concerns raised with CQC for the trust's mental health services since 1 October 2014. These related to some inpatient wards and crisis teams. Safeguarding alerts are where the CQC are the first receiver of information about abuse or possible abuse, or where we may need to take immediate action to ensure that people are safe. Safeguarding concerns are where the CQC are not the first receiver of information about abuse, and there is no immediate need for us to take regulatory action. For example, where we are told about abuse, possible abuse or alleged abuse in a regulated setting by a local safeguarding authority or the police.
- Safeguarding was not always given sufficient priority. The trust had policies in place relating to safeguarding procedures. Additional guidance was available to staff via a flow chart which was on display in some services for staff to refer to.Safeguarding referrals for other services within the trust was being processed through

community based adult mental health teams. The safeguarding referrals were being sent to email addresses within the community based mental health teams where the service was operating nine to five office hours. This meant referrals made out of hours were not being seen until the next working day. Staff were unclear how to make a safeguarding referral out of hours or at weekends. Staff did not always record safeguarding information appropriately and clearly. Compliance in training for safeguarding was not meeting the trust target in some services especially in the community adult service.

- Five whistleblowing enquiries were raised with the CQC regarding the trust since 1 October 2014. These included concerns about inpatient wards and crisis teams.

Track record on safety

- We analysed data about safety incidents from three sources: incidents reported by the trust to the National Reporting and Learning system (NRLS) and to the Strategic Executive Information System (STEIS) and serious incidents reported by staff to the trust's own incident reporting system (SIRI). These three sources were not directly comparable because they used different definitions of severity and type and not all incidents were reported to all sources. For example, the NRLS does not collect information about staff incidents, health and safety incidents or security incidents.
- Providers are encouraged to report all patient safety incidents of any severity to the NRLS at least once a month. The average time taken for the trust to report incidents to NRLS was 15 days for incidents reported between 1 October 2014 and 30 September 2015. The most recent patient safety incident report covering 1 October 2014 to 31 March 2015 stated that for all mental health organisations, 50% of all incidents were submitted to the NRLS (by all MH trusts) more than 26 days after the incident occurred. For Camden and Islington, 50% of incidents were submitted more than 7 days after the incident occurred.
- The trust reported a total of 2,684 incidents to the NRLS between 1 October 2014 and 30 September 2015. When benchmarked the trust were in the middle 50% of reporters of incidents when compared with similar trusts. Of the 2,684 incidents reported to NRLS, 2224 resulted in no harm, 349 in low harm, 102 in moderate harm, 2 in severe harm and 7 in death. The NRLS considers that trusts that report more incidents than average and have a higher proportion of reported incidents that are no or low harm have a maturing safety culture.
- Of the incidents reported to NRLS, 22% were related to access, admission, transfer, discharge (including missing patient), 20% to patient accident and 14% to disruptive, aggressive behaviour (includes patient-to-patient).
- Trusts are required to report serious incidents to STEIS. These include never events which are serious patient safety incidents that are wholly preventable. The trust reported 88 serious incidents between 1 October 2014 and 30 September 2015. None of these was a never event. The top three types of incidents were as follows: 21 were classed as apparent/actual/suspected self-inflicted harm, 16 were unexpected death of a community patient in receipt of services and 13 were pending review. 75 of the 88 incidents were shown as ongoing on STEIS when the data were extracted on 14 December 2015. In terms of core service the highest number of STEIS serious incidents was as follows: Community adults (17); community, other specialist services (15) and substance misuse (15).
- The trust also records serious incidents (or SIRI). Between 1 October 2014 and 30 September 2015, there were 83 serious incidents reported. Thirty of these related to deaths, 26 were suicides and 22 were incidents resulting in severe harm. The core service with largest number of serious incidents was the crisis services with 20 incidents followed by community adults with 18 incidents.
- The number of the most severe incidents recorded by the trust incident reporting system was 83 and was different to that reported to STEIS at 88. There were five more reported to STEIS compared to the SIRI data provided by the trust.
- Some of the responses to questions in the NHS Staff Survey 2014 provided circumstantial evidence about the culture of safety and incident reporting. The trust was in the worst 20% of all mental health and learning disability trusts for the question related to those who had witnessed potentially harmful errors, near misses or incidents in last month, along with the question about them agreeing that they would feel secure raising concerns about unsafe clinical practice.
- The NHS Safety Thermometer measures a monthly snapshot of four areas of harm including falls and pressure ulcers. The safety thermometer data showed

that there were four new pressure ulcers relating to mental health services as follows: Garnet ward had one each in January, March and May 2015; and Pearl ward had one in May 2015.Garnet and Pearl were the older adults' wards.

- Between November 2014 and November 2015, the safety thermometer results showed there were five falls with harm throughout the year (a 0.6% incidence rate due to a patient sample of 816). The breakdown was as follows: one each in November 2014 on Pearl ward and December 2014 on Garnet ward; two in January 2015, one was on Jasper ward and the other on Pearl ward and one in August 2015 in Islington older adults' community team.

Any risks relating to patient safety were detailed in the trust's risk register.

- The trust were flagged as an elevated risk for, trusts flagging for risk in relation to the number of deaths of patients detained under the Mental Health Act and also specifically for, trusts flagging for risk in the number of suicides of patients detained under the Mental Health Act (all ages). This was based on 2014 data.

Reporting incidents and learning from when things go wrong

- From the 88 serious incidents recorded on STEIS between 1 October 2014 and 30 September 2015, 74 were listed as ongoing with the remaining 14 classed as closed.
- The trust provided us with 14 Prevention of Future Deaths (PFD) reports which they received regarding deaths of service users who had been receiving treatment from them between 22 October 2013 and 12 November 2015. These reports are produced by local coroners following deaths, with the intention of learning lessons from the cause of death and providing recommendations to prevent future deaths from occurring.
- The breakdown by core service for the 14 PFD reports can be seen below, with the highest number relating to crisis services who received eight, one of which also related to the community adult teams). The South Camden Crisis and Resolution team and Islington Crisis team were both mentioned in two reports each. One report related to a service user who was in contact about admission to Rivers Crisis House. Another report related to a service user who was under the care of Islington Crisis Team and another service user who had been referred to the team. Camden and Islington Mental Health Assessment Team, North Camden Crisis Team and the approved mental health professional team were all involved in communications about service users prior to death.
- The main themes in two or more prevention of future death reports were, delay in finding a bed, observations whilst service users were bathing, failure to ask the suicide question, information sharing or accessibility of information within the trust and communication between teams and external agencies (e.g. police / GP), delays in Mental Health Act assessment, insufficient information on patient notes.
- All staff could describe what an incident was and how to report it using the reporting system. Incidents were investigated and learning identified. However, learning was not always shared with all relevant staff, it was usually done through team meetings or by email and this meant some staff missed it if they were off duty or didn't pick up their emails. We saw some evidence of learning from incidents.

Duty of Candour

- In November 2014 the CQC introduced a requirement for NHS trusts to be open and transparent with people who use services and other 'relevant persons' in relation to care and treatment and particularly when things go wrong.
- The trust had a policy to guide staff in relation to their responsibilities under duty of candour. Staff we spoke with knew about their responsibilities and the need for openness and transparency when things went wrong. We examined case records where patients had experienced a notifiable event to check that staff had been open and honest in their dealings with patients and carers. We found that the trust was meeting its duty of candour responsibilities.

Anticipation and planning of risk

- The trust had an emergency planning policy which had been successfully implemented in a live situation the week before the inspection.

Requires improvement

Are services effective?

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

Summary of findings

We rated Camden and Islington NHS Foundation trust as requires improvement for effective because:

- Record keeping was disorganised in paper files which meant information was difficult to find and could lead to key information being missed. Confidentiality was breached in some teams where patient names on files in the office could be seen by others. Staff had not stored hard copy care plans and legal documents effectively.
- Some care plans were not person centred or holistic. Patients had not signed their care plans because care plans were completed electronically separately from the patient appointment. There were gaps in records. In the learning disabilities service there were two electronic recording systems in operation in each team that did not link to each other at all, meaning that information may be entered twice on some occasions or being recorded on one system but not the other. In order to address this, the teams had a protocol that identified their social care system as their primary record where all information should routinely be stored, with defined information being up loaded to the trust system when the patient was in hospital or at risk of going into hospital.
- Compliance for Mental Health Act (MHA) and Mental Capacity Act (MCA) training were low with some staff not receiving any training at all in MHA or MCA. Some staff were not aware of their responsibilities under the MHA and MCA.
- Section 17 leave papers, section 117 aftercare meeting papers and consent to treatment forms were missing from the electronic database and no hard copies were available. Section 17 leave forms lacked information related to terms and conditions of leave. Staff did not regularly inform patients of their rights under the MHA or record consent to treatment properly. Some patients were not told of their right to have an advocate. There was a lack of consistency in how patients' mental capacity was assessed and recorded.
- There was a trust system in place to identify patients who were prescribed high dose antipsychotics or lithium, and to carry out the necessary monitoring. However this was not being followed in the community-based mental health services for adults of working age, so these patients were not being effectively monitored.
- At North Camden recovery team, only one out of five patients had a record of physical health checks being carried out when they needed one.
- There were gaps in the management and support arrangements for staff, such as appraisal, supervision and professional development. Managers reported that staff received in house specialist training but some managers did not keep a record of staff's attendance centrally. Compliance with appraisal was low across most teams. Staff on Montague ward and Amber ward had not received an annual appraisal. Although staff received supervision sufficient records were not always kept.

However:

- Patients' physical health needs were assessed and were monitored by most teams, apart from North Camden recovery team. Patients were able to access specialist care for physical health care problems. Staff in the older adults' teams assessed and recorded in case records capacity to consent for people who might have impaired capacity at every appointment. In the rehabilitation service care plans were holistic and up to date and created using resident's own life stories, likes, and dislikes. Residents received regular health checks and examinations when necessary from the local GP surgeries. We saw evidence of how staff had supported residents to access local GP's. Staff used the recovery approach to focus their treatment interventions.

Requires improvement

Are services effective?

- Staff followed guidelines from the National Institute for Health and Care Excellence (NICE) when prescribing medication. A range of nationally recognised outcome tools were used.
- A range of multi-disciplinary team (MDT) meetings took place on a regular basis. The MDT was made up of psychiatrists, activity co-ordinators, pharmacists, nurses and support workers. Staff from community teams attended the weekly inpatient ward round to ensure that patients that they were involved in discharge planning. Handovers between shifts were effective and included relevant information for staff. Wards had dedicated psychologist support that provided one to one as well as group sessions for patients.
- In the older adults' service 100% of staff received monthly clinical and managerial supervision and 93% of non-medical staff who had received an appraisal in the last 12 months.
- The trust had an audit programme and most staff were actively involved in clinical audit.

Our findings

Assessment of needs and planning of care

- Generally we found the care plans were detailed, individualised to the patients' needs and showed the patients' involvement in the care planning process. In the majority of mental health services people's care needs and risks were assessed and care plans had been put in place. Some care plans were not person centred or holistic, patients had not signed their care plans because care plans were completed electronically separately from the patient appointment. There were gaps in records.
- The quality of records was variable. In the acute wards many care plans did not include the full range of patients' problems and needs, or consider discharge planning. In the substance misuse services staff did not fully complete assessment. Information was missing about physical health, mental health and safeguarding. Staff said the electronic system in the substance misuse teams was difficult to navigate and information was missed.
- A number of electronic record systems were in operation as well as paper records. Some teams used partial electronic and partial paper notes. This made it difficult to follow information and meant that the trust could not ensure that people's records were accurate, complete and up to date. In the learning disabilities service there were two electronic recording systems in operation in each team that did not link to each other at all, meaning that information may be entered twice on some occasions or being recorded on one system but not the other. In order to address this, the teams had a protocol that identified the social care system as their primary record where all information should routinely be stored, with defined information being up loaded to the trust system when the patient was in hospital or at risk of going into hospital.
- Record keeping was disorganised in paper files which meant information was difficult to find and could lead to key information being missed. Confidentiality was breached in some teams where patient names on files in the office could be seen by others. Staff had not stored hard copy care plans and legal documents effectively. There was a risk on the trust risk register, for the quarter July to September 2015, around paper based medical records. The risk was added on 7 May 2015 and this risk was marked as overdue, although it was to be revised on 30 November 2015.

Best practice in treatment and care

- Staff followed guidelines from the National Institute for Health and Care Excellence (NICE) when providing care and treatment. Within services patients' physical health needs were usually identified. Patients had a physical healthcare check completed by the doctor on admission and their physical healthcare needs were being met. Physical health examinations and assessments were usually documented by medical staff following the patients' admission to the ward. Ongoing monitoring of physical health problems was taking place. However, at North Camden recovery team we found evidence of regular physical health checks being

carried out for only one of five patients who were identified as requiring them. There was no equipment such as urine analysis and blood pressure machines to facilitate health checks at North Camden recovery team.

- Outcomes measures, such as health of the nation outcome scores, were used in all services.
- There was a comprehensive audit programme. Staff in some teams were actively involved in audits whilst in other teams the audits tended to be undertaken by the managers and so staff were unaware of them.
- The trust provided documentation for participation in the National Audit of Schizophrenia, six documents detailing participation in the National Audit of Psychological Therapies, nine internal safety audit reports, eight documents in reference to a Clinical Audit Event and four documents showing participation in the Prescribing Observatory for Mental Health.

Skilled staff to deliver care

- All teams consisted of a range of disciplines including psychiatrist, nurses, social workers, occupational therapist, psychologists, support workers and administration staff.
- Training was completed on a 12 month rolling programme for all annual refresher training (i.e. if completed in January then refresher would due the following January).
- Completion rates for the (annual) Mental Capacity Act and DoLS training course were the lowest at 26%. The safeguarding children course completion rate was also low at 35%. The trust stated that this had been impacted by changes in safeguarding children requirements, which led to a high number of staff falling out of compliance and was being addressed by a programme of update training. Compliance for Mental Health Act (MHA) training was low with some staff not receiving any training at all in MHA or MCA.
- The trust scored in the bottom 20% of all mental health trusts in the NHS staff survey 2014 for % of staff having equality and diversity training in the last 12 months. This was evident in the interviews we had with staff.
- At 30 November 2015 the percentage of non-medical staff at the trust who had an appraisal in the last 12 months was 72%. Learning disabilities teams was 100%, out of 11 staff and acute adult/PICU was 53% out of 108 staff. The trust was in the lowest 20% of mental health and learning disability trusts in the 2014 NHS staff survey for the proportion of staff who had received an appraisal in last 12 months. This was flagged as having dropped significantly from the previous survey.
- The trust moved to an open appraisal system, with appraisals done throughout the year and not in a window from April to July. This was a planned change as part of their organisational development strategy and a move towards micro coaching, the trust recognised that objectives needed more regular review and staff appreciated three annual micro coaching sessions rather than one annual meeting.
- The trust was flagged as a risk for the proportion of staff who had received an appraisal in last 12 months based on 2014 data.
- The trust sent through details regarding nine mandatory training courses for the previous 12 month period, October 2014 to October 2015.Details were received for 161 teams, 111 are specified by core service, the other 50 being included in other.
- Staff told us that they had access to skills specific training to ensure they could meet the demands of their work roles but all managers did not keep records of this training. For example managers could not evidence the specialised training staff had received to work with people with substance misuse problems. A tissue viability nurse was available to give specialist input to the management of pressure ulcers. There was access to specialist pressure ulcer prevention equipment when required.

Multi-disciplinary and inter-agency team work

- The results of the NHS staff survey 2014 found that the trust scored 3.89, slightly better than the average of 3.84, relating to effective team working.
- We observed effective multi-disciplinary working. Where appropriate staff held regular multi-disciplinary team meetings in which staff considered all aspects of the patient's care. This included a discussion on risk, discharge, consent and capacity in most cases.

Requires improvement

Are services effective?

- We observed effective handovers between shifts in the inpatient areas. Staff worked well with local services such as GP surgeries, a leisure centre, shops, and cafes, and had good relationships with the local authorities and housing departments.

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

- The trust ran a Mental Health Law (MHL) training programme (which includes both MHA and MCA training). They stated that, none of the MHL training courses was considered mandatory. Compliance rates were not provided but the trust saw the training as essential to the role for certain categories of staff, for example staff who received legal documents such as section papers. This training plan was agreed in the MHL training meeting and ratified by the MHL committee. The trust provided details of their MHL training plan 2015-16.
- Compliance for Mental Health Act (MHA) and Mental Capacity Act (MCA) training was low with some staff not receiving any training at all in MHA or MCA. Some staff were not aware of their responsibilities under the MHA and MCA. The trust set a target of 80% for mandatory training.
- Nineteen MHA reviewer visits between March 2014 and September 2015 highlighted issues for the trust to learn from and action. The top three issues were as follows: issues with evidence of patient capacity to treatment (16 issues), missing or insufficiently filled out care plans (16 issues) and poor management of discussion of rights on admission (13 issues).
- Section 17 leave papers, section 117 aftercare meeting papers and consent to treatment forms were missing from the electronic database and no hard copies were available. Section 17 leave forms lacked information related to terms and conditions of leave. Staff did not regularly inform patients of their rights under the MHA or record consent to treatment properly.
- The trust's policy on MHA was available for staff to access and staff could seek advice when needed. However, the issues we identified had not been picked up in any MHA audits.
- Independent mental health advocacy services were available for patients but not all were aware of this.

Good practice in applying the Mental Capacity Act

- The trust reported the training completion rate for the Mental Capacity Act and Deprivation of Liberty Safeguards within the 12 months October 2014 to October 2015 was 26%. This was completed by 336 of the 1417 staff eligible. This is an annual training course.
- Between May and October 2015 the trust listed that four Deprivation of Liberty Standards applications were made relating to mental health services. Three of the four related to acute/PICU, specifically the four learning disability beds on Dunkley ward and one in Pearl Ward which is for older adults.
- Previous MHA reviewer visits highlighted issues with evidence of the patient's capacity to consent to treatment.
- The risk register reflected a risk around MCA. The trust recognised a risk of not having suitable arrangements in place for ensuring staff had appropriate knowledge (of MCA or DoLS). This meant that decisions were made that might not take into account people's human rights. This was added to the risk register on 30 September 2014 and was last reviewed on 9 October 2015. Risks were flagged regarding the suitability of arrangements in place for obtaining and acting in accordance with the consent of people or where that did not apply for establishing and acting in accordance with people's best interests. Fourteen actions have been taken, 12 are complete and two are ongoing.
- There was a lack of consistency in how patients' mental capacity was assessed and recorded. Staff's lack of understanding of the MCA had been identified in previous inspections. The trust reported the training completion rate for the Mental Capacity Act and DoLS from October 2014 to October 2015 was 26%. Training had been completed by 336 of the 1417 staff eligible. This was an annual training course.
- The trust's policy on MCA and DoLS was available for staff to access and staff could seek advice when needed.
- Between May and October 2015 the trust listed that four Mental Health Deprivation of Liberty Standards applications had been made relating to mental health services. Three of the four relate to acute/adult psychiatric intensive care and one in the older adult ward, Pearl Ward.

Good

Are services caring?

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

Summary of findings

We rated Camden and Islington NHS Foundation trust as good for caring because:

- Staff treated patients with care, compassion and communicating effectively. They spoke with patients in a kind and respectful manner. Staff had a good understanding of the personal, cultural and religious needs of patients. Staff were passionate and enthusiastic about providing care to patients with complex needs. They demonstrated good understanding of the care and treatment needs of these patients.
- Most care records showed that patients had been involved in the planning of their care and treatment. Carers spoke highly of the care their relatives received.
- Staff in the older adults' community team offered families and carers access to psychological therapies. For example strategies for relatives of people living with dementia (START) and cognitive stimulation therapy (CST).
- Service users and families were able to give feedback on the care they receive by completing the family and friends test and satisfaction surveys.
- Advocacy services were provided.

However:

- Records did not consistently show patient involvement in care and treatment options. Care plans did not always include the patients' views. Staff did not always clearly document the level of involvement of patients in their care plan or reasons why patients had not been involved. Some patients had not signed their care plan to indicate agreement with it.
- Several at Aberdeen Park and Highview told us that they were not happy about the trust's blanket policy of not allowing people to have a bath without supervision. Staff advised us that this was trust policy following decisions taken after a serious untoward incident had occurred elsewhere in the trust.

Our findings

Kindness, dignity, respect and support

- We observed staff interactions with service users and their families in a variety of settings, found that they were responsive, respectful, and provided appropriate practical and emotional support. Staff were committed to working in partnership with people to ensure that the service users felt supported and safe. Staff treated patients with care, compassion. Staff had a good understanding of the personal, cultural and religious needs of patients.
- In Aberdeen Park and Highview several residents told us that they were not happy about the trust's blanket policy of not allowing people to have a bath without supervision. Staff advised us that this was trust policy following decisions taken after a serious untoward incident had occurred elsewhere in the trust.
- The Trust's overall score for privacy, dignity and wellbeing in the PLACE 2015 was 93% which was above the England average of 91%.
- There were four individual issues raised with the CQC via the share your experience web form. These included physical threat and restraints of patients on Jade ward, patient property stolen or taken away by staff, communication problems, staff making untrue accusations about family members, rough handling by staff when restraining, senior staff behaving in an unaccountable manner, staff rushing and producing inaccurate reports, patients/carers suffering, extreme risk to the well-being of patients and a service user suffered a fall whilst in the care of the trust but no explanation provided as to what had happened.

Good

Are services caring?

- The percentage of trust staff feeling satisfied with the quality of work and patient care they deliver from the NHS staff survey 2014 was 73%, which was a decrease from the 2013 result of 76%. It was also below the England average of MH/LD Trusts of 76%. The highest score for mental health and learning disabilities was 89%.
- The latest friends and family test data, in quarter two 2015/16, showed that 62.5% of respondents were either likely or extremely likely to recommend the trust as a place to receive care this was below the England average of 78.7%.
- The trust performed similarly to other trusts in the CQC community mental health patient experience survey 2015 for the question relating to 'Do the people you see through NHS Mental Health services understand what is important to you in your life?'; 'Do the people you see through NHS Mental Health Services help you with what is important to you?'; 'Did the person or people you saw listen carefully to you?'; 'Were you given enough time to discuss your needs and treatment?'; and 'Did the person or people you saw understand how your Mental Health needs affect other areas of your life?'

The involvement of people in the care they receive

- Most care records showed that patients had been involved in the planning of their care and treatment. However, in the older adults' wards and community adults services the records did not always show the involvement of the patient. Patients were not always offered a copy of their care plan. Staff in the substance misuse service did not record that clients were offered a copy of their recovery plan. Care plans did not always include the patients' views.
- However, in the community rehabilitation service we saw evidence of how residents had been involved in planning their weekly activity schedules. Weekly house meeting records showed how residents had been involved in reviewing house rules and daily running of Aberdeen Park and Highview.
- Staff in substance misuse service wrote the recovery plans in a way that did not demonstrate that clients have set the goals.
- Service users and families were able to give feedback on the care they receive by completing the family and friends test and satisfaction surveys.
- The trust performed similarly to other trusts in the CQC community mental health patient experience survey 2015 for questions relating to 'Have you been told who is in charge of organising your care and services?' How well does this person organise the care and services you need? 'Were you involved as much as you wanted to be in agreeing what care you will receive?
- MHA reviewer visits highlighted issues with missing or insufficiently filled out care plans and no or poorly managed discussion of rights record on admission.
- The trust was flagged as an elevated risk for, whether the patient was provided with written information, or an appropriate alternative about the most recent antipsychotic prescribed. However, this was based on 2013 data.
- The trust performed similarly to other trusts regarding CQC community mental health patient experience survey 2015 'Do you know how to contact this person if you have a concern about your care?'
- The trust scored lower (poorer score) than other trusts for the question 'Were you involved as much as you wanted to be in discussing how your care is working?'
- The trust scored higher (better) than other trusts for the question 'Have NHS mental health services given you information about getting support from people with experience of the same mental health needs?'
- In the older adults' community service staff offered families and carers access to psychological therapies. For example staff offered strategies for relatives of people living with dementia (START) and cognitive stimulation therapy (CST).

Requires improvement

Are services responsive to people's needs?

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

Summary of findings

We rated Camden and Islington NHS Foundation trust as requires improvement for responsive because:

- Waiting times in some services were long. The waiting time for psychological support with the complex depression, anxiety and trauma service (CDAT) was one year. The assessment and advice team had a waiting list for routine referrals to be seen for an initial assessment of five weeks. North Camden recovery team had a patient waiting list for therapy of nine months, the personality disorder service had a waiting list to be allocated to a care coordinator of 16 weeks and a 12 month wait for therapy.
- The trust is not commissioned to provide female psychiatric intensive care (PICU) beds. Female patients requiring a PICU bed were placed away from their local area.
- The trust had four learning disability beds 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. The requirement for a learning disabilities bed was escalated via the bed managers. These patients were supported through the learning disabilities multidisciplinary team. The trust did not employ any learning disability trained nurses on the inpatient wards.
- Staff in the rehabilitation service said that when patients went on leave their beds were sometimes used for patients from other wards. This meant that patients returning from leave would not have access to their room until a bed was found for the patient who was sleeping over. The four wards had a bed occupancy of more than 85% over the last six months.
- Some wards at St Pancras had insufficient rooms for care and treatment. Several wards at the 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 has some wards on upper floors. Patients requiring a nurse escort reported difficulties accessing outside space when wards were busy or staffing was low.
- There were limited information leaflets in languages other than English available most of the services inspected, although they were made available upon request.

However:

- Services took active steps to engage with patients reluctant to engage or who did not attend appointments.
- 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.
- Patients could make telephone calls in private. Patients had access to outside space, although this proved difficult for patients on the wards on the upper floors. Patients were able to personalise their bedrooms. A range of activities was provided in the inpatient areas throughout the week.
- There was disabled access for most buildings. The environment in older adults wards had been adapted to meet the needs of the patients, signage was easy to read and at eye level.
- In the learning disabilities service information was available in both easy to read and standard formats.
- Information about the complaints process, and feedback process, was available as an easy to read leaflet. Information about meeting spiritual needs, independent advocacy, access to interpreters, making a complaint and local services for carers was displayed in most areas. Patients said that they had access to appropriate spiritual support and were able to visit church or mosque and see the Iman.
- There was a robust and effective complaints process. Patients and carers in all services knew how to make

Requires improvement

Are services responsive to people's needs?

a complaint. Staff tried to resolve complaints at a local level. If unable to they became formal complaints that were referred to the trust complaints team. Staff knew how to respond to complaints and said that outcomes of investigations were discussed at the weekly ward business meeting.

Our findings

Service planning

- The trust used information about the local population when planning service developments and delivering services. The trust had good working relationships with commissioners and other stakeholders. There were close links with the commissioners and ongoing discussions about developments to improve services.

Access and discharge

- The trust performed below the England average for the proportion of patients on the care programme approach followed up within seven days of being discharged from a psychiatric inpatient unit, for four of the seven quarters between October 2013 and June 2015. There were 102 out of area placements between 1 June 2015 and 1 December 2015.
- In the learning disabilities service there was a single point of referral to each community learning disability team. Each service had a maximum waiting time target which was met and neither team had a waiting list. In the older adults' service staff prioritised service users referred to the service from primary care, or who were not receiving support from another service. Managers reported that were able to see urgent referrals quickly. Staff in the community adult service responded promptly when patients called the service. The services had clear referral criteria. Staff took active steps to engage with patients reluctant to engage or who did not attend appointments.
- In substance misuse the services that were the first point of contact for clients offered open access drop in sessions so people did not need to wait for formal appointments to start treatment. The service had clear criteria for clients that would be offered support. Staff understood the criteria of other services in the partnership and would sign post appropriately. All services completed engagement plans with clients that listed ways in which staff could support them to stay in treatment if they started to disengage. Clients gave examples of how staff had adjusted treatment to respond to their individual need.
- The waiting time for psychological support with the complex depression, anxiety and trauma service (CDAT) was one year. The assessment and advice team had a waiting list for routine referrals to be seen for an initial assessment of five weeks. North Camden recovery team had a patient waiting list for therapy of nine months. The personality disorder service had a waiting list to be allocated to a care coordinator of 16 weeks and a 12 month wait for therapy.
- 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.
- Between 1 May and 31 October 2015 the average bed occupancy rate was 96.8% across the 15 wards. The information on bed occupancy excludes leave and AWOL and relates to total patients occupying bed overnight / total bed days for period. Malachite Ward had a bed occupancy rate at 103.5% over the six month period. Both Jade ward and Amber ward had occupancy rates of 101.1% and 100.4% respectively.
- The trust has noted that they do not manage the bed base by ward. The mean occupancy for acute inpatient wards to date for this year was as follows:

  April 2015 - 97%

  May 2015 - 97%

  June 2015 - 97%

  July 2015 - 96%

  August 2015 - 96%

- The trust was flagged as a risk for, bed occupancy ratio, looking at the average daily number of beds available and the occupied beds open overnight. They are also flagged as a risk for occupancy ratio, looking at the number of detained patients allocated to a location compared with the number of available beds. This is based on 2014 data.

Requires improvement

Are services responsive to people's needs?

- The average length of stay data were provided for 11 wards across the trust, both for average stays across the 12 month period from 1 December 2014 to 30 November 2015 and also for patients at 17 December 2015. For each ward details were provided according to the electronic patient record (EPR) system, with correction for altered ward stay start dates, and also according to the inpatient dashboard.
- Taking the EPR data, Coral, the PICU ward, had the highest length of stay over the 12 months with 151 days on average. However, for current patients the longest average length of stay was at Rosewood unit at 199 days.
- Patients in the rehabilitation services had the opportunity to visit the ward before their transfer to meet the staff. However, they told us their bed was sometimes used for other patients when they were on leave.
- There were 97 readmissions within 90 days reported by the trust between May and October 2015 across 12 wards. The wards with the highest number of readmissions within 90 days were Sapphire ward with 22, this is an assessment ward, Amber ward with 16 and Jade ward with 13 these are acute treatment wards.
- During April to September 2015 there were a total of 17 new delayed transfers of care across all wards, figures were not been provided for by ward. Owing to the planned ligature works programme, there had been times during the period where ward teams had moved sites. When this occurred, service users and teams moved together and retained their ward name.
- In July and August 2015, readmission rates in 28 days were:

  St Pancras July 10.2%, August 4.1%.

  Highgate July 10.5%, August 4.0%.
- Between October 2013 and June 2015 the trust performed below the England average for delayed transfers of care in four of the seven quarters.
- The trust proportion of admissions to acute wards gate kept by the crisis resolution home treatment team has been above the England average for three of the past four quarters, although this slipped below in the last reported quarter July to September 2015 (from 100% to 96%). Each quarter was above the England target of 95%.

The facilities promote recovery, comfort, dignity and confidentiality

- Some wards at St Pancras had insufficient rooms for care and treatment. Several wards at the 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 has some wards on upper floors. Patients requiring a nurse escort reported difficulties accessing outside space when wards were busy or staffing was low.
- Patients could make telephone calls in private. Patients had access to outside space, although this proved difficult for patients on the wards on the upper floors. Patients were able to personalise their bedrooms rooms. A range of activities was provided in the inpatient areas throughout the week.
- In the 2015 Patient-led assessments of the care environment (PLACE) the overall trust score for food was above the England average at 91%.
- The information leaflets we saw were written in the English language, however translation services where used as necessary. Information was available in both easy to read and standard formats. Information about the complaints process, and feedback process, was available as an easy to read leaflet when appropriate Information about meeting spiritual needs, independent advocacy, access to interpreters, making a complaint and local services for carers was displayed. However, we found limited easy read information available on the rehabilitation units. Residents told us that they did not always understand their care plans and other information given to them.
- Staff in older adults' teams provided an information pack at the point of assessment, which also provided information on treatments, local services, patients' rights, and advocacy and how to complain. On Garnet ward care plans were placed in the patient bedrooms to provide guidance for staff when caring for the patient. Easy read signage was positioned at eye level on both wards. Activity programmes were available in all inpatient areas.

Requires improvement

Are services responsive to people's needs?

Meeting the needs of all people who use the service

- The trust reported that there had been one complaint related to equality and diversity which was upheld. A patient used homophobic language towards another patient on Jade Ward. Some acute wards had adopted interventions from the 'Safe wards' programme, to promote reduced conflict within inpatient settings.
- There was a risk on the trust risk register for the quarter July to September 2015 around the lack of diversity at senior and board levels. The action plan to address this risk included the plan to investigate potential board apprentice programme and the equality and diversity plan which set a target of 25% of the board to be from Black and Minority Ethnic (BME) communities within four years.
- The trust recognised equality and diversity as an area where they aim to do better in their Quality Assurance Framework.
- The trust hosted two diversity forums with an external organisation specialising in improving diversity and inclusion at work. The aim was to explore the experiences of BME staff working within the trust as they represent 41% of the workforce. The external organisation, a specialist in the field, facilitated the event which was led by the Director of Nursing and People and the Chief Operating Office so they could listen to black staff talking about what it is like to be black and work in the trust.The trust has shared the report with staff and is working together with staff on the findings as part of its Workforce Race Equality Standards (WRES).
- Sixteen BME members attended a trust forum, with 61 BME members having completed the online questionnaire. The results of this questionnaire were collated after 13 November 2015 and used to inform the trust's Equality and Diversity Strategy (EDS) and action plan.
- The trust produced the Equality and Health Inequalities Action Plan 2015–18. The action plan has been developed around the EDS goals and outcomes and has been aligned with CQC standards and includes Equality Objectives and Workforce Race Equality Standards (WRES).
- The trust detailed four goals which are summarised below. The information as to whether the trust was on target with meeting these goals was unknown because the rating column had not been populated in the source document).

  EDS Goal 1: Better health outcomes for all

  EDS Goal 2: Improved patient access and experience

  EDS Goal 3: A representative and supported workforce

  EDS Goal 4: Inclusive Leadership
- There was disabled access to all services we visited. The trust had four learning disability beds on Dunkley ward. 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 did not employ any learning disability trained nurses on the inpatient wards. The trust has some wards on upper floors. Patients requiring 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 the Highgate Mental Health Unit had no cups or crockery for patient use. Patients reported having to ask staff to access drinks and snacks.

Listening to and learning from concerns and complaints

- The trust received 181 formal complaints in 2014/15 and of these 9.4% was fully upheld. In addition to this, 275 concerns were resolved informally. No complaints were referred to the Ombudsmen.
- There were 71 complaints about aspects of clinical treatment and 27 about the attitude of staff received between November 2014 and November 2015. 32 of the 71 and 9 of the 27 were either partially or fully upheld.
- Community-based mental health services for adults received the highest number of complaints during the 12 month period, 82 complaints were received with two fully upheld and 27 partially upheld.
- The substance misuse and long stay rehabilitation wards both received the lowest number of complaints, three for each core service. None of these complaints was upheld.
- The trust received 14 compliments during the last 12 months, 1 December 2014 to 30 November 2015

Requires improvement

Are services responsive to people's needs?

through their advice and complaints team. These data reflect only compliments formally shared with the team, and as such did not capture the majority of compliments which came via other informal routes. From October to December 2015 236 compliments were received via the trust's online feedback system.

- In terms of formal compliments there were:
- Seven for Highgate Mental Health Centre
- Seven for St Pancras Hospital
- The highest number of compliments by core service was five compliments received for adult community services.

Requires improvement

Are services well-led?

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

Summary of findings

We rated Camden and Islington NHS Foundation trust as requires improvement for well-led because:

- The leadership, governance and culture did not always support the delivery of high quality person-centred care.
- The health based places of safety breached guidance and were not fit for purpose. This had not been resolved with the acute trusts that managed the estate where these were situated. The trust was not providing a service that was safe in those areas. This was not on the trust's risk register.
- Most staff told us that they felt that trust senior management were remote and seldom seen on the wards. Staff knew who the senior managers were locally. However, they had not met nor knew who the executive and non-executive directors were.
- 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, they did not address all ligature risks and an unacceptable number of ligature risks remained at the St Pancras site. Monitoring systems were inconsistent across the trust. There was no standardised system to record supervision and appraisals. There was a lack of consistency in the quality, storage and format of supervision. Supervision records lacked clear staff objectives.
- The trust was reliant on the use of bank and agency nurses to fill vacant shifts. Patients and staff reported difficulties in accessing leave, ward activities and outside space when extra staffing was not available.
- The trust did not ensure that staff met 80% compliance rate for mandatory training across the services. 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. Staff on Montague and Amber ward had not had an annual appraisal and appraisal compliance rates in other areas were below the trust standard. The trust could not be sure that performance issues or development opportunities were discussed with staff working in the acute services.
- There was no team leader in place at Islington early intervention service and a lack of management input. Staff morale was low in this team.
- Staff in some teams were not able to submit items to the trust risk register, this was completed at divisional level with no local or team risk registers. The trust had not addressed the issues with the electronic case records in a timely way and there was no plan in place to resolve this.

However:

- Most staff were aware of the visions and values of the trust. Senior nurses and managers in some teams were highly visible, approachable and supportive.
- The provider used balance score cards to gauge performance of teams. The scorecards were presented in an accessible format. Not all teams were using these.
- Staff said they felt supported to raise concerns without fear of victimisation. Staff told us morale and job satisfaction was good.
- Staff were committed to improving the service by participating in research. They had been innovative in implementing a 'Brain food' group that was making a positive difference to service users.

Requires improvement

Are services well-led?

- Some wards were using the 'Productive Ward – Releasing Time to Care' materials. The 'Productive Ward' initiative encouraged staff to think about how time may be wasted so they can spend more time with patients.
- Ward managers had sufficient authority to run the ward and administration support to help them. Staff were provided with opportunities for leadership training at ward management level
- Staff knew how to use the whistle-blowing process and said they felt able to raise concerns without fear of victimisation. Staff said that they felt supported by senior managers.

Our findings

Vision, values and strategy

- The trust had six values which were as follows: Welcoming, Respectful, Kind, Professional, Positive and Working as a team.
- The board of directors agreed the following principal objectives for 2014/16 :

1. We will provide service users with the highest quality and safest care possible within existing resources using the latest research and best practice
2. We will design, recruit, manage, and develop the best possible workforce for the future within existing resources, one that is competent to deliver the highest possible quality of care to our service users, now and in the future
3. We will keep to budget as part of our long term financial plan, while delivering value for money efficiencies
4. We will continue to develop, in partnerships with others, accessible new services, which will enable the trust to continue to grow
5. We will develop an Estate Strategy which will enable us to progress our plans and vision for the trust's usage of the St Pancras Hospital site
6. We will increase the effectiveness of the Board of Directors and Council of Governors through improved governance systems, greater transparency and a programme of engagement
7. We will work in partnership with commissioners and providers to enable new integrated solutions, which will meet the mental health needs of the population.

- Posters were on display in all services. Progress on achieving the objectives was monitored by the trust board. Most staff were aware of the visions and values of the trust. Senior nurses and local managers were highly visible, approachable and supportive. However, in older adults' services most staff told us that they felt that trust senior management were remote and seldom seen on the wards. Staff knew who the senior managers were locally however they had not met nor knew who the executive and non-executive directors were.

Good governance

- The trust provided a copy of their Quality Assurance Framework (QAF) which was published in October 2015 which defined the approach the trust takes to ensure services are delivered at a high quality standard through every step of the patient journey, and for each of the three quality dimensions: patient safety, clinical effectiveness and patient experience. The trust has said that the QAF was closely aligned with the standards set for us by our regulators, the Care Quality Commission.
- The QAF had three key elements which were: the integrated quality assurance dashboard; internal quality assurance reviews; and Improvement plans for services with quality concerns. It contains information about the approach to assessing and monitoring quality, and the approach taken to ensure slippage against any standard is identified and addressed effectively.
- The trust provided a copy of their board assurance framework' for 2015/16.This document detailed major risks to the process of achieving the trust's identified seven priority objectives for 2015/16. The audit and risk committee monitored the implementation of action plans as well as the cross over between the board assurance framework and the risk register as set out in the trust's risk management strategy. The seven objectives were as follows:

1. We will provide service users with the highest quality and safest care possible within existing resources using the latest research and best practice

Requires improvement

Are services well-led?

2. We will design, recruit, manage and develop the best possible workforce for the future within existing resources, one that is competent to deliver the highest possible quality of care to our service users now and in the future.
3. We will keep to budget as part of our long term financial plan, while delivering value for money and efficiencies.
4. We will continue to develop in partnership with others, accessible, innovative new services which will enable the trust to continue to grow.
5. We will develop an estates strategy which will enable us to progress our plans and vision for the trust's usage of the SPH site.
6. We will increase the effectiveness of the Board of Directors and Council of Governors through improved governance systems, greater transparency and a programme of engagement.
7. We will work in partnership with commissioners and providers to enable new integrated solutions which will meet the mental health needs of the population.

- The trust produced a mental health crisis care concordat local action plan. The actions were identified as key to improving the interagency response in relation to people in crisis because of their mental health condition. There were 27 actions under the following categories:

1. Commissioning, strategy and infrastructure to support responsive high quality crisis services
2. Improved information about crisis services and how to access them
3. Improved urgent and emergency access to crisis care
4. Improved experience of crisis care
5. Improved quality of response when people are detained under Section 135 and 136 of the Mental Health Act 1983
6. Improved crisis prevention and planning
7. Children and young people's action plan

- The trust produced a handbook which set out the Board of Directors committee structure, with their respective terms of reference, decision making powers, membership and planned dates of future meetings.
- The trust was rated as satisfactory in the 2014/15 information governance toolkit.
- Board minutes showed the trust had performed solidly over the last year and had only missed its planned year-end surplus by a small margin. Income and operating surplus had both increased on the previous year, allowing headway to develop new services.
- The arrangements for governance and performance management did not always operate effectively. Although the trust was aware of the issues in relation to the health based places of safety the directors and senior management had not taken this on board fully nor addressed the issues with the acute trust. The issue was not on the trust risk register nor mentioned in the estates strategy.
- 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, they did not address all ligature risks and an unacceptable number of ligature risks remained at the St Pancras site.
- Staff knew what incidents needed to be reported and ensured that incident forms were completed and recorded. Staff in some teams received feedback from investigations of incidents both internal and external to the service in monthly team meetings and via email. Staff were able to describe their duty of candour as the need to be open and honest with patients when things go wrong. There were systems in place for tracking and learning from safeguarding and other reportable incidents. The trust was working towards reducing the use of restraint, particularly prone restraint as recommended in the Department of health guidance: Positive and Proactive Care: reducing the need for restrictive interventions (2014).
- Safeguarding was not always given sufficient priority. Safeguarding referrals for other services within the trust was being processed through community based adult mental health teams. The safeguarding referrals were being sent to email addresses within the community based mental health teams where the service was operating nine to five office hours. This meant referrals made out of hours were not being seen until the next working day. Staff were unclear how to make a safeguarding referral out of hours or at weekends. Staff did not always record safeguarding information appropriately and clearly.

Requires improvement

Are services well-led?

- 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. Use of the dashboard was inconsistent across the trust.
- In substance misuse services managers did not record specialised training that staff had attended. The managers had not addressed the issues with the electronic case records in a timely way and there was no plan in place to resolve this. The substance misuse service was not meeting all contractual targets, particularly discharging people from the service in a positive, planned way.
- There was a comprehensive audit programme. Staff in some teams were actively involved in audits whilst in other teams the audits tended to be undertaken by the managers and so staff were unaware of them.
- Most team managers had a local risk register for the service, which they completed and monitored in monthly senior management meetings. However, staff in the community teams told us they felt they were not able to submit items to the trust risk register, this was completed at divisional level with no local or team risk registers. Ward managers had sufficient authority to run the ward and administration support to help them.
- Acute services had a high reliance on the use of bank and agency nurses to fill vacant shifts. Patients and staff reported difficulties in accessing leave, ward activities and outside space when extra staffing was not available. Although the managers tried to use consistent bank or agency staff when possible.
- Some managers across the trust did not ensure that staff met 80% compliance rate for mandatory training. Compliance for Mental Health Act (MHA) and Mental Capacity Act (MCA) training were low with some staff not receiving any training at all in MHA or MCA. Some staff were not aware of their responsibilities under the MHA and MCA. Appraisal rates were low across the trust and staff on Montague and Amber ward had not had an annual appraisal.
- Most staff had access to supervision on a regular basis and we saw evidence of this. However in the substance misuse service supervision records were poor quality and did not reflect that staff were able to use this time to discuss their personal development. In community adult services there was no standardised system in place to record supervision and audits. There was a lack of consistency in the quality, storage and format of supervision. Supervision records lacked clear staff objectives.
- Neither the manager nor staff at Aberdeen Park and Highview were compliant with, or understood, their responsibilities for administering and monitoring the Mental Health Act. There was no administrative support for the manager who was covering both Aberdeen Park and Highview.

Fit and proper persons test

- The trust provided three documents which detailed their policy and procedures relating to Fit and Proper Persons Requirement checks. We reviewed the files for six directors and the trust had met these requirements and had ongoing monitoring for regular reviews of FPPR. We reviewed 40 staff files and the trust followed correct recruitment processes in all.

Leadership and culture

- Although the trust had systems in place for monitoring performance the senior management had not ensured the systems were embedded at local levels in the different teams. The use of the balanced score card was inconsistent. In the NHS staff survey 2014 the trust performed better than other mental health trusts for questions related to support from immediate managers.
- The trust performed better than other mental health trusts, and in the best 20% of all mental health and learning disabilities trusts for questions related to communication between senior management and staff.
- The trust performed about the same as other mental health trusts for job satisfaction, but below the average for staff motivation.
- The trust compared negatively to other mental health trusts and in the worst 20% of all mental health and learning disabilities trusts for nine of the 29 questions. These nine questions related to the following:

1. The number of staff who were appraised in the last 12 months;
2. Staff who had witnessed potential harmful errors, near misses or incidents in the last month;

Requires improvement

Are services well-led?

3. Staff who would feel secure raising concerns about unsafe clinical practices;
4. Staff experiencing physical violence from patients, relatives, or the public in last 12 months;
5. Staff experiencing physical violence from staff in last 12 months;
6. Staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months
7. Staff who have had equality and diversity training in the last 12 months;
8. Staff who believe the trust provides equal opportunities for career progression or promotion and
9. Staff who have experienced discrimination at work in the last 12 months.

- The trust scored below average against other mental health trusts in the NHS Staff Survey 2014 for staff suffering work related stress in the last 12 months, with 44% of staff agreeing they had suffered this.
- 57.7% of respondents in the staff friends and family test data in July to September 2015 were either likely or extremely likely to recommend the trust as a place to work, this was below the England average of 61.6%.
- The General Medical Council (GMC) training scheme survey flagged two outliers – the workload and local teaching within old age psychiatry. Also flagged as being in the lower quartile (but not an outlier) was feedback within general psychiatry, medical psychotherapy and old age psychiatry.
- At 30 September 2015 the staff sickness rate for the previous 12 months was 3.2%. The highest of these were the Camden Assessment Team at St. Pancras Hospital and the team at 154 Camden Road which both had a sickness rate of 12.2%. The trust's sickness rate of 3.2% (at 30 Sept 2015) was below the most recent national data showing that the average sickness rate for mental health and learning disability trusts was 4.6% as at August 2015.
- Staff said they felt part of a team and received support from each other. Staff knew how to use the whistle-blowing process and said they felt able to raise concerns without fear of victimisation. Staff told us morale and job satisfaction was good. Staff reported that they enjoyed their roles and that morale within the team was good. However, staff morale was low at Islington early intervention service, there was no team leader in place there was a lack of management input.
- Staff were provided with opportunities for leadership training at ward management level.

Engagement with the public and with people who use services

- The trust had a number of service user groups representing service users from a range of backgrounds and parts of the service. We attended one of these meetings prior to the inspection. The trust actively engaged with, and sought the opinions of people who used the services and their carers.

Quality improvement, innovation and sustainability

- In the NHS staff survey 2014 the trust performed better than other mental health trusts for staff being able to contribute towards improvements at work and for the use of patient or service user feedback to make informed decisions in directorates/departments.
- The Islington learning disabilities service had set-up and were running a "health hub" from their premises, twice a month.
- Older adults' community staff were committed to improving the service by participating in research. They had been innovative in implementing a 'brain food' group that was making a positive difference to service users.
- Both older adults' wards were using the 'Productive Ward – Releasing Time to Care' materials. The 'Productive Ward' initiative encouraged staff to think about how time may be wasted so they can spend more time with patients.
- The trust was applying to the Accreditation for Inpatient Mental Health Services (AIMS) schemes and also the Psychiatric Liaison Accreditation Network (PLAN). The trust was accredited to the Home Treatment Accreditation Scheme (HTAS).

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 12 HSCA (RA) Regulations 2014 Safe care and treatment Regulation 12 The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Safe care and treatment • In the health based places of safety the environment was not suitable. Patients in the health based place of safety at the accident and emergency department in the Royal Free hospital had to walk past other cubicles to use the toilet. The premises did not meet the guidance in the Mental Health Act code of practice or from the Royal College of Psychiatrist's. The toilet also had ligature points in which could be used by a patient to self harm. The places of safety were housed in the acute hospital and were cleaned by their staff but the trust had not ensured the environment was clean and well maintained. Facilities at two of the three health based places of safety did not promote dignity, recovery, comfort or confidentiality for people using this service. • 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, they did not address all ligature risks and an unacceptable number of ligature risks remained at the St Pancras site. • Repairs to the patient care areas were not always completed in a timely manner. • We found essential emergency equipment was not present, or was perished. Emergency equipment was not always checked to make sure it was clean and functioning. There was no emergency equipment available at any of the sites visited in the community based mental health services for adults of working age. We found some emergency equipment in other areas out of date. There was emergency equipment available

This section is primarily information for the provider

Requirement notices

in rehabilitation services but some of the equipment such as airways and syringes was out of date. Other equipment such as weighing scales had not been re-calibrated.

- The clinic room fridge temperature at North Camden recovery team was not being recorded regularly, meaning that staff would not know if the fridge temperature had gone over the optimum range, this meant that medication that should have been disposed of may have still been used. On Pearl ward the clinic room and fridge temperature records showed gaps in recording, the worst being a week of no monitoring between 15 February 2016 and 22 February 2016.

This is a breach of Regulation 12 (1)(2)(a)(b)(d)(e)(f)(g).

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 Regulation 17 The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 • Record keeping was disorganised in paper files which meant information was difficult to find and could lead to key information being missed. Confidentiality was breached in some teams where patient names on files in the office could be seen by others. Staff had not stored hard copy care plans and legal documents effectively. Risk assessments were not kept up to date in some services. Some care plans were not person centred or holistic. Patients had not signed their care plans because care plans were completed electronically separately from the patient appointment. Staff did not always clearly document the level of involvement of patients in their care plan or reasons why patients had not been involved. Some patients had not signed their care plan to indicate agreement with it. There were gaps in records. In the learning disabilities service there were two electronic recording systems in operation that did not link to each other at all, meaning that information may be entered twice on some occasions or being recorded on one system but not the other.

This section is primarily information for the provider

Requirement notices

- Safeguarding informationwas not alwaysrecorded appropriately and clearly. MHA documentation had gaps in and did not show patients had been read their rights regularly or had been informed of their right to advocacy.
- Prescribers in the substance misuse service did not see clients for formal medication reviews regularly. We found one example where a doctor last saw a client in 2013. Staff in substance misuse services did not always complete medication records in full including information about client allergies, pharmacy details and medical histories. Medicines records were not completed fully in the North Camden crisis team.
- Caseloads were not monitored in all teams.

This is a breach of Regulation 17(1)(2)(a)(c).

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing Regulation 18 The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Staffing

- There were gaps in the management and support arrangements for staff, such as appraisal, supervision and professional development. Managers reported that staff received in house specialist training but some managers did not keep a record of staff's attendance centrally. Compliance with appraisal was low across most teams. Staff on Montague and Amber ward had not received an annual appraisal. Although staff received supervision sufficient records were not always kept.
- In some services compliance with mandatory training for the service was below the trust target of 80%. Compliance for Mental Health Act (MHA) and Mental Capacity Act (MCA) training were low with some staff not receiving any training at all in MHA or MCA. Some staff were not aware of their responsibilities under the MHA and MCA.

This is a breach of regulation 18 (2)(a).