Good

Cumbria Partnership NHS Foundation Trust

Community-based mental health services for adults of working age

Quality Report

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Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RNNDJ	Voreda	Allerdale Community Mental Health Team	CA14 2RR
RNNDJ	Voreda	South Lakes Community Mental Health Team Garburn House Kendal	LA9 7RG
RNNDJ	Voreda	Furness Community Mental Health Team Duddon House	LA13 9AZ

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

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

Summary of findings

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

Summary of findings

Ratings

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

Overall rating for the service	Good
Are services safe?	Good
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

we rated community based mental health services for adults of working age as good because:

- the environment at the team bases were clean and there were systems in place for reporting required estates work
- staffing levels were safe, bank and agency staff who knew the service were used and recruitment was in progress for vacancies. The teams were multi-disciplinary consisting of psychiatrists, psychologists, nurses, social workers, occupational therapists and support workers
- risk assessments were recorded and updated regularly. Physical health care needs were considered and comprehensive assessments were completed in a timely manner. Records showed care was recovery orientated and personalised. Confidential information was stored and moved securely
- all staff had a good understanding of safeguarding and understood their responsibilities in reporting concerns. Safeguarding champions had been identified in teams. CMHTs had good arrangements for the management of medicines
- there was an effective incident reporting system in place and staff knew how to report incidents. De-briefs were offered and there was shared learning from serious incidents. Staff were aware of their responsibilities in relation to the duty of candour and formal complaints from patients were received and monitored by the patient experience team
- all newly recruited staff received corporate and local induction. Role specific training needs were identified and staff had received training such as cognitive behavioural therapy and physical health care. Supervision protocols were in place and staff attended regular team meetings. Staff were aware of and followed National Institute for Health and Care Excellence (NICE) guidance. Outcome measures were used to evaluate the effectiveness of care and treatment
- staff were respectful and caring when they spoke with people and there was positive feedback from people who used the services. People said they felt staff listened to them and they were involved in their care planning and treatment.Staff offered carers assessments and provided support
- patients were assessed in a timely manner and teams took active steps to engage with people who used the service. Patients could access help outside normal working hours from the crisis team. Teams were recovery focused and decisions to discharge patients were agreed within the multi-disciplinary team. Rooms were accessible for people with disabilities and available for confidential discussions. Information was displayed such as advocacy services and how to complain
- managers used key performance indicators to gauge the performance of their teams such as time from referral to assessment and contact with general practitioners. There was sufficient administrative support available to team managers
- managers were able to use the trust absence policy to support staff in their return to work. Staff reported a supportive team culture and were confident about raising concerns without fear of victimisation.

However;

- staff identified that the transition of young people from the community mental health services for children and young people (CAMHS) did not always occur from the age of 17 and a half as stated in the trust policies.The trust recognised improving transition from children's services as a priority for 2014-15. This meant that staff did not always work together to assess and plan ongoing care and treatment in a timely way when people move between services or teams
- the mandatory training rate across the teams was 67% which was below the 80% compliance level expected by the trust. Adherence to the trust Mental Health Act and Mental Health Act Code of Practice mandatory training was 55%
- teams were using a combination of paper and electronic records in order to maintain a complete record in respect of each patient. Staff regarded the

Summary of findings

paper record as the primary record of patient care and treatment however, paper records were not always complete and contemporaneous. Transfer of paper records between teams were delayed whilst awaiting typed notes to be filed

- a list of patient names were visible from the reception area at one team base. This meant patients' confidentiality was not being maintained and we requested this be removed immediately
- staff did not routinely participate in clinical audit and were not aware of any trust wide audits that had taken place involving their services. This meant staff were not involved in activities to monitor and improve people's outcomes
- the trust reported 38% of non-medical staff had an appraisal in the past 12 months for the CMHTs. Individual clinical supervision was not fully embedded in all the teams we visited
- there were no trust targets to measure waiting times from assessment to treatment or allocation to a care co-ordinator. The waiting times across the teams we visited were varied and patients told us they were waiting too long for treatment
- we did not see any evidence of how patient feedback was being routinely collected or used by the services we visited.

Summary of findings

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

Are services safe?

Good

we rated safe as good because:

- the environment at the team bases were clean and there were systems in place for reporting required estates work
- staffing levels were safe, bank and agency staff who knew the service were used and recruitment was in progress for vacancies
- risk assessments were recorded and updated regularly. Physical health care needs were considered and comprehensive assessments were completed in a timely manner. Records showed care was recovery orientated and personalised.Information was stored and moved securely
- there was an effective incident reporting system in place and staff knew how to report incidents. De-briefs were offered and there was shared learning from serious incidents
- all staff had a good understanding of safeguarding and understood their responsibilities in reporting concerns. Safeguarding champions had been identified in teams
- CMHTs had good arrangements for the management of medicines involving storage, transportation, and administration of medication.

However;

- the mandatory training rate across the teams was 67% which was below the 80% compliance level expected by the trust
- teams were working with a combination of paper based and electronic records. Contemporaneous information was not always available and not all information held in the paper record was available electronically. There were delays in accessing paper files when a patient moved to different teams within the service
- information held in the estates and fire management files we viewed was not updated.

Are services effective?

Good

we rated effective as good because:

Summary of findings

- physical health care needs were considered and comprehensive assessments were completed in a timely manner. Records showed care was recovery orientated and personalised and confidential information was stored and moved securely
- CMHTs were multi-disciplinary consisting of psychiatrists, psychologists, nurses, social workers, occupational therapists and support workers. There was regular and effective multi-disciplinary meetings,opportunities for team clinical supervision and good working relationships with other teams and agencies
- practice was in line with the Mental Health Act and Mental Capacity Act
- staff followed National Institute for Health and Care Excellence (NICE) guidance.

However:

- CMHTs were working with a combination of paper based and electronic records. Contemporaneous information was not always available and not all information held in the paper record was available electronically. There were delays in accessing paper files when a patient moved to different teams within the service
- The trust reported 38 % of non-medical staff had an appraisal in the past 12 months for the CMHTs.Individual clinical supervision was not fully embedded in the teams we visited
- adherence to the trust Mental Health Act and Mental Health Act Code of Practice mandatory training was 55% which is below the standard expected by the trust
- staff did not routinely participate in clinical audit and were not aware of any trust wide audits that had taken place involving their services. This meant staff were not involved in activities to monitor and improve people's outcomes.

Are services caring?

Good

we rated caring as good because:

- staff were respectful and caring when they spoke with people and there was positive feedback from people who used the services. People said they felt staff listened to them and they were involved in their care planning and treatment. Staff offered carers assessments and provided support
- information was displayed in every team base we visited informing patients how to contact the patient experience team.

Summary of findings

However:

- a list of patient names were visible from the reception area at one team base This meant patient's confidentiality was not being maintained and we requested this be removed immediately

- One staff member informed us there was a survey to give to patients at every initial assessment but this was not routinely used. We did not see any evidence of how patient feedback was being routinely collected or used by the services we visited. This meant people were not always able to give feedback on the care they receive.

Are services responsive to people's needs?

Good

we rated responsive as good because:

- patients were assessed in a timely manner and teams took active steps to engage with people who used the service. Patients could access help outside normal working hours from the crisis team
- teams were recovery focused and decisions to discharge patients were agreed within the multi-disciplinary team
- rooms were accessible for people with disabilities and available for confidential discussions
- information was displayed such as advocacy services and how to complain
- staff were aware of their responsibilities in relation to the duty of candour and formal complaints from patients were received and monitored by the patient experience team.

However :

- One team base did not have an identified clinical room which was suitably equipped with all the necessary equipment to carry out physical health care checks
- the hearing loop system at one reception area appeared to be broken had not been reported. This meant people who used a hearing aid might have difficulty communicating with staff.

Are services well-led?

Good

we rated well led as good because:

Summary of findings

- There were good governance arrangements in place to monitor performance and clinical care. Managers used key performance indicators to gauge the performance of their teams such as time from referral to assessment and contact with general practitioners
- outcome measures such as the Health of the Nation Outcome Scales (HoNOS)were routinely collected
- managers felt they had the authority they needed in their role and there was sufficient administrative support available to them
- managers were able to use the trust absence policy to support staff in their return to work
- staff reported a supportive team culture and were confident about raising concerns without fear of victimisation.

However ;

- Not all staff could describe the trust vision and values and some staff could not identify senior managers in the trust.

Summary of findings

Information about the service

The community mental health teams (CMHTs) for adults provide a range of community support and treatment to adults who experience psychosis and non-psychotic illness across six counties in Cumbria. The CMHTs are made up of consultant psychiatrists, psychiatric nurses, social workers, support workers, occupational therapists, and psychologists and are supported by administrative staff. People who are experiencing mild to moderate depression and anxiety are referred to "First Steps". This is a service Improving access to psychological therapies (IAPT) offering talking therapies for adults. We visited Allerdale CMHT at Park Lane in Workington, which covered the north west region of Cumbria, South Lakes CMHT at Garburn House based at the Westmorland General Hospital in Kendal, which covered the central region of Cumbria and Furness CMHT at Duddon House in Barrow-in-Furness, which covered the south west region of Cumbria.

The Care Quality Commission has inspected the Cumbria Partnership Foundation Trust 22 times across 11 locations.

The Furness CMHT at Barrow-in-Furness was inspected on 23 September 2014. This was an unannounced inspection in response to concerns that one or more of the essential standards of quality and safety of the Health and Social Care Act 2008 (HSCA 2008) (Regulated Activities) Regulations 2010 were not being met. The inspection found patients were not protected against the risks of unsafe or inappropriate care and treatment because care records were not always accessible and easily located. This was judged as having a moderate impact on people and compliance action for Regulation 20 HSCA 2008 (regulated activities) Regulations 2010 was needed to meet the standard for records.

When we inspected the CMHTs we found there was improved information when patients moved between teams, which meant the trust was no longer in breach of the regulation. Staff were using a combination of paper and electronic records in order to maintain a complete record in respect of each patient. Staff used the trust record tracking system to locate paper records and we saw records were sent securely and in a timely way. Staff regarded the paper record as the primary record of patient care and treatment however, paper records were not always complete and contemporaneous. One staff member gave an example of when transfer of a paper record was delayed whilst awaiting typed notes to be filed. A manager we spoke with gave an example of how effective joint working between teams ensured relevant information was shared verbally to ensure safe care and treatment was provided. The risks have been recorded and mitigated by the trust whilst awaiting the implementation of the new primary electronic record system. However, the timescale for the implementation has been delayed by three months.

Our inspection team

Our inspection team was led by: Chair: Paddy Cooney

Team Leader: Jenny Wilkes, Head of Hospital Inspection, mental health hospitals, CQC

Inspection Manager: Brian Cranna, mental health hospitals, CQC

The team was comprised of: two CQC Inspectors, a pharmacist and three specialist advisors including a mental health nurse, a social worker, and a consultant psychiatrist.

Why we carried out this inspection

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

Summary of findings

How we carried out this inspection

To fully understand the experience 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 the inspection visit, we reviewed information that we held about these services, asked a range of other organisations for information and sought feedback from patients at three focus groups.

During the inspection visit, the inspection team:

- spoke with eight patients who were using the service
- spoke with the managers or acting managers for each of the teams
- spoke with 24 staff members; including psychiatrists, nurses, student nurses, psychologists, occupational therapists, social workers and administrative staff
- attended and observed a variety of multi-disciplinary meetings
- visited one patient in their home and observed three patient interviews to determine how staff were caring for people who used the service. This was with the approval of the person using the service.
- reviewed 18 patient treatment records
- we looked at the medicine related records for seven patients at one service
- looked at a range of policies, procedures, meeting minutes and other documents relating to the running of the services.

What people who use the provider's services say

We spoke with eight people and collected 24 comments cards from people who use services.

- There was positive feedback from people who used services and people said they felt involved in their care planning and treatment
- the trust score from the annual CQC mental health survey for people who received community mental health services in October 2015 was in line with other similar trusts
- people who used services were unhappy about delays in waiting for psychological therapies following assessment.

Good practice

- All teams we visited offered the "decider group" to help their patients with non-psychotic mental health problems. Identified staff had been trained in delivering the group, which ran for 12 sessions, and there was a plan to cascade this training to other staff members. Patients could become graduates and co-facilitate future groups. It aimed to provide people with the skills to deal with impulsive behaviours such as self-harm, avoidance, withdrawal and isolation, aggression, substance misuse and binge eating. This approach uses evidence based cognitive behavioural therapy and dialectical behavioural therapy. Outcome measures were used to measure the effectiveness of the interventions. At Workington, the team could demonstrate how using this approach was improving access for patients waiting for psychological therapy.
- There was identified nurse leads who had developed effective working relationships with the local maternity service to provide peri-natal wellbeing groups. NICE guidelines were used to provide an in-reach service to support the development of pre and post-natal plans with pregnant women. Staff

reported effective relationships with the local authority, and there was timely access to psychological therapies and a mother and baby unit if appropriate.

Areas for improvement

Action the provider SHOULD take to improve

- The trust should ensure all staff are involved in activities to monitor and improve the care and treatment outcomes and experiences of people who use services
- the trust should ensure all patients are offered a copy of their care plan
- the trust should ensure all staff have access to mandatory training, clinical supervision and appraisal to meet the standard expected by the trust
- the trust should ensure all staff document patient consent and capacity decisions about care and treatment in a consistent way.

Cumbria Partnership NHS Foundation Trust

Community-based mental health services for adults of working age

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Allerdale Community Mental Health Team Workington	Cumbria Partnership NHS Foundation Trust
South Lakes Community Mental Health Team Garburn House Kendal	Cumbria Partnership NHS Foundation Trust
Furness Community Mental Health Team Duddon House	Cumbria Partnership NHS Foundation Trust

Mental Health Act responsibilities

- The trust reported 55% of CMHT staff had received mandatory training in the Mental Health Act (MHA). Workington CMHT had 44% compliance, Kendal 75% and Barrow 53% compliance. Managers were aware of the mandatory requirement and staff told us they had received training or training was planned. Some members of staff in the CMHTs had undergone approved mental health professional training, which meant teams had access to staff who understood the legal powers of detention under the MHA.
- One manger we spoke with had oversight of the numbers of patients subject to the MHA and community treatment order (CTO) which were monitored on a weekly basis. A CTO is a legal order, which sets out terms under which a person must accept treatment whilst living in the community.
- Staff described a good working knowledge of the MHA and how to apply it including those patients subject to a CTO. We saw care plans contained details of conditions stipulated within a CTO. We observed multi-disciplinary meetings where staff discussed care and treatment of patients subject to a CTO.

Detailed findings

- Advocacy information was available for patients and staff were aware of how to support patients to access advocacy services. Patients told us they knew about advocacy services and how to access them if needed.

Mental Capacity Act and Deprivation of Liberty Safeguards

- The trust identified Mental Capacity Act (MCA) training as a mandatory requirement and reported 88% of CMHT staff had received MCA training. Workington and Kendal CMHTs had 87% compliance and Barrow 93% compliance. We spoke to one member of staff who had trained to become a best interests assessor
- staff we spoke with were familiar about obtaining peoples consent and we observed staff considering issues of capacity and consent during multi-disciplinary meetings. We observed consent being obtained from patients during consultations and patients told us they were involved in decisions about their care and treatment
- staff documented patient consent and considered capacity to make a decision about care and treatment at every initial assessment. However, this was only fully documented in nine of the 18 records we reviewed. This meant that peoples consent to care and treatment was always sought in line with legislation and guidance but not always fully recorded
- the trust did not provide evidence to indicate regular audits of adherence to the MCA was being carried out. This meant there was no process for monitoring if the CMHTs were meeting their responsibilities within MCA legislation and following relevant national guidance.

Good

Are services safe?

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

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

Our findings

Safe and clean environment

- People were seen in all three of the community mental health (CMHT) bases we visited. Access for appointments was through a staffed reception with identified waiting areas
- all staff had access to personal alarms for use in interview rooms where there was no alarm fitted
- the team bases at Kendal and Barrow had identified clinic rooms where there was the necessary equipment to carry out physical examinations. The environments and equipment were generally well maintained. However, Workington had no identified clinical area where the necessary equipment to carry out physical health care checks was kept.

Safe staffing

- The trust reported the CMHTs establishment levels of whole time equivalent (WTE) qualified nurses as 189 and nursing assistants as 31. There were 38 qualified nurse vacancies and one vacancy for a nursing assistant
- the overall sickness rate in a twelve month period was 6% and the staff turnover rate reported as 46 substantive staff leavers in the last 12 months
- Barrow CMHT had an establishment of 17 WTE qualified nurses and nine WTE nursing assistants with 20% overall staffing vacancies, 11% overall permanent staff sickness and seven substantive staff leavers in the past 12 months
- Workington CMHT had and establishment of 15 WTE qualified nurses and 4 WTE nursing assistants with 6% overall staffing vacancies, 7% overall permanent staff sickness and two substantive staff leavers in the past 12 months
- Kendal CMHT had an establishment of 11 WTE qualified nurses and 4 WTEnursing assistants with 13% overall staffing vacancies,6% overall permanent staff sickness and one substantive leaver in the past 6 months
- mangers said maintaining adequate staffing levels was a challenge particularly in the more remote areas of the trust and there was an example of three unsuccessful recruitment attempts for an advanced practitioner post in one team. However, staff told us that staffing numbers were improving and we saw that short-term cover was in place with bank and agency staff. We interviewed staff who had recently been recruited and all managers were able to clearly describe the longer-term recruitment plans in place to address the situation. This meant arrangements for staffing were in place to keep people safe at all times
- caseloads varied between teams based on a number of factors such as referral rates and the impact of low staffing levels. Staff said caseloads were between 35 - 45 over the past 12 months but were now reducing to approximately 25. Team managers showed us the systems they used to monitor and manage caseloads which reflected these figures
- each CMHT had ready access to a consultant psychiatrist. Psychiatrists operated outpatient clinics and participated in multi-disciplinary discussions. Staff felt well supported by the consultant psychiatrist in Workington who facilitated a regular reflective staff supervision group. However, cover at Kendal CMHT had been provided by locum psychiatrists, which staff felt had impacted on the consistency of service to patients. Two patients said they felt they had waited too long to see a psychiatrist
- mandatory training compliance across all teams was reported as 67% which is below the 80% compliance rate required by the Trust. In October 2015 the mandatory training reportidentified all six teams scored 75% or below for informed consent to treatment, mental health legislation update, risky business, manual handling in the workplace, basic life support with defibrillator, clinical records keeping, infection prevention and control level two and hand hygiene training . Five teams scored below 75% for equality and diversity training. Four teams scored below 75% for PVMA level two training, safeguarding children, working with children and their families, information governance and fire safety training. Two teams scored below 75% for

Good

Are services safe?

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

safeguarding adults level one, local induction, and safeguarding children-think family training. This meant that not all staff had received mandatory training in systems, processes and practices to keep people safe

- all team managers spoke of the difficulties accessing training for staff. This was due to a combination of historically low staffing levels and availability and accessibility of the training. Staff told us that training took place at central locations, which involved long distance travel. In response, managers had arranged some local mandatory training to help improve compliance. All teams achieved above 75% compliance for corporate induction, mental capacity act and deprivation of liberty level one training.

Assessing and managing risk to patients and staff

- we reviewed a total of 18 care records and saw that in all of the records individual risks were assessed, clearly documented and up to date using the Galatean risk assessment tool (GRIST). This was an evidence-based tool that identified the individual risks associated with each patient. Risk assessments were completed at initial assessment, updated as necessary and at least every six months. Staff completed crisis plans, which formed part of the "staying well plan" with patients and recorded information on the electronic record system. Patients told us they knew about their risk management plans and how to get help
- all three teams operated a duty system and were able to respond promptly to any sudden deterioration in a patient's mental health by arranging appointments the same day if necessary
- we saw staff referred to the trust standard operational policy for CMHT management of waiting lists during multi-disciplinary meetings to discuss new referrals to the service. Managers maintained oversight of the waiting lists using the electronic system. These meant risks to people who used the services were assessed and their safety was monitored and maintained
- safeguarding adults and children was part of the trust mandatory training requirement. Two of the three teams we visited had achieved above 75% compliance of safeguarding adults and safeguarding children training. All staff had a good understanding of safeguarding and understood their responsibilities in reporting concerns. Safeguarding champions or leads had been identified in teams. We saw evidence of safeguarding concerns being discussed at multi-disciplinary meetings and recorded where appropriate
- the trust lone working policy was out of date. However, staff were aware of the policy and used their own local protocols. We saw staff used electronic diaries, signing out boards, mobile phones, and a buddy system. Joint visits were undertaken when risks where identified and staff reported they felt safe at work
- we looked at the medicine related records for seven patients receiving support from the CMHT in Barrow. We found details of patients currently prescribed medicines were requested before medication reviews by the consultant. Medication reviews and information about any treatment changes were promptly forwarded to the general practitioner. Requests for physical health monitoring under the trust shared care protocol was prompted by care co-ordinators and prescribers whoreviewed medication
- staff we spoke with confirmed they could access advice from a pharmacist on request, however support from a regular specialist mental health pharmacist was not provided to support and drive forward medicines optimisation
- suitable arrangements were in place for the management of medicines where teams were involved in the storage, transportation or administration of medication. This meant there were reliable systems, processes, and practices in place to keep people safe.

Track record on safety

- There were five serious incidents involving a death of a community patient in receipt of community mental health services in the 12 months leading up to our inspection. This included four deaths as a result of suicide/suspected suicide by hanging and one unexpected death. The trust had developed a suicide prevention plan and identified preventing people from dying prematurely as a consequence of suicide as one of the five quality priorities for 2015/16.

Reporting incidents and learning from when things go wrong

Good

Are services safe?

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

- There were 77 incidents reported via the trusts electronic incident reporting system across the CMHT services. There was evidence that 72 hour reports and an investigation took place where safety incidents had occurred
- staff spoke of never events and were aware of serious incidents events that had occurred
- information was communicated via a range of methods including monthly clinical governance meetings, quality and safety team reports, team meetings and learning reviews
- we observed a multi-disciplinary learning lessons meeting taking place where actions were agreed to make changes to processes. We also saw there were plans for two further learning review events to take place. In Workington, a change to the duty system had been made and patients were asked for up to date contact numbers in response to incidents that had occurred. This meant that lessons were shared and learned to make sure action was taken to improve safety
- staff we spoke with knew how to report incidents using the trust electronic risk reporting system and could describe what should be reported. The system notified and escalated the incident to managers dependent on the severity of the incident. Arrangements were in place for staff to escalate adverse events to managers using the bronze, silver and gold on call system
- staff were able to describe their duty of candour as the need to be open and honest with patients when things go wrong
- managers offered staff a de-brief following serious incidents and staff described the investigation process as being supportive rather than a blaming culture.

Are services effective?

Good

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

Our findings

Assessment of needs and planning of care

- We looked at 18 care records across the three CMHTs. We found patients had a comprehensive assessment completed as part of their initial assessment process. This information was entered onto the trust electronic recording system and was accessible to all staff. Assessments included information about social factors including housing, income and substance misuse in addition to physical and mental health needs. Staff signposted carers to local agencies where identified carers needs could be assessed

Best practice in treatment and care

- CMHTs were able to offer psychological therapies as recommended by the National Health and Care Excellence (NICE) Guidance. We observed guidelines were referred to when specific interventions were discussed with people who use services
- the CMHTs were able to refer patients to First Steps which is the access to psychological therapies service. Patients could also receive psychological therapies from psychologists and therapists in the teams
- there were no targets identified by the trust with regards to access to psychological therapies in the CMHTs and waiting lists varied from team to team. For example, patients waited eight months at Kendal and 16 months at Barrow for psychological assessment. However managers were aware of the variable waiting times and we saw that there was a strategy in place to clear the waiting lists across the services by January 2016
- people who used the services received support around employment, housing and benefits from social workers and support workers. People could also be referred to an appropriate local agency such as the local authority and voluntary groups
- the trust was developing its physical health care policies at the time of our visit to help promote patient wellbeing through prompt referral to physical health monitoring
- physical health care checks were carried out by identified members of the CMHTs who had received specific training. Monitoring arrangements were in place with the local general practitioners using a shared care protocol where physical health monitoring was undertaken by the trust for an initial 12 month period
- the trust used a standard physical health assessment tool, however primary care services did not use a standardised form to communicate results
- in Workington support workers carried out a weekly physical health clinic for all patients who were prescribed anti-psychotic medication, however they did not have an identified clinical room at the team base. In Barrow and Kendal a physical health practitioner had been identified and there was an agreement that physical health checks were carried out with the hospital primary care assessment service
- all people who used services received care under the care programme approach (CPA) and reviews of their care were carried out according to the CPA guidelines. CMHTs measured outcomes by recording health of the nation outcome scales (HoNOS) and payment by results clustering tool.

Skilled staff to deliver care

- Staff who had received training in the structured care model were able to offer a 12-18 month period of psychological and psychosocial support to patients on the non-psychosis pathway
- other staff we spoke to had received training to deliver cognitive behavioural therapy (CBT) and eye movement and desensitisation and reprocessing interventions
- one member of staff we spoke described how the effectiveness of their CBT interventions was checked using cognitive therapy rating scales measures with people who used the service
- psychologists in the teams offered supervision and support to staff delivering CBT approaches in their work
- All teams we visited were offering the "decider group" to help their patients with non-psychosis related mental health problems. Identified staff had been trained in delivering the group, which ran for 12 sessions, and there was a plan to cascade this training to other staff members. Patients could become graduates and co-facilitate future groups. It aimed to provide people with the skills to deal with impulsive behaviours such as self-

Are services effective?

Good

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.

harm, avoidance, withdrawal and isolation, aggression, substance misuse and binge eating. This approach uses CBT and dialectical behavioural therapy. Outcome measures were used to measure the effectiveness of the interventions. At Workington the team could demonstrate how using this approach was improving access for patients waiting for psychological therapy

- the trust reported 38% of non-medical staff had an appraisal in the past 12 months for the CMHTs. Most staff we spoke with said they had an up to date appraisal or an appraisal was planned. However administrative staffat Workington had not had an appraisal in the preceding year
- individual clinical supervision was not fully embedded across all CMHTs we visited. Some teams had recently appointed clinical leads or were recruiting into senior posts to support clinical supervision. Managers had supervision plans in place and we observed a staff meeting where supervision arrangements were discussed. Staff said they felt supported in their clinical work and had access to a range of opportunities such as team meetings, reflective group supervision and informal peer support
- all newly recruited staff received a corporate induction and managers had local induction procedures in place. We spoke to newly recruited staff who had received local induction and managers showed us scheduled local induction plans for staff recently appointed.

Multi-disciplinary and inter-agency team work

- We attended seven multi-disciplinary meetings and observed staff worked well together to share relevant information and deliver effective care and treatment. All teams we visited had established close working relationships with other teams including the in-patient, crisis and memory service teams
- staff we spoke with said that the transition from community mental health services children and young people was not always effective. This meant that staff did not always work together to assess and plan ongoing care and treatment in a timely way when people move between services or teams
- there was identified nurse leads in the teams who had developed effective working relationships with the local maternity service to facilitate peri-natal wellbeing groups. NICE guidelines were used to provide an in-reach service to support the development of pre and post-natal plans with pregnant women.

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

- The trust identified training in mental health legislation as a mandatory requirement and reported 55% of CMHT staff had received training in the Mental Health Act (MHA). Workington CMHT had 44% compliance, Kendal 75% and Barrow 53% compliance. Managers and staff we spoke with were aware of the requirement and staff told us either they had had training or training was planned. Some members of staff in the CMHTs had undergone approved mental health professional training which meant teams had access to staff who understood the legal powers of detention under the Mental Health Act
- one manger we spoke with had oversight of the numbers ofpatients subject to the MHA and CTO which were monitored on a weekly basis
- Staff described a good working knowledge of the MHA and how to apply it including those patients subject to a community treatment order (CTO). A CTO is a legal order, which sets out the terms under which a person must accept treatment whilst living in the community. We saw care plans contained details of conditions stipulated within a CTO and observed multi-disciplinary meetings where staff discussed care and treatment of patients subject to a CTO
- advocacy information was available for patients, and staff were aware of how to support patients to access advocacy services. Patients told us they knew about advocacy services and how to access them if needed.

Good practice in applying the Mental Capacity Act

- The trust identified Mental Capacity Act (MCA) training as a mandatory requirement and reported 88% of CMHT staff had received MCA training. Workington and Kendal CMHTs had 87% compliance and Barrow 93% compliance. We spoke to one member of staff who had trained to become a best interests assessor
- staff we spoke with were familiar about obtaining peoples consent and we observed staff considering issues of capacity and consent during multi-disciplinary

Are services effective?

Good

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.

meetings. We observed consent being obtained from patients during consultations and patients told us they were involved in decisions about their care and treatment

- staff documented patient consent and considered capacity to make a decision about care and treatment at every initial assessment. However, this was only fully documented in nine of the 18 records we reviewed. This meant that peoples consent to care and treatment was always sought in line with legislation and guidance but not always fully recorded
- there was no evidence provided by the trust to indicate regular audits of adherence to the MCA was being carried out. This meant there was no process for monitoring if the CMHTs were meeting their responsibilities within MCA legislation and following relevant national guidance.

Good

Are services caring?

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

Our findings

Kindness, dignity, respect and support

- staff demonstrated compassion and genuine feeling about the patients they supported. We observed staff talking to patients in a respectful and caring manner and patients told us staff were helpful, professional and offered excellent support. One patient commented "all staff are really lovely"
- staff we spoke with demonstrated understanding of the individual needs and circumstances of the patients they were providing care for. Patients told us their care plans reflected their needs and they were being supported in their recovery
- we observed staff were aware of the need to maintain confidentiality. However, we saw a list of patient names displayed clearly to anyone using the reception window at Workington. This meant patients' confidentiality was not being maintained and we requested this be removed immediately.

The involvement of people in the care that they receive

- Care plans incorporated the views of the patient with regards to their care and treatment and patients told us they felt fully informed and involved in their care. Patients we spoke with said they had a copy of their care plan. However only nine of the records we reviewed showed evidence that the patient had received a copy of their care plan
- we saw reviews taking place involving family and carers where the patient's views and wishes were taken into account. We saw patients were sent a letter, which invited them to their reviews and asked who else they would like to be invited. Patients told us their reviews were held regularly and their family attended when appropriate
- information about advocacy was clearly displayed at the team bases. Staff we spoke with knew how to access the service and could give examples of when advocacy had been used. Patients told us they were aware of advocacy and had not needed the service. This meant that people who use services and those close to them were involved as partners in their care
- people who used services we spoke with said they were not actively engaged in making decisions about the services. However staff told us that a person who used services was included on the interview panel for staff recruitment
- information was displayed in every team base we visited informing patients how to contact the patient experience team. One staff member informed us there was a survey to give to patients at every initial assessment but this was not routinely used. We did not see any evidence of how patient feedback was being routinely collected or used by the services we visited. This meant people were not always able to give feedback on the care they receive.

Are services responsive to people's needs?

Good

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

Our findings

Access and discharge

- Patients were able to access the CMHTs between Monday to Friday and between the hours of 09.00am and 5.00pm. Patients needing help outside of these times were referred to the local crisis team
- all teams had a local system in place where referrals were reviewed on a daily basis. The majority of referrals came by post from the GP
- in Workington we observed a daily multi-disciplinary screening meeting where all referrals were discussed and actions agreed. There were clear referral routes to the First Steps service for patients requiring short–term psychological interventions and who would not be suitable for CMHT
- Overall CMHTs achieved the trust target of 15 working days from referral to initial assessment and we saw the electronic mental health performance information which confirmed this
- there were no trust targets for assessment to treatment times and waiting lists varied across the teams. For example, patients waited eight months at Kendal and 16 months at Barrow for psychological assessment. Patient feedback indicated dissatisfaction with access to psychological therapies and some patients remained on the home treatment team caseload longer than needed. This was due to delays in allocating a care-coordinator from the CMHT
- managers explained that there had been an increase in referrals and most people were waiting for treatment with the non-psychosis teams. However, we saw waiting lists were reduced with effective screening of referrals, the recruitment of additional staff and introduction of group therapy across the teams
- staff referred to the trust standard operational policy for CMHT management of waiting lists during multi-disciplinary meetings and managers maintained oversight of the waiting lists using the electronic system
- in all teams staff told us the procedure for following up patients who cancelled or did not attend planned appointments. This ranged from making telephone contact, arranging a home visit, and sending a letter. In Barrow, staff explained how text messages were automatically sent to patients the day before their **s**cheduled appointment
- appointments were scheduled into the electronic diaries of clinical staff and wherever possible cancellations were avoided. Patients were asked to provide a contact number to ring in the event of cancellations and staff would endeavour to make contact with the patient as soon as possible. Patients told us they had regular appointments at times that suited their needs. This meant that people could access care and treatment in a timely way
- patient care was recovery focused and discharge from services was considered and discussed at the beginning of the patient's pathway. Discharge meetings provided an opportunity for multi-disciplinary team decision making where there was positive risk taking identified. People who used services spoke about their recovery plans.

The facilities promote recovery, comfort, dignity and confidentiality

- In all three team bases, there was a range of rooms to be used for individual or group work. Staff said there was pressure on room availability and this had been raised with senior management. Staff arranged alternative locations in the local area or conducted home visits
- the rooms we saw were adequately sound proofed and at Workington music played to maintain confidentiality in the waiting area
- all waiting areas had notice boards and leaflets which provided a range of information such as local services, advocacy support and how to raise concerns and complaints
- most of the patients told us they were aware advocacy services and how to raise their concerns and felt the facilities promoted their dignity and confidentiality
- at Kendal people who use services told us they liked the shared reception facilities as it reduced the stigma of using mental health services. However, at Workington, patients commented that the waiting area was "awful" and "was like sitting in a corridor".

Are services responsive to people's needs?

Good

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

Meeting the needs of all people who use the service

- The trust served a population with low ethnicity and covered a wide geographical area with some remote locations. There were recognised areas of high social deprivation with associated alcohol and substance misuse problems, unemployment and housing difficulties
- staff worked from satellite bases and arranged home visits and appointments at local GP surgeries
- information could be provided in other languages if required and people with mobility difficulties were able to access the facilities. There was no hearing loop system available at Barrow and the hearing loop system appeared to be broken at the Workington. This meant people who used a hearing aid may have difficulty communicating with staff
- patients were offered a choice of appointments. Staff telephoned patients to offer a choice of appointments and we saw this was followed up by a letter sent to patients confirming their appointment date and time. Patients told us they were offered appointments that took account of their needs. This meant that wherever possible patients could access care and treatment at a time to suit them
- the trust had access to information in accessible formats and staff knew how to request information and interpretation services. We saw that an interpreter had attended a patient's appointment and translated care plans and letters. This meant that services had removed barriers and engaged with people who find it hard to access or use services.

Listening to and learning from concerns and complaints

- The trust reported that community based mental health services for adults of working age had 230 complaints from 1 November 2014 to 29 October 2015. This included complaints concerning the CMHTs, First Steps and the anorexia intensive support services
- Ninety four complaints had been upheld by the trust and two were referred to the Ombudsman. 78 of these complaints related to the services we visited and the trust upheld 29 of these complaints. Both complaints referred to the Ombudsman concerned the services we visited; one was an ongoing investigation since January 2015 and one had no further actions
- the trust had undertaken a review of their response to patient experience and ensured regular patient stories were shared with the board
- staff we spoke with were aware of the trust complaints procedure and how it could be accessed
- staff were able to describe their duty of candour as the need to be open and honest with patients when things go wrong
- one person who used services we spoke with said they had been supported to make a complaint and received feedback from the trust in response to their complaint
- complaints were discussed at senior management and team meetings which meant lessons were learned and shared with others.

Are services well-led?

Good

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

Our findings

Vision and values

- Trust vision and values were displayed in the team bases and we observed staff demonstrate the trust values in their behaviours. However not all staff were aware or could describe the trust vision and values
- some staff were not aware of senior management and said senior managers had not visited all teams. However, staff referred to a range of regular trust communication methods including blogs, newsletters, and e-mails.

Good governance

- There were good governance arrangements in place to monitor performance and clinical care. Managers attended monthly mental health care group meetings and monitored performance locally and addressed any issues
- the trust had identified key performance indictors including a 15 day target from referral to initial assessment, seven day follow up compliance, care plan and risk assessment completion and minimum mental health data set completeness
- all teams were able to monitor their progress using the electronic mental health performance data. The teams had access to an electronic dashboard and managers had also developed their own local monitoring systems
- the trust did not have key performance indicators to monitor waiting times from assessment to referral targets. However managers were aware of the variable waiting times across teams and we saw that there was a strategy in place to clear the waiting lists across the services by January 2016
- individual clinical supervision was not embedded across all CMHTs we visited however all staff had access to a range of opportunities such as team meetings, reflective group supervision and informal peer support. Staff said they felt supported in their clinical work
- individual and team training needs had been identified and teams had access to the appropriate training to meet their learning needs. Managers had responded to the practical barriers to accessing training such as the long distances to travel
- the mental health directorate risk register recorded 40 risks as at 5 November 2015 associated with CMHTs for adult services. Managers told us they had the opportunity to raise local risks such as staffing resource implications and we saw evidence that these were captured on the directorate risk register. There was evidence of how the risks identified with regards to access to records was mitigated
- all staff said they could raise issues with their manager if required however not all were confident action would be taken by the trust in a timely way in response to their complaints
- there was learning from incidents and there were good systems in place in relation to safeguarding
- the mandatory training for the MHA and MCA compliance was below the standard expected by the trust and not all consent was documented clearly in the care records.

Leadership, morale and staff engagement

- Staff were aware of the whistleblowing policy and felt there was an open and honest culture within the teams and that they could raise concerns
- staff told us that colleagues were supportive and worked well together. Staff said they were aware of improvements across the service such as additional staff recruitment and decreased caseloads and waiting times for psychological therapies. Morale amongst staff had improved over the past few months
- sickness rates in two teams were higher than the trust reported average. However, managers addressed attendance using the trust policy and support from human resources. Staff were supported in a phased return to work and had access to psychological therapies if required

Commitment to quality improvement and innovation

- There was a strong commitment across teams to making improvements in the care they provided. Training needs had been identified and there was a clear strategy to reduce waiting lists for psychological therapies
- staff were not aware of any trust wide audits that had taken place involving their services.