Cambridgeshire and Peterborough NHS Foundation Trust

Quality Report

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Core services inspected	CQC registered location	CQC location ID
Acute wards for adults of working age and psychiatric intensive care units	CPFT at Fulbourn Hospital	RT113
Acute wards for adults of working age and psychiatric intensive care units	CPFT at Cavell Centre	RT1JJ
Child and adolescent mental health wards	CPFT at Ida Darwin Hospital	RT1X9
Eating Disorder Services Adult, Community and CAMHS	MH Services (CPFT) at Addenbrookes	RT190
Eating Disorder Services Adult, Community and CAMHS	CPFT at Ida Darwin Hospital	RT1X9
Eating Disorder Services Adult, Community and CAMHS	Trust headquarters	RT13
Forensic inpatient /secure wards	CPFT at Fulbourn Hospital	RT113
Long stay/rehabilitation mental health wards for working age adults	CPFT at Fulbourn Hospital	RT113

Summary of findings

Long stay/rehabilitation mental health wards for working age adults	CPFT at Cavell Centre	RT1JJ
Wards for people with learning disabilities and autism	CPFT at Cavell Centre	RT1JJ
Wards for people with learning disabilities and autism	CPFT at Ida Darwin Hospital Learning Disability & Specialist Services	RT1Y1
Wards for older people with mental health	CPFT at Cavell Centre	RT1JJ
Wards for older people with mental health	CPFT at Fulbourn Hospital	RT113
Community-based mental health services for adults of working age.	Trust headquarters	RT13
Community-based mental health services for older people	Trust headquarters	RT13
Specialist community mental health services for children and young people.	Trust headquarters	RT13
Mental health crisis services and health-based places of safety.	Trust headquarters	RT13
Community health services for children, young people and families	Trust headquarters	RT13

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

Summary of findings

Ratings

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

Overall rating for services at this Provider	Good
Are Services safe?	Requires improvement
Are Services effective?	Good
Are Services caring?	Good
Are Services responsive?	Good
Are Services well-led?	Good

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

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

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

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

Summary of findings

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Summary of findings

Overall summary

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

We rated Cambridgeshire and Peterborough NHS Foundation Trust as good overall because:

- Services were effective, responsive and caring. Where concerns had arisen the board had taken urgent action to address areas of improvement.
- Staff treated people who used the service with respect, listened to them and were compassionate. They showed a good understanding of people's individual needs.
- Admission assessment processes and care plans, including for physical healthcare, were good.
- The board and senior management had a vision with strategic objectives in place and staff felt engaged in the improvement agenda of the trust. Performance improvement tools and governance structures were in place and had brought about improvement to practices.
- Morale was found to be good in most areas and staff felt supported by local and senior management. There was effective team working and staff felt supported by this.
- The trust had undertaken positive engagement action with service users and carers.
- A good range of information was available for people and the trust was meeting the cultural, spiritual and individual needs of patients.
- The inpatient environments were conducive to mental health care and recovery.
- The bed management system within adult and older people's services was effective.
- Information systems were in place to ensure effective information sharing across teams.
- Services were using evidence based models of treatment and made reference to National Institute for Health and Care Excellence (NICE) guidelines.
- The trust had an increasingly good track record on safety in the previous 12 months. Effective incident, safeguarding and whistleblowing procedures were in place. Staff felt confident to report issues of concern. Learning from events was noted across the trust.
- The trust had met its targets required under the Department of Health's 'Positive and Proactive Care: reducing the need for restrictive interventions' agenda. There had also been a decreasing level of restraint and seclusion in the previous 12 months.
- Medicines management was effective and pharmacy was embedded into ward practice.
- Arrangements were in place to ensure effective use of the Mental Health Act and Mental Capacity Act
- There was a commitment to quality improvement and innovation.

However:

- We had some concerns about restrictive practice in some areas of the trust. However, the trust was engaging in work to reduce these episodes. In addition not all environments where people were secluded were appropriate.
- Staffing issues in some community children's teams and acute services were affecting waiting targets.
- There were clear arrangements for ensuring that there was single sex accommodation on the majority of wards. However, improvement was needed to ensure that arrangements for managing mixed sex accommodation at Maple 1 ward were followed to ensure the privacy of patients.
- There were ligature points in some inpatient services and observation should be improved in some areas.
- Not all patients had easy access to psychological therapies.
- Consent to treatment procedures needed improvement.

Summary of findings

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

We always ask the following five questions of the services.

Are services safe?

Requires improvement

We rated Cambridgeshire and Peterborough NHS Foundation Trust as requires improvement for Safe because:

- Ligature points remained although the trust had addressed some of these. Within acute and children's services, we were concerned that low levels of staffing could mean that patients could potentially access these without the notice of staff. We also found areas of the children's and adolescent wards that could not easily be observed.
- Three clinical rooms at the Cavell Centre were not fit for purpose and did not comply with infection control guidance. Not all community clinical areas had hand-wash facilities. Some medical equipment required checking and recalibration.
- Staffing was not always sufficient within the acute service particularly Springbank ward.
- Some community children's team were experiencing vacancies. This had affected waiting targets.
- On the IASS ward there was no out-of-hours learning disability psychiatry rota to support patients and staff. Patients had to attend the acute hospital out-of-hours.
- We had some concerns about restrictive practice in some areas of the trust. However, the trust was engaging in work to reduce these episodes. In addition not all environments where people were secluded were appropriate.
- The health based place of safety did not meet the guidelines set by the Royal College of Psychiatrists.

However:

- Clinical risk assessments were thorough and comprehensive. They reflected the needs and risks of patients.
- The trust had an increasingly good track record on safety over the previous 12 months.
- Effective incident, safeguarding and whistleblowing procedures were in place. Staff felt confident to report issues of concern. Learning from events was noted across the trust.
- Staff were aware of their responsibilities under the duty of candour requirements.
- The trust had met its targets required under the Department of Health's 'Positive and Proactive Care: reducing the need for restrictive interventions' agenda. There had also been a decreasing level of restraint and seclusion over the previous 12 months.

Summary of findings

- Medicines management was effective and pharmacy was embedded into ward practice.

Are services effective?

Good

We rated Cambridgeshire and Peterborough NHS Foundation trust as good for Effective because:

- Admission assessment processes and care plans, including for physical healthcare, were good.
- Information systems were in place to ensure effective information sharing across teams.
- Services were using evidence based models of treatment and made reference to National Institute for Health and Care Excellence (NICE) guidelines.
- Outcome measures were used across services.
- The trust had participated in a number of quality improvement programmes, research and quality audit.
- We found a strong commitment to multidisciplinary team working across all services and staff were qualified, skilled and supported to perform their roles.
- Arrangements were in place to ensure effective use of the Mental Health Act and Mental Capacity Act

However:

- Not all patients had easy access to psychological therapies.
- Improvement was needed to procedures to ensure consent to treatment.

Are services caring?

Good

We rated Cambridgeshire and Peterborough NHS Foundation trust as good for Caring because:

- Staff treated people who used the service with respect, listened to them and were compassionate. They showed a good understanding of people's individual needs.
- People were involved in their care and treatment and were aware of their care plans.
- Staff encouraged people to involve relatives and friends in care planning if they wished.
- Information about services was available to patients and staff supported people to understand their treatment.
- We were told by patients that staff respected their personal, cultural and religious needs. We saw some very good examples of the trust delivering services in line with peoples' cultural needs.

Summary of findings

- Information on how to access advocacy was available for people who used the service.
- The trust had a detailed programme of work to involve people in the planning and delivery of services.

Are services responsive to people's needs?

Good

We rated Cambridgeshire and Peterborough NHS Foundation trust as good for Responsive because:

- The inpatient environments were clean and maintained, and were conducive for mental health care and recovery.
- The bed management system within adult and older people's services was effective. It ensured that patients received timely access to services when they required it.
- In adult and older people's community services target times for assessment were set and met: referrals were seen quickly by skilled professionals.
- Proactive steps were taken to engage with people who found it difficult or were reluctant to engage with mental health services.
- Complaint information was available for patients and staff had a good knowledge of the complaints process.
- A good range of information was available for people in appropriate languages.
- The trust was meeting the cultural, spiritual and individual needs of patients.

However:

- There were significant waiting lists for some child and adolescent mental health and healthcare services.
- There were clear arrangements for ensuring that there was single sex accommodation on the majority of wards. However, improvement was needed to ensure that arrangements for managing mixed sex accommodation at Maple 1 ward were followed to ensure the privacy of patients.

Are services well-led?

Good

We rated Cambridgeshire and Peterborough NHS Foundation Trust as good for Well Led because:

- The trust board had developed a vision statement and values for the trust and most staff were aware of this.
- Good governance arrangements were in place, which supported the quality, performance and risk management of the services.
- Key performance indicators were used to gauge performance.

Summary of findings

- The trust had undertaken positive engagement action with service users and carers.
- Team managers had sufficient authority to manage the service effectively.
- There was effective team working and staff felt supported by this.
- Staff knew how to use the whistleblowing process and could submit items to the risk register.
- There was a commitment to quality improvement and innovation.

Summary of findings

Our inspection team

Chair: Professor Steve Trenchard, Chief Executive, Derbyshire Healthcare NHS Foundation Trust

Team Leader: Julie Meikle, Head of Hospital Inspection, mental health hospitals, CQC

Inspection Manager: Lyn Critchley, mental health hospitals, CQC

The team included CQC managers, inspection managers, inspectors, Mental Health Act reviewers, support staff and a variety of specialist and experts by experience that had personal experience of using or caring for someone who uses the type of services we were inspecting.

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

Why we carried out this inspection

We inspected this provider as part of our ongoing comprehensive mental health inspection programme.

How we carried out this inspection

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

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

Before visiting, we reviewed a range of information we hold about Cambridgeshire and Peterborough NHS Foundation Trust and asked other organisations to share what they knew.

We carried out an announced visit between 18 and 22 May 2015. Unannounced inspections were also carried out on the 5 June 2015.

Prior to and during the visit the team:

- Held service user focus groups and met with local user forums.
- Held focus groups with 36 different staff groups.
- Talked with more than 250 patients and 50 carers and family members.
- Attended community treatment appointments.
- Looked at the personal care or treatment records of over 250 patients and service users.
- Looked at patients' legal documentation including the records of people subject to community treatment.
- Observed how staff were caring for people.
- Interviewed almost 300 staff members.
- Interviewed senior and middle managers.
- Attended an executive team meeting.
- Met with the Mental Health Act hospital managers
- Reviewed information we had asked the trust to provide.
- Attended multi-disciplinary team meetings.
- Met with local stakeholders and user groups.
- Collected feedback using comment cards.

We visited all of the trust's hospital locations and sampled a large number of community healthcare and community mental health services.

We inspected all wards across the trust including adult acute services, the psychiatric intensive care unit (PICU), secure and rehabilitation wards, older people's wards, and specialist wards for people with learning disabilities, children and adolescents and people with eating disorders. We looked at the trust's place of safety under section 136 of

Summary of findings

the Mental Health Act. We inspected community services including all of the trust's crisis services, children and adolescents services and sampled older peoples' and adult community teams.

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

Information about the provider

The trust was created in 2003 to provide mental health, learning disability and substance misuse health and social care services. It became a foundation trust on 1 June 2008. Since 2013 it had also provided physical health community children's services in Peterborough. At the time of our inspection the trust, working in partnership with a local acute trust, had also taken over the running of older people's healthcare and adult community services across Cambridgeshire under the Uniting Care Partnership.

The trust operates in four directorates: adult mental health services, integrated care services (older people's mental health and integrated community services), children's and young people services and the specialist directorate. The specialist directorate included inpatient services for people with a learning disability, prison mental health in-reach teams, eating disorders service, substance misuse, neurodevelopmental services and criminal justice services.

The trust works closely with two local authorities: Cambridgeshire County Council and Peterborough City Council. The Trust is commissioned predominantly by the Cambridgeshire and Peterborough clinical commissioning group.

At April 2015 the trust served a population of almost 900,000 and employed almost 2500 staff including nursing, medical, psychology, occupational therapy, social care, administrative and management staff. It had a revenue income of £125 million for the period of April 2013 to March 2014. In 2012/13, the trust staff treated more than 50,000 individuals. The trust services were delivered from more than 75 different buildings.

Cambridgeshire and Peterborough NHS Foundation Trust had a total of 21 locations registered with CQC and had been inspected 12 times since registration in April 2010.

At the time of our visit there was one location with compliance actions in place following previous visits. This was Fulbourn Hospital. We had last visited this location in October 2013 and it was found to be non-compliant in relation to safeguarding practice. This was reviewed as part of this inspection and found to be met.

What people who use the provider's services say

The Care Quality Commission community mental health survey 2014 was sent to people who received community mental health services from the trust to find out about their experiences of care and treatment. Those who were eligible for the survey where people receiving community care or treatment between September and November 2013. There were a total of 250 responses, which was a response rate of 29%. The trust was performing about the same as other trusts across all areas. Where comparable it was noted that trust had improved against previous results in some areas. These included information about treatment, involvement in care planning and crisis response.

A review of people's comments placed on the 'patient opinion' and 'NHS choices' websites to March 2015 was conducted ahead of the inspection. Four comments were noted on of which three were partly of wholly positive. Positive comments included that the doctors were good in a community team and that staff were kind, compassionate and listened.

The trust had used the friends and families test (FFT) since April 2014. In the 12 months prior to our visit there had been almost 7000 responses to this survey. At March 2015 the results indicated that 85% of patient respondents were

Summary of findings

likely or extremely likely to recommend the trust services. In community services this rose to 91%. The trust demonstrated an improving picture of satisfaction during the 12 months before our inspection.

Prior to the inspection we spoke with services users and their carers across the trust. This included conversations with independent user led local organisations and advocacy groups and attendance at user and carer groups linked to the trust. We also facilitated focus groups at two inpatient services. During these sessions we heard both positive and negative comments about the trust services. Generally people stated that staff were caring. A number commented on improvement in care delivery across the trust. However, a number of people stated that access to services, particularly in a crisis, was difficult.

During our inspection we received comment cards completed by service users or carers. We also received a large number of phone calls and emails directly to CQC from service users, carers and voluntary agencies supporting service users. Throughout the inspection we spoke with over 350 people who had used inpatient services or were in receipt of community treatment. We also spoke with over 50 relatives of people who used the service.

People who use inpatient services generally felt safe and supported. Almost all spoke about staff in a positive way. We heard some very good examples of where staff had effectively supported patients. This was particularly evident in learning disability and older peoples' services.

Most people who use adult community and crisis services told us that staff were good, supportive and respectful. A number of people told us they were very happy with the care and service received. They said they were kept informed and involved in planning care. They said staff had provided good care and had responded quickly to changing need. People told us that appointments ran on time and they were kept informed if there were any unavoidable changes. They told us they often saw different members of staff due to the nature of the service. However, most said that this did not concern them and some felt that this added to the service as they had the opportunity to see people with different skills and style.

Prior to our inspection we heard a number of negative comments about children's community and inpatient mental health services. During the inspection we did hear that there could be some challenges in accessing services. However, across the children's directorate, we heard only positive comments about the delivery of the service. At all teams both children and parents told us that told us staff were friendly, helpful and treated them with respect. Patients told us that they felt respected and cared for by staff and included in not only their care but what happened on the ward. Young people at the Phoenix Centre told us that staff went out of their way to support them, by giving them space or engaging them in an activity when they were struggling. Parents told us that they fully involved in their child's care, that staff were always available to talk to them, and that they were responsive to parents concerns. In physical healthcare services some young parents being supported by the family nurse partnership told us that the team 'treat you like an adult and respect your wishes' and 'they are really helpful, supportive and show you the right path'.

Most people we spoke with across the trust knew how to raise concerns and make a complaint. They felt they would be able to raise a concern should they have one and believed that staff would listen to them and act upon the issues.

Areas for improvement

Action the provider MUST take to improve

- The trust must review systems relating to the monitoring of the administration of, and adherence with, the Mental Health Act 1983, and associated Code of Practice, specifically in relation to consent to treatment (Section 58) and practices amounting to seclusion.
- The trust must ensure staffing issues are addressed in some community children's teams and acute services.
- The trust must ensure that within inpatient services ligature risks are removed or fully managed and that observation is improved in some areas.

Summary of findings

Action the provider SHOULD take to improve

- The trust should ensure that all relevant patients have timely access to psychological therapies.
- The trust should ensure that arrangements in place to manage mixed sex accommodation are always adhered to.

Cambridgeshire and Peterborough NHS Foundation Trust

Detailed findings

Mental Health Act responsibilities

The mental health legislation group had overall responsibility for the application of the Mental Health Act (MHA) and the Mental Capacity Act (MCA) within the trust. A MHA quality assurance report, based on a schedule of audits and reviews, was compiled quarterly. The report was approved by the mental health legislation group and submitted to the quality, safety and governance committee (QSG committee).

We met with members of the mental health legislation group to discuss MHA governance and the key functions of the group, which included:

- Monitoring all aspects of MHA performance.
- Receiving MHA reviewer reports, monitoring actions and responses.
- Escalating issues of concern to the QSG committee.
- Reviewing and updating policies in line with any changes to legislation or the Code of Practice.

We met with a team of hospital managers who confirmed they worked closely with the MHA administrators. New hospital managers had induction training and were offered opportunities for ongoing development. However, there was no formal supervision or appraisal. A non-executive director had been appointed to join the team, which would help to strengthen communication between the board and the hospital managers.

MHA and MCA training was mandatory at the trust. Staff completed e-learning modules, which were followed up by face to face classroom sessions. Despite the training, there were fundamental gaps in the knowledge of a few nursing staff. An example was of a registered nurse on an older people's ward not being clear about the use of holding powers under sections 5(2) and 5(4) of the Act.

The new Code of Practice was available to all staff in an electronic format and there was a hard copy of the code on each of the wards. A summary of the key changes had been disseminated to relevant staff. MHA and MCA policies had been updated in accordance with the new code and were supported by helpful flow charts.

We visited wards at the Cavell Centre and Fulbourn Hospital, where detained patients were being treated. We also reviewed records of people subject to community treatment orders.

There was a clear process for receiving and scrutinising detention papers. Copies of detention documents, including reports by approved mental health professionals (AMHP) were available on the wards. The one exception was Willow ward, where there were delays in uploading the copies onto the electronic records system and there were no paper copies available.

There was a standardised system for authorising and recording section 17 leave. There were some good examples of records of leave, including risk assessments

which included the patients' views. However, the system was not always followed. The recurring theme was a lack of records to show whether the patient, or other relevant people, had received a copy of the leave form.

Patients were provided with information about their legal status and rights under section 132 as soon as possible after their detention. The information given to patients was as recommended in the Code of Practice and the patient's understanding was recorded. Patients generally received regular reminders about their rights except for five patients on Denbigh ward. The rationale for this omission was that it was too distressing for them. For one patient there was a record that this decision had been discussed with their family. There were no records of a best interest decision for the remaining four patients.

The MHA legislation manager told us patients who lacked capacity to understand their right of appeal, would be referred to an independent mental health advocate (IMHA). There was information about IMHA services on all wards.

Assessment and recording of patients' capacity to consent at the start of their treatment varied across the wards. The expectation of the trust was that capacity and consent would be assessed and recorded on admission and at regular intervals throughout the patient's stay. Recording in the clinical notes was not consistent and the trust had introduced an electronic form to record the data. Notes of the latest mental health legislation group meeting showed the MHA administrators were monitoring compliance with this.

Treatment was being given in line with the Code of Practice on the majority of the wards. However, on Springbank ward five patients had T2 certificates which did not match their prescription charts. This meant the patients were being given medication they had not consented to. There was also an incident of an informal patient on another ward being restrained and given medication without their consent. The first record of consideration of the use of the MHA was approximately six hours after the incident.

There were other examples of apparent delays in the use of the MHA, or a lack of recording of reasons why it was not appropriate. On one of the older people's wards a patient tried to leave by jumping out of the window. The patient was pulled back onto the ward by staff. Following the incident there was no record to show the nurse had considered using a section 5(4) to detain the patient until they could be assessed.

Mental Capacity Act and Deprivation of Liberty Safeguards

The trust had a policy in place on the application of the Mental Capacity Act (MCA) and the Deprivation of Liberty Safeguards (DoLS). Reporting to the QSG committee, the mental health legislation group had overall responsibility for the application of the MCA. A quarterly report was presented to the board, to inform the executive of performance and required actions across this area.

The trust told us that training rates for staff in the Mental Capacity Act were good with 90% of staff trained at May 2015. Staff confirmed that they had received this training and updates were provided. Generally most staff had an awareness of the Mental Capacity Act and the Deprivation of Liberty Safeguards. Deprivation of Liberty safeguards applications had usually been made when required.

Generally at mental health inpatient units' people's capacity had been assessed and details were recorded. However, in the older peoples and acute inpatient services we found that this was not always recorded or recorded in sufficient detail.

In community services staff had a clear understanding of their responsibilities in relation to the Mental Capacity Act. They were able to differentiate between ensuring decisions were made in the best interests of people who lacked capacity for a particular decision and the right of a person with capacity to make an unwise decision.

Detailed findings

Requires improvement

Are services safe?

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

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

Summary of findings

We rated Cambridgeshire and Peterborough NHS Foundation Trust as requires improvement for Safe because:

- Ligature points remained although the trust had addressed some of these. Within acute and children's services, we were concerned that low levels of staffing could mean that patients could potentially access these without the notice of staff. We also found areas of the children's and adolescent wards that could not easily be observed.
- Three clinical rooms at the Cavell Centre were not fit for purpose and did not comply with infection control guidance. Not all community clinical areas had hand-wash facilities. Some medical equipment required checking and recalibration.
- Staffing was not always sufficient within the acute service particularly Springbank ward.
- Some community children's team were experiencing vacancies. This had affected waiting targets.
- On the IASS ward there was no out-of-hours learning disability psychiatry rota to support patients and staff. Patients had to attend the acute hospital out-of-hours.
- We had some concerns about restrictive practice in some areas of the trust. However, the trust was engaging in work to reduce these episodes. In addition not all environments where people were secluded were appropriate.
- The health based place of safety did not meet the guidelines set by the Royal College of Psychiatrists.

However:

- Clinical risk assessments were thorough and comprehensive. They reflected the needs and risks of patients.
- The trust had an increasingly good track record on safety over the previous 12 months.
- Effective incident, safeguarding and whistleblowing procedures were in place. Staff felt confident to report issues of concern. Learning from events was noted across the trust.
- Staff were aware of their responsibilities under the duty of candour requirements.
- The trust had met its targets required under the Department of Health's 'Positive and Proactive Care: reducing the need for restrictive interventions' agenda. There had also been a decreasing level of restraint and seclusion over the previous 12 months.
- Medicines management was effective and pharmacy was embedded into ward practice.

Our findings

Track record on safety

We reviewed all information available to us about the trust including information regarding incidents prior to the inspection. A serious incident known as a 'never event' is where it is so serious that it should never happen. The trust had reported no 'never events' since March 2014. We did not find any other incidents that should have been classified as never events during our inspection.

Since 2004, trusts have been encouraged to report all patient safety incidents to the National Reporting and

Learning System (NRLS). Since 2010, it has been mandatory for trusts to report all death or severe harm incidents to the CQC via the NRLS. Between March 2014 and February 2015 the trust had reported 6039 incidents to the NRLS. There were 9 incidents categorized as death during the period and a further 29 had resulted in severe harm. The majority of these had occurred in adult mental health services.

There were 90 serious incidents reported by the trust during this period. 40% of these reports related to self-harm including suicide. Other unexpected deaths accounted for 24%. Slips, trips and falls were the third largest category at 10% equating to 9 incidents. This was within the expected range of incidents for a trust of this type and size. Overall, the trust had improved its reporting rates and had been a good reporter of incidents during 2014/15 when compared to trusts of a similar size. It was noted that the overall rate of serious incidents decreased during the reporting period.

The National Safety Thermometer is a national prevalence audit which allows the trust to establish a baseline against which they can track improvement. During the 12 months to February 2015 it was noted that there were no pressure ulcers or new cases of catheter and urinary tract infections. Falls resulting in harm had not occurred since September 2014.

Every six months, the Ministry of Justice published a summary of Schedule 5 recommendations which had been made by the local coroners with the intention of learning lessons from the cause of death and preventing deaths. No concerns had been raised about the trust between March 2014 and March 2015.

Learning from incidents

The staff survey 2014 had indicated that incident reporting was good. However, it also indicated that not all staff felt they would always be supported following a report or thought that procedures were fair and effective.

Arrangements for reporting safety incidents and allegations of abuse were in place.

Staff had access to an online electronic system to report and record safety incidents and near misses. Staff had received mandatory safety training which included incident reporting and were able to describe their role in the reporting process. Staff told us that they were encouraged to report incidents and near misses and felt supported by their manager following any incidents or near misses. Staff told us that the trust encouraged openness. Most staff felt that there was clear guidance on incident reporting. However, a small number of staff in community mental health teams stated they were confused regarding the trust incident rating scale.

We were told that all serious incidents were reviewed by the patient safety and clinical risk group which reports to the quality, safety and governance committee. Meeting minutes confirmed that the board also receive regular updates about actions undertaken as a result of serious incidents.

Where serious incidents had happened we saw that investigations were carried out. The trust had a group of trained staff to undertake serious incident investigations. Most investigations were carried out within the timescales required. We found the investigatory process was robust and followed the National Patient Safety Agency guidelines for incident investigation.

Ward and team managers confirmed clinical and other incidents were reviewed and monitored through trust-wide and local governance meetings and shared with front line staff through team meetings. Most were able to describe learning as a result of past incidents and how this had informed improvements or service provision. We saw some particularly good examples of positive change following incidents within the community mental health services.

Staff received alerts and newsletters following learning from incidents in other parts of the trust. Generally, staff knew of relevant incidents and were able to describe learning as a result of these. The majority of staff felt that they got feedback following incidents they had reported. A number of staff told us that incident reporting had improved at the trust during the last 12 to 18 months.

Duty of Candour

In November 2014 a CQC regulation was introduced requiring NHS trusts to be open and transparent with people who use services and other 'relevant persons' in relation to care and treatment and particularly when things go wrong. The trust had set up a working group in August 2014 to ensure readiness for this duty of candour. Following this a number of actions were undertaken including the development of a duty of candour operating procedure, staff training and policy and procedure review. Duty of candour considerations were incorporated into the serious

investigation framework, tools and report, and complaints procedures. Minutes of directorate and locality governance groups evidenced discussion about the duty of candour. Staff were aware of the duty of candour requirements in relation to their role.

We examined case records where patients had experienced a notifiable event to check that staff had been open and honest in their dealings with patients and carers. We found that the trust was meeting its duty of candour responsibilities.

Safeguarding

The trust had clear policies in place relating to safeguarding and whistleblowing procedures. Additional guidance was available to staff via the trust's intranet. We were told that the safeguarding team was also accessible and available to staff for additional advice.

The trust runs a reporting hotline known as 'stop the line'. Managers and staff told us of occasions where this had been used to raise urgent issues of concern. We heard about a number of positive actions as a result of this.

Safeguarding training requirements were set out in line with the specific role undertaken by staff. We found that all but a few staff had received their mandatory safeguarding training and knew about the relevant trust-wide policies relating to safeguarding. Most staff were able to describe situations that would constitute abuse and could demonstrate how to report concerns. A governance process was in place that looked at safeguarding issues at both a trust and at directorate levels on a regular basis.

Assessing and monitoring safety and risk

The trust had an integrated assurance framework and risk register. The risk register identified the responsible owner and the timescales for completion of identified actions.

Board meeting and assurance committee minutes confirmed that corporate and any high level or emerging risks were discussed on an ongoing basis. Risk registers were also in place at service and directorate level. These were monitored through the directorate assurance groups.

We looked at the quality of individual risk assessments across all the services we inspected. In all inpatient and community mental health services these were in place and addressed people's risks. However, in a small number of cases in the community adult mental health and eating disorder teams these had not always been updated to reflect people's changing needs. In the children and young peoples' service there was a lack of documented care planning within community nursing. We were told that this was due to clinical commitments meaning there was not enough time to update records onto the electronic system. This meant that not all clinical risks may have been fully documented.

The trust had an observation policy in place. Generally staff were aware of the procedures for observing patients. Ward managers indicated that they were able to request additional staff to undertake observations.

Safe and clean environments and equipment

The trust had undertaken an annual programme of environmental health and safety checks.

Ligature risk assessments were reviewed as part of this programme. The trust told us that all wards had been reviewed in the previous 12 months and that all keys risks had been addressed. However, we were concerned that ligature risks remained at the psychiatric intensive care unit, (Poplar ward) and the Darwin Centre. The trust told us and we observed at the time of our inspection that these risks were mitigated through additional staffing and observation.

We found that the layout of the wards generally allowed clear lines of sight for staff to observe patients. However, we found areas of the Croft, the Phoenix Centre and S3 ward that could not easily be observed. The trust told us and we observed at the time of our inspection that these risks were mitigated through additional staffing and observation.

On the majority of wards there were clear arrangements for ensuring that there was single sex accommodation in adherence to guidance from the Department of Health and the MHA Code of Practice, to protect the safety of patients. However, we were concerned that on Maple 1 unit the designated female lounge was being used by male patients. While action had been taken to mitigate this risk through deployment of staff we were concerned that this could compromise patient's dignity. At the Croft Unit the bedroom and bathrooms were not gender specific. This was because all bedrooms were family rooms so it was not possible for bedrooms to be single sex. The bathrooms and toilets at either end of the bedroom corridor were unisex however there was provision for the user to change the

door sign, to indicate the gender of the person using the facility. Staff also managed access to this space to ensure patients safety and dignity was maintained. On all other mixed sex wards bedrooms and bathrooms were appropriately segregated and there was access to safe and quiet areas for patients that accommodated privacy and dignity within a mixed sex ward.

The health-based place of safety at Fulbourn Hospital did not meet the guidance of the Royal College of Psychiatrists as some areas could not be observed. Staff were aware of these issues and had taken mitigating action to ensure people who used the service were observed at all times.

Fire procedures and equipment were in place at all services. Most staff had received fire safety training and were aware of what to do in an emergency.

All clinic rooms we visited appeared clean. However, we were concerned that the clinic rooms at three wards at the Cavell Centre were not fit for purpose and did not comply with infection control guidance. A ward manager informed us that a business plan had been submitted for an improved clinical area.

Not all clinic rooms in community mental health team bases (where medicines were stored) had hand washing facilities which could increase the risk of infection or cross contamination. Most inpatient services were found to have hand-washing facilities readily available and we observed staff adhering to the trust's 'bare below the elbow' policy where appropriate.

The trust had an infection control committee that oversees a programme of audit for this work. Hand hygiene and infection control audits were regularly undertaken and showed that staff demonstrated good hand hygiene. Staff receive infection control practice as part of mandatory training. We found good levels of completion for this training. Regular trust-wide cleanliness audits were undertaken. Services were clean and most were well maintained. Patients were mainly happy with the standards of cleanliness.

Inpatient services had systems in place to ensure equipment was serviced and electrically tested. Equipment was labelled with testing dates which were current. Staff told us about the procedure in place to clean equipment between patients. However, we found that in community adult mental health teams not all medical equipment, such as weighing scales and blood pressure monitoring machines had been checked and re-calibrated according to the manufacturer's instructions.

Not all adult, older peoples' and children's community mental health team bases had emergency alarms where required.

Emergency resuscitation equipment was available and checked regularly across services. Staff could describe how they would use the emergency equipment and what the local procedures were for calling for assistance in medical emergencies.

Community services staff had been trained in basic life support, and informed us that if a patient deteriorated or had a cardiac arrest at the community hospital, they would start resuscitation and call the emergency services through 999.

Potential risks

Systems were in place to maintain staff safety in the community. The trust had lone working policies and arrangements and staff in community teams told us that they felt safe in the delivery of their role.

The trust had necessary emergency and service continuity plans in place and most staff we spoke with were aware of the trust's emergency and contingency procedures. Staff told us that they knew what to do in an emergency within their specific service.

Restrictive practice, seclusion and restraint

The director of nursing is executive lead for oversight of restrictive practice. Policies and procedures were in place covering the management of aggression, physical intervention and seclusion. These policies had been reviewed to reflect latest guidance regarding the safe management of patients in a prone position and addressed the specialist needs of children or people with a learning disability, autism or a physical condition. The seclusion policy had been reviewed to reflect the updated Mental Health Act Code of Practice.

The trust confirmed that initial work had been undertaken to meet the guidance set out in the Department of Health's 'Positive and Proactive Care: reducing the need for restrictive interventions'. The trust had been funded by the National Institute for Health Research

Detailed findings

Collaboration for Leadership in Applied Health Research and Care East of England to deliver a programme to reduce restrictive practice. This programme known as 'PROMISE' had included a review of all relevant policies and training delivery, development of audit procedures, and amendments to reporting structures. The lead for physical intervention confirmed that this work programme continued to ensure that restrictive practice was minimised.

The use of restraint and seclusion were defined as reportable incidents at the trust and arrangements were in place to monitor such incidents. Incidents were recorded on a database and would be discussed and monitored at the patient safety group and the quality, safety and governance meetings. An annual report on restrictive practice was presented to the board in March 2015.

Prior to the visit we asked the trust for restraint and seclusion figures. Restraint was used 114 occasions in the six months to February 2015. Of these face down (prone) restraint was used on 51 occasions. This equated to almost 45% of all restraints. It was noted that 43 of these (84%) had resulted in rapid tranquilisation. The majority of restraints had occurred in acute services at 79%.

The trust reported that seclusion was only used on two occasions during the period. Both incidents had occurred within the forensic service. The trust stated that there had been no use of long term segregation.

We reviewed seclusion practice across the trust and we had a number of concerns about restrictive practice and seclusion. These included:

- On Mulberry 2 the intensive nursing suite had been used to restrict patients. This practice amounted to seclusion without the safeguards required by the Mental Health Act Code of Practice. This area did not meet the required standard for seclusion.
- On the PICU, staff described occasions when people were secluded in their bedrooms in an emergency as there was no seclusion facility. This issue had been placed on the trust's risk register.
- At George MacKenzie House the seclusion room was placed away from main area of the ward on the male side and did not have ensuite facilities. A toilet specifically for seclusion could be accessed, but the patient had to be taken out of the seclusion room to use it. However, at the time of our visit a de-escalation room was being finished on the female side of the ward.
- Within child and adolescent mental health services the seclusion room on the Croft Unit did not meet the required environmental standards as defined within the Mental Health Act Code of Practice.
- The Darwin Centre did not have a seclusion room. However, the staff were using an intensive nursing area (INA). We were told by staff they did not seclude patients but the description staff gave of how the INA was used constituted seclusion.
- In the older people's wards there were procedures and training in place for the use of both restraint and 'safe holds' however not all staff were clear what interventions constituted restraint, and how this practice should be recorded.

We found no practices that amounted to long term segregation.

We observed a number of examples of staff managing patients' aggressive behaviour effectively with an emphasis on de-escalation techniques. Additional data supplied by the trust indicated that levels of restraint had decreased since January 2014.

Generally we found that staff did not restrict patients' freedom and that informal patients understood their status and knew how, and were assisted, to leave the wards.

However, on Mulberry ward we found one example of where an informal patient had been secluded without consideration of a MHA assessment. At the Croft we found that informal patients had been secluded using the consent of the children's parents.

Safe staffing

In 2014 the trust reviewed and set staffing levels for all teams. Since April 2014 the trust had published both the planned and actual staffing levels on their website.

Figures provided indicated that during March 2015 overall staffing had generally met the planned level with 98% of planned registered nurses and 120% of unregistered staff shifts filled across inpatient services throughout the month. However, there were particular services were staffing had not met the target. These included levels of registered staff

shifts filled in acute services at Springbank, Mulberry 1, Mulberry 2, Oak 1 and Oak 2 wards. It was noted that in most cases these vacant shifts had been filled by unregistered staff.

At the time of our inspection in May 2015 we found that staffing remained an issue on some acute wards, particularly Springbank. During April 2015, 22% of the requested registered staff shifts and a further 16% of unregistered staff shifts requested remained unfilled. Other wards were better staffed through the use of bank and agency staff.

Within community teams for children and adolescents there were high vacancies that were impacting on the referral to assessment and treatment time. Other community teams were better staffed through the use of bank and agency staff.

The trust confirmed that they have a vacancy rate of 5.3% and that staff turnover stood at 10% in May 2015. During May 2015 over 20% of shifts within inpatient services were covered by agency or bank staff.

The trust acknowledged challenges regarding recruitment and retention and maintaining safe staffing levels and told us that they were working hard to address this issue. We saw detailed action plans and positive information about recruitment initiatives. We found that staffing levels were improving for a number of teams.

In some services the trust used specific dependency tools to evaluate the number of staff required to ensure the service was safely staffed. However, in child and adolescent services, there was no specific tool in use. Ward and team managers confirmed that processes were in place to request additional staff where required.

At the health based place of safety at Fulbourn Hospital there was not specific staff to manage the service. This meant that agency and bank staff where used to facilitate this. The trust used regular agency staff who were familiar with the service. The trust confirmed that funding had been agreed for permanent staff for the suite and recruitment had begun.

Medical cover was generally acceptable. However, we were told that out of hours medical cover could be an issue in learning disability services.

Medicines management

Across the trust we found efficient medicine management.

Pharmacy staffing had been identified as a risk issue. The risk had been reduced with the approval of appointing two clinical pharmacists to support the mental health community teams.

The pharmacy team provided a well-established clinical service to ensure people were safe from harm. We found that the pharmacy team were actively involved in all aspects of a person's individual medicine requirements at the point of admission through to discharge.

The pharmacy team provided annual training to nurses on safe medicine management. Nursing staff told us that the pharmacy team were a good support and if they had any medicine queries they always had access to pharmacist advice including out of hours.

We found that pharmacists provided advice to patients. For example, at the Cavell Centre, the pharmacists provided a weekly medicine group meeting on each ward for patients. Doctors also visited wards twice a week to discuss medicine issues individually with patients. Nursing staff told us these meetings were supportive and helpful for patients. In particular it allowed patients an opportunity to discuss concerns and gave choice to patients.

Arrangements were in place to ensure that medicine incidents were documented and investigated. We found that there was an open culture of reporting medicine errors when they were identified in order to change practice and learn from these. Medicine errors were reported directly to the medicine management committee and the patient safety group. However, the process for shared learning from medicine related incidents was inconsistent across the trust. The chief pharmacist agreed that communication pathways could be strengthened.

The pharmacy team had undertaken an audit on the use of rapid tranquillisation. They found that the required clinical observations following rapid tranquillisation were not always recorded. The learning from this audit was fed back to nursing staff in order to change practice. We looked at the records for four patients who had been given treatment using 'rapid tranquillisation'. We found comprehensive clinical observation records had been completed including the support and reassurance given to patients.

Arrangements were not fully in place to ensure that medicines for destruction were stored securely. Whilst

medicines across the trust were stored safely in locked cupboards we found open containers of medicines for destruction in some treatment rooms. We discussed the lack of consistent secure storage for medicines for destruction with the chief pharmacist who agreed that this would be investigated.

At the Cavell Centre patients were not always given their prescribed medicines on Oak 1. The reason documented on patients' prescription charts often stated the medicine was not available. All the nursing staff we spoke with knew how to access an out of hours medicine cupboard and a pharmacist was also on call for advice. However, we found that on two occasions nursing staff had failed to follow the correct procedure to access medicines which were available from the out of hour's medicine cupboard. This meant that patients had not been given their prescribed treatment. We informed the chief pharmacist who agreed that this should not happen and to investigate further.

At Springbank ward concerns had been identified by the pharmacy team in relation to the required documentation for treatment for mental disorder for people detained under the Mental Health Act. In particular we noted that patients on Springbank were prescribed medication which did not always have the necessary authorised consent to treatment documentation in place.

Good

Are services effective?

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

Summary of findings

We rated Cambridgeshire and Peterborough NHS Foundation trust as good for Effective because:

- Admission assessment processes and care plans, including for physical healthcare, were good.
- Information systems were in place to ensure effective information sharing across teams.
- Services were using evidence based models of treatment and made reference to National Institute for Health and Care Excellence (NICE) guidelines.
- Outcome measures were used across services.
- The trust had participated in a number of quality improvement programmes, research and quality audit.
- We found a strong commitment to multidisciplinary team working across all services and staff were qualified, skilled and supported to perform their roles.
- Arrangements were in place to ensure effective use of the Mental Health Act and Mental Capacity Act

However:

- Not all patients had easy access to psychological therapies.
- Improvement was needed to procedures to ensure consent to treatment.

Our findings

Assessment of needs and planning of care

The Care Quality Commission community mental health survey 2014 found that overall the trust was performing about the same as other trusts in all areas. Almost 8 out 10 respondents felt involved in the planning of their care. Almost 8 out of 10 respondents stated that they had received a review of their care in the last 12 months and had been involved in this. 7 out of 10 respondents stated that they had information about who to contact in a crisis.

In all services we found that people were appropriately assessed at admission and that relevant treatment had been put in place.

Generally we found the care plans were detailed, individualised to the patient's needs and showed the patient's involvement in the care planning process. In the majority of mental health services people's care needs and risks were assessed and care plans had been put in place. However, this was not the case at the community children's services where we found gaps in care plans. In addition, at these services and the forensic and PICU services, we found that the quality of care plans varied and some lacked sufficient detail. In the majority of services care plans had been reviewed following changes to people's needs, and risk assessments had been updated. Most care plans reviewed indicated the involvement of the patient. This was not the case within forensic services. However, we found that patients were knowledgeable about their care.

Within services patients' physical health needs were identified. Patients had a physical healthcare check completed by the doctor on admission and their physical healthcare needs were being met. Physical health examinations and assessments were usually documented by medical staff following the patient's admission to the ward. Ongoing monitoring of physical health problems was taking place. However, there were some access issues to blood test in learning disability and community eating disorder services. The majority of records we saw included a care plan which provided staff with clear details of how to meet patient's physical needs.

Electronic record systems operated across the trust. In the mental health services information could be shared between the wards, home treatment teams and other community teams. Relevant staff in community teams also had access to local authority systems, meaning that information could be shared effectively across organisations. We found that crisis teams were linked in to the local acute trusts' systems assisting information sharing at times of crisis. The children's directorate operated a paper light approach to patient records using an electronic patient record system. This was accessible by

password across the health community by all health professionals including general practitioners. However, we found in the children and adolescent community mental health teams' staff used both paper based and electronic systems where paper records were scanned and uploaded on to the electronic record. Due to delays in scanning we found that some key documents had not been uploaded to the system.

Best practice in treatment and care

Services were using evidence based models of treatment and made reference to National Institute for Health and Care Excellence (NICE) guidelines. Generally people received care based on a comprehensive assessment of individual need and usually outcome measures were considered using the Health of the Nation Outcome Scales or other relevant measures.

Generally we saw evidence that NICE guidance, such as the clinical guidance on the use of rapid tranquilisation, prescribing and psychological therapy, was followed in community and inpatient services. However, we noted that adult early intervention teams had moved to a two year model of engagement from a three year model. The NICE recommendation is a three to five year model.

In most community and inpatient mental health services we found good access to psychological therapies. This was particularly so in the CAMHS wards. However, we found that a shortage of psychology staff in some community adult and learning disability services meant that they were not all able to offer psychological therapies in line with NICE guidance.

Skilled staff to deliver care

In the 2014 NHS Staff Survey, the trust scored worse than average for staff receiving relevant training and development but above average for receiving an appraisal. Overall the trust had improved its position across relevant indicators against the 2013 survey results.

New permanent staff underwent a formal induction period. This involved attending a corporate induction, learning about the service and trust policies and a period of shadowing existing staff before working alone. A number of newly qualified nurses told us of a well-structured and in-depth preceptorship programme. Preceptorship was a period of time in which to guide and support all newly qualified practitioners to make the transition from student to develop their practice further. Bank and agency staff received a local induction and where appropriate mandatory training.

The trust supplied details of their set mandatory training requirements and uptake. At May 2015 this indicated that that the trust was on target at 95% of staff compliant with core mandatory training. Most staff told us that they do have access to mandatory training. However, not all staff in community CAMHs team had completed their mandatory training. Some specialist training to meet the needs of the client group was available. For example, staff in CAMHs inpatient services had access to specialist training in family therapy, attachment therapy and leadership training. There was also a nine month accredited programme, 'empowered to care', for health care assistants to complete.

Most teams were fully compliant with their annual appraisal programme. Most staff told us that clinical and management supervision was available and was used to manage performance issues and development.

CAMHS service and at Springbank ward told us that a lack of staffing and service pressures meant that they did not always receive supervision and therefore had little feedback on their performance.

Multi-disciplinary and inter-agency team work

At most mental health units we saw input from doctors, occupational therapists, psychologists, and pharmacy. In community services we also saw input from social workers and social care staff. However, we found a shortage of psychology staff in some community adult and learning disability services, and a shortage of occupational therapists in learning disability services. This had some impact on the multidisciplinary process.

There was a strong commitment to multidisciplinary team working across all services. On the wards we visited we usually saw good multidisciplinary working, including ward meetings and regular multidisciplinary meetings to discuss patient care and treatment.

We saw documentary evidence of a multidisciplinary approach to discharge planning. We saw that community teams usually attended discharge planning meetings making the process of leaving the wards more effective. Generally we saw that the community teams worked well with inpatient teams to meet people's individual needs.

Good

Are services effective?

There was effective inter-agency in community teams working in assessing and supporting those people subject to detention. There were effective links between the approved mental health professionals (AMHPs), the acute services and the trust nursing team.

Whilst medical cover was generally good across mental health services, there were no on-call evening and weekend arrangements for specialist medical cover within learning disability services.

At most wards there were effective handovers with the ward team at the beginning of each shift. These helped to ensure that people's care and treatment was co-ordinated and the expected outcomes were achieved. However, we were concerned about the limited time allowance for these within acute services.

Adherence to the MHA and MHA Code of Practice

The mental health legislation group had overall responsibility for the application of the Mental Health Act (MHA) and the Mental Capacity Act (MCA) within the trust. A MHA quality assurance report, based on a schedule of audits and reviews, was compiled quarterly. The report was approved by the mental health legislation group and submitted to the quality, safety and governance committee (QSG committee).

We met with members of the mental health legislation group to discuss MHA governance and the key functions of the group, which included:

- Monitoring all aspects of MHA performance.
- Receiving MHA reviewer reports, monitoring actions and responses.
- Escalating issues of concern to the QSG committee.
- Reviewing and updating policies in line with any changes to legislation or the Code of Practice.

We met with a team of hospital managers who confirmed they worked closely with the MHA administrators. New hospital managers had induction training and were offered opportunities for ongoing development. However, there was no formal supervision or appraisal. A non-executive director had been appointed to join the team, which would help to strengthen communication between the board and the hospital managers.

MHA and MCA training was mandatory at the trust. Staff completed e-learning modules, which were followed up by face to face classroom sessions. Despite the training, there were fundamental gaps in the knowledge of a few nursing staff. An example was of a registered nurse on an older people's ward not being clear about the use of holding powers under sections 5(2) and 5(4) of the Act.

The new Code of Practice was available to all staff in an electronic format and there was a hard copy of the code on each of the wards. A summary of the key changes had been disseminated to relevant staff. MHA and MCA policies had been updated in accordance with the new code and were supported by helpful flow charts.

We visited wards at the Cavell Centre and Fulbourn Hospital, where detained patients were being treated. We also reviewed records of people subject to community treatment orders.

There was a clear process for receiving and scrutinising detention papers. Copies of detention documents, including reports by approved mental health professionals (AMHP) were available on the wards. The one exception was Willow ward, where there were delays in uploading the copies onto the electronic records system and there were no paper copies available.

There was a standardised system for authorising and recording section 17 leave. There were some good examples of records of leave, including risk assessments which included the patients' views. However, the system was not always followed. The recurring theme was a lack of records to show whether the patient, or other relevant people, had received a copy of the leave form.

Patients were provided with information about their legal status and rights under section 132 as soon as possible after their detention. The information given to patients was as recommended in the Code of Practice and the patient's understanding was recorded. Patients generally received regular reminders about their rights except for five patients on Denbigh ward. The rationale for this omission was that it was too distressing for them. For one patient there was a record that this decision had been discussed with their family. There were no records of a best interest decision for the remaining four patients.

The MHA legislation manager told us patients who lacked capacity to understand their right of appeal, would be referred to an independent mental health advocate (IMHA). There was information about IMHA services on all wards.

Good

Are services effective?

Assessment and recording of patients' capacity to consent at the start of their treatment varied across the wards. The expectation of the trust was that capacity and consent would be assessed and recorded on admission and at regular intervals throughout the patient's stay. Recording in the clinical notes was not consistent and the trust had introduced an electronic form to record the data. Notes of the latest mental health legislation group meeting showed the MHA administrators were monitoring compliance with this.

Treatment was being given in line with the Code of Practice on the majority of the wards. However, on Springbank ward five patients had T2 certificates which did not match their prescription charts. This meant the patients were being given medication they had not consented to. There was also an incident of an informal patient on another ward being restrained and given medication without their consent. The first record of consideration of the use of the MHA was approximately six hours after the incident.

There were other examples of apparent delays in the use of the MHA, or a lack of recording of reasons why it was not appropriate. On one of the older people's wards a patient tried to leave by jumping out of the window. The patient was pulled back onto the ward by staff. Following the incident there was no record to show the nurse had considered using a section 5(4) to detain the patient until they could be assessed.

Good practice in applying the MCA

The trust had a policy in place on the application of the Mental Capacity Act (MCA) and the Deprivation of Liberty Safeguards (DoLS). Reporting to the QSG committee, the mental health legislation group had overall responsibility for the application of the MCA. A quarterly report was presented to the board, to inform the executive of performance and required actions across this area.

The trust told us that training rates for staff in the Mental Capacity Act were good with 90% of staff trained at May 2015. Staff confirmed that they had received this training and updates were provided. Generally most staff had an awareness of the Mental Capacity Act and the Deprivation of Liberty Safeguards. Deprivation of Liberty safeguards applications had usually been made when required.

Generally at mental health inpatient units' people's capacity had been assessed and details were recorded. However, in the older peoples and acute inpatient services we found that this was not always recorded or recorded in sufficient detail.

In community services staff had a clear understanding of their responsibilities in relation to the Mental Capacity Act. They were able to differentiate between ensuring decisions were made in the best interests of people who lacked capacity for a particular decision and the right of a person with capacity to make an unwise decision.

Good

Are services caring?

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

Summary of findings

We rated Cambridgeshire and Peterborough NHS Foundation trust as good for Caring because:

- Staff treated people who used the service with respect, listened to them and were compassionate. They showed a good understanding of people's individual needs.
- People were involved in their care and treatment and were aware of their care plans.
- Staff encouraged people to involve relatives and friends in care planning if they wished.
- Information about services was available to patients and staff supported people to understand their treatment.
- We were told by patients that staff respected their personal, cultural and religious needs. We saw some very good examples of the trust delivering services in line with peoples' cultural needs.
- Information on how to access advocacy was available for people who used the service.
- The trust had a detailed programme of work to involve people in the planning and delivery of services.

Our findings

Kindness, dignity, respect and support

Assessments undertaken under the patient-led assessment of the care environment (PLACE) reviews in 2014 identified that the trust scored better than average at 89% for the privacy, dignity and well-being element of the assessment against an England average of 88%. However, one inpatient service at Addenbrookes Hospital scored below the average at 80%.

We observed some positive examples of staff providing emotional support to people.

We saw that staff were kind, caring and responsive to people and were skilled in the delivery of care. We observed many instances of staff treating patients with respect and communicating effectively with them. Staff demonstrated that they wanted to provide high quality care and were knowledgeable about the history, possible risks and support needs of the people they cared for.

Almost all of the patients and relatives we spoke with told us that staff were kind and supportive, and that they or their loved one was treated with respect. We received particularly positive comments in children's mental health services and older people's services.

We were told that staff respected people's personal, cultural and religious needs. We saw some very good examples of the trust attempting to deliver services in line with people's cultural needs. For example, in Peterborough a project had been undertaken to capture the views of South Asian women. Learning from this had been shared across services.

The involvement of people in the care they receive

Inpatient services oriented people to the ward on admission. At services we found welcome packs that included detailed information about the ward and a range of information leaflets about the service. Notice boards on the wards held a variety of information for patients and carers as well as staff picture boards. Almost all patients we spoke with told us that they were given good information when they were admitted to the wards. Some patients told us that staff had taken time to clearly explain ward procedures when they had been unclear or confused. However, on some older people's wards we found that there was not always clear recording of when people had been given information about the Mental Health Act.

Patients had access to advocacy including an independent mental health advocate and specialist children's or learning disability advocates. There was information on the notice boards at most wards on how to access these services. Arrangements were also in place to access independent mental capacity advocates and we saw examples of where this was actively promoted.

Across services we found good patient involvement of patients in their care. Almost all care plans and records reviewed demonstrated the person's involvement. In all services we found that there was an opportunity for

Good

Are services caring?

patients to attend care planning meetings. In child and adolescent and learning disability services we found that care plans were written in an appropriate format to be accessible to the patients. We found a number of examples of relatives being involved in care planning where this was appropriate. We observed that where a patient was unable to be actively involved in the planning of their care, or where they wanted additional support, staff involved family members with the patients' consent.

Patients told us that they had opportunities and were encouraged to keep in contact with their family where appropriate. Visiting hours were in operation within inpatient services. We found there was a sufficient amount of dedicated space for patients to see their visitors. There were specific children's visiting areas at the inpatient facilities.

The trust had a partnerships strategy that set out arrangements for engagement with service users and carers. Underpinning this was a detailed user and carer engagement programme. This work was overseen by a trust wide patient and carer experience group. Work had included development of a dedicated patient experience team and service based engagement co-ordinators, promotion of advocacy, increased partnerships with voluntary and community groups and service user involvement in training, recruitment, research and audit. The trust had developed peer support workers as part of the recovery college. As a result the trust formally employed over 50 peer support workers across the trust. Other initiatives developed included the use of the 'triangle of care' toolkit which provides an accredited framework to develop carer involvement within local services and a large number of public engagement events delivered in line with service reconfiguration in community mental health, CAMHS and other inpatient services.

The trust had been involved in an action research project with a local university since 2011 which had aimed to increase shared decision making in treatment. The findings had demonstrated improved involvement of service users. At the time of our visit the project was in the operational stage.

Prior to the inspection we spoke with a large number of user groups, community support organisations and advocacy services. Generally we heard of positive relationships with the trust and of opportunities to be involved in providing feedback on how services were run or planned. However, we did hear concerns about the availability of mental health services for children and adolescents.

The trust had a number of carers' forums and inpatient services had community meetings to engage patients in the planning of the service and to capture feedback. In most services this meeting was chaired by patients and was attended by relevant ward staff. Some meetings were supported by local advocacy services. Minutes were usually taken and we saw evidence of actions that were raised being completed. Patients told us they felt able to raise concerns in the community meetings and that they usually felt listened to.

We saw that there was information available throughout the trust and via its website about how to provide feedback on the specific services received by people. The trust had employed latest technology to capture individual patient views. This included a brief survey for completion by all inpatients via the use of tablets.

The trust had used the friends and families test since April 2014. In the 12 months prior to our visit there had been almost 7000 responses to this survey. At March 2015 the results indicated that 85% of patient and 60% of staff respondents were likely or extremely likely to recommend the trust services. The trust demonstrated an improving picture of satisfaction during the 12 months before our inspection.

Good

Are services responsive to people's needs?

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

Summary of findings

We rated Cambridgeshire and Peterborough NHS Foundation trust as good for Responsive because:

- The inpatient environments were clean and maintained and were conducive for mental health care and recovery.
- The bed management system within adult and older people's services was effective. It ensured that patients received timely access to services when they required it.
- In adult and older people's community services target times for assessment were set and met: referrals were seen quickly by skilled professionals.
- Proactive steps were taken to engage with people who found it difficult or were reluctant to engage with mental health services.
- Complaint information was available for patients and staff had a good knowledge of the complaints process.
- A good range of information was available for people in appropriate languages.
- The trust was meeting the cultural, spiritual and individual needs of patients.

However:

- There were significant waiting lists for some child and adolescent mental health and healthcare services.
- There were clear arrangements for ensuring that there was single sex accommodation on the majority of wards. However, improvement was needed to ensure that arrangements for managing mixed sex accommodation at Maple 1 ward were followed to ensure the privacy of patients.

Our findings

Access, discharge and bed management

We found that community adult, older people and crisis services where meeting their targets for assessment.

During 2014 the advice and referral centre (ARC) became operational providing a single point of referral, triage and signposting for the trust. A recent evaluation had highlighted a need to review the operation of the service. Staff told us they were engaged in this process.

Crisis referrals were initially triaged by ARC and promptly referred through to the crisis teams. The crisis teams were meeting their set target of assessment within 24 hours from referral. Information from the trust indicated that most people were assessed within four to six hours from referral and that 96% of admissions to acute wards were gate-kept by crisis teams between October and December of 2014.

Liaison psychiatry had set targets that had been agreed with the acute hospitals that commissioned their service. Targets were being met. For example, the liaison psychiatry service in Addenbrooke's hospital had a target of assessing patients within one hour in an emergency and within four hours as a routine referral. Information from the trust showed that 98% of patients were assessed within target.

Community adult mental health teams were meeting the five day standard for seeing urgent referrals and the eight weeks for routine referrals. Actual times for adult locality teams were 3-4 days for urgent and 3-4 weeks for routine. The Peterborough locality team provided extra clinics to address a large number of unmet referrals to ensure waiting time targets were met.

The trust monitors both bed occupancy rates and delayed transfers of care. During 2014 bed occupancy rates at the trust averaged at 90% across all mental health services, which was slightly above the England average. At the time of the inspection the number of delayed transfers of care was 3% against a target of 6% for mental health services.

During this inspection we found that there was not a shortage of beds within adult, older people, forensic or learning disability services. There was, however, a waiting list for CAMHS inpatient services with waiting times at an average of 13.6 weeks from referral to initial assessment and 27 weeks from initial assessment to onset of treatment. The eating disorders service had temporarily

stopped admissions due to the acuity of patients and staffing levels. We were told that occasionally there could be delays in accessing a PICU bed but this was not evident during our inspection.

Waiting times for young people to access mental health services could be as long as 62 weeks for some young people. There was then a further waiting list for referral to medical treatment or psychological therapies. The trust was not accepting referrals for young people with ADHD and ASD unless they had a co-morbidity of moderate to severe mental health issues.

In community children's healthcare services there were long waiting times following referral in some services, especially speech and language therapy, and caseloads exceeded those of national recommendation. Service provision had not been increased in line with the population increases in recent years.

In all services patients were not moved between wards during an admission episode unless it was justified on clinical grounds and was in the interests of the patient. For example if a patient needed to be admitted to general hospital or became unwell and needed a more acute setting. Patients were not moved around in order to juggle beds.

The trust operated a '3-3-3' pathway model of assessment, treatment and recovery within adult services. The model consisted of three stages of care, namely three days of assessment, three weeks of treatment and three months of recovery. Each ward had a designated function. For example, Oak 3 ward was for admissions for specialist assessment within 72 hours, resulting in either recommendation for admission to another ward for treatment and/or recovery, transfer of care to the crisis resolution and home treatment team, to the general practitioner, or to a community team or agency. The ward managers confirmed that this system worked, although there could be short delays in transferring patients between wards.

During 2014 the trust was below its target for percentage of patients on CPA followed up within 7 days of discharge at between 92% and 96%.

The mental health ward teams worked closely with both crisis services and community teams to ensure continuity of care when patients were discharged from hospital We observed that at all inpatient services' staff worked with other services to make arrangements to transfer or discharge patients. We found that generally there was evidence of different groups working together effectively to ensure that patients' needs continued to be met when they moved between services.

The service environment optimises recovery, comfort and dignity

Since 2013 'patient-led assessments of the care environment' (PLACE) visits had taken place to a number of inpatient services. This is a self-assessment process undertaken by teams including service users and representatives of Healthwatch. The results indicated that the trust overall scored above average for the standard of cleanliness, facilities, and privacy, dignity and wellbeing.

Generally we found that inpatient services were clean, well maintained and had environments that promoted recovery. Most had room for activities, space for quiet and a place to meet visitors. Services at the Cavell Centre and Fulbourn Hospital had access to a space for children to visit.

We found that most services had access to grounds or outside spaces. Wards we visited had a telephone available for patients' private use. Most inpatient services had lockable storage available to patients. Whilst patients had access to a lockable storage space at the acute wards, they did not have the keys for the storage and had to approach a member of staff. In all longer stay services we found that people were able to personalise their bedroom space.

At a number of services many patients were not happy with the choice and quality of food available to them. Most wards had facilities for drinks and snacks outside of meal times. In the majority of cases these were open to patients as appropriate. At the PICU and forensic service, patients did not have access to the kitchen but staff facilitated access to drinks.

Meeting the needs of all people who use the service

Inpatient and community services were mainly provided from facilities that were equipped for disability access. In environments where this was not possible arrangements were in place to ensure alternative access to the service.

We found a wide range of information available for service users regarding their care and treatment both within services and via the trust website. Many of the leaflets

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Are services responsive to people's needs?

viewed were available in other languages and formats. Some services had access to a 'leaflet factory' to provide information leaflets in languages spoken by people who used the service.

Staff told us that interpreters were available via local interpreting service and language line and were used to assist in assessing patients' needs and explaining their care and treatment.

The trust had a spirituality strategy for 2014-2019 which set out the trust's aims for ensuring cultural and spiritual needs were met. At most inpatient services we saw that multi-faith rooms were available for patients to use and that spiritual care and chaplaincy was provided. We saw that generally there was a range of choices provided in the menu that catered for patients dietary, religious and cultural needs. However, in eating disorder services we heard that there were not enough vegetarian options.

Listening to and learning from concerns and complaints

The trust provided details of all complaints received during 2014. There had been 158 formal complaints. The largest number of these related to 'all aspects of clinical treatment'. The analysis of this highlighted key themes as staff attitudes, issues with appointments, admission and discharge, and communication. The trust informed us that during the period 48% of complaints had been upheld. During the period no complaints had been referred to the parliamentary and health service ombudsman. The trust also provided information about the complaint issues and the actions they had taken as a result of the findings. We reviewed this information and saw some good examples of learning from complaints.

The trust provided details of their formal complaints process. This set out arrangements for response, investigation and ensured lessons were learned and shared. We found that complaints were logged on the trust's incident management system and were notified to the trust complaints team. All formal complaints were reviewed by the director responsible for the service. Complaints information was discussed at local governance meetings and was reviewed by the clinical governance and patient safety committee. The board received the report from the clinical governance and patient safety committee which included details of complaints received and any relevant actions.

Staff received training about the complaints process during their induction and an ongoing basis. Staff were generally aware of the complaints process. Staff told us they that were aware of complaints raised in the service and usually heard of the outcome and any learning this raised. We saw that staff discussed the learning from complaints at a number of team meetings we observed.

At the inpatient services most patients told us that they were given information about how to complain about the service. This was usually contained within the ward information pack and included information about how to contact the patients' advice and liaison service. Information about the complaints process was usually displayed at the wards. All patients knew how to complain and most felt they would be listened to. At most community teams we found that complaints information was displayed and that additional information was available. Most community patients knew how to complain.

Complaints information was also looked at some of the services we visited. Reports usually detailed the nature of complaints and a summary of actions taken in response. Generally complaints had been appropriately investigated and included recommendations for learning. At some units we saw actions that had occurred as the result of complaints.

The trust told us that they were actively trying to manage complaints on an informal basis. In a number of community and inpatient services verbal complaints were managed at service level and the findings were usually acted upon.

Good

Are services well-led?

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

Summary of findings

We rated Cambridgeshire and Peterborough NHS Foundation Trust as good for Well Led because:

- The trust board had developed a vision statement and values for the trust and most staff were aware of this.
- Good governance arrangements were in place, which supported the quality, performance and risk management of the services.
- Key performance indicators were used to gauge performance.
- The trust had undertaken positive engagement action with service users and carers.
- Team managers had sufficient authority to manage the service effectively.
- There was effective team working and staff felt supported by this.
- Staff knew how to use the whistleblowing process and could submit items to the risk register.
- There was a commitment to quality improvement and innovation.

Our findings

Vision, values and strategy

The trust board and senior management team had a clear vision with strategic objectives and values. We were told that the he trust developed their mission statement, vision and values during 2013 following detailed engagement with service users, staff and commissioners. The mission statement was: 'To offer people the best help to do the best for themselves'.

The values were stated as:

- Patients first: patients are in the driving seat. We aim to exceed their expectations by making every interaction count.
- Our staff matter: we trust, value, and develop each other. We build a great place to work, where people are inspired to be the best they can be.
- Only the best: we have high standards in all that we do. We are uncompromising in our pursuit of excellence. We measure everything we do and share the data with others to judge. We expect that everyone will give the best they can.
- Together, as one: We are a good organisation to do business with. We value our teams and our partners and believe that by working together we achieve more. We focus our efforts only on what we can become best at.

The vision was stated as:

"We want to give those people who need our services the best possible chance to live a full and happy life, despite their condition or circumstances.

- Recovery – we will adopt the principle in all our services of empowering patients to achieve independence and the best possible life changes removing dependence and giving them and their families (in the case of children) control over their care.
- Integration – we will work closely with providers along pathways to deliver integrated person-centred care and support to local people close to their homes principally in non-institutional settings. We will integrate with key partners to improve efficiency and effectiveness and simplify access.
- Specialist services – we are one of England's leading providers of key specialist mental health services with particular expertise in eating disorders, children and young people's mental health, autistic spectrum disorders and female personality disorders."

The trust gave us a copy of their strategy for 2014 to 2019. This set out the trust's overarching objectives. The operational plan from 2015 to 2016 also set out more detailed objectives to meet this strategy, as well as arrangements to monitor progress.

Additional annual objectives were also set out in the annual quality account. For 2014/15 the objectives included development of better quality indicators,

improved friends and family test results and implementation of Health of the Nation Outcome Scales. It was found that the trust had made significant progress across these objectives.

The trust board, executive team and quality, safety and governance committee review performance against the strategy on a monthly basis via a business performance report and dashboard approach known as the quality performance dashboard. Performance against annual objectives was also published within the quality account.

The vast majority of staff we spoke with said they were aware of the trust's vision and values, and strategic objectives. Staff were generally familiar with the trust mission statement. We found evidence of the vision and values on display within the services and this was also available to staff on the trust intranet. Staff told us that they received regular information and newsletters setting out progress against objectives.

The trust board members we spoke with were clear about the vision and strategy and were able to articulate their specific areas for improvement. Senior management were aware of the strengths and improvement needs of the trust and the specific objectives of their own service areas.

We found that staff were committed to ensuring that they provided a good and effective service for patients and felt able to influence change within their service. Most staff were aware of the trust's management structure and who their locality managers were. Most staff had an understanding of the trust vision, values and strategy. Staff demonstrated that they usually had a good understanding of directorate and service level objectives.

Good governance

The trust had a board of directors who were accountable for the delivery of services and assurance through its governance structure for the quality and safety of the trust. Reporting to this were committees for quality assurance, workforce and organisational development, finance and performance, and audit and assurance. The trust managed all quality governance through the quality, safety and governance committee. Reporting to this were sub-committees for clinical effectiveness, audit and research, patient safety, safeguarding, risk and health and safety, infection control, patient and carer experience, medicines management, resuscitation and the mental health legislation. These committees had terms of reference, defined membership and decision making powers.

The trust had an integrated board assurance framework and risk register which is reviewed monthly by the board. Risk registers were also in place held at different levels of the organisation which were reviewed at directorate meetings. We saw that there was a clear connection between the risks identified at grass roots level and those recognised by the board.

At inspection we found that the board members had a good grip on issues the trust faced in delivering services. We found that the board held staff to account in an appropriate way whilst enabling executives to manage the delivery of services.

The quality performance dashboard acts as a performance report against key indicators and an early warning system for identifying risks to the quality of services. This includes measures of organisational delivery, workforce effectiveness and quality and safety. These include: complaints, serious incidents, access and waiting time targets, delayed transfers of care, bed occupancy, average length of stay, as well as staffing measures such as vacancies, sickness, turnover and training rates.

A mental health legislation group had overall responsibility for the application of the Mental Health Act and the Mental Capacity Act. We met with the hospital managers and found that they provided a regular annual report to the board, to inform of performance in this area. The board also received further information and assurance regarding the Mental Health Act through the board committee structure.

Staff demonstrated they were aware of their responsibilities in relation to governance. Most staff told us that they were aware of the governance structure and had access to performance information and meeting minutes. Most staff told they would escalate risks they were aware of.

Team managers confirmed that they were involved in governance groups and that they were able to raise issues through the risk register and operational groups. We reviewed the risk registers for the trust and directorates and noted that the concerns we found had been highlighted and were part of risk registers.

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Are services well-led?

We reviewed the performance reports for the previous year's objectives. We noted that there had been significant progress against objectives. We found that there was good performance monitoring across mental health and learning disability services. However, in children's services there was a lack of performance monitoring. Measures were under development and senior staff were aware of a requirement to implement a statutory national dashboard from September 2015. Work had recently started on evaluating the information requires and to put systems in place to meet the requirements of the dashboard.

Leadership and culture

Morale was found to be good in most areas. A number of staff commented that morale had steadily increased over the previous 18 months following a change of leadership. Generally staff felt engaged by the trust. Staff told us that the chief executive and senior managers were visible.

The trust confirmed that they have a vacancy rate of 5% and that staff turnover stood at 10% in May 2015. During May 2015 over 20% of shifts within inpatient services were covered by agency or bank staff.

In the 2014 NHS Staff Survey, the trust was ranked about average overall. However, CPFT had scored within the worst 20% of mental health and learning disability on 46% of the key findings. These included support from immediate managers, feeling valued, job satisfaction and being able to contribute to development. Overall the trust had slightly improved its position across relevant indicators against the 2013 survey results.

The trust told that they had undertaken a range of initiatives to engage staff. These included implementing a 'team brief' system to engage staff in developments, a direct method of feedback to the senior team, twice-yearly informal meetings for the CEO to meet, a 'back to the floor' programme, an email system which gives staff direct access to the CEO and launched the 'middle manager's network' and 'manager's charter' and developing a new Manager's handbook.

The trust used the friends and family test on a quarterly basis to consider staff's views. Since April 2014 this had shown a steadily increasing improvement in staff's level of satisfaction.

Most staff told us they knew their immediate management team well and most felt they had a good working relationship with them. Most staff were aware of, and felt supported by, the trust's directorate management structures. Most staff were aware of who the senior management team were at the trust. Some staff stated that they had met with or seen senior managers at their service and felt supported by this. Some staff reported that the senior team had worked within their service and this was welcomed. The chief executive worked regular shifts as an unregistered staff member in order to be visible and also to gain first hand experience of the work staff do. Other directors were very responsive in listening to staff concerns and ideas.

Staff were aware of their role in monitoring concerns and assessing risks. They knew how to report concerns to their line manager and felt they would be supported if they did. Staff were aware of the 'stop the line' initiative and some stated they had used this to good effect. We found some good examples of staff feeling that learning from past incidents was informing planning of services or service provision.

In November 2014 a CQC regulation was introduced requiring NHS trusts to ensure that all directors were fit and proper persons. As a consequence of this the trust had checked that all senior staff met the necessary requirements. The trust had set up policies and procedures to ensure that all future senior staff have had the relevant checks.

Engagement with the public and with people who use services

The trust had a partnership strategy that set out arrangements for engagement with service users and carers. Underpinning this was a detailed user and carer engagement programme. This work was overseen by a trust wide patient and carer experience group. Work had included development of a dedicated patient experience team and service based engagement co-ordinators, promotion of advocacy, increased partnerships with voluntary and community groups and service user involvement in training, recruitment, research and audit. The trust had developed peer support workers as part of the recovery college. As a result the trust formally employed over 50 peer support workers across the trust. Other initiatives developed included the use of the 'triangle of care' toolkit which provides an accredited framework to

develop carer involvement within local services and a large number of public engagement events delivered in line with service reconfiguration in community mental health, CAMHS and other inpatient services.

The trust had used the friends and families test since April 2014. In the 12 months prior to our visit there had been almost 7000 responses to this survey. At March 2015 the results indicated that 85% of patient and 60.5% of staff respondents were likely or extremely likely to recommend the trust services. The trust demonstrated an improving picture of satisfaction during the 12 months before our inspection.

The trust had a number of carers' forums and inpatient services had community meetings to engage patients in the planning of the service and to capture feedback. In most services this meeting was chaired by patients and was attended by relevant ward staff. Some meetings were supported by local advocacy services. Minutes were usually taken and we saw evidence of actions that were raised being completed. Patients told us they felt able to raise concerns in the community meetings and that they usually felt listened to.

Patients and their families or carers were engaged by staff in community services using a variety of methods. We saw that there was information available throughout the trust and via its website about how to provide feedback on the specific services received by people.

Many patients told us that they felt listened to and their requests were usually acted upon.

Across services we found good patient involvement of patients in their care. Almost all care plans and records reviewed demonstrated the person's involvement. In all services we found that there was an opportunity for patients to attend care planning meetings. In child and adolescent and learning disability services we found that care plans were written in an appropriate format to be accessible to the patients. We found a number of examples of relatives being involved in care planning where this was appropriate.

Prior to the inspection we spoke with a large number of user groups, community support organisations and advocacy services. Generally we heard of positive relationships with the trust and of opportunities to be involved in providing feedback on how services were run or planned.

Quality improvement, innovation and sustainability

The trust had participated in a number of applicable Royal College of Psychiatrists' quality improvement programmes or alternative accreditation schemes. The ECT suites, at the Cavell Centre and Addenbrookes, forensic services and learning disability services held Royal College of Psychiatrists' accreditation. Acute wards either had or were working towards accreditation from the accreditation for inpatient mental health services programme. Eating disorder services had the quality network for eating disorders accreditation. The children's community service was level three accredited by UNICEF for infant feeding in January 2015. The Darwin Centre was accredited with the quality network for inpatient CAMHS and the Croft Unit was working towards accreditation. Liaison psychiatry service in Addenbrooke's hospital had been rated as excellent by the psychiatric liaison accreditation network. However, facilities in the health-based place of safety at Fulbourn Hospital and the PICU at the Cavell Centre did not meet aspects of the Royal College of Psychiatrists' guidance so were yet to be accredited.

The trust had academic health service centre status and worked with local universities through the Cambridge University health partnership. It was also the host of the collaboration for leadership in applied health research and care for East Anglia. There was a research strategy in place and the trust had participated in a wide range of clinical research. There was a dedicated research function and through links with local universities the trust appointed three academic leads in 2014 to work across services. This trust included detailed information on research projects on their website and actively promotes user participation. As a result over 1300 service users engaged in research in the last year. The trust also had a number of action research projects underway, for example a project to involve services users in research regarding treatment options. The trust was participating in a number of national research projects such as a national programme on use of health records to benefit patients with dementia and other diseases.

The trust undertook a wide range of clinical effectiveness and quality audits. These included safeguarding practice, medicines management, prescribing, compliance with NICE guidance, suicide prevention, clinical outcomes, physical healthcare, care planning, record keeping,

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Are services well-led?

pressure ulcer management, consent and capacity, Mental Health Act administration and patient satisfaction. We also found a number of localised audits looking at practice within services.

During 2014 the trust participated in the national audit of schizophrenia. The trust performed below average for service user satisfaction. However the trust performed better than average for care planning. National audit of psychological therapies and National confidential inquiry into suicide and homicide by people with mental illness. The trust also participated in prescribing observatory for mental health audits in prescribing for attention deficit hyperactivity disorder, prescribing antipsychotic medication in CAMHS, prescribing anti dementia drugs and monitoring of patients prescribed lithium.

The trust had undertaken a trust-wide audit using the green light toolkit in 2013. This audit aims to assess whether services were appropriate for people with a learning disability. The trust provided us with an action plan indicating they were compliant in most areas. Work was underway to meet full compliance. This included development of accessible information regarding the Mental Health Act and wider services, additional training for staff and the development of further expertise in autism.

The trust had participated in the Mental Health Crisis Care Concordat with their partners and had developed an action plan to improve services that was being monitored regularly.

The trust's recovery college was a successful innovation and was expanding to provide more courses and more involvement with the local communities.

Staff told us that they had opportunities for leadership development and that leadership training was available.

Managers in older people's services described plans to research further and introduce a new initiative to help with easy identification of the levels of risks patients presented of falls. This was encouraged by the trust.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment The trust must review systems relating to the monitoring of the administration of, and adherence with, the Mental Health Act 1983, and associated Code of Practice, specifically in relation to consent to treatment (Section 58) and practices amounting to seclusion.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment Premises must be fit for purpose in line with statutory requirements and should take account of national best practice. The trust must ensure that in inpatient services ligature risks are removed where possible, and any remaining risks are fully managed. The trust must ensure that observation is improved in some areas.

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 The trust did not take appropriate steps to ensure there were sufficient numbers of staff. Not all community and inpatient services had sufficient staffing to safely meet patient need.