Cambridgeshire and Peterborough NHS Foundation Trust

Inspection report

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

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

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

Ratings

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

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

Summary of findings

Background to the trust

Cambridgeshire and Peterborough NHS Foundation Trust was created in 2002 to provide mental health, learning disability and substance misuse health and social care services. It became a foundation trust on 1 June 2008. Since 2015 it had also provided community health services. The chair has been in post since July 2014 and the chief executive since August 2017.

The trust provides services at ten registered locations with its main locations being Cambridge and Peterborough.

The trust was last inspected by the Care Quality Commission between 19 and 21 May 2015. The report was published on 13 October 2015. The overall rating was good. The trust was rated as requires improvement for safe, and good for effective, caring, responsive and well-led. There were breaches across three regulations, which the trust had addressed following that inspection.

Overall summary

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

What this trust does

The trust operates in three directorates:

Adult mental health services (45 teams / 24 services) had 120,024 patient contacts in 2016-17. These services comprised of inpatient wards and community mental health teams in Cambridgeshire and Peterborough, crisis resolution, psychological medicine services and home treatment teams, IAPT teams and the advice and referral Centre (ARC). Specialist services included prison mental health in-reach teams, eating disorders, substance misuse, learning disability, autism and ADHD services, and criminal justice services and arts therapies were also provided.

Older people and adult community services (64 teams / 29 services) had 850,392 patient contacts in 2016-17. These services comprised of neighbourhood community services teams, joint emergency teams (JET), older people inpatient rehabilitation services and long term condition specialist services. Older People and Adult Community Services also provided inpatient and community mental health services in Cambridgeshire and Peterborough for people over 65.

Children young people and family services (29 teams / 22 services) had 108,325 patient contacts in 2016-17. These services comprised of child and adolescent mental health community services in Cambridgeshire and Peterborough, children's community services in Peterborough, an adolescent intensive support team, and a young people's drug and alcohol service

The trust employs more than 3,500 staff. The largest bases are at the Cavell Centre in Peterborough, and Fulbourn Hospital in Cambridge. Trust staff are based in more than 90 locations. The trust has 310 inpatient beds spread across 25 wards They had a turnover of £200 million in 2016/2017 and had a surplus of £2.263 million in 2016/2017. Capital expenditure in 2016/2017 was £3.3 million.

The trust provides the following mental health services:

- Acute wards for adults of working age and psychiatric intensive care units
- Child and adolescent mental health wards
- Community mental health services for people with learning disabilities or autism
- Community-based mental health services for adults of working age

Summary of findings

- Community-based mental health services for older people
- Forensic / secure wards
- Long stay/rehabilitation mental health wards for working age adults
- Mental health crisis services and health-based places of safety
- Specialist community mental health services for children and young people
- Wards for older people with mental health problems
- Wards for people with learning disabilities or autism
- Specialist mental health services.

The trust provides the following community health services:

- Community health services for adults
- Community health services for children young people and families
- Urgent and emergency care
- Community health inpatient wards

Key questions and ratings

We inspect and regulate healthcare service providers in England.

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

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

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

What we inspected and why

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

We inspected nine core services and one specialist mental health service. These services had been previously rated as requires improvement, had not been inspected previously or had been risk assessed as requiring inspection this time.

Those inspected were:

- Acute wards for adults of working age and psychiatric intensive care units
- Child and adolescent mental health wards
- Wards for people with a learning disability or autism
- Forensic inpatient or secure services.
- Wards for older people with mental health needs
- Community mental health services for people with a learning disability or autism

Summary of findings

- Specialist community mental health services for children and young people
- Specialist mental health services for people with an eating disorder
- Community health services for children young people and families
- Community health inpatient services

Our comprehensive inspections of NHS trusts have shown a strong link between the quality of overall management of a trust and the quality of its services. For that reason, all trust inspections now include inspection of the well-led key question for the trust overall. What we found is summarised in the section headed is this organisation well-led?

What we found

Overall trust

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

- We rated safe as requires improvement and effective, caring, responsive and well-led as good. In rating the trust, we took into account the previous ratings of the five services not inspected this time. We rated the trust overall for well-led as good.
- At this inspection, we rated seven core services as good, one specialist mental health service (The eating disorder service) as good and two core services as requires improvement. In rating the trust, we took into account the previous ratings of the four services not inspected this time. Therefore, following this most recent inspection, 12 of the trust's services are rated as good, and two as requires improvement.
- The trust managed patient safety well. Staff had recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned. When things went wrong, staff apologised and gave patients honest information and suitable support. The trust applied the Duty of Candour appropriately. Those serious incident reports reviewed included clear communication with and attempts to communicate with family and carers throughout the investigation process. Staff had training on how to recognise and report abuse and applied it. The trust had effective systems for identifying risks and planning to eliminate or reduce them. The trust was committed to improving services by learning from when things go well and when they went wrong. Staff training and service development was prioritised.
- Staff kept clear records of patients' care and treatment. Care and treatment records were clear, up-to-date and available to all staff providing care. The trust provided care and treatment based on national guidance. Patients had access to psychological support and occupational therapy. The physical healthcare needs of inpatients'' with mental health needs were met. Patients in community health services benefitted from the support provided by staff.
- Trust staff worked well with each other and external organisations to provide care and treatment to patients based on national guidance. Bed management processes were effective and included daily bed management meetings.
- Staff completed Mental Health Act paperwork correctly. There was administrative support to ensure these records were up to date and regular audits took place.
- Systems for the safe management and administration of medicine were in place. Incidents and errors within the pharmacies were reported and investigated and shared at team meetings to ensure consistency across different sites. The pharmacy team reviewed serious incident reports when medicines were involved. The trust had subscribed to the Choice and Medication website to support patients including at the point of discharge.
- Positive feedback was received from those patients, families and carers spoken with about the care and treatment received from staff. Patients told us that they felt safe across the trust.

Summary of findings

- The trust promoted a person-centred culture and staff involved patients and those close to them as partners in their care and treatment. Staff provided positive emotional support to patients.
- Local leadership across the trust was strong, visible and effective. Executive directors were known to staff and visited services. They provided inspirational leadership and the board encouraged feedback from all levels of the organisation. Staff were particularly positive about the chief executive's approach. The responsiveness of the trust to issues raised during the inspection was immediate.

However:

- There were a number of environmental issues that prevented the trust from offering safe services. The current ward ligature risk assessments did not address all the potential ligature risks on the wards. The environment in which the LD and autism community intensive support team saw patients had areas that patients could access that were unsafe. Wards had some outstanding maintenance tasks. Staff environmental checks on the wards were not thorough. Staff did not effectively implement the trust's smoke free policy on some wards. The trust took immediate action to address these concerns once these were identified.
- Staff did not always record information thoroughly. Staff supervision rates and the recording of; were not monitored on a consistent basis by ward managers. Some seclusion records were incomplete and these did not reflect the interventions provided by staff during seclusion episodes.
- In the specialist community mental health services for children and young people, the trust did not routinely monitor the risk of those young people waiting to receive treatment. Staff had not followed the trust policy on the recording of risk. The trust had not ensured that staff followed their new access policy on patients who did not attend appointments. Patients, who failed to attend appointments, were not followed up. Some staff were not aware of their responsibilities under the Mental Capacity Act and relating to capacity assessment and Gillick competencies.
- Managers did not monitor the arrangements in place for the safe management of alarms, keys and access cards. Staff were taking these away from the hospital which meant that these could be misplaced and access gained by unauthorised persons.

Are services safe?

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

- The current ward ligature risk assessments did not address all the potential ligature risks on the wards. Wards had some outstanding maintenance tasks. Staff environmental checks on the wards were not thorough. Staff did not effectively implement the trust's smoke free policy on some wards.
- The trust had not identified a number of environmental risks in areas to which patients had access. For example, at the community mental health services for people with a learning disability or autism. Staff at this service was not recording key patient information in the trust's electronic recording system.
- The seclusion room on Poplar ward could pose a potential safety risk to patients and staff. The trust had not considered the potential impact upon the privacy and dignity of patients using the facility.
- In the specialist community mental health services for children and young people staff did not follow the trust policy on the recording of risk. Risk assessments were incomplete and had not been updated following changes in the patient's risk presentation. Staff had not developed comprehensive care plans for patients to ensure that patients received safe care.
- There was not sufficient numbers of staff to meet the needs of the patients in the specialist community mental health services for children and young people. Staff turnover and vacancies had adversely affected service continuity, availability of treatment options for patients and staff morale.

Summary of findings

However:

- The trust took immediate action following the initial concerns raised that the ligature risk assessments did not identify all risks or detail sufficiently how they were to be managed.
- Managers told us they could increase staffing as required to meet the assessed needs of patients.
- Services used recognised risk assessment tools. Staff had completed personalised, holistic, recovery focused risk assessments for patients on admission in all wards. Ward staff identified and responded to changing risks and updated patient risk assessments following incidents.
- Managers and staff demonstrated a good understanding of safeguarding concerns, reporting, and recording incidents and escalated concerns immediately. Managers shared learning from incidents across the trust and disseminated this through the trust's lessons in practice bulletin and in ward team meetings. Evidence was seen of changes and improvement in practice following incidents.
- Wards had fully equipped clinic rooms with accessible resuscitation equipment and emergency drugs.
- Managers ensured that staff received induction and mandatory training to prepare them for their roles.

Are services effective?

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

- Staff provided a range of care and treatment suitable for patients including a variety of psychological therapies. Physical healthcare needs were being met and recorded. Patients were supported to live healthier lives. Staff had the right skills and knowledge to meet their patient's needs.
- Staff had a good knowledge of the Mental Health Act and Mental Capacity Act and applied the principles well in their work. Staff explained rights under the Mental Health Act to patients, regularly and in a way that they understood. Staff ensured patients were able to take their Section 17 leave as agreed. Instances of staff cancelling this leave were rare. Staff knew how to access support and advice on Mental Health Act and Mental Capacity Act concerns.
- The trust ensured that care and treatments were provided in line with the guidance issued by recognised outcome measures for patients including the health of the nation outcome scales were used by staff.
- Reflective practice meetings with an external facilitator enabled staff to improve practice and offer better patient care on the child and adolescent mental health wards.
- Staff held multidisciplinary meetings. Patients, carers and commissioners were invited to these. Teams worked closely with external parties, such as social services, GPs and other service providers. Services had a full range of professional disciplines that provided input into patient care. For example, pharmacists used their links with ward based staff to encourage change in practice.

However:

- Staff did not always record information thoroughly. Staff supervision rates and the recording of these were not monitored on a consistent basis by ward managers. Some seclusion records were incomplete and these did not reflect the interventions provided by staff during seclusion episodes.
- Some staff were not aware of their responsibilities under the Mental Capacity Act and specific issues relating to capacity assessment and Gillick competencies as they related to patients in the specialist community mental health services for children and young people.

Are services caring?

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

Summary of findings

- Staff treated patients with kindness, compassion and respect. Staff were responsive to the individual needs of patients. Communication was discreet and respectful.
- Staff treated each patient with dignity and engaged patients in meaningful activities. For example, staff on the community health inpatient wards found innovative ways to promote wellbeing by supporting patients with social interaction and activities.
- Staff interacted with patients at a level that was appropriate to their individual needs. For example, on the child and adolescent mental health inpatient wards.
- Patients were encouraged to participate and share their views about their care and treatment in multidisciplinary team meetings. There were opportunities for families and carers to attend support groups.

However:

- There were privacy and dignity concerns identified on Denbigh ward where patients were given identity bands on their ankles without a risk assessment.
- There were potential privacy and dignity issues to patients in the seclusion room as staff had to observe patients when using the bathroom.

Are services responsive?

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

- The trust was managing their treatment waiting lists well in most services. We found that these varied across individual core services and were being monitored by senior managers.
- Care and treatment records showed that discharge planning was considered upon admission. Daily bed management meetings took place every week day. These meetings reviewed all wards to identify the availability of beds and potential patient discharges.
- There were activities across the week for patients, including weekends. There was access to spiritual support if required. Patients had access to drinks and snacks throughout the day. There was adequate space for treatment and therapies.
- Staff supported patients to maintain contact with their families and carers. Wards had quiet areas for patients and rooms either on or off the ward where they could meet visitors. Dedicated child visiting rooms were available.
- Wards had information on the complaints process and this was displayed to patients on ward notice boards and was available inpatient information leaflets. The trust had systems in place for the recording and management of complaints. Staff supported patients to make complaints. Patients were able to raise concerns and provided feedback about the wards at community meetings. All complaints where discussed at team meetings. The learning from these was disseminated to the wider trust through the lessons in practice bulletin.
- Patients had access to information leaflets in a variety of languages and there was access to a translation service. Staff knew how to access additional information that was not readily available on the wards.

Are services well-led?

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

Summary of findings

- The trust board had the appropriate range of skills, knowledge and experience to perform its role. The chief executive had been in post since August 2017 and the chair since July 2014. There were seven non-executive directors who had a wide range of previous and suitable experience. The appointments within medical specialities and other areas enabled the trust to move forward in innovative ways. For example, partnership working and research. The trust had re-organised their governance and management arrangements for better effectiveness.
- There was robust scrutiny at board level and non-executive directors challenged decisions where necessary. Staff felt able to report issues and successes through local meetings and through local risk registers which fed into the directorate's monthly performance and risk executive meeting attended by the chief executive. This meant that the board had oversight of local challenges, developments and successes. Governors told us about effective induction, training and support to carry out their roles. They described a positive working relationship with the executive directors. The board had a good understanding of the challenges the trust faced, the plans in place to address them and also the progress being made. There were strategic plans in place underpinned by operational plans that leaders were able to discuss. Staff spoken with knew the trust's high level risks and their own local risks. We reviewed the trust risk register and saw that the board reviewed this regularly and each risk had actions and clear mitigations.
- There was evidence of a shared understanding of the financial issues faced by the trust and engagement throughout to support the Trust to deliver financial sustainability. The senior finance team at the trust was stable and experienced. The financial information provided to Board was clear and consistent with the monthly financial returns submitted to NHS Improvement. Where cost improvements were taking place there were arrangements to consider the impact on patient care. Where cost improvements were taking place, the focus was on not compromising patient care.
- Ward managers had access to a range of information to enable them to undertake their management role. This included a ward performance dashboard. The trust was aware of each directorate's performance through the use of key performance indicators and other metrics. Trust wide information was in an accessible format, timely, accurate and identified areas for improvement. This data fed into the board assurance framework via the performance and risk executive of each directorate.
- The trust had a clear vision and set of values with quality and sustainability as the top priorities. The trust's values were professionalism, respect, innovation dignity and empowerment known by the acronym PRIDE. The trust's vision was 'to give those people who need our services the best possible chance to live a full and happy life, despite their condition or circumstances'. These were embedded within trust processes for example; staff appraisals, recruitment and staff awards were aligned to these. Leaders showed a positive culture with a shared purpose towards the vision, values and strategy. Staff showed pride and talked passionately about their roles. Individual teams had positive relationships, worked well together and addressed any conflict appropriately.
- Board directors were visible and carried out a programme of ward and service based visits to meet staff. Front line staff confirmed they found these visits supportive and most knew who the trust's directors were. Staff confirmed that they found senior trust leaders approachable and easy to talk to.
- Fit and Proper Person checks were in place for all board members and non-executive directors. We reviewed six files and found that enhanced disclosure and barring checks were in place. Individual files were well organised and there were effective assurances in place. This included an annual review and confirmation at public board meetings.
- The trust had appointed a freedom to speak up guardian in August 2017. They attended national meetings for training and development. There was a robust system to report to the trust board on their work via the quality and compliance executive, performance and risk executive and quality safety and governance committee meetings. The number of referrals to the freedom to speak up guardian at the trust was 13 between October and December 2017. Front line staff had been given the opportunity to contribute to a current review of the trust's vision and values.

Summary of findings

Frontline staff felt respected and supported by their line manager and considered that morale was generally good across the trust. They felt able to raise concerns without fear of retribution and knew the trust had a freedom to speak up policy which they would use if they needed to. Staff side representatives were consulted about trust development and changes at monthly joint consultation and negotiation partnership meetings.

- The Trust ensured that its strategy aligned with the key priorities of the local sustainability and transformation partnership. We were impressed by the extent to which the trust board and other senior staff formed and led positive relationships within the wider local system. This was building a system that would be sustainable in the future delivery of health and social care. The trust had productive relationships with external stakeholders. For example the trust worked closely with the University of Cambridge's Department of Psychiatry and other partners. Areas of research supported covered a wide number of conditions, including dementia, bipolar disorder, depression, psychosis, schizophrenia and autism.
- The trust had identified four key priorities for medicines optimisation. Actions were being taken to address these priorities led by the chief pharmacist. Services had been planned to take into account the needs of the local population. For example, amalgamating physical health care and older people's mental health community services within locally based hubs based on General Practitioner surgeries had led to improvements in the delivery of care at a local level and a reduction in admissions.
- The trust followed a robust process when investigating deaths and serious incidents. Investigations were carried out jointly by an investigation manager and a clinical reviewer. Monitoring of these investigations took place at weekly serious incident group meetings with the lessons learnt escalated to the quality and compliance executive, quality safety and governance committee and board meetings. We reviewed a sample of four cases where the patient had died. The trust had carried out comprehensive investigations following each death and action plans were in place as a result. There was a comprehensive trust wide audit programme with 85 audits in place in December 2017
- The trust's workforce race equality scheme report and action plan for 2016 – 2017 was published on their website in August 2017. This identified a number of actions to be taken by the trust; for example, equality of opportunity and representation of people at senior manager level. The board had recognised equality and diversity required further work and had plans in place to address the issues.
- The trust had a draft action plan in place to address the 2017 NHS staff survey results. This covered work force wellbeing, quality of appraisals, improving engagement and resourcing and support. Senior managers told us they were committed to ensuring that this action plan was implemented fully. The trust reviewed the findings of the friends and family test as part of the integrated performance report which was escalated to the trusts' performance and risk executive meetings and the quality safety and governance committee meetings.
- Mandatory training rates were monitored by the trust through each directorate's performance dash board via each directorate's monthly performance and risk executive meeting attended by the chief executive. A red amber and green rating was used to identify where action was required by line managers.
- The trust had a robust process in place for managing complaints and cross checking for any safeguarding and welfare concerns and immediate actions. Duty of Candour consideration had been included in the investigation process. Final investigation letters were approved by the Directorate Heads of Nursing and signed off by the Chief Executive. Managers shared learning and action plans from complaints at ward based team meetings and more widely via the trust's quarterly 'lessons in practice' bulletin. We saw evidence of compliments received by the trust across those services inspected. The trust's staff recognition scheme; the PRIDE awards acknowledged staff contribution to patient care. Compliments were discussed at ward level team meetings.
- The medical director was the executive Mental Health Law lead for the trust and the Head of Mental Health Law was the non-executive lead. The head of MHA legislation had restructured the MHA and MCA meetings to ensure information was presented in the right format to the right people. The trust's Mental Health Act administration team

was working well for the benefit of those patients who were detained. The head of Mental Health Law had ensured that understanding of the Act and its implications for practice was well understood within the relevant leadership teams. The trust had a section 75 agreement in place for the delivery of Local Authority functions. There was representation from partners on Mental Health Act working groups and committees. Examples of joint working groups included the Crisis Concordat Mental Health Delivery Board and Mental Health Law Liaison group. The police cited positive partnership working around the recent changes to section 136 of the Mental Health Act.

- The trust had a major incident and continuity plan in place for emergencies. This covered a range of potential concerns and there was a clear protocol for the escalation of local concerns.
- The trust had a recruitment and retention strategy which had delivered innovative ways to recruit staff, such as career events, links with universities, bank opportunities for their own staff, 'growing our own' staff development strategies. For example, offering research posts to band five nurses in the specialist eating disorders service.
- The trust used research and innovation to improve patient care and also built alliances within the wider system. Patients and frontline staff were encouraged to make suggestions for improvements at ward and service levels. The trust had responded to feedback and changed the way that it worked as a result. For example, the introduction of the trust's first response service had led to a reduction in waiting times and presentation at local accident and emergency departments. The trust had employed a family liaison officer to provide support for families and carers following serious incidents and unexpected deaths. The trust participated in a wide range of audits and accreditation schemes and shared learning. For example, in clinical research studies as part of the (CLAHRC).

However:

- We found that there was underrepresentation at senior level for BME groups. BME groups did not always feel that they had sufficient opportunities.
- The extent to which managers recorded whether staff had an appraisal of their performance or supervision varied between services. The trust's 2016 NHS Staff survey had identified some staff concerns about the quality of the appraisals provided by the trust.
- The community health service for children young people and families used a different electronic reporting system to the one used by trust staff working in the child and adolescent mental health service (CAMHS). As a result, community staff were unable to see whether a patient was receiving any CAMHS intervention. The trust had established mitigation plans to address this.
- The trust had set a target that staff should record the identity of the family carer for 60% of patients under the care of the trust. This was to ensure that carers' needs assessments were completed. At the time of the inspection, staff had done this for only 22% of patients

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

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

- Patients had an individualised risk assessment which was completed on admission and updated on a regular basis. Care plans included physical healthcare needs and care and treatment records showed that patients had a physical health examination on admission.
- Staff treated patients with kindness, compassion and respect. Patients were encouraged to participate and share their views about their care and treatment in multidisciplinary team meetings.
- The trust held daily bed management meetings every week day. These meetings reviewed all wards to identify the availability of beds and potential patient discharges.
- Staff had been given the opportunity to contribute to a review of the trust's vision and values.

Summary of findings

However:

- There were a number of environmental issues that prevented the trust from offering safe services. The current ward ligature risk assessments did not address all the potential ligature risks on the wards. The seclusion room on Poplar ward could pose a potential safety risk to patients and staff. The trust had not considered the potential impact upon the privacy and dignity of patients using the facility. Wards had some outstanding maintenance tasks. Staff environmental checks on the wards were not thorough. Staff did not effectively implement the trust's smoke free policy.
- Staff did not always record information thoroughly. Staff supervision rates and the recording of this were not monitored on a consistent basis by ward managers. Some seclusion records were incomplete and these did not reflect the interventions provided by staff during seclusion episodes.
- Managers did not monitor the arrangements in place for the safe management of alarms, keys and access cards. Staff were taking these away from the hospital which meant that these could be misplaced and access gained by unauthorised persons.
- The trust had not ensured that infection control guidance was followed on Oak four ward. Creams issued by the trust pharmacy were shared between patients.

Child and adolescent mental health wards

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

- The environment was safe, clean, and had rooms for therapies and activities. Following high level feedback about the identified ligature risk assessments; senior managers agreed to take action across the trust to review these.
- Wards had an adequate number of staff to provide safe care. Where there were vacancies, managers were actively recruiting new staff. The trust used suitably skilled bank and agency staff to cover any gaps.
- Staff managed risks well. Children and young people's risk assessments were robust, and up to date. Front line staff were trained to manage behaviours that may challenge. They managed and administered medication correctly. Nominated staff were the safeguarding leads. Staff knew how to report incidents and managers monitored these reports to identify and implement any lessons that might be learnt.
- A wide range of outcome measures were used to gauge how children and young people were doing. For example children's global assessment scale and health of the nation outcome scales child and adolescent. Each child and young person had an individualised care plan, which informed discharge planning. Staff developed care plans that met the needs of the individual child and young people; they were up to date personalised, holistic and recovery orientated. This included meeting the patient's physical health care needs. We saw in children care records that consent was recorded taking into consideration Gillick competence.
- Staff were caring and passionate when talking about children and young people. We observed positive interactions between children, young people and staff. Staff understood the individual needs of children and young people.
- Children and young people had access to an advocacy service and knew how to make a complaint, if they felt they needed to.
- A positive, supportive local team working environment was reported by staff. Managers had a good understanding of the services they managed and demonstrated good leadership. All staff were offered development opportunities. Managers made service improvements on feedback received from children and young people.

However:

- Ligature risk assessments at both sites were not sufficiently detailed or up to date.

Summary of findings

- At the Croft Centre the seclusion room had a partial blind spot and the hatch door needed repairing to fully ensure children's safety.

Wards for people with a learning disability or autism

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

- Patients had individualised risk assessments that were completed on admission and updated regularly. Staff discussed incidents and learning from these at team meetings. The ward had systems in place for the safe storage and administration of medication. The ward met the trust's safer staffing requirements. There was sufficient staff for patients to have escorted leave and for staff to engage with patients during therapeutic and meaningful activities.
- Patients had comprehensive, recovery focused care plans that were updated regularly. Patients had positive behaviour support plans in place and had access to psychological therapies as recommended by the National Institute for Health and Care Excellence.
- The ward areas were visibly clean and well maintained. The trust had met the Department of Health Guidance on the elimination of same sex accommodation.
- Staff interacted in a positive, kind and respectful manner with patients.
- The trust provided managers with opportunities to develop their own skills and also develop their team for example: the trust had supported health care workers to progress to nurse training.

However

- Appraisal and supervision completion rates fell below the trust's own targets.

Forensic Inpatient or secure services

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

- We found that the trust had addressed the concerns identified during the last inspection. These were; that patient involvement in their care is recorded, patients' access to a general practitioner, bedrooms and hot drinks during the day and review patient dissatisfaction with the food provided.
- Patients' needs were being met. Care plans were personalised, holistic and recovery focussed. Physical health needs were identified. Care plans showed patient involvement and cultural, religious and social needs were taken into consideration. Staff identified any change to patient risk and recorded this on patient care records and risk assessment plan.
- Ward areas were visibly clean throughout. All three areas had good furnishings which were robust and well maintained. Staff completed environmental risk assessments regularly and managers audited these and took action when concerns were identified. Patients had their own bedrooms and were able to personalise them with personal photographs, art work and posters.
- Staff treated patients with kindness, compassion and respect. A qualified nurse was present on the ward and in the communal areas, and staff had enough time to spend one to one time with their named patients. The ward had a recovery integration worker. This was a newly appointed role. Their key role was to help patients integrate as part of their step down from the hospital to the community. There was no use of agency staff on the ward and bank staff were regular and familiar with the ward and individual patient needs.
- Admissions were planned and a multidisciplinary meeting held to consider admission and suitability. Multidisciplinary team meetings were held on a regular basis. Patents and advocates were involved in these meetings

Summary of findings

- Senior trust managers were visible in the service. Staff knew who they were, and said they were very supportive. The manager was on the ward regularly to support patients and staff.

Wards for older people with mental health needs

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

- The service did not have robust governance systems in place to identify the concerns identified on this inspection. Managers had not upheld their duty of candour on one occasion. Staff had not reported a safeguarding incident on Denbigh ward, as per the trust's own policy. Care and treatment records did not indicate if carers or patients had been offered a copy of their care plan. Staff had not recorded their supervision on the trust's centralised supervision recording system. The acting ward manager did not have full access to all information on the trust's governance dashboard.
- There were some environmental concerns. Denbigh ward had removed curtains from the ward areas for deep cleaning, and not replaced them with any temporary coverings. On the day of inspection, staff were using the quiet area to feed a patient. Staff did not realise the process could be observed by people passing the ward outside. While bedrooms had partial opaque glass, there was nothing to stop daylight entering, causing early morning waking and shadowing at night when the light was on. Both of these issues meant that the privacy and dignity of patients was being compromised.
- There was environmental damage on two wards. There were blind spots on the Maple wards, and three of the four ward based ligature risk assessments were not complete. Staff had not identified ligature points in the garden areas on Denbigh ward, and there were outstanding actions on Maple wards.
- On Denbigh ward each patient was wearing identity bands on their wrists or their ankles. Those patients who voiced an opinion about this did not like them on their ankles. There was no risk assessment in place to support this practice.
- There were gaps in the night-time duty doctor on call roster which meant that patients may have experienced delays in receiving medical treatment in an emergency.

However:

- The trust took immediate action following the initial concerns raised that the ligature risk assessments did not identify all risks or detail sufficiently how they were to be managed.
- There were pleasant, quiet areas both on and off the ward, where patients could spend time. There was a visitors' room on each ward.
- Clinic rooms were fully equipped with accessible resuscitation equipment and emergency drugs that staff checked regularly. Staff maintained equipment and kept it clean. There was good medicines management and prescribing practice. Pharmacy staff visited the wards regularly and were contactable to provide advice including out of hours.
- Nurses were visible on the wards. The ward had access to nurses and other staff who were able to support patients with their physical health care needs. Patients' Section 17 leave and activity programmes were rarely cancelled due to insufficient staff.
- Care and treatment records reviewed showed good practice in linking risk assessment with care planning. Staff completed a risk assessment for every patient on admission and updated it regularly, including after any incident. Staff were aware of, and dealt with any specific risk issues, such as falls or pressure ulcers. They identified and responded to changing risks to, or posed by, patients. Care records were holistic, recovery focussed and person centred. Patients were encouraged to complete an easy read "My care matters profile".
- Staff carried out mental capacity assessments with patients. When patients lacked capacity, staff made decisions in their best interests, recognising the importance of the person's wishes, feelings, culture and history.

Summary of findings

- Bed management was effective and all wards had a discharge facilitator. The average length of stay had been 8-12 weeks between September 2017 and February 2018, and there had only been two delayed discharges during the same period.
- The trust recognised staff success within the service. The trust had recently awarded Denbigh ward their PRIDE accolade.

Community mental health services for people with a learning disability or autism

We rated this service as good because:

- Staff provided a range of care and treatment suitable for patients. They supported patients to live healthier lives. Staff had the right skills and knowledge to meet their patient's needs.
- Staff held meetings with out of area placement providers, the patient's social care support staff, carers and the in-patient unit staff, along with social work and education providers. This enabled them to provide holistic support to individual patients.
- Staff understood the individual needs of patients and how they presented when concerned, anxious or deteriorating in health.
- Staff provided a period of intensive support during the patient transition time from their out of area placements.
- The trust provided development opportunities for front line staff.

However:

- The trust's environmental risk register did not identify all risks to patients. Access to parts of the building that were unoccupied was not restricted. Staff did not carry alarms, nor were there any in the interview rooms to summon help if needed.
- Two care plans were not holistic or recovery orientated. One was not up to date and not personalised.
- The trust had not ensured that frontline staff complied with their own policy on the completion of patient records on the trust's own electronic recording system

Specialist community mental health services for children and young people

We rated this service as requires improvement because:

- The trust had not identified the risk to patients waiting for treatment on the local risk register. The trust did not routinely monitor the risk of those young people waiting to receive treatment. Staff did not follow the trust policy on the recording of risk. Risk assessments were incomplete and had not been updated following changes in the patient's risk presentation. Staff had not developed comprehensive care plans for patients. These were not personalised, holistic, and recovery focused.
- There was not sufficient numbers of staff to meet the needs of the patients. This adversely affected patient care and treatment.
- The trust had not implemented quality improvement plans for this service. The number of recent changes in the senior management team had affected the service. Staff turnover and vacancies had adversely affected service continuity, availability of treatment options for patients and staff morale.
- The trust had not ensured that staff followed their new access policy on patients who did not attend appointments. Patients, who failed to attend appointments, were not followed up.

- Some staff were not aware of their responsibilities under the Mental Capacity Act and specific issues relating to capacity assessment and Gillick competencies.

However:

- The staff had good working relationships with the trusts' safeguarding team, local safeguarding children board and worked in partnership with other agencies to protect patients.
- Staff provided patients with help and emotional support in a timely manner. Carers confirmed that staff supported them.

Specialist mental health services for people with an eating disorder

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

- There was a culture of learning to ensure improvements were made and maintained in this service. Staff were encouraged to report incidents and received timely feedback. There was evidence of learning from incidents, which was shared across the service. Staff used appropriate governance frameworks, risk management strategies and quality monitoring measures to improve patient care, safety and outcomes. There were effective processes in place to assess and escalate deteriorating patients.
- Staff provided care and treatment in line with national guidance and good practice. The service monitored the effectiveness of care and treatment through local and national audits.
- The multidisciplinary team worked in partnership with patients, families and carers. Staff interacted with patients and their carers in a caring, polite and friendly manner. They were aware of the need to provide emotional support for patients, families and carers. This included providing a variety of therapeutic approaches. There was a range of information and support available for patients, families and carers.
- Senior managers were visible, approachable and supportive. Staff were supported to develop their knowledge and skills whilst working in this service.

However:

- Staff at the Phoenix Centre did not have access to suitable equipment for searching patients.

Community health services for children young people and families

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

- Staff kept patients safe from harm and abuse. They understood and followed procedures to protect vulnerable children and families. Staff assessed and monitored individual patient risk.
- Staff had the appropriate skills, knowledge and experience to deliver effective care and treatment. There was effective multidisciplinary working across the service. Care was provided in line with national and best practice guidelines. Staff planned and delivered services to meet individual needs.
- Staff cared for patients with compassion, treating them with dignity and respect. Complaints were effectively managed and the outcomes used to improve the quality of the service.
- The trust actively monitored patient waiting times to identify trends and ensure services in high demand were managed appropriately to prevent patient pathway delays.
- The trust had governance frameworks, risk management plans and quality monitoring systems in place to improve patient care, safety and outcomes.

However:

Summary of findings

- Staff caseloads remained high, specifically for school nurses and health visitors. Nursing and support staff were working below planned staffing levels. Services for children, young people and families had been reduced due to lack of capacity.
- There was no systematic programme of clinical audit across the service which meant senior staff could not be assured of the safety of the service.
- The trust's patient satisfaction survey was not child-friendly, preventing the service from capturing feedback from its younger patients.

Community health inpatients

We rated this service as good because:

- The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned. When things went wrong, staff apologised and gave patients honest information and suitable support. Staff understood how to protect patients from abuse. Staff had training on how to recognise and report abuse and they knew how to apply it.
- Staff kept appropriate records of patients' care and treatment. Care and treatment records were clear, up-to-date and available to all staff providing care. The service provided care and treatment based on national guidance.
- Staff gave patients enough food and drink to meet their needs and improve their health. Patients were given choice. Staff of different kinds worked together as a team to benefit patients. Doctors, nurses and other healthcare professionals supported each other to provide good care.
- Staff cared for patients with compassion and feedback from patients confirmed that staff treated them well and with kindness.
- Leaders promoted a strong person-centred culture and staff involved patients and those close to them as active partners in their care and treatment. Staff provided emotional support to patients to minimise their distress.
- Staff found innovative ways to promote wellbeing and rehabilitation, through activities including knitting, painting, exercise groups, a breakfast club and seasonal activities such as a Christmas carol service.
- The trust investigated concerns and complaints thoroughly and learned lessons from these which were shared with staff.
- Managers promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values. The trust had effective systems for identifying risks and planning to eliminate or reduce them. The trust was committed to improving services by learning from when things go well and when they go wrong, promoting training and service development.

However:

- Compliance with role-specific mandatory training, including training on the Mental Capacity Act and Deprivation of Liberty Safeguards, was variable.
- There was variability in the frequency and type of local clinical audits carried out on each ward and learning from these.
- Compliance with appraisals was variable and staff did not always receive formal supervision.

Summary of findings

Ratings tables

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

Outstanding practice

We found examples of outstanding practice in the acute wards for adults of working age and psychiatric intensive care units, children and adolescent mental health wards, community health inpatient services, specialist mental health service for eating disorders and the community health services for children young people and families

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

Areas for improvement

We found areas for improvement including 26 breaches of legal requirements that the trust must put right. We found 31 things that the trust should improve to comply with a minor breach that did not justify regulatory action, to prevent breaching a legal requirement, or to improve service quality.

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

Action we have taken

We issued three requirement notices to the trust. Our action related to breaches in five core services

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

What happens next

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

Outstanding practice

Trust wide

- The trust participated in a wide range of audits and accreditation schemes and shared learning. For example, in clinical research studies as part of the Collaborations for Leadership in Applied Health Research and Care East of England (CLAHRC).
- The police cited positive partnership working with the trust around the recent changes to section 136 of the Mental Health Act.

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

- The trust had supported the clinical nurse specialist on Mulberry one ward to develop a sexual health clinic available to patients on a weekly basis. The clinical nurse specialist had been invited to present her work at a conference at the Royal College of Psychiatry.
- Staff on Mulberry wards had developed a debating workshop to encourage creative thinking on topical issues and identify improvements for the quality of the service.

Summary of findings

Children and adolescent mental health wards

- Staff at the Darwin Centre used innovative approaches when supporting young people with de-escalation for example scented oils sprays and textured materials with a good effect on patient behaviour.
- At both units there was high regard for staff development, reflective practice and clinical supervision for therapeutic models.

Community health inpatient services

- Staff gave us several examples of how they had gone the extra mile to support patients' dignity and wellbeing. On Trafford ward staff had sourced regular donations of clothing, which they gave to patients who did not have any relatives that could bring in clothes for them. Staff on Lord Byron A ward arranged regular activities, including painting, knitting and a breakfast club, to support wellbeing and rehabilitation, and staff on Trafford ward told us how they had arranged for a patient who was bedbound to go to the dayroom, so they could watch the football world cup on a big screen television

Specialist mental health service for eating disorders

- The Phoenix Centre engaged young people in music activities with members of the Royal Philharmonic Orchestra (RPO), where professional musicians worked with young people in a series of workshops aimed at promoting young people's social, physical and emotional rehabilitation. The service were also in discussions with the RPO in regards to generating further research into the efficacy of music in recovery

Community health services for children young people and families

- The trust's safeguarding team had developed a 'safeguarding satchel' to support staff with all aspects of safeguarding. The satchel was a comprehensive online tool containing safeguarding flowcharts, local authority and lead contact numbers, safeguarding policies and procedures. There was also a user guide to ensure staff used this correctly.
- Health visitors had recently started using innovative video interaction guidance (VIG) to improve mother and baby interactions. VIG works by allowing the parent to reflect on video clips of their own positive interactions with their baby.
- The trust provided integrated neuro-disability clinics for children with cerebral palsy spasticity. The clinics were developed through integrated working between community paediatricians; occupational therapists, physiotherapists and orthopaedic surgeons from the local acute hospital. The clinic was fully NICE guidance compliant and provided a much needed specialist service.

Areas for improvement

Action the trust MUST take is necessary to comply with its legal obligations. We told the trust that it must take action to bring services into line with four legal requirements.

Action the trust MUST take to improve

This action related to five services.

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

- The trust must ensure that ward ligature risk assessments address all the potential ligature risks on the wards.
- The trust must review the environment of the seclusion room on Poplar ward.

Summary of findings

- The trust must review the arrangements for ensuring the privacy and dignity of patients using the seclusion room.
- The trust must ensure that all seclusion records are completed in line with the Mental Health Act Code of Practice.
- The trust must ensure that infection control guidance is followed regarding not sharing creams issued by the trust pharmacy.

Wards for older people with mental health needs

- The trust must review their governance processes for this service and ensure that improvements are made.
- The trust must ensure that all managers and the acting manager have easy access to data and information that would allow them to run the wards safely and effectively.
- The trust must ensure that the privacy and dignity of patients is maintained at all times.
- The trust must review the practice of all patients on Denbigh ward wearing identity bands on their ankles.
- The trust must ensure that ward ligature risk assessments address all the potential ligature risks on the wards.
- The trust must ensure that all staff follow the trust's own policies on the duty of candour and safeguarding vulnerable adults.

Community mental health services for people with a learning disability or autism

- The trust must ensure that the local environmental risk register is reviewed and updated to reflect the risks to patients and staff.
- The trust must review their lone working policy for this service.
- The trust must ensure that key patient information is recorded by staff in the trust's electronic recording system.
- The trust must ensure that all care plans are current and recovery orientated.

Specialist community mental health services for children and young people

- The trust must identify the risks to patients waiting for treatment on the local risk register.
- The trust must ensure that staff monitor the risk of those young people waiting to receive treatment.
- The trust must ensure that staff follow the trust policy on the recording of risk.
- The trust must ensure that all patient risk assessments are completed and updated following changes in the patient's risk presentation.
- The trust must ensure that staff update care plans following changes in assessed patient need.
- The trust must ensure that sufficient staff are recruited to meet the needs of patients.
- The trust must implement quality improvement plans for this service.
- The trust must ensure that staff follow their new access policy on patients who did not attend appointments.
- The trust must ensure that all staff are aware of their responsibilities under the Mental Capacity Act and specific issues relating to capacity assessment and Gillick competencies.

Specialist mental health services for people with an eating disorder

- The trust must ensure that all items which could pose a risk to patients in the ward environment are securely stored.
- The trust must ensure that Phoenix Centre staff have access to suitable equipment for searching patients.

Summary of findings

Action the trust SHOULD take to improve

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

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

- The trust should review the arrangements for the monitoring and recording of staff supervision.
- The trust should review the systems in place for the safe management of keys and access cards.
- The trust should address maintenance tasks promptly.
- The trust should ensure that environmental checks on the wards are thorough.
- The trust should ensure the effective implementation of the trust's smoke free policy.

Child and adolescent mental health wards

- The trust should ensure that all ligature risk assessments are reviewed and updated as required.
- The trust should take action to address the partial blind spot and the outstanding repairs to the hatch door to the seclusion room on the Croft Centre

Wards for people with a learning disability or autism

- The trust should ensure that all staff receive and record their supervision and annual appraisal in line with the trust's policy.
- The trust should review the arrangements in place for the safe management of alarms, keys and identification cards which were taken home by staff.

Forensic inpatient or secure services

- The trust should have cleaning schedules in place on the ward.

Wards for older people with mental health needs

- The trust should review the arrangements for the monitoring and recording of staff supervision.
- The trust should address maintenance tasks promptly.
- The trust should ensure that environmental checks on the wards are thorough.
- The trust should ensure that care and treatment records indicate whether carers or patients had been offered a copy of their care plan.
- The trust should ensure that any gaps in the night-time duty doctor on call roster are addressed

Community mental health services for people with a learning disability or autism

- The trust should ensure that there is no access to other parts of the building that are unoccupied.
- The trust should ensure that formal guidance is available for staff to refer to regarding visitors to the premises. This should include what to do when high risk patients attended the service alone

Specialist community mental health services for children and young people

- The trust should ensure that all patients have a comprehensive care plan, which is personalised, holistic, and recovery focused.

Summary of findings

Specialist mental health services for people with an eating disorder

- The trust should ensure that further initiatives for staff recruitment and retention are explored.
- The trust should ensure that staff mandatory training attendance meets the trust's compliance standard of 95%.
- The trust should ensure that staff attendance at their safeguarding children level 3 mandatory training meets the trust's 95% compliance standard.
- The trust should ensure that all patients are involved in planning their care and have this recorded.

Community health services for children young people and families

- The trust should continue to review caseloads for school nurses and health visitors to ensure they are managed safely.
- The trust should ensure that the actual staffing levels meet the planned levels for nursing and support staff.
- The trust should implement a systematic programme of clinical audit.
- The trust should ensure that systems are reviewed in order to capture feedback from as many patients as possible

Community health inpatient services

- The trust should ensure that the storage areas on Welney ward comply with infection prevention and control requirements.
- The trust should ensure there is clear oversight of cleaning audits on ICU.
- The trust should ensure that all staff complete their role-specific mandatory training, including training on the Mental Capacity Act and Deprivation of Liberty Safeguards.
- The trust should ensure that there is an effective programme of local, clinical audit in place across the service.
- The trust should ensure that all staff receive an appraisal and regular supervision, in line with trust policy.
- The trust should review the responsiveness of ICU and Trafford wards, for patients requiring admission at weekends.

Is this organisation well-led?

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

We rated well-led at the trust as good because:

- The trust board had the appropriate range of skills, knowledge and experience to perform its role. The chief executive had been in post since August 2017 and the chair since July 2014. There were seven non-executive directors who had a wide range of previous and suitable experience. The appointments within medical specialities and other areas enabled the trust to move forward in innovative ways. For example, partnership working and research. The trust had re-organised their governance and management arrangements for better effectiveness.
- There was robust scrutiny at board level and non-executive directors challenged decisions where necessary. Staff felt able to report issues and successes through local meetings and through local risk registers which fed into the directorate's monthly performance and risk executive meeting attended by the chief executive. This meant that the

board had oversight of local challenges, developments and successes. Governors told us about effective induction, training and support to carry out their roles. They described a positive working relationship with the executive directors. The board had a good understanding of the challenges the trust faced, the plans in place to address them and also the progress being made. There were strategic plans in place underpinned by operational plans that leaders were able to discuss. Staff spoken with knew the trust's high level risks and their own local risks. We reviewed the trust risk register and saw that the board reviewed this regularly and each risk had actions and clear mitigations.

- There was evidence of a shared understanding of the financial issues faced by the trust and engagement throughout to support the Trust to deliver financial sustainability. The senior finance team at the trust was stable and experienced. The financial information provided to Board was clear and consistent with the monthly financial returns submitted to NHS Improvement. Where cost improvements were taking place there were arrangements to consider the impact on patient care. Where cost improvements were taking place, the focus was on not compromising patient care.
- Ward managers had access to a range of information to enable them to undertake their management role. This included a ward performance dashboard. The trust was aware of each directorate's performance through the use of key performance indicators and other metrics. Trust wide information was in an accessible format, timely, accurate and identified areas for improvement. This data fed into the board assurance framework via the performance and risk executive of each directorate.
- The trust had a clear vision and set of values with quality and sustainability as the top priorities. The trust's values were professionalism, respect, innovation dignity and empowerment known by the acronym PRIDE. The trust's vision was 'to give those people who need our services the best possible chance to live a full and happy life, despite their condition or circumstances'. These were embedded within trust processes for example; staff appraisals, recruitment and staff awards were aligned to these. Leaders showed a positive culture with a shared purpose towards the vision, values and strategy. Staff showed pride and talked passionately about their roles. Individual teams had positive relationships, worked well together and addressed any conflict appropriately.
- Board directors were visible and carried out a programme of ward and service based visits to meet staff. Front line staff confirmed they found these visits supportive and most knew who the trust's directors were. Staff confirmed that they found senior trust leaders approachable and easy to talk to.
- Fit and Proper Person checks were in place for all board members and non-executive directors. We reviewed six files and found that enhanced disclosure and barring checks were in place. Individual files were well organised and there were effective assurances in place. This included an annual review and confirmation at public board meetings.
- The trust had appointed a freedom to speak up guardian in August 2017. They attended national meetings for training and development. There was a robust system to report to the trust board on their work via the quality and compliance executive, performance and risk executive and quality safety and governance committee meetings.The number of referrals to the freedom to speak up guardian at the trust was 13 between October and December 2017. Front line staff had been given the opportunity to contribute to a current review of the trust's vision and values. Frontline staff felt respected and supported by their line manager and considered that morale was generally good across the trust. They felt able to raise concerns without fear of retribution and knew the trust had a freedom to speak up policy which they would use if they needed to. Staff side representatives were consulted about trust development and changes at monthly joint consultation and negotiation partnership meetings.
- The Trust ensured that its strategy aligned with the key priorities of the local sustainability and transformation partnership. We were impressed by the extent to which the trust board and other senior staff formed and led positive relationships within the wider local system. This was building a system that would be sustainable in the future

delivery of health and social care. The trust had productive relationships with external stakeholders. For example the trust worked closely with the University of Cambridge's Department of Psychiatry and other partners. Areas of research supported covered a wide number of conditions, including dementia, bipolar disorder, depression, psychosis, schizophrenia and autism.

- The trust had identified four key priorities for medicines optimisation. Actions were being taken to address these priorities led by the chief pharmacist. Services had been planned to take into account the needs of the local population. For example, amalgamating physical health care and older people's mental health community services within locally based hubs based on General Practitioner surgeries had led to improvements in the delivery of care at a local level and a reduction in admissions.
- The trust followed a robust process when investigating deaths and serious incidents. Investigations were carried out jointly by an investigation manager and a clinical reviewer. Monitoring of these investigations took place at weekly serious incident group meetings with the lessons learnt escalated to the quality and compliance executive, quality safety and governance committee and board meetings.. We reviewed a sample of four cases where the patient had died. The trust had carried out comprehensive investigations following each death and action plans were in place as a result. There was a comprehensive trust wide audit programme with 85 audits in place in December 2017
- The trust's workforce race equality scheme report and action plan for 2016 – 2017 was published on their website in August 2017. This identified a number of actions to be taken by the trust; for example, equality of opportunity and representation of people at senior manager level. The board had recognised equality and diversity required further work and had plans in place to address the issues.
- The trust had a draft action plan in place to address the 2017 NHS staff survey results. This covered work force wellbeing, quality of appraisals, improving engagement and resourcing and support. Senior managers told us they were committed to ensuring that this action plan was implemented fully. The trust reviewed the findings of the friends and family test as part of the integrated performance report which was escalated to the trusts' performance and risk executive meetings and the quality safety and governance committee meetings.
- Mandatory training rates were monitored by the trust through each directorate's performance dash board via each directorate's monthly performance and risk executive meeting attended by the chief executive. A red amber and green rating was used to identify where action was required by line managers.
- The trust had a robust process in place for managing complaints and cross checking for any safeguarding and welfare concerns and immediate actions. Duty of Candour consideration had been included in the investigation process. Final investigation letters were approved by the Directorate Heads of Nursing and signed off by the Chief Executive. Managers shared learning and action plans from complaints at ward based team meetings and more widely via the trust's quarterly 'lessons in practice' bulletin. We saw evidence of compliments received by the trust across those services inspected. The trust's staff recognition scheme; the PRIDE awards acknowledged staff contribution to patient care. Compliments were discussed at ward level team meetings.
- The medical director was the executive Mental Health Act (MHA) lead for the trust and the Head of MHA Legislation was the non-executive lead. The head of MHA legislation had restructured the MHA meetings to ensure information was presented in the right format to the right people. The trust's Mental Health Act administration team was working well for the benefit of those patients who were detained. Leaders of this team had ensured that understanding of the Act and its implications for practice was well understood within the relevant leadership teams. The trust had a section 75 agreement in place for the delivery of Local Authority functions. There was representation from partners on Mental Health Act working groups and committees. Examples of joint working groups included the Crisis Concordat Committee and Mental Health Law Liaison group. The police cited positive partnership working around the recent changes to section 136 of the Mental Health Act.

Summary of findings

- The trust had a major incident and continuity plan in place for emergencies. This covered a range of potential concerns and there was a clear protocol for the escalation of local concerns.
- The trust had a recruitment and retention strategy which had delivered innovative ways to recruit staff, such as career events, links with universities, bank opportunities for their own staff, 'growing our own' staff development strategies. For example, offering research posts to band five nurses in the specialist eating disorders service.
- The trust used research and innovation to improve patient care and also built alliances within the wider system. Patients and frontline staff were encouraged to make suggestions for improvements at ward and service levels. The trust had responded to feedback and changed the way that it worked as a result. For example, the introduction of the trust's first response service had led to a reduction in waiting times and presentation at local accident and emergency departments. The trust had employed a family liaison officer to provide support for families and carers following serious incidents and unexpected deaths. The trust participated in a wide range of audits and accreditation schemes and shared learning. For example, in clinical research studies as part of the (CLAHRC).

However:

- We found that there was underrepresentation at senior level for BME groups. BME groups did not always feel that they had sufficient opportunities.
- The extent to which managers recorded whether staff had an appraisal of their performance or supervision varied between services. The trust's 2016 NHS Staff survey had identified some staff concerns about the quality of the appraisals provided by the trust.
- The community health service for children young people and families used a different electronic reporting system to the one used by trust staff working in the child and adolescent mental health service (CAMHS). As a result, community staff were unable to see whether a patient was receiving any CAMHS intervention. The trust had mitigation plans to address this.
- The trust had set a target that staff should record the identity of the family carer for 60% of patients under the care of the trust. This was to ensure that carers' needs assessments were completed. At the time of the inspection, staff had done this for only 22% of patients

Ratings tables

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

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

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

Ratings for the whole trust

Safe	Effective	Caring	Responsive	Well-led	Overall
Requires improvement →← Jun 2018	Good →← Jun 2018	Good →← Jun 2018	Good →← Jun 2018	Good →← Jun 2018	Good →← Jun 2018

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

Ratings for a combined trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community	Good Jun 2018	Good Jun 2018	Good Jun 2018	Good Jun 2018	Good Jun 2018	Good Jun 2018
Mental health	Requires improvement →← Jun 2018	Good →← Jun 2018	Good →← Jun 2018	Good →← Jun 2018	Good →← Jun 2018	Good →← Jun 2018
Overall trust	Requires improvement →← Jun 2018	Good →← Jun 2018	Good →← Jun 2018	Good →← Jun 2018	Good →← Jun 2018	Good →← Jun 2018

The rating for the well-led key question is based on our inspection at trust level, taking into account what we found in individual services. Ratings for other key questions take into account the ratings for different types of service. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Ratings for community health services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community health services for adults	N/A	N/A	N/A	N/A	N/A	N/A
Community health services for children and young people	Good ↑ Jun 2018	Good →← Jun 2018	Good →← Jun 2018	Good ↑ Jun 2018	Good →← Jun 2018	Good ↑ Jun 2018
Community health inpatient services	Good Jun 2018	Good Jun 2018	Outstanding Jun 2018	Good Jun 2018	Good Jun 2018	Good Jun 2018
Urgent care	N/A	N/A	N/A	N/A	N/A	N/A
Overall*	Good Jun 2018	Good Jun 2018	Good Jun 2018	Good Jun 2018	Good Jun 2018	Good Jun 2018

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

Ratings for mental health services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Acute wards for adults of working age and psychiatric intensive care units	Requires improvement ➔➔ Jun 2018	Good ➔➔ Jun 2018	Good ➔➔ Jun 2018	Good ➔➔ Jun 2018	Good ➔➔ Jun 2018	Good ➔➔ Jun 2018
Long-stay or rehabilitation mental health wards for working age adults	Good Oct 2015	Good Oct 2015	Good Oct 2015	Good Oct 2015	Good Oct 2015	Good Oct 2015
Forensic inpatient or secure wards	Good ➔➔ Jun 2018	Good ➔➔ Jun 2018	Good ➔➔ Jun 2018	Good ➔➔ Jun 2018	Good ➔➔ Jun 2018	Good ➔➔ Jun 2018
Child and adolescent mental health wards	Good ➔➔ Jun 2018	Outstanding ➔➔ Jun 2018	Good ➔➔ Jun 2018	Good ➔➔ Jun 2018	Good ➔➔ Jun 2018	Good ➔➔ Jun 2018
Wards for older people with mental health problems	Requires improvement ➔ Jun 2018	Good ➔➔ Jun 2018	Requires improvement ➔ Jun 2018	Good ➔➔ Jun 2018	Good ➔➔ Jun 2018	Requires improvement ➔ Jun 2018
Wards for people with a learning disability or autism	Good ➔➔ Jun 2018	Good ➔➔ Jun 2018	Good ➔➔ Jun 2018	Good ➔➔ Jun 2018	Good ➔➔ Jun 2018	Good ➔➔ Jun 2018
Community-based mental health services for adults of working age	Good Oct 2015	Good Oct 2015	Good Oct 2015	Good Oct 2015	Good Oct 2015	Good Oct 2015
Mental health crisis services and health-based places of safety	Good Oct 2015	Good Oct 2015	Good Oct 2015	Good Oct 2015	Good Oct 2015	Good Oct 2015
Specialist community mental health services for children and young people	Requires improvement ➔➔ Jun 2018	Requires improvement ➔ Jun 2018	Good ➔➔ Jun 2018	Good ➔ Jun 2018	Requires improvement ➔ Jun 2018	Requires improvement ➔➔ Jun 2018
Community-based mental health services for older people	Good Oct 2015	Good Oct 2015	Good Oct 2015	Good Oct 2015	Good Oct 2015	Good Oct 2015
Community mental health services for people with a learning disability or autism	Requires improvement Jun 2018	Good Jun 2018	Good Jun 2018	Good Jun 2018	Good Jun 2018	Good Jun 2018
Specialist Eating disorder service	Requires improvement ➔ Jun 2018	Good ➔➔ Jun 2018	Good ➔➔ Jun 2018	Good ➔➔ Jun 2018	Good ➔➔ Jun 2018	Good ➔➔ Jun 2018
Overall	Requires improvement ➔➔ Jun 2018	Good ➔➔ Jun 2018	Good ➔➔ Jun 2018	Good ➔➔ Jun 2018	Good ➔➔ Jun 2018	Good ➔➔ Jun 2018

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

Community health services

Background to community health services

The trust has provided community health services since 2015. The trust provided services at ten registered locations with its main locations being Cambridge and Peterborough.

The trust provided the following community health services:

- Community health services for adults
- Community health services for children young people and families
- Urgent and emergency care
- Community health in patient wards

During this inspection we inspected the community health in patient services and the children young people and families services.

Most of the services provided in community health services were from the older people and adult community services which had 850,392 patient contacts in 2016-17. These services comprised of neighbourhood community services teams, joint emergency teams (JET), older people inpatient rehabilitation services and long term condition specialist services. The community inpatient service for adults in the Cambridgeshire and Peterborough area; included inpatient rehabilitation for patients discharged from local acute hospitals and for patients referred from community services.

Other community health services were provided by the children young people and family services which had 108,325 patient contacts in 2016-17. These services comprised of children's community services in Peterborough and specialist inpatient services for children, young people and their families. The trust provided both universal services such as health visiting and schools nursing, and targeted services. Targeted services included children in care, therapy, family nurse partnership, community paediatricians and community nursing.

Summary of community health services

Good

Our rating of these services stayed the same. We rated them as good because:

- The services managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned. When things went wrong, staff apologised and gave patients honest information and suitable support.
- Staff understood how to protect patients from abuse. Staff had training on how to recognise and report abuse.
- Staff followed best practice in relation to infection prevention and control. Clinical areas were clean and equipment well maintained. Medicines were recorded, stored and disposed of safely.

Summary of findings

- Staff worked together as a multi-disciplinary team to benefit patients. They supported each other to provide good care.
- Staff cared for patients with compassion. Patients, families and carers gave positive feedback about their care.
- The trust had established effective relationships with a wide range of organisations including local commissioners, acute hospitals, GPs, schools, mental health services and charities, to improve patient access to services.
- Complaints were effectively managed and used to improve the quality of the service.
- There were opportunities for further learning and development. Several staff members described how they had developed and progressed within the organisation. Staff told us that they were encouraged to go on courses that enabled them to develop personally and professionally.

However:

- Some service provision for children, young people and families had been reduced by the trust due to a lack of commissioned capacity.
- Compliance with appraisals was variable and staff did not always receive formal supervision.

Community health services for children and young people

Good

Key facts and figures

Cambridge and Peterborough NHS Foundation Trust is commissioned to provide a range of community health services for children, young people and families in Peterborough.

The trust provides both universal services such as health visiting and schools nursing, and targeted services. Targeted services include children in care, therapy, family nurse partnership, community paediatricians and community nursing.

The school nursing service provides services for all children and young people in mainstream and special schools and in the pupil referral unit. Children's community therapy teams provide psychology, occupational therapy, speech and language therapy and physiotherapy to children and young people. The children in care team carry out statutory health assessment of all children and young people who are looked after by the local authority. They also offer consultations; advice and support to promote the health and well-being of looked after children and young people. The family nurse partnership team offers intensive and structured home visiting to vulnerable young parents aged 19 years and younger.

Services are provided at the trust's multi-disciplinary Child Development Centre, as well as in schools, health centres, GP surgeries and in the patients' own home. The Child Development Centre assesses and provides treatment programmes for children (up until the age of five) who have significant developmental problems.

The trust works closely with a range of partners including other acute and community trusts, GPs, local authorities, schools and children's adolescent and mental health service (CAMHS).

We inspected the whole core service and looked at all five key questions.

Our inspection was announced one week prior to the inspection, to ensure that everyone we needed to talk to was available.

During the inspection we spoke with:

- 54 members of staff including service managers, team leaders, paediatricians, health visitors, school nurses, community nurses, healthcare assistants and allied health professionals.
- three patients
- eight parents
- one carer
- we reviewed 12 sets of patient records.

Summary of this service

The summary for this service appears in the overall summary of this report.

Is the service safe?

Good

Community health services for children and young people

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

- Staff had received training from the trust in safety systems, processes and practices.
- Staff kept patients safe from harm and abuse. They understood and followed procedures to protect vulnerable children and families. Health risks to children, young people and their families were assessed, monitored and managed appropriately.
- Staff followed best practice in relation to infection prevention and control. Clinical areas were clean and equipment well maintained. Medicines were recorded, stored and disposed of safely.
- Care and treatment records were accurate, stored securely and provided comprehensive details of care and treatment.
- Staff recognised incidents and knew how to report them. Managers investigated incidents and shared lessons learned.
- The trust was actively recruiting for staff to address vacancies within the teams and senior managers had rearranged caseloads to ensure the universal service was still delivered.

However:

- Staff caseloads remained high, specifically for school nurses and health visitors. Nursing and support staff were working below planned staffing levels.

Is the service effective?

Good

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

- Staff provided care and treatment in line with evidence-based practice and national guidelines. Internal reviews ensured that individual patient care and treatment supported good outcomes and that patients were on the most effective treatment pathway.
- The service promoted and supported breastfeeding. Staff supported people to live healthier lives.
- Staff had the appropriate skills, knowledge and experience to deliver effective care and treatment.
- There was effective multidisciplinary team working across the service. Staff worked together for the benefit of patients.
- Staff were aware of their responsibilities to seek individual patient consent, in line with current legislation.

However:

- There was no systematic programme of clinical audit across the service which meant senior staff could not be assured of the safety of the service.

Is the service caring?

Good

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

Community health services for children and young people

- Staff cared for patients with compassion, treating them with dignity and respect. Staff involved patients and carers in decisions about their care and treatment. They provided emotional support to patients to minimise individual distress. Staff used various age-appropriate tools to assess emotional wellbeing. For example, staff used patient health questionnaires to monitor severity of depression and response to treatment.
- Staff provided patients with relevant information, both verbal and written, so they could make informed decisions about their care and treatment.
- Staff had ensured that patients and families were able to find further information and support, including community and advocacy services.
- Patients, families and carers gave positive feedback about their care.

Is the service responsive?

Good 

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

- The trust had established effective relationships with a wide range of organisations including local commissioners, GPs, schools, mental health services and charities, to improve patient access to services.
- The service was delivered to meet the needs of different people, including those in vulnerable circumstances. For example, there was specialist equipment available for children with individual needs, such as bariatric equipment and mobility aids at the Child Development Centre.
- The trust actively monitored patient waiting times to identify trends and ensure services in high demand were managed appropriately to prevent patient pathway delays. The trust's universal service was working hard to address a significant backlog of patients identified in January 2018. This was caused by an information sharing error between GP surgeries and the trust's child health information service.
- Complaints were effectively managed and used to improve the quality of the service.

However:

- Some service provision for children, young people and families had been reduced by the trust due to a lack of commissioned capacity.

Is the service well-led?

Good 

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

- There were clear lines of management responsibility and accountability. Service managers knew about the quality issues, priorities and challenges. Local leaders were clear on the vision and purpose of the service, and their role within it.
- Staff described the culture within the service as open and transparent. They said managers were visible and approachable and could raise concerns and felt listened to. Staff were actively engaged in the planning and delivery of the service.
- The service had governance, risk management and quality measures to improve patient care, safety and outcomes.

Community health services for children and young people

- The trust had arrangements to ensure that the availability, integrity and confidentiality of patient confidential information were in line with data security standards.
- There were opportunities for further learning and development. Several staff members described how they had developed and progressed within the organisation. Staff told us that they were encouraged to go on courses that enabled them to develop personally and professionally.

However:

- The trust's patient satisfaction survey was not child-friendly, preventing the service from capturing feedback from its younger patients.

Outstanding practice

We found examples of outstanding practice in this service. See the outstanding practice section above.

Areas for improvement

We found areas for improvement in this service. See the areas for improvement section above.

Community health inpatient services

Good

Key facts and figures

Cambridgeshire and Peterborough NHS Foundation Trust (CPFT) provided a community inpatient service for adults in the Cambridgeshire and Peterborough area. The service included inpatient rehabilitation for patients discharged from local acute hospitals and for patients referred from community services.

Information provided by the trust showed that from April 2017 to March 2018 there were 1178 admissions to the community inpatient service.

The service is provided from five inpatient wards, located at four sites, as follows:

City Care Centre: Peterborough Intermediate Care Unit (ICU), which is a 34 bed rehabilitation unit.

Brookfields Hospital: Lord Byron A ward, which is a 20 bed rehabilitation ward and Lord Byron B ward, which is a 20 bed rehabilitation ward.

North Cambridgeshire Hospital: Trafford ward, which is a 16 bed ward, offering rehabilitation and also end of life care.

Princess of Wales Hospital: Welney ward, which is a 15 bed rehabilitation ward.

This service had not been previously inspected. The trust started providing the community inpatient service for adults in 2015. Before this, the service was run by a different provider.

At this inspection, we inspected all key questions. We rated safe, effective, responsive and well-led as good, and caring as outstanding, providing a rating of good overall.

Our inspection was announced at short notice to ensure that everyone we needed to talk to was available.

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

During this inspection we visited all five inpatient wards. We spoke to 27 members of staff including service leads, ward managers, nursing staff, allied health professionals, and support staff. We spoke with 11 patients, three relatives and reviewed nine patient care records. We also observed multidisciplinary team meetings, staff handovers and reviewed information including meeting minutes, audit data, action plans and training records.

Summary of this service

The summary for this service appears in the overall summary of this report.

Is the service safe?

Good

We rated it as good because:

Community health inpatient services

- The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned. When things went wrong, staff apologised and gave patients honest information and suitable support. The service used safety monitoring results well. Staff collected safety information and shared it with staff, patients and visitors. The service used this information to improve the service.
- The service prescribed, gave, recorded and stored medicines well.
- Staff kept appropriate records of patients' care and treatment. Care and treatment records were clear, up-to-date and available to staff providing care.
- Staff understood how to protect patients from abuse. Staff had training on how to recognise and report abuse.
- The trust had contingency plans for emergencies and staff understood what to do if required.

However:

- Staff on ICU did not have an oversight of cleaning audits. There were two storage areas on Welney ward, which did not have suitable shelving and contained sinks, which staff had to regularly flush for infection prevention purposes.
- Compliance with role-specific mandatory training, including training on the Mental Capacity Act and Deprivation of Liberty Safeguards, was variable across the wards.

Is the service effective?

Good

We rated this service as good because:

- The service provided care and treatment based on national guidance.
- Staff spoken with had a good understanding of the Mental Capacity Act and how this was used to support individual patients.
- Staff gave patients enough food and drink to meet their needs and improve their health. Patients were given choice.
- Staff worked together as a multi-disciplinary team to benefit patients. They supported each other to provide good care.
- Staff had access to current, accurate and comprehensive information on patients' care and treatment.

However:

- There was variability in the frequency and type of local clinical audits carried out on each ward and learning from these.
- Compliance with appraisals was variable and staff did not always receive formal supervision.

Is the service caring?

Outstanding

We rated this service as outstanding because:

Community health inpatient services

- Staff cared for patients with compassion. Feedback from patients was consistently positive and confirmed that staff treated them well and with kindness.
- Leaders promoted a strong person-centred culture across all wards. Staff on Trafford ward gave us several examples of how they had provided patients with compassionate care and supported the emotional wellbeing of patients and relatives. The ward manager told us how five staff had attended a patient's funeral to pay their respects and support the patient's relative.
- Staff went the extra mile to support patients' dignity and meet their care needs. On ICU, staff had contacted a patient's relative, who lived abroad, and arranged for a local launderette to launder the patient's clothes, so the patient had access to clean clothes while on the ward.
- Staff involved patients and those close to them as active partners in their care and treatment. Patients were involved in planning their care and staff encouraged relatives and carers to be involved in providing care on the ward.
- Staff provided emotional support to patients to minimise their distress. A nurse on Lord Byron A ward told us how they had stayed after their shift ended to provide emotional support to a patient who was worried about a hospital appointment.
- Staff found innovative ways to promote wellbeing by supporting patients with social interaction and activities. Activities included knitting, painting, exercise groups, a breakfast club and seasonal activities such as a Christmas carol service.

Is the service responsive?

Good

We rated this service as good because:

- The trust planned and provided services in a way that met the needs of local people. .
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, which were shared with all staff.
- Staff supported patients to access the service. Senior staff monitored waiting times and worked with the local clinical commissioning group to improve access to and discharge from the service.
- The service took account of patients' individual needs.

Is the service well-led?

Good

We rated this service as good because:

- The service had managers with the right skills and abilities to run a service providing high-quality care.
- Managers promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values. The trust had effective systems for identifying risks and planning to eliminate or reduce them.
- Senior staff were clear about plans and priorities for the service and ward managers shared in this vision.

Community health inpatient services

- The trust was committed to improving services by learning from when things go well and when they go wrong, promoting training and service development.
- The trust engaged well with patients and staff to plan and provide this service, and worked well with external organisations.

Outstanding practice

We found examples of outstanding practice in this service. See the outstanding practice section above.

Areas for improvement

We found areas for improvement in this service. See the areas for improvement section above.

Mental health services

Background to mental health services

Cambridgeshire and Peterborough NHS Foundation Trust was created in 2003 to provide mental health, learning disability and substance misuse health and social care services. It became a foundation trust in June 2008. The trust provided services at ten registered locations with its main locations being Cambridge and Peterborough.

The trust provided the following mental health services:

- Acute wards for adults of working age and psychiatric intensive care units
- Child and adolescent mental health wards
- Community mental health services for people with learning disabilities or autism
- Community-based mental health services for adults of working age
- Community-based mental health services for older people
- Forensic / secure wards
- Long stay/rehabilitation mental health wards for working age adults
- Mental health crisis services and health-based places of safety
- Specialist community mental health services for children and young people
- Wards for older people with mental health problems
- Wards for people with learning disabilities or autism
- Specialist mental health services.

During this inspection we inspected the following mental health services:

- Acute wards for adults of working age and psychiatric intensive care units
- Child and adolescent mental health wards
- Wards for people with a learning disability or autism
- Forensic inpatient or secure services.
- Wards for older people with mental health needs
- Community mental health services for people with a learning disability or autism
- Specialist community mental health services for children and young people
- Specialist mental health services for people with an eating disorder

The trust provided mental health services from three directorates:

Summary of findings

Adult mental health services which had 120,024 patient contacts in 2016-17. These services comprised of in-patient wards and community mental health teams in Cambridgeshire and Peterborough, crisis resolution, psychological medicine services and home treatment teams, IAPT teams and the advice and referral Centre (ARC). Specialist services included prison mental health in-reach teams, eating disorders, substance misuse, learning disability, autism and ADHD services, and criminal justice services and arts therapies were also provided.

Older people and adult community services which had 850,392 patient contacts in 2016-17. These services provided inpatient and community mental health services in Cambridgeshire and Peterborough for people over 65.

Children young people and family services which had 108,325 patient contacts in 2016-17. These services comprised of child and adolescent mental health, an adolescent intensive support team, a young people's drug and alcohol service and specialist inpatient services for children, young people and their families.

Summary of mental health services

Good  

Our rating of these services stayed the same. We rated them as good because:

- The trust managed patient safety well. Staff had recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned. When things went wrong, staff apologised and gave patients honest information and suitable support. The trust applied the Duty of Candour appropriately. Those serious incident reports reviewed included clear communication with and attempts to communicate with family and carers throughout the investigation process. Staff had training on how to recognise and report abuse and applied it. The trust had effective systems for identifying risks and planning to eliminate or reduce them. The trust was committed to improving services by learning from when things go well and when they went wrong. Staff training and service development was prioritised.
- Staff kept clear records of patients' care and treatment. Care and treatment records were clear, up-to-date and available to all staff providing care. The trust provided care and treatment based on national guidance. Patients had access to psychological support and occupational therapy. The physical healthcare needs of in patients with mental health needs were met.
- Trust staff worked well with each other and external organisations to provide care and treatment to patients based on national guidance. Bed management processes were effective and included daily bed management meetings.
- The trust promoted a person-centred culture and staff involved patients and those close to them as partners in their care and treatment. Staff provided positive emotional support to patients.

However:

- There were a number of environmental issues that prevented the trust from offering safe services. The current ward ligature risk assessments did not address all the potential ligature risks on the wards. Staff environmental checks on the wards were not thorough.
- Staff did not always record information thoroughly. Staff supervision rates and the recording of; were not monitored on a consistent basis by ward managers. Some seclusion records were incomplete and these did not reflect the interventions provided by staff during seclusion episodes.
- The current ward ligature risk assessments did not address all the potential ligature risks on the wards.

Wards for older people with mental health problems

Requires improvement 

Key facts and figures

The wards for older people with mental health problems are part of the trust's services for older people with mental health problems living in Cambridgeshire and Peterborough. There are four wards, situated in the grounds of two hospitals run by the trust.

Denbigh and Willow wards are located at Fulbourn Hospital in Cambridge. Denbigh ward is a 15 bed mixed sex ward for patients over 65 years with cognitive impairment. Willow ward is a 19 bed mixed sex ward for patients over 65 years with acute functional illness.

Maple 1 and Maple 2 wards are located at the Cavell Centre in Peterborough. Maple 1 ward is a 10 bed mixed sex ward for patients over the age of 65 years with cognitive impairment. Maple 2 ward is a 17 bed mixed sex ward for patients over 65 years with acute functional illness.

CQC have carried out 13 announced inspections of this trust, and 16 unannounced Mental Health Act review visits. Following the last comprehensive CQC inspection in May 2015, we rated this service as good overall.

On this occasion our inspection was announced five days in advance, (staff knew we were coming) and comprehensive. Before the inspection visit, we reviewed information that we held about this service along with information requested from the trust.

The inspection team visited every ward on between 13 and 15 March 2018. During the visit the inspection team:

- visited Willow, Denbigh, Maple 1 and Maple 2 wards and observed the care being given to patients and the support given to carers
- met with 17 patients who were using the service
- met with four carers of patients who were using the service
- interviewed three managers or the acting manager for the four wards we visited
- met with 36 nurses, healthcare assistants and other members of the multidisciplinary team
- spoke with one senior manager
- observed three multidisciplinary meetings, four activity sessions and two lunchtimes
- reviewed 29 patient care and treatment records relating to physical healthcare, risk assessments and care plans
- carried out a specific check of the medication management on all four wards
- carried out a specific review of Mental Health Act and Mental Capacity Act paperwork and processes on all four wards
- Reviewed a range of policies, procedures and other documents relating to the running of the service.

Summary of this service

The summary for this service appears in the overall summary of this report.

Wards for older people with mental health problems

Is the service safe?

Requires improvement 

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

- A safeguarding incident on Denbigh ward involving two patients who lacked capacity had not been reported in line with the trust's own policy.
- Managers had not upheld their duty of candour on one occasion. They had told a family that following their investigation of an incident involving their relative they had raised a safeguarding alert for that patient, which had not happened.
- Three of the four ward based ligature risk assessments were not complete. Ligature points in the garden areas were not identified on Denbigh ward and the audit for Maple wards had outstanding actions to be completed.
- There was damage to the environment on two wards. The toilet seat in the assisted bathroom on Maple Two ward was broken, and a bedroom on Denbigh ward had holes in the walls. These had not been reported for repair.
- Some areas on the wards were not easily observed by staff, though since the last inspection we noted that some convex mirrors had been installed in some key spots. Staff told us they observed the blind spot areas at all times, and did not have unaccompanied patients in these areas. However, we noted that this did not always happen.
- Staff had not completed the cleaning record for the communal use hoist in the assisted bathroom on Maple ward.
- There were gaps in the night-time duty doctor on call roster which meant that patients may have experienced delays in receiving medical treatment in an emergency.

However:

- The trust took immediate action following the initial concerns raised that the ligature risk assessments did not identify all risks or detail sufficiently how they were to be managed.
- Care and treatment records reviewed showed good practice in linking risk assessment with care planning. Staff completed a risk assessment of every patient on admission and updated it regularly, including after any incident. Staff were aware of and dealt with any specific risk issues, such as falls or pressure ulcers. They identified and responded to changing risks to, or posed by, patients. Care records were holistic, recovery focussed and person centred. Patients were encouraged to complete an easy read "My care matters profile".
- Staff used effective verbal de-escalation strategies and quiet time to support patients in distress. There were enough trained staff to carry out physical interventions such as observations, de-escalation and restraint. Wards participated in the trust's restrictive interventions reduction programme.
- Wards were clean and well maintained and staff had completed most cleaning records in a timely manner. Furnishings were clean and well maintained. Patients and staff had access to appropriate equipment designed to safely assist patients with independent living, and staff with safe manual handling practice.
- Clinic rooms were fully equipped with accessible resuscitation equipment and emergency drugs that staff checked regularly. Staff maintained equipment well and kept it clean. Patients had access to nurse call systems throughout the wards.

Wards for older people with mental health problems

- Although the service had high vacancy rates managers were addressing this with the appropriate use of consistent bank and agency staff. This ensured the wards retained safe staffing levels. When agency and bank nursing staff were used, those staff received an induction and were familiar with the ward. Patients' Section 17 leave and activity programmes were rarely cancelled due to insufficient staff.
- At the time of inspection, mandatory training was 91%. This had improved since the provider's data submission in September 2017, when the figure was 87%.
- There was good medicines management and prescribing practice. Pharmacy staff visited the wards regularly and were contactable to provide advice including out of hours.
- Pharmacy staff carried out medicines reconciliation daily Monday-Friday and gave advice to staff as required.
- Staff reported incidents correctly and in a timely manner. We saw evidence of learning following the investigation of incidents across the wards.

Is the service effective?

Good 

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

- Care and treatment records demonstrated a robust assessment of patients physical and mental health needs and these were recorded in a timely manner.
- Care plans were personalised, holistic, and recovery orientated. Care plans addressed the needs identified in the assessments. Staff linked their daily care notes to the patients identified care needs. Staff updated care plans as required in a timely manner.
- Staff used recognised outcome measures such as health of the nation's outcome scales. They provided a range of care and treatment interventions suitable for this patient group, staff based their interventions on recognised models of care including the Canadian model of occupational performance and model of creative ability.
- Staff had ensured that patients had good access to physical healthcare, including access to specialists when needed. Staff assessed and met patients' needs for food and drink and for specialist nutrition and hydration advice where required.
- Staff held regular multidisciplinary meetings, including twice-weekly multidisciplinary ward rounds, a monthly team meeting, and twice-daily shift handovers.
- Staff had established good working relationships with teams outside the organisation for example, local authority social services, community mental health teams, CRISIS team and GPs.
- Staff had trained in and had a good understanding of the Mental Health Act, the Code of Practice and the guiding principles. Staff had access to administrative support and legal advice on implementation of the Mental Health Act and its Code of Practice.
- Ninety one percent of staff had completed training in Mental Capacity Act and Deprivation of Liberty Safeguarding. The trust had a policy on the Mental Capacity Act, including deprivation of liberty safeguards. Staff were aware of the policy and had access to it. Informal patients could leave at will, and notices on the wards informed them of this.

- Staff carried out capacity assessments with patients. Staff gave patients assistance to make a specific decision for themselves before they assumed that the patient lacked the mental capacity. When patients lacked capacity, staff made decisions in their best interests, recognising the importance of the person's wishes, feelings, culture and history.

However:

- Staff were not recording their supervision on the trust's centralised supervision recording system

Is the service caring?

Requires improvement 

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

- Denbigh ward had removed curtains from the ward areas for deep cleaning, and not replaced them with any temporary coverings. On Denbigh ward, staff used the quiet area to feed a patient, staff did not realise the process could be observed by people passing the ward. While bedrooms had partial opaque glass, there was nothing to stop daylight entering, causing early morning waking and shadowing at night when the light was on. This meant that the privacy and dignity of patients could have been compromised.
- On Denbigh ward each patient was wearing identity bands on their wrists or on their ankles. Those patients who voiced an opinion about this did not like them on their ankles. There was no risk assessment in place to support this practise.
- Care and treatment records did not indicate if carers or patients had been offered a copy of their care plan.

However:

- Patients said staff treated them well and behaved appropriately towards them. Staff supported patients to understand and manage their care, treatment and health conditions. Staff understood the individual needs of patients, including their personal, cultural, social and religious needs.
- Staff directed patients to other services and advocacy when appropriate and, if required, supported them to access those services. Staff encouraged patients to access activities and services in the community where possible.
- Staff used the admission process to inform and orient patients to the ward and to the service. Staff told us that the orientation could include family members if the patient wished. Staff gave welcome packs to patients and their carers or family member on admission.
- Care plans and minutes of ward round meetings showed staff had involved patients in their care planning and risk assessment. Patients were encouraged to complete an easy read "My care matters profile." This included the things the patient liked and things they did not like, and what level of assistance they felt they needed to return home.
- Staff enabled patients and carers to give feedback on the service they received through a comments card and box system. Staff reviewed these comment cards and recorded them and the outcomes on a "you said we did" notice board in the communal area of the wards.
- Staff provided carers with information about how to access a carer's assessment

Wards for older people with mental health problems

Is the service responsive?

Good 

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

- Bed management was effective. The average length of stay had been 8-12 weeks between September 2017 and February 2018. There had only been two delayed discharges during the same period. There was a discharge facilitator on each ward and, staff planned for patients' discharge, with care managers and care co-ordinators in community teams.
- Patients did not have to move wards unless it was in the interests of the patient. There was always a bed available when patients returned from leave. Staff supported patients during referrals and transfers between services, for example, if they required treatment in an acute hospital or temporary transfer to a psychiatric intensive care unit.
- Patients could personalise their own bedrooms. Staff and patients had access to the full range of rooms and equipment needed to support treatment and care.
- There were quiet areas on the ward and a room where patients could meet visitors. Patients had access to outside space.
- Staff ensured that where possible patients could access activities in the community including the gym, social activities and places of worship. Staff encouraged patients to develop and maintain relationships with people that mattered to them, both within the services and the wider community.
- When patients had complained or raised concerns, they had received feedback. Staff knew how to handle complaints and compliments appropriately. Staff received feedback on the outcome of investigation of complaints at ward meetings and acted on the findings.

Is the service well-led?

Good 

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

- Managers had a good understanding of the services they managed. They could explain clearly how the teams were working to provide high quality care. Managers were visible in the service and approachable for patients and staff. Staff told us they respected their team leaders.
- Front line staff had implemented trust wide recommendations from reviews of deaths, incidents, complaints and safeguarding alerts at the service level. Staff linked patients risk assessments to environmental risk management.
- Staff used quality improvement methods, such as models of practice, and knew how to apply them. Staff participated in national audits relevant to the service and learned from them.

However:

- The service did not have robust governance systems in place to identify the concerns identified on this inspection.
- The acting ward manager on Maple ward told us that they did not have full access to all governance systems and information and that they had to ask the modern matron to access this information for them. Neither could they access historical information that had been uploaded by their predecessors.

Wards for older people with mental health problems

Areas for improvement

We found areas for improvement in this service. See the areas for improvement section above.

Child and adolescent mental health wards

Good ➔➔

Key facts and figures

The trust operates the children young people and family services directorate. Within the children young people and family services there are 29 teams and 22 services. Teams had 108,325 patient contacts between 2016 and 2017. There are child and adolescent mental health community services in both Cambridgeshire and Peterborough. These include children's community services, an adolescent intensive support team, a young people's drug and alcohol service; and specialist inpatient services for children, young people and their families.

The Darwin Centre and the Croft Child and Family Unit are both located on the Ida Darwin site in Fulbourn Cambridge.

The Darwin Centre for Young People is a specialist adolescent inpatient unit for the assessment and treatment of young people aged from 13 to 18 presenting with severe and acute mental health problems. The service provides 14 beds. The Darwin Centre is part of the Tier 4 acute care child and adolescent mental health pathway.

The Croft Child and Family Unit is an NHS day and inpatient service for children aged 0 to 12 years with mental health problems and their families. The Family Unit is the only unit in the UK offering specialist in-patient and day-patient mental health treatment for children, siblings and their families. The service opens five days a week (Monday to Friday), and during the school holidays and is closed on bank holidays. The service provides a whole family approach, alongside an integrated educational programme. Twelve beds are commissioned and the service provides these for six children and six parents/carers. Parents are admitted alongside their child. The service provides intensive assessment and treatment for children with complex emotional, behavioural and social difficulties. It also offers intensive work with parents to develop their parenting skills. The service provides a day patient service for children who live locally and do not require 24 hour treatment or observation.

Both services had a school. These were rated by OFSTED as 'outstanding'. These schools provided a wide range of subjects. For example at Darwin Centre Ariel silk syllabus (moves and exercise with silk ropes) was provided for one young person to study.

This service had been previously inspected as part of a comprehensive inspection in May 2015, when we rated the core service as good overall. A Mental Health Act monitoring visit took place in August 2017.

This inspection took place on 13 and 14 March 2018. During the inspection we:

- spoke with two young people that were using the service
- spoke with four family carers
- interviewed 17 staff and managers
- observed one staff handover
- reviewed nine care records relating to physical health, risk assessments and care plans
- reviewed three medication charts
- observed children and young people at onsite school provision
- Joined young people for lunch.

Child and adolescent mental health wards

Summary of this service

The summary for this service appears in the overall summary of this report.

Is the service safe?

Good  

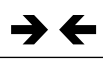
Our rating of safe improved. We rated it as good because:

- The environment was safe, clean, and had rooms for therapies and activities.
- Wards had an adequate number of staff to provide safe care. Where there were vacancies, managers were actively recruiting new staff. They used suitably skilled bank and agency staff to cover any gaps.
- Staff managed risks well. Children and young people's risk assessments were robust, and up to date. Staff were trained deal with behaviours that may challenge. Nominated staff were the safeguarding leads.
- Staff knew how to report incidents and managers monitored these reports to identify and implement any lessons that might be learnt.
- Staff managed and administered medication correctly.

However

- Ligature risk assessments were not comprehensive. However, risks had been mitigated by relational security.
- At the Croft Centre the seclusion room had a partial blind spot and the hatch door needed repairing to fully ensure children's safety.

Is the service effective?

Outstanding  

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

- Staff developed care plans that met the needs of the individual child or young person. They were up to date, personalised, holistic and recovery orientated. This included meeting the patient's physical health care needs. Staff at the Darwin Centre used innovative approaches when supporting young people with de-escalation for example scented oils sprays and textured materials with a good effect on patient behaviour.
- We saw in the care records that consent was recorded and discussed with patients and their families taking into consideration Gillick competence and parental responsibility.
- A wide range of outcome measures were used to gauge how children and young people were doing. For example children's global assessment scale and health of the nation outcome scales child and adolescent.
- Staff on both wards provided a full and comprehensive handover for each young person. Staff from different disciplines worked well together to provide care. Children and young people had access to a child psychotherapist and art and music therapists. All aspects of a patient care were taken into consideration to promote their recovery.

Child and adolescent mental health wards

- At the Croft Centre there was weekly team training and staff received bespoke training in managing young children who presented with behaviours that may challenge.
- Clinical staff on both wards received regular supervision and appraisal. The service had a strong commitment to developing skills, competence and knowledge of staff. Reflective practice meetings with an external facilitator enabled staff to improve practice and offer better patient care.
- The Croft Centre admitted children and their families so that the whole family could be offered therapy as a unit. Staff used a specialised parenting programme for families with pre-school child presenting with behavioural problems. This included a weekly parenting support group.

Is the service caring?

Good 

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

- Staff were caring and passionate when talking about children and young people. We observed positive interactions between children, young people and staff. At the Darwin Centre we saw a young person become distressed. A staff member intervened, and remained patiently with the young person talking, until they were calmer. Staff understood the individual needs of children and young people.
- Staff offered family therapy to all families weekly at both services. Staff supported families with welfare needs. Carers, children and young people were complimentary about the staff and the care they received.
- Each child and young person had a named nurse/key worker. Confidential personal information about children and young people were kept confidential.

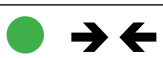
Is the service responsive?

Good 

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

- Staff provided home cooked meals at Croft Centre at all times. At Darwin Centre some cooked meals were provided. Healthy options were available at both sites.
- Children and young people were able to personalise bedrooms. Children and young people had access to outside space. Facilities and resources included access to a full range of rooms, a low sensory garden, equipped playground area. The Croft Centre had a dual kitchen area for staff and families to cook together.
- Each child and young person had an individualised care plan, which informed discharge planning.
- Children and young people had access to an advocacy service and knew how to make a complaint, if they felt they needed to.

Is the service well-led?

Good 

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

Child and adolescent mental health wards

- Staff reported a positive, supportive local team working environment.
- Managers had a good understanding of the services they managed and demonstrated good leadership. All staff were offered development opportunities.
- Managers provided weekly case discussion groups run by external doctors for staff; and weekly clinical supervision /reflective practice groups.
- Managers had made service improvements on feedback received from children and young people.
- Staff were preparing for accreditation of services by the Quality Network for Inpatient CAMHS (QNIC).

Outstanding practice

We found examples of outstanding practice in this service. See the outstanding practice section above.

Areas for improvement

We found areas for improvement in this service. See the areas for improvement section above.

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

Good ➔➔

Key facts and figures

The acute wards for adults of working age are based at the Fulbourn Hospital in Cambridge, and the Cavell Centre in Peterborough. The trust operated a 3-3-3 pathway model of assessment, treatment and recovery. The model consists of three days of assessment, three weeks of treatment and three months of recovery. The average length of stay data indicated a variation from the model. This was due to the acuity of patients admitted and delays in discharge

Each acute ward had a designated function, providing services for adults aged 18 years old and over. The trust also provided a psychiatric intensive care unit for male adults aged 18 years old and over. This was based at the Cavell Centre in Peterborough.

The last comprehensive trust inspection took place in May 2015. At the time of that inspection, there were no breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 at this core service.

Our inspection was announced five days in advance to ensure that everyone we needed to talk to was available. Before the inspection visit we reviewed information that we held about these services and information requested from the trust.

The inspection team visited all six acute wards and the psychiatric intensive care ward on 13, 14 and 15 March 2018. During the visit the inspection team:

- spoke with 23 patients who were using the service
- interviewed seven managers or acting managers for each of the wards
- interviewed three senior managers
- met with 31 staff members
- spoke with three carers / family members
- attended three nursing staff shift handovers and two multidisciplinary meetings
- joined three patient community meetings
- reviewed 47 patient care and treatment records relating to physical health, risk assessments and care plans
- reviewed 19 medication charts
- reviewed a range of policies, procedures and other documents relating to the running of the service

Summary of this service

The summary for this service appears in the overall summary of this report.

Is the service safe?

Requires improvement ➔➔

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

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

- Managers had not identified potential ligature risks across all seven wards. This was escalated to trust senior managers at the time of inspection.
- The wards had some outstanding maintenance tasks across three wards. For example, fire doors had missing panels on Oak four ward and Mulberry one ward and a veneer strip was missing on a bed on Oak four ward. These presented a safety risk to patients.
- Staff environmental checks on the wards were not thorough. For example, we saw a shower facility at Mulberry three ward where an electrical light fitting was exposed within the shower cubicle. We raised this with the ward manager who immediately closed the bathroom.
- The layout of the psychiatric intensive care unit's seclusion room could pose a safety risk to patients and staff. This was because staff had to enter the room to support patients to use the en-suite facility. Seclusion records had not been fully completed. These did not reflect the interventions provided by staff during seclusion episodes.
- Some wards had shifts that were unfilled. All wards used bank and agency staff. Staffing rotas showed that not all shifts were filled.
- Staff did not effectively implement the trust smoke free policy. We identified evidence that patients were smoking on Mulberry one ward. This posed a potential fire safety risk. We found a cigarette lighter in a patient's bedroom on Mulberry two ward.
- Staff on Oak four ward confirmed that creams issued by the trust pharmacy were shared between patients.

However:

- All wards were visibly clean and tidy. Managers monitored monthly audits of hand hygiene, cleanliness and infection control within ward performance dashboards.
- Patients said that one to one time with keyworkers, activities or escorted leave was rarely cancelled.
- Patients had an individualised risk assessment which was completed on admission and updated on a regular basis.
- Staff discussed incidents and learning points in team meetings.
- The trust took immediate action to deal with the sharing of creams on Oak four ward following the inspection.

Is the service effective?

Good  

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

- Care plans included physical healthcare needs and care and treatment records showed that patients had a physical health examination on admission.
- The trust had supported the clinical nurse specialist on Mulberry one ward to develop a sexual health clinic available to patients on a weekly basis.
- Staff received opportunities to develop their skills and knowledge by attending both internal and external training suitable for their role.
- Staff had produced an 'ABC of local induction' leaflet which had been nominated for a trust award.
- Staff completed Mental Health Act paperwork correctly. There was administrative support to ensure paperwork was up to date and regular audits took place.

- Patients had access to psychological support and occupational therapy.

However:

- The monitoring and recording of staff supervision rates varied across the wards.

Is the service caring?

Good 

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

- Staff treated patients with kindness, compassion and respect. Staff were responsive to the individual needs of patients. Communication was discreet and respectful.
- Staff treated each patient with dignity and engaged patients in meaningful activities. Staff interacted with patients at a level that was appropriate to their individual needs.
- Patients were encouraged to participate and share their views about their care and treatment in multidisciplinary team meetings.
- The trust had established opportunities for families and carers to attend support groups.

Is the service responsive?

Good 

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

- The trust held daily bed management meetings every week day. These meetings reviewed all wards to identify the availability of beds and potential patient discharges.
- Patients personalised their bedrooms. Patients had use of their own mobile phones across all wards and they had access to gardens and patio areas. Patient's valuables were kept in lockers either within locked cabinets in their bedrooms or locked containers within secure rooms.
- Wards had assisted bathrooms or shower rooms for patients with restricted mobility. Each patient was assessed on admission for specific needs including protected characteristics. This was supported by those care and treatment records seen.
- Wards had information on the complaints process and this was displayed to patients on ward notice boards and was available in patient information leaflets. The trust had systems in place for the recording and management of complaints. All complaints where discussed at team meetings. The learning from these was reviewed by the ward team. Patients raised concerns and provided feedback about the wards at the daily community meetings.

However:

- There were potential privacy and dignity issues to patients in the seclusion room as staff had to observe patients when using the bathroom.

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

Is the service well-led?

Good 

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

- Staff had been given the opportunity to contribute to a review of the trust's vision and values.
- Ward managers collected data and produced a performance dashboard which measured key performance indicators. For example, sickness levels, turnover, complaints, incidents, restraints, audits and patient experience information.
- The trust took immediate action after the inspection to review their processes for the safe management of alarms, keys and identification cards which were being taken home by staff.

However:

- Ward managers had not captured all ligature risks on the relevant monitoring form.
- Ward managers did not monitor the arrangements in place for the safe management of alarms, keys and identification cards which were taken home by staff. Staff were taking these away from the hospital which meant that these could be misplaced and access gained by unauthorised persons.
- The recording of staff supervision varied across the wards.

Outstanding practice

We found examples of outstanding practice in this service. See the outstanding practice section above.

Areas for improvement

We found areas for improvement in this service. See the areas for improvement section above.

Community mental health services for people with a learning disability or autism

Good

Key facts and figures

Cambridgeshire and Peterborough NHS Foundation Trust (CPFT) have one Intensive Support Team (IST) for patients with a learning disability or autism based at the Gloucester Centre Peterborough. The trust also employed three staff managed as part of the learning disability partnership based in Toft, Cambridge. Some people with learning disabilities and autism were offered work placements at the Ida Darwin Nurseries at Fulbourn.

This inspection focussed on the service offered by the IST in Peterborough. This was the first CQC inspection this service had undergone.

The service had 16 patients on their books, seven were being actively managed in the Community, two were in-patients, one was at a residential college and six were being supported out of area.

The service offered two pathways. These were the prevention of 'out of area' placements and the re-settlement pathway and the crisis stabilisation pathway. This pathway had been in operation for one day at the time of the inspection.

During our inspection we:

- interviewed seven staff, including nurses, consultant psychiatrists, the team lead and healthcare support workers
- toured the premises
- spoke with two carers of patients and listened to the views of two patients
- observed staff interaction with patients
- reviewed 12 care and treatment records
- case tracked one patient pathway
- reviewed a range of policies and records relevant to the running of the service
- examined two each of minutes of multi - disciplinary team meetings, Business and Governance meetings and Specialist Service Adult Intensive Support team meetings and attended a multi - disciplinary meeting
- Attended one care review.

Summary of this service

The summary for this service appears in the overall summary of this report.

Is the service safe?

Requires improvement

We rated this service as requires improvement because:

Community mental health services for people with a learning disability or autism

- The environmental risk register did not identify all risks to the patient group using this service. Access to other parts of the building that were unoccupied was not restricted. Staff did not carry alarms, nor were there any in the interview rooms to summon help if needed.
- Staff had not updated patient records to reflect the assessed needs of those patients being cared for in out of area services. This meant that information was not always available to staff should they need it.
- The lone working policy did not address risk robustly. It did not cover the recently introduced out of hours service offered by the crisis stabilisation pathway. Staff had no formal guidance to refer to regarding visitors to the premises or what to do if higher risk patients attended the service alone.
- Key patient information was not recorded by staff in the trust's electronic recording system.

However:

- Case- loads were discussed every two weeks at the multi- disciplinary meeting. This gave an opportunity for the team to review their individual caseloads within a multi-disciplinary meeting.
- Learning from trust wide incidents was shared in the weekly team meeting and in individual supervision. Those team meeting minutes seen referred to a 'discussion slot' that allowed staff to share experiences and reflect upon practise.
- There was enough staff of varying disciplines, including nurses, health care support workers, consultant psychiatrist and social worker, to meet the needs of the patient group. Staff were up to date with their mandatory training.

Is the service effective?

Good

We rated this service as good because:

- Staff provided a range of care and treatment suitable for patients. They supported patients to live healthier lives. Minutes of the multi- disciplinary meeting showed that the physical healthcare needs of patients were regularly reviewed. Staff had the right skills and knowledge to meet their patient's needs.
- Recognised rating scales to assess outcomes for patients including the health of the nation outcome scales for learning disability were used by staff.
- Staff held meetings with out of area placement providers, the patient's social care support staff, carers and the in-patient unit staff, along with social work and education providers. This enabled them to provide holistic support to individual patients.
- Staff had regular managerial and clinical supervision and received an annual appraisal.

However:

- Staff recorded information in the patient progress notes, rather than in the trust's electronic recording system which delayed the recording of information.
- Front line staff did not participate in audits.

Is the service caring?

Good

Community mental health services for people with a learning disability or autism

We rated this service as good because:

- Staff spoke to patients in a manner that was both respectful and appropriate for the communication needs of the patient. Staff understood the individual needs of patients. They could describe, in depth the cultural needs, history, likes and dislikes of their patients and how they presented when concerned, anxious or deteriorating in health
- Two patients told us they were able to discuss the care and treatment offered to them with staff. They confirmed that staff listened to them and took their views into account. This was reflected in the records seen. Two carers who told us that they were fully supported to be involved in the care of her relatives.
- All patients and carers were invited to give feedback on the service by completing the trust's 'friends and family' test.

Is the service responsive?

Good

We rated this service as good because:

- The trust was meeting their responsibilities under the transforming care programme by assessing patients and then transferring them into their care from out of area placements.
- The trust had clear criteria for admission into treatment and care. We saw that standard operating procedures were in place for both pathways. The service was meeting their targets in assessing and treating patients referred to it. Staff provided a period of intensive support during the patient transition time from their out of area placements.
- Patients told us that appointments were rarely cancelled, and when they were they were given an explanation and offered a further appointment.
- Patients were encouraged to attend a variety of group and work opportunities. Staff provided information leaflets in a range of formats for patients and carers
- Patients understood how to make a complaint. There had been no complaints about this service during the past 12 months.

However:

- The service's telephone line was only manned for three hours, from nine am until 12 pm, four mornings per week.

Is the service well-led?

Good

We rated this service as good because:

- Senior managers expressed clear understanding of the service, its aims and vision and knowledge of the needs of the patient group. They were supported to undertake their role with information about key performance indicators including staffing levels and patient care.
- Staff had been supported to undertake development opportunities. For example, one healthcare support worker had gained a foundation degree and other staff professional opportunities were provided by the trust. Staff supervision and appraisals included discussions about individual performance and career progression in the trust.

- Staff liaised closely with other agencies to share information about individual patients in line with the trust's confidentiality policy.

However:

- The trust had not taken action to ensure that risks to patients and staff from the environment were assessed and mitigated.
- The trust had not ensured that frontline staff complied with the trust's own policy. For example, the recording of clinical information on patient's electronic records was reliant on the office administrator uploading the information.

Areas for improvement

We found areas for improvement in this service. See the areas for improvement section above.

Specialist community mental health services for children and young people

Requires improvement 

Key facts and figures

Specialist community mental health services for children and young people in Cambridge and Peterborough Foundation Trust provide a wide range of services for children, young people and their families. Services provided include pathways for children and young people with mild, moderate and severe mental health problems, and care and treatment for children and young people with developmental problems.

Care pathways within the service are aligned to the children and adolescent mental health tiered model of service. The main treatment pathway for children and young people entering secondary care includes a comprehensive and holistic assessment and a wide range of therapeutic approaches to address identified needs including:

- family therapy
- cognitive behavioural therapy
- group therapy
- psychotherapy
- psycho-education.

Services are provided in Peterborough, Huntingdon and Cambridge.

During our visit, we inspected Specialist Community and Mental Health services for children and young people at all three sites, the neurodevelopmental services/teams at two sites (Peterborough and Cambridge) and the substance misuse services for children and young people in Huntingdon.

Our inspection was announced, five days in advance to ensure that everyone we needed to talk to was available.

During the inspection visit, the inspection team:

- visited all three community bases, looked at the quality of the environment and observed how staff were caring for patients
- met with 13 patients
- met with 13 carers
- interviewed the managers for each of the teams, the service manager, general manager, interim associate director of operations and directorate head of nursing
- interviewed 36 other staff members; including doctors, nurses and social workers.

We also:

- reviewed 30 care and treatment records of patients
- attended and observed four multi-disciplinary meetings and a peer review meeting.
- accompanied staff on two patient reviews at outpatients' clinic and an assessment at a local acute trust.
- reviewed a range of policies, procedures and other documents relating to the running of the service.

Specialist community mental health services for children and young people

Summary of this service

The summary for this service appears in the overall summary of this report.

Is the service safe?

Requires improvement ● →←

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

- Staff were not routinely monitoring the risk of those young people waiting to receive treatment. Patients and carers were advised to contact the service or attend the local accident and emergency department if there was a rapid deterioration in the patient's health.
- Staff did not follow the trust policy on the recording of risk. Those risk assessments seen were incomplete and had not been updated following changes in the patient's risk presentation.
- The trust had not ensured that there were sufficient staffing to meet the needs of the patients. This was adversely affecting patient care and treatment.
- There were no fixed alarms in the Huntingdon bases.
- The trust had not identified a number of environmental risks in areas to which patients had access.
- Staff were not aware of the trust new access policy on patients who did not attend appointments. This meant that patients, who failed to attend appointments, were not robustly followed up.
- Staff knew how to report an incident however reporting levels were low.
- The number of recent changes in the senior management team had affected the service. Staff turnover and vacancies had adversely affected service continuity, availability of treatment options for patients and staff morale.
- Managers did not identify that staff were not reporting all incidents

However

- Services were clean and well maintained with good furnishings
- The choice and partnership model of care had determined safe staffing levels for the service. There was a proactive recruitment process in place.
- There are fixed alarms in the Peterborough bases, Staff had access to personal alarms in Huntingdon and used them as necessary.
- Staff knew how to identify adults and children at risk of, or suffering significant harm. The service had good working relationships with the trusts' safeguarding team, local safeguarding children board and worked in partnership with other agencies to protect patients.

Is the service effective?

Requires improvement ● ↓

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

Specialist community mental health services for children and young people

- Staff had not developed comprehensive care plans for patients. These were not recovery focused. Staff were not updating care plans following changes in assessed patient risk.
- Some staff were not aware of their responsibilities under the Mental Capacity Act and specific issues relating to capacity assessment and Gillick competencies as they related to patients.
- There was no family therapy or psychology service in the substance misuse team.
- Mental Health Act training was not part of the mandatory training provided to them by the trust. This meant that only 33% of staff had received this training.

However:

- Staff received referrals for assessment and treatment from the single point of access team. They held regular multidisciplinary team meetings, where new referrals, risk and cases of concern were discussed. Staff used a wide variety of outcome measures to monitor patient progress.
- Staff were skilled and experienced and able to meet the needs of the patient group. They worked collaboratively with the third sector services that provided a mental health and emotional wellbeing service for children and young people.

Is the service caring?

Good

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

- Staff attitudes and behaviours when interacting with patients were discreet, respectful and responsive. Staff provided patients with help and emotional support in a timely manner.
- Patients and carers said staff were caring, respectful and supportive. Carers confirmed that staff supported them.
- Staff used a variety of methods to communicate effectively with patients, including the use of signing and age appropriate language.

However:

- Patient care plans were not all personalised and holistic.

Is the service responsive?

Good 

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

- The service's waiting lists from referral to assessment had reduced from 181 days in November 2017 to 52 days in March 2018.
- Staff responded promptly when patients telephoned the service. We observed a number of interactions with both patients and carers, during which staff were attentive and supportive.
- Staff offered patients appointments at a time that best suited them where possible.
- Staff saw urgent referrals in a timely manner.

However:

- Waiting lists were long in some specialist services especially the neuro rehabilitation service.

Is the service well-led?

Requires improvement 

Our rating of well-led went down. We rated it as requires improvement because:

- The number of recent changes in the senior management team had affected the service. Staff turnover and vacancies had adversely affected service continuity, availability of treatment options for patients and staff morale.
- The trust had not identified the risk to patients waiting for treatment on the local risk register. There were long waits for treatment for some patients.
- Managers did not identify that staff were not reporting all incidents.
- The trust had not implemented quality improvement plans for this service.

However:

- Staff had access to support for their own physical and emotional health needs through the trust's occupational health service. We found that staff well-being was high on the agenda for managers.

Areas for improvement

We found areas for improvement in this service. See the areas for improvement section above.

Wards for people with a learning disability or autism

Good

Key facts and figures

The Hollies was a 10 bedded specialist ward providing care and treatment for adults with a learning disability, autism and additional mental health needs. The Service admitted adults who had been identified as having additional complex needs and were at immediate risk to themselves or others.

The ward was split in to two areas called Hollies one and Hollies two. Hollies one had six bedrooms and only admitted female patients and the Hollies two had four bedrooms and only admitted male patients. There were three patients admitted on the wards.

The Hollies was located at the Cavell Centre in the Peterborough hospital site. The service was provided by Cambridge and Peterborough Foundation Trust to carry out the following regulated activities.

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Diagnostic and screening procedures

Treatment of disease, disorder or injury

The Care Quality Commission last inspected the Hollies in May 2015. There were no breaches identified of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 during that inspection.

We rated the service a good in all areas. During this inspection we found the trust had taken action to implement the recommended actions which were: that patients should have access to medical staff, psychology and occupational therapy.

This inspection was announced. This was because the Care Quality Commission was inspecting a number of core services simultaneously. Before the inspection we reviewed information that we held about the Hollies.

The inspection team consisted of one lead inspector, one inspector and two specialist advisors with a specialist background in learning disability and autism. During the inspection we:

- interviewed the ward manager, deputy ward manager, two nurses and one health care assistant
- met with one psychiatrist
- spoke with one family carer
- spoke with all three patients with staff support
- observed care interactions
- reviewed three care and treatment records that included physical health checks, risk assessment and care plans
- Examined three medication administration records.

Summary of this service

The summary for this service appears in the overall summary of this report.

Wards for people with a learning disability or autism

Is the service safe?

Good 

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

- The ward had good lines of sight and where needed the ward manager had installed convex mirrors to improve observation. All staff had access to a personal alarm.
- Ward areas were well-presented, clean and regularly maintained. Ward staff completed environmental checks, if they identified any areas of concern, staff knew the process to escalate these findings appropriately.
- Trust records showed that 95% of staff had complete infection control training and there were hand wash posters on the ward to remind staff to wash their hands.
- Staff followed good practice guidance in medication management. The clinic room was well stocked; clinical staff recorded the temperatures of the room and drug storage refrigerator. Staff maintained health monitoring equipment appropriately.
- The trust had established and calculated the number of staff required to meet the needs of the patients. We saw evidence over the last three months that whilst the ward used high levels of agency and bank staff they were able to achieve the safer staffing requirement.
- There was sufficient staff for patients to have escorted leave and for staff to engage with patients during therapeutic and meaningful activities.
- Patients received an individualised risk assessment on admission that was regularly reviewed in line with their needs.
- Ward staff could demonstrate their roles and responsibilities regarding safeguarding and keeping people safe from preventable harm.
- Clinical staff followed best practice guidelines regarding the safe management of medication

However:

- Substantive staff were allocated an alarm, keys and an identification card, which were all taken home at the end of each shift. The identification card gained entry past security doors before accessing the ward. This was raised with the ward manager as a potential security risk.

Is the service effective?

Good 

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

- Patients had comprehensive, recovery focused care plans that were updated regularly. Patients had positive behaviour support plans in place and had access to psychological therapies as recommended by the National Institute for Health and Care Excellence.
- New staff took part in a corporate induction programme. They also learnt about the ward and shadowed existing staff before working independently on shifts.

However:

Wards for people with a learning disability or autism

- Appraisal and supervision completion rates fell below the trust's own targets. Some staff were not recording their supervision on the trust's centralised supervision recording system.

Is the service caring?

Good 

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

- Staff interacted in a positive, kind and respectful manner with patients.
- Staff considered the patient's cultural and religious preferences within their personalised care plan.
- A family carer told us the Hollies was providing a good service and was in regular communication with the family, there appeared to be activities offered that met the needs of their relative and they felt that staff were caring.
- Patients and carers were involved in developing their care plans and their individual activity plans.
- The manager had made reasonable adjustments to the ward environment and involved patients where possible in the running of the ward. For example we saw evidence of patients requesting equipment and activities that were then provided by the trust.

Is the service responsive?

Good 

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

- The ward manager and the clinical ream planned for patients' discharge in partnership with community care co-ordinators, local housing services and the local authority to ensure that after care was to a standard that met the needs of the patient.
- Patients had their own en-suite bedroom that was accessible through the day by using an electronic key fob. We saw patients could personalise their bedrooms with decorations and wall art. Each bedroom had a secure lockable cabinet to keep personal possessions safe.
- The ward had a range of rooms and equipment to meet the needs of the patients. These rooms included, separate day rooms, a clinic room, a faith room, designated visitor rooms and a dining room. Patients could access fresh air at all times by using the secure garden.
- Patients had access to fresh fruit, and both hot and cold drinks throughout the day. Patients were also able to buy their own snacks and store them in a lockable cabinet.
- There was a variety of leaflets detailing how to complain about the service, what to expect during the patient's care and treatment, care planning, advocacy information and patients' rights. Staff also had access to interpreters to promote communication with patients, as needed.

Is the service well-led?

Good 

Wards for people with a learning disability or autism

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

- Managers had a good understanding of their service and were able to describe how their team provided high quality care to patients.
- The trust provided managers with opportunities to develop their own skills and also develop their team for example: the trust had supported health care workers to progress to nurse training.
- Staff were able to raise concerns without fear of retribution and knew the trust had a whistle blowing policy which they would use if they needed to.
- Staff told us they could access the trust's occupational health service for support with both physical and mental health issues.
- The ward manager told us they felt supported by their line manager and had the autonomy to make daily decisions in their role.
- Staff were able to contribute to the local risk register.

Areas for improvement

We found areas for improvement in this service. See the areas for improvement section above.

Specialist Eating Disorder Services

Good ➔➔

Key facts and figures

Ward S3 is specialist unit for individuals with an eating disorder who have been assessed by the community team and are considered to need a more intensive approach to the treatment of their eating disorder. The ward is a mixed-sex in-patient unit for adults aged 18-plus, based at Addenbrookes Hospital in Cambridge. The ward has 14 beds, all-single-room facility. In-patient treatment is provided for individuals with severe anorexia nervosa who are at high risk physically and psychologically.

The Phoenix Centre is a specialist eating disorders in-patient unit in Cambridge, for young people aged 13-18 years with complex eating disorders. The service offers three strands of treatment: weight restoration and dealing with behaviours related to this; help with recognising and countering anorexic thoughts and feelings; and return to aspects of normal life.

The community eating disorder service offers assessment and treatment to adults with a moderate to severe eating disorder within the community across Cambridgeshire, Peterborough and Norfolk

Summary of this service

The summary for this service appears in the overall summary of this report.

Is the service safe?

Requires improvement ➔

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

- Staff did not ensure patients' safety at all times. We found items which could pose a risk accessible to patients on both S3 Ward and the Phoenix Centre.
- Staff at the Phoenix Centre did not have access to suitable equipment for searching patients. For example, a metal detecting wand had to be borrowed from another ward.
- There were high rates of nursing vacancies. The overall vacancy rate was 18% for registered nurses at 30 September 2017 and an overall vacancy rate of 22% for registered nursing assistants.
- There was a high rate of staff turnover. Turnover rates across the year was 37%, more than double the trust's overall outcome of 16% and above the trust target of 10.5%.
- Not all staff were up to date with mandatory training. Attendance at safeguarding children level 3 mandatory training did not meet the trust's 95% compliance standard. In September 2017 the service had reported the rate of compliance as 55%.

However:

- The trust had addressed previous concerns in regards to those parts of both wards which could not easily be observed by staff, including the use of mirrors in the Phoenix Centre and video monitoring of public areas in S3 Ward, as well as increased staff monitoring.

- Staff were aware of some items on the two wards that could pose a risk to patients and were proactively managing these.
- The trust had addressed previous concerns that the service did not have a rostering tool in use. The service had introduced an e-rostering staffing tool, which was widely used across the NHS, to plan staffing requirements for each shift.
- The service had introduced a 'High Risk' register. This was used to monitor those patients whose risk assessments indicated the individual patient was at high risk of deterioration.
- Staff were aware of the importance of reporting incidents and how learning from these fed into service improvements.

Is the service effective?

Good 

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

- Staff maintained effective relationships with other services and organisations such as social services and GP services to ensure patients received on-going care and treatment when they were discharged.
- Staff planned and delivered care and treatment interventions based on best practice and evidence based guidance. For example, the staff team followed guidance based on the management of patients with anorexia nervosa (MARSIPAN) guidelines. Patients had meal plans which were devised with input from the dietician and multidisciplinary team (MDT).
- The Phoenix Centre engaged young people in music activities with members of the Royal Philharmonic Orchestra (RPO), where professional musicians worked with young people in a series of workshops aimed at promoting young people's social, physical and emotional rehabilitation.
- There were daily and supportive multi-disciplinary team (MDT) meetings, including ward rounds and handover meetings.
- Staff had a good understanding of the Mental Health Act (MHA) and the MHA Code of Practice and the Mental Capacity Act 2005.

However:

- Patients care records audits indicated that there were inconsistencies with the recording of patients' involvement in their care planning.
- Bank staff did not receive clinical supervision.

Is the service caring?

Good 

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

- Interactions between staff and patients were positive and professional. We observed that staff were discreet, respectful and responsive in providing patients with help, emotional support and advice. Most patients told us that staff were caring. Staff demonstrated a good understanding of the individual needs of patients on the ward.

- Patients' involvement in their care included access to a range of meetings and events in the community. These events were arranged by the Chaplaincy. For example, coffee clubs. Carers and families' involvement included access to family therapy, collaborative workshops and meetings to learn and practice skills in supporting their family member on discharge from the wards.
- There was a wide range of printed information for patients, families and carers.

Is the service responsive?

Good 

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

- S3 Ward was meeting their 18 week wait standard from assessment to treatment. There were no patients on the waiting list for the Phoenix Centre.
- Patients personalised their bedrooms with posters and photographs. Young people at the Phoenix Centre were involved in volunteering activities.
- Patients, carers and families had access to interpreters twenty four hours a day, seven days a week. Staff could access information leaflets in a variety of languages for patients whose first language was not English. Staff had received training in dealing with patients' complaints.

However:

- The Phoenix Centre had reduced their number of beds to eight in November 2017 to ensure safe staffing levels in this service.

Is the service well-led?

Good 

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

- Governance and performance arrangements were in place within the service that supported the delivery of the service, identified risk and monitored the quality and safety of the services provided. Senior managers had a good understanding of risks to the service and these were appropriately documented on local risk registers. There were clear lines of clinical and managerial accountability from both wards to the trust board.
- Staff were dedicated and knowledgeable about their work and passionate about caring for people with eating disorders.
- Staff had access to the necessary equipment to enable them to access and manage patient information.

However:

- Some staff felt the pace of the trust's transformation process did not consider the need for stability of the service.

Outstanding practice

We found examples of outstanding practice in this service. See the outstanding practice section above.

Specialist Eating Disorder Services

Areas for improvement

We found areas for improvement in this service. See the areas for improvement section above.

Forensic inpatient or secure wards

Good

Key facts and figures

Cambridge and Peterborough Foundation Trust provide forensic and secure services for adults of working age in George Mackenzie House at Fulbourn Hospital in Cambridge. We inspected this core service as part of our ongoing mental health inspection programme.

George Mackenzie House is a low secure unit with facilities to care for up to 20 patients, both men and women, who are under the care of either the general consultant psychiatrist or the forensic consultant psychiatrist. The purpose of George Mackenzie House is to provide assessment and therapeutic treatment for adults who require interventions within a safe and secure environment.

The ward had three areas: Trinity with seven beds, Sidney with six beds and Lucy with seven beds. At the time of inspection there were 19 patients.

The Care Quality Commission last inspected George Mackenzie House in May 2015 as part of a full comprehensive inspection.

We inspected the whole service and reviewed each domain.

Our inspection was announced to the trust a week before we inspected due to the number of core services being inspected simultaneously

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

During the inspection visit, the inspection team:

- visited all three areas, looked at the quality of all of the ward environment and observed how staff were caring for patients
- met with 10 patients who were using the service
- spoke with a carer of a patient at the service
- interviewed the ward manager and team leader of the ward
- met with 10 members of staff: including the consultants, nurses, recovery integration worker, and health care assistants
- attended and observed, four clinical review meetings, and one handover meeting
- examined five care and treatment records of patients
- carried out a specific check of the clinic room and medication management arrangements
- Reviewed in detail a range of policies, procedures and other documents relating to the running of the ward.

Summary of this service

The summary for this service appears in the overall summary of this report.

Forensic inpatient or secure wards

Is the service safe?

Good ➔➔

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

- Staff completed environmental risk assessments regularly. We saw clear review dates for the risk assessments and managers had audited these and addressed any identified risks.
- Staff had access to personal alarms for use in an emergency.
- The ward areas were visibly clean. All three areas had good furnishings which were robust and well maintained
- Staffing rotas were reviewed. There was no use of agency staff on the ward. Bank staff were used on occasion and had received an induction. They were familiar with the ward and patients.
- A qualified nurse was present on the ward and in communal areas at all times to oversee care and treatment. Staff interviewed reported that they had enough time to spend one to one time with their named patients.
- Staff had identified and recorded changes in patient risk levels on their individualised risk assessment and on their electronic care and treatment records.
- The ward had a strong emphasis on using de-escalation to manage behaviours that may challenge. Staff only used restraint after de-escalation had failed. This was confirmed by those patients and staff interviewed.
- Those patients prescribed anti-psychotic medication had an appropriate medication monitoring care plan in place.
- Staff confirmed that they received debriefs and support following serious incidents.

However:

- There were no cleaning schedules in place on the ward for managers to refer to.

Is the service effective?

Good ➔➔

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

- Care plans were personalised, holistic and recovery focussed. Physical healthcare needs were identified. Care plans evidenced individual patient involvement.
- The ward had a range of skilled and experienced staff to meet the needs of patients.
- Managers provided staff with monthly supervision and annual appraisals
- Multidisciplinary team meetings were held on a regular basis. Patients were involved in these.
- The ward had in place a recovery integration worker. This was a newly appointed role. Their key focus was to help patients integrate as part of the step down pathway from the hospital to the community.
- There was a clear process in place for the granting of Section 17 leave and patients were accessing this. Staff had stored copies of detention paperwork correctly so they were available to the ward team.

Forensic inpatient or secure wards

Is the service caring?

Good 

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

- Staff treated patients with kindness, compassion and respect. Staff were responsive to needs of the patients
- Advocates attended multidisciplinary meetings and patients community meetings. They had a good working relationship with both patients and staff.
- Staff supported patients to give feedback on the service via community meetings and patient surveys. Action was taken by staff to address this feedback where possible.
- Patients' cultural, social and religious needs were assessed by staff and formed part of their care plan.
- Patients and carers were involved wherever possible in their care and treatment.

Is the service responsive?

Good 

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

- All admissions were planned, and multidisciplinary meetings held to consider the admission and the suitability of this.
- The ward manager and the clinical team planned for patients' discharge in partnership with the Ministry of Justice, community care co-ordinators and local housing services.
- Patients had their own bedrooms and were able to personalise them with personal photographs, art work and posters.
- Activities were planned for seven days. Examples of activities on offer were gardening, gymnasium, tai chi, adult education, media groups, relaxation, crafts and creative writing. There were individual groups scheduled for men and women.
- Staff encouraged patients to develop and maintain relationships with the people that mattered to them. This support continued for one month following discharge.
- The ward was on one level and accessible to disabled patients if required. Other facilities on the ward supported this.
- Staff provided patients with information on how to make a complaint. Patients said they knew how to complain if they needed to.

Is the service well-led?

Good 

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

Forensic inpatient or secure wards

- Senior trust managers were visible and staff knew who they were. Staff stated they were very supportive and that the ward manager was on the ward regularly supporting patients and staff.
- Staff knew and understood the visions and values of the trust. Staff followed these values and was passionate about working in this service. The trust's visions and values were under review and frontline staff had been asked to get involved in this.
- Staff knew the trust's whistleblowing process and those spoken with said they would not hesitate to use this process if this was required.
- Staff meetings followed agendas and documented actions and outcomes. We saw that minutes were reviewed and then fed back into further meetings when needed.
- Staff were aware of the local risk register and how they could contribute to this at any time

Areas for improvement

We found areas for improvement in this service. See the areas for improvement section above.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

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

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

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care

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

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

Our inspection team

Julie Meikle Head of Hospital inspection led this inspection.

Peter Johnson inspection manager supported this inspection

The team included three inspection managers, 17 inspectors, two members of the Commission's medicines team, two Mental Health Act reviewers, 23 specialist advisers and six experts by experience.

Specialist advisers are experts in their field who we do not directly employ. Experts by experience are people who have personal experience of using or caring for people who use health and social care services.