Cumbria Partnership NHS Foundation Trust

Inspection report

Trust Headquarters
Voreda House, Portland Place
Penrith
Cumbria
CA11 7BF
Tel: 01228602000
www.cumbriapartnership.nhs.uk

Date of inspection visit: 21 MAY 2019 to 25 June 2019
Date of publication: 25/09/2019

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

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

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

Ratings

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

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

Summary of findings

Background to the trust

Cumbria Partnership NHS Foundation Trust (CPFT) became a foundation trust in 2007.

The trust provides mental health, learning disability across Cumbria and community physical health services to North Cumbria to a population of approximately half a million people. The trust also provides health care services into HMP Haverigg. The trust employs 3,579 staff to deliver its services (4,254 including bank staff).

Cumbria is rural county, which is sparsely populated in some areas. Cumbria has an older population than the national average with 27% of residents aged over 60 compared to a national average of 22%. The proportion of those residents over 60 in Cumbria has risen faster than the national average of 11%. In the last 10 years, the population over age 60 has increased by 16% and is forecast to continue to rise.

Children and young people under 20 years of age make up 21% of the population. Infant and child mortality rates in Cumbria are similar to the national average. The level of child poverty in Cumbria is better than the national average with 14% of children under 16 years of age living in poverty. Rates of family homelessness are also rated better than the national average.

The trust operates within a complex commissioning environment, with recent changes to clinical commissioning group structures. The Cumbria Clinical Commissioning Group was dissolved, and two locality clinical commissioning groups established – North Cumbria CCG and Morecombe Bay CCG.

At the time of the inspection the trust were making plans to merge with North Cumbria University Hospitals NHS Trust. The two organisations had joint management and governance structures in place and Stephen Eames was the joint Chief Executive for both this trust and North Cumbria University Hospitals NHS Foundation Trust.

The mental health services in the north of the trust were due to be transferred to Northumberland Tyne and Wear NHS Foundation Trust and the mental health services in the south of the trust were due to be transferred to Lancashire Care NHS Trust. The changes were planned to take place on the 1 October 2019. Stephen Eames was also the chief executive of the North Cumbria Integrated Health and Care System.

The last CQC comprehensive inspection of Cumbria Partnership NHS FT was in March 2016. We carried out an inspection between September and October 2017, during which time we inspected six core services and well led. We also carried out focused inspections for Wards for people with learning disability / autism in February 2017; Community Services for children, young people and families in April 2017; Acute wards for adults of a working age and psychiatric intensive care units in July 2017.

At the last inspection we rated the trust as requires improvement overall. The trust had regulatory breaches in relation to Regulation 9 - Person-centred care; Regulation 11 - Need for consent; Regulation 12 - Safe care and treatment; Regulation - 13 Safeguarding service users from abuse and improper treatment; Regulation - 15 Premises and equipment; Regulation 17 - Good governance and Regulation 18 – Staffing.

Overall summary

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

What this trust does

The trust provide the following community health core services;

Summary of findings

•Community Health inpatient services

•Community health services for adults

•Community health services for children, young people and families

•End of life care

•Community dental services

•Community sexual health services

•Community urgent care services

The trust provide the following mental health core services:

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

•Community mental health services for people with learning disabilities or autism

•Community based mental health services for older people.

•Long stay/rehabilitation mental health wards for working age adults

•Mental health crisis services and health based places of safety

•Specialist community mental health services for children and young people

•Wards for older people with mental health problems

•Wards for people with learning disability or autism

The trust provide primary healthcare services into HMP Haverigg. This includes immunisation and screening programs, wound care, venepuncture and blood-borne virus testing, chronic disease clinics for conditions such as diabetes, asthma, COPD and cardiac risk assessments clinics to inmates. There is also a physiotherapist, an optician, a podiatrist and GUM service on site.

Key questions and ratings

We inspect and regulate healthcare service providers in England.

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

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

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

What we inspected and why

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

We inspected four core services,

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

•Wards for older people with mental health problems

Summary of findings

•Wards for people with learning disability or autism

•Mental health crisis services and health-based places of safety

These were selected due to their previous inspection ratings or because our ongoing monitoring identified that an inspection at this time was appropriate to understand the quality of service provided.

Our comprehensive inspections of NHS trusts have shown a strong link between the quality of overall management of a trust and the quality of its services. For that reason, all trust inspections now include inspection of the well led key question at trust level. Our findings are in the section headed 'Is the organisation well led'.

What we found

Overall trust

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

- We rated 9 of the of the 14 core services provided by the trust as requires improvement overall. This takes account of the previous ratings of core services that we did not inspect this time.
- We rated safe, effective, responsive and well led as requires improvement for the trust overall. Our rating for the trust took into account the previous ratings of services not inspected this time.
- We rated well led for the trust as requires improvement overall.
- The trust did not always have effective governance systems at service level in assessing, monitoring and improving care and treatment.
- The trust board did not have effective systems in place to monitor operation and compliance of the Mental Health Act or its administration.
- The trust had not ensured all patient care areas were suitable for the purpose they were being used for. In the health-based places of safety we found areas which did not comply with the Mental Health Act code of practice. Dova ward was not maintained to a reasonable standard. Oakwood and Kentmere wards provided dormitory style accommodation.
- The trust had not fully implemented the role of the freedom to speak up guardian. Staff did not always know who the freedom to speak up guardian was or their role in the core services. Staff said that the guardian was not independent as they reported direct to the chief executive.
- Medicines management arrangements were not effective in all areas of the trust.
- Risk assessment and management were not always updated, individualised or updated in line with trust policy.
- Blanket restrictions were not individually risk assessed or reviewed and there was no trust policy in place.
- Not all staff were up to date with mandatory training.

However:

- We rated caring as good overall.
- Staff treated patients with compassion and kindness. They respected patients' privacy and dignity. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.

Summary of findings

- Staff understood their roles and responsibilities under the Mental Health Act 1983, the Mental Capacity Act and their codes of practice.
- Wards and teams had access to the full range of specialists required to meet the needs of patients. The staff worked well together and with partner agencies and stakeholders.
- The trust aligned its strategy to local plans in the wider health and social care economy and had developed it with external stakeholders and had active involvement in sustainability and transformation plans. The trust worked closely with local authority public health colleagues. There were good links with health and well-being strategy.

Are services safe?

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

- We rated 8 of the of the 14 core services provided by the trust as requires improvement in safe. This takes account of the previous ratings of core services that we did not inspect this time.
- Medicines management arrangements were not effective in all areas of the trust. In wards for people with a learning disability or autism there were unlabelled medication in storage and no risk assessment for the use of sodium valproate for women of childbearing age. In acute wards for adults of a working age and psychiatric intensive care units, staff did not always monitor the physical health of patients after the administration of rapid tranquilisation in accordance with national guidance and trust policy.
- Not all care areas were fit to provide safe care and treatment. Dova ward had some areas where there was an ongoing issue with water leaks from the ceiling, this was in several areas including a patient bedroom. The physical environment of the health-based place of safety at Kendal did not meet the requirements of the Mental Health Act code of practice and were not safe. Some patients on Oakwood ward slept in dormitory style accommodation with beds separated only by a curtain. Kentmere ward had dormitory style accommodation separated by solid partitions and the trust had not made any robust interim measures to asses or manage the risk of patients being accommodated in these areas. There were no nurse alarms in wards for people with a learning disability or autism.
- Risk assessment and management were not always updated or individualised. In mental health crisis and health-based place of safety risk assessments were not always updated in line with trust policy. Patients at risk of violence and aggression did not have an individualised plan about the use of medication.
- In acute wards for adults of a working age and psychiatric intensive care units blanket restrictions were not individually risk assessed or reviewed and there was no trust policy in place.
- The health-based places of safety did not have dedicated staffing establishments. Nursing staff from the inpatient wards staffed and coordinated the assessments of two of the health-based places of safety and two were staffed by the access and liaison integration service and home treatment teams. In the inpatient areas staffing the health-based places of safety, there wasn't always a dedicated member of staff to observe patients in the health-based place of safety suites.

However:

- Staff knew how to report incidents and made safeguarding referrals when required. Lessons learned from investigating incidents and safeguarding issues were used to improve the service.
- Staff developed holistic, recovery-oriented wellbeing diaries which were informed by a comprehensive assessment. Wards for older people with mental health problems provided a range of treatments suitable to the needs of the patients and in line with national guidance about best practice. Staff engaged in clinical audit to evaluate the quality of care they provided.

Summary of findings

- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Are services effective?

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

- We rated 7 of the of the 14 core services provided by the trust as requires improvement in effective. This takes account of the previous ratings of core services that we did not inspect this time.
- Staff were either not receiving regular supervision or this was not recorded accurately. The trust had no clear way to monitor supervision quantity and quality. We identified problems with supervision in three of the four core services that we inspected.
- Staff did not always maintain comprehensive care records. In wards for people with a learning disability care plans were not always reviewed, did not always match identified risk, positive behaviour support plans were incomplete, and a care record referred to the patient using the wrong gender. In crisis and health-based places of safety physical health needs were assessed but were not recorded in the correct plan in the patient records and there was no record of patients receiving a copy of their care plan.
- Staff did not always complete physical health care assessments as required in acute wards for adults of a working age and psychiatric intensive care units.
- Staff did not always complete necessary basic training. Only 12.5% of staff on the wards for people with a learning disability had completed the mandatory training in mental health legislation. In crisis and health-based places of safety not all staff who were required to complete the prevention and management of violence and aggression had done so.
- Not all services complied with parts of the Mental Health Act code of practice. In two of the cores services we inspected, not all patients were provided with information regarding their legal position and rights in line with the Mental Health Act code of practice. In wards for older people with mental health problems, section 17 leave forms on Ruskin and Oakwood were generic and not patient specific. Patients were not individually risk assessed to take leave. Families were not given copies of forms. This issue had been raised in the Mental Health Act monitoring visit and was still an issue at the inspection.
- Staff did not always ensure the physical health care needs of patients on Ramsey ward. Families raised concerns that physical healthcare needs were not always identified and responded to in a timely manner.

However:

- Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. The ward teams had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.
- The wards and teams included or had access to the full range of specialists required to meet the needs of patients on the wards. Managers made sure they had staff with a range of skills. They supported staff with opportunities to update and further develop their skills. Managers provided an induction programme for new staff.

Are services caring?

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

- We rated 13 of the of the 14 core services provided by the trust as good and one as outstanding in caring. This takes account of the previous ratings of core services that we did not inspect this time.

Summary of findings

- Staff treated patients with compassion and kindness. They respected patients' privacy and dignity. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition. Feedback from patients and carers confirmed that staff treated them well. In wards for people with a learning disability or autism staff used tools to communicate with patients such as Makaton, flash cards, signers and translators.
- Staff involved patients and carers in care planning and risk assessment. Carers told us they felt informed and involved in the care being provided in most core services we inspected. Staff ensured that patients had easy access to independent advocacy services. In wards for older people with mental health problems staff worked with patients and family members to develop 'wellbeing diaries' for each patient. Staff had detailed knowledge about patient's backgrounds, things that were important to them, personal strengths and the support they needed to maintain wellbeing. Staff proactively used this information to inform the delivery of personalised care.
- Staff actively sought feedback for patients, their families and carers on the service they received through the use of comments cards, a 'thank you' boards and the provider's complaints procedure.

However:

- Not all carers spoke positively about the care their relatives received. Three carers from Ramsey ward were unhappy with care on the ward.

Are services responsive?

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

- We rated 6 of the of the 14 core services provided by the trust as requires improvement in responsive. This takes account of the previous ratings of core services that we did not inspect this time.
- Staff did not always manage beds effectively. In acute wards and psychiatric intensive care units patients could not access the service when they needed it because bed management was poor. Patients were often on wards a distance away from their communities and families and when they were recovering. If they had leave, they risked losing their bed whilst they were away. There were a high number of out of area placements.
- Not all care areas were suitable for the purpose they were being used for. In the health-based places of safety we found areas which did not comply with the Mental Health Act code of practice relating to access to toilet facilities, access to outside space, sleeping arrangements and privacy and dignity in the suites. Dova ward was not maintained to a reasonable standard in the communal areas and one bedroom. Oakwood and Kentmere wards provided dormitory style accommodation and the trust had not made any robust interim measures to asses or manage the risk of patients being accommodated in these areas. During the last inspection plans for the relocation of the wards had been agreed, the plans had been delayed and it was unclear when the move would take place.
- Staff did not always provide enough access to activities for patients. In wards for people with a learning disability or autism there was no activities co-ordinator on the ward and occupational therapy input was limited to two days. We saw little evidence of activities on the ward which was having a negative impact on patients' morale.
- Staff did not always attend safeguarding strategy meetings on Ruskin ward. There were instances where staff on Ruskin ward had not attended safeguarding strategy meetings.

However:

- Staff met the needs of all patients who used the service. Staff assisted patients with communication needs and had access to interpreters, translators and other services designed to meet individual needs. All areas were accessible for people with mobility issues.

Summary of findings

- In acute wards for adults of a working age and psychiatric intensive care units patients had a good range of activities available seven days a week, during the daytime and evening.
- Patients and carers knew how to complain, staff dealt with complaints appropriately and lessons learned from complaints were used to improve the service.
- The mental health crisis service was available 24-hours a day and was easy to access. The service could be accessed through a dedicated crisis telephone line. The referral criteria for the mental health crisis teams did not exclude patients who would have benefitted from care. Staff assessed and treated patients promptly. Staff followed up patients who missed appointments.

Are services well-led?

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

- We rated 7 of the of the 14 core services provided by the trust as requires improvement and one as inadequate in well led. This takes account of the previous ratings of core services that we did not inspect this time.
- Not all of the governance systems at service level were effective in assessing, monitoring and improving care and treatment. Systems and audits had failed to identify issues such as patient observation following restrictive physical interventions, medicines management, mandatory training compliance, clear oversight of supervision, bed management, issues with staff experience and skill mix, care records or staff support following incidents.
- The trust board did not have a robust system to provide clear oversight of both quantity and quality of supervision. At our last inspection in 2016 we told the trust they must ensure that regular supervision was provided to in line with policy and that this was monitored to provide assurance of compliance to the senior management team. The trust only had local monitoring in care groups which recorded and monitored supervision. The trust planned to continue to audit on a quarterly basis and report this to the board until a more robust solution had been implemented.
- Not all Fit and Proper Person checks were in place. The trust did not have an appropriate system or process in place to ensure that all existing directors continue to be fit and do not meet any of the unfitness criteria set out in Schedule 4 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
- Senior managers were not always visible in the trust. Although there was a programme of board visits to services, visits were less frequent in the mental health services. Few staff had seen or spoken with the senior managers of the trust.
- Not all staff felt engaged in the trust's vision, values and strategy. Not all staff in the core services were aware of the new values of the trust. Not all staff in the mental health services felt able to contribute to service developments or the strategy for their service. They did not know what the changes would mean for them going forward and staff in the east of the service had received little or no information regarding the changes.
- The trust had not fully implemented the role of the freedom to speak up guardian. There were areas within the core services where staff did not know who the freedom to speak up guardian was or their role. Staff were concerned that the guardian reported direct to the chief executive and was not independent.
- Not all staff teams had positive relationships or worked well together. The trust did not ensure that all staff working on Rowanwood ward felt supported, valued or respected following serious incidents. They did not assure that there were measures in place to protect them from reoccurrence of incidents.
- The trust board did not have effective systems in place to monitor operation and compliance of the Mental Health Act or its administration. Appropriate governance arrangements were not in place in relation to Mental Health Act administration and compliance. The trust had identified that the current structure of governance for the Mental Health Act was not effective and there were plans to address this.

Summary of findings

- Not all areas of the trust provided patients with privacy and dignity. Oakwood wards had dormitory style accommodation and only a curtain between beds. Kentmere had dormitory style accommodation separated by a solid partition. The trust had not made any robust interim measures to asses or manage the risk of patients being accommodated in these areas.
- The trust had not completed work on the link between the risk register and board assurance framework. At our last inspection we told the trust it must ensure that the risk register is effectively reviewed and managed in line with the trust policy and that there is evidence of a clear link between the register and the board assurance framework. At this inspection the trust had only made some progress on this.

However:

- Senior leaders were new appointments in the last year and were skilled and experienced. The executive team were passionate and motivated to lead the work that needed to be done to move the organisation forward. There was an acknowledgement that progress had been made and there was a lot of work to do especially with the merge of the organisations.
- The executive team were able to identify most of the challenges the trust faced across their services, the plans in place to meet those challenges and the current strategic direction for the trust within the wider healthcare system in Cumbria.
- The trust aligned its strategy to local plans in the wider health and social care economy and had developed it with external stakeholders. This included active involvement in sustainability and transformation plans. The trust worked closely with local authority public health colleagues. There were good links with health and well-being strategy. The trust worked with partners to align strategies and plans for the system rather than individual organisations.
- Staff generally felt positive and proud about working for the trust and their team. Most teams reported good morale, although acknowledged this could fluctuate in changing circumstances. The coming changes to the trust and merger had led to low morale from staff in some services.
- The trust recognised staff success by staff awards and through feedback. Staff awards and recognition were taking place. The trust was aware of the need to support and encourage staff through the changes. Over the past two years the Trust had increased its focus on staff recognition introducing Glimpse of Brilliance, weekly staff recognition, staff awards and offering leaders training in appreciative leadership.
- The trust applied duty of candour appropriately. At our last inspection in 2016 we found the trust were not fully applying the duty of candour requirement. At this inspection staff in the core services had a good understanding of duty of candour. Incidents meeting the duty of candour requirement contained an apology to the appropriate person. There was a trust 'being open and duty of candour' policy in place and in date.
- Staff had access to support for their own physical and emotional health needs through occupational health. The trust had a range of programmes to support staff's physical and emotional health needs. The trust provided access to complimentary therapies, counselling and stress management services occupational health service.
- Staff networks were in place promoting the diversity of staff. The trust had four staff networks that met quarterly and they had an executive board sponsor.
- There were organisational systems to support improvement and innovation work. The trust were working in partnership with organisations across North Cumbria through the Cumbria learning and improvement collaborative (CLIC) and had adopted a common approach to continuous improvement. A common toolkit of lean based improvement tools was available on the Cumbria learning and improvement collaborative website and cross organisational training was available through Cumbria learning and improvement collaborative. Staff in the core services felt engaged in quality improvements.

Summary of findings

Ratings tables

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

Outstanding practice

We found examples of outstanding practice. For more information, see the Outstanding practice section of this report.

Areas for improvement

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

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

Action we have taken

We issued requirement notices to the trust. That meant the trust had to send us a report saying what action it would take to meet these requirements.

Our action related to breaches of legal requirements in four core services.

What happens next

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

Outstanding practice

Wards for older people with mental health problems

- Staff on Ruskin ward used innovative approaches when working with patients. This included the use of the extra care area for patients who would otherwise need to be transferred. The area had been used for patients who required a low stimulus area during periods of agitation. The area had also been used for patients at the end of life. This meant that families could stay with their loved ones on the ward in a private. Comfortable area.
- The environment on Ruskin was particularly dementia friendly. The ward had a homely feel and staff ensured that patients were conformable on the ward.

Areas for improvement

We found areas for improvement in this service.

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

Action the trust MUST take to improve:

Summary of findings

Trust wide;

- The trust must ensure it reviews and improves its governance systems at a service level to ensure they effectively assess, monitor and improve care and treatment. HSCA 2008 Regulation 17 (1)(2)(a)(b)(e).
- The trust must ensure it continues to make progress against the trust risk register and board members and members of staff understand the process of escalating risks to the board through the board assurance framework. HSCA 2008 Regulation 12 (1)(2)(a)(b).
- The trust must ensure it continues its development of staff supervision and the board have clear oversight of both quantity and quality of supervision. HSCA 2008 Regulation 18 (1)(2)(a).

In acute wards for adults of working age and psychiatric intensive care units:

- The trust must ensure that blanket restrictions are all reviewed and individually risk assessed.

HSCA 2008 Regulation 12 (1)(2)(a)(b)

- The trust must ensure staff monitor patients' physical health including, following rapid tranquilisation, in accordance with national guidance, best practice and trust policy.

HSCA 2008 Regulation 12 (1)(2)(a)(b)

- The provider must maintain premises in good condition and suitable for the purpose for which they are being used.

HSCA 2008 Regulation 15 (1)(c)

- The trust must continue to look at ways of reducing out of area placements and the management of bed availability to ensure this meets the needs of people requiring the service.

HSCA 2008 Regulation 17 (1)(2)(a)

- The trust must ensure they have effective systems and processes to assess, monitor and improve care and treatment. This includes identifying, individually assessing and reviewing, blanket restrictions, clear oversight of staff supervision and ensuring all physical health monitoring is completed as required.

HSCA 2008 Regulation 17 (1)(2)(a)(b)

- The trust must deploy sufficient numbers of qualified, competent, skilled and experienced staff to meet the needs of patients care and treatment.

HSCA 2008 Regulation 18 (1) (2)(a)

- The trust must ensure staff working on Rowanwood feel supported, valued and respected following serious incidents beyond ward level.

HSCA 2008 Regulation 18 (1) (2)(a)

In wards for older people with mental health problems:

- The provider must ensure that all section 17 leave forms are individually completed for each patient and show consideration of patient need and risks.

HSCA 2008 Regulation 12 (2) (a)

- The provider must ensure that plans to relocate Oakwood ward are progressed and the use of dormitory style accommodation on both Oakwood and Kentmere is either no longer used or a robust assessment and mitigation of risk is put in place.

Summary of findings

HSCA 2008 Regulation 10 (2) (a)

Wards for people with a learning disability or autism:

- The provider must ensure that all medicines used are labelled and that risk assessments are always in place for the use of sodium valproate in female patients of child bearing age.

HSCA 2008 Regulation 12 (2) (a) (b) (g)

- The provider must ensure that all staff review patients' observations following the use of rapid tranquilisation to comply with the provider's rapid tranquilisation policy and National Institute of Health and Care Excellence guidance.

HSCA 2008 Regulation 12 (1) (2) (a) (b)

- The provider must ensure that all staff complete body maps and carry out and record physical observations following the use of restraint and ensure that there is a rationale recorded for any 'as required' medication being administered following the use of restraint.

HSCA 2008 Regulation 12 (1) (2) (a) (b)

- The provider must ensure that all patients have regular access to therapeutic activities to meet their needs and preferences.

HSCA 2008 Regulation 9 (1) (a) (b) (c)

- The provider must ensure that staff complete their mandatory and statutory training.

HSCA 2008 Regulation 18 (2) (a)

- The provider must ensure that all staff receive regular supervision.

HSCA 2008 Regulation 18 (2) (a)

- The provider must ensure that clinical audits are effective in identifying and addressing areas of improvement within the service.

HSCA 2008 Regulation 17 (2) (a) (b) (c)

Mental health crisis services and health-based place of safety:

- The trust must ensure the physical environment of the health-based place of safety at Kendal meets the requirements of the Mental Health Act Code of Practice and is safe to use for its intended purpose and in a safe way. HSCA 2008 (Regulation 12).
- The trust must ensure there is always a dedicated member of staff to observe patients in the health-based places of safety. HSCA 2008 (Regulation 18).
- The trust must ensure facilities in the health-based place of safety in Kendal are suitable for the purpose they are being used for and meet the Mental Health Act Code of Practice. HSCA 2008 (Regulation 15).
- The trust must ensure that the health-based places of safety promote the privacy and dignity of patients in Kendal, Carlisle and Whitehaven. HSCA 2008 (Regulation 10).
- The trust must ensure that systems and processes are established and operating effectively to assess monitor and improve the quality and safety of services. HSCA 2008 (Regulation 17).
- The trust must ensure systems and processes are established and operating effectively to assess, monitor and mitigate the risks relating to the health, safety and welfare of patients. HSCA 2008 (Regulation 17).

Summary of findings

- The trust must ensure systems and processes are established to maintain the records of each patient accurately, completely and contemporaneously. HSCA 2008 (Regulation 17).
- The trust must ensure they take action in response to regulatory requirements and the findings of external bodies. HSCA 2008 (Regulation 17).

Action the trust should take to improve:

Trust wide:

- The trust should ensure it continues to review the capacity of the leadership team to ensure it has capacity to effectively manage the services and changes to the trust.
- The trust should ensure the fit and proper person's process is updated to meet the guidance for carrying out regular checks of board members.
- The trust should ensure that staff understand the role of the freedom to speak up guardian, how to contact them and have confidence in their independence.
- The trust should ensure it continues to develop and embed the governance around the Mental Health Act.

In acute wards for adults of working age and psychiatric intensive care units:

- The trust should ensure that staff are compliant with their mandatory training.
- The trust should ensure entries are clear and complete in seclusion records.
- The trust should ensure staff record incidents of restraint fully including de-escalation methods used prior to the restraint and details of debriefs following the incident.
- The trust should ensure incidents of rapid tranquilisation are reported in line with trust policy.
- The trust should ensure that seclusion takes place in a designated and approved seclusion room or suite of rooms which serves no other function to the ward in accordance with their own policy.
- The trust should ensure appropriate documentation is completed for medicines prescribed under the Mental Health Act.
- The trust should ensure that all staff consistently receive and record appropriate supervision.
- The trust should ensure patients at risk of violence and aggression should have an individualised plan about the use of medication to calm, relax, tranquillise or to sedate.
- The trust should ensure staff provide information on patients' legal position and rights in line with the Mental Health Act code of practice at the frequency required.
- The trust should continue with their plans to eliminate dormitory accommodation on Kentmere Ward.
- The trust should ensure that all staff have awareness of the trust's visions and values and who the freedom to speak up guardian is and how to contact them.
- The trust should ensure they have a policy regarding the arrangements for children and young people who visit patients in hospital.

In wards for older people with mental health problems:

- The provider should ensure that physical health needs are identified on Ramsey unit.

Wards for people with a learning disability or autism:

Summary of findings

- The provider should ensure that all patient's care records, care plans and positive behaviour plans contain all relevant and accurate information required to deliver effective treatment. This should include patients' strengths, needs, goals, problems and steps to take when behaviours that challenge are heightened.
- The provider should ensure that staff follow the agreed protocols in relation to dealing with medical emergencies during the night.
- The provider should ensure that all 'as required' medicines plans are regularly reviewed to monitor any potential effects upon patients' health and wellbeing.
- The provider should ensure that all patients' risk assessments identify how potential risk to patient and visitor safety is managed in the absence of a nurse call system on the ward.
- The provider should ensure that records include the correct details in relation to staff involved in restrain.
- The provider should ensure all staff understand the duty of candour and their responsibilities under it and are aware of the role of the freedom to speak up guardian.
- The provider should ensure that staff have access to appropriate specialist training in order to carry out their role and develop their skills and knowledge.

Mental health crisis services and health-based place of safety:

- The trust should ensure that the correct documentation is completed including risk assessments and care plans. The trust should ensure there is a record that all patients are offered a copy of their care plan.
- The trust should ensure that those staff who require training in the prevention and management of violence and aggression have completed this.
- The trust should ensure that all records show that patients are explained their rights as required under section 132 of the Mental Health Act.
- The trust should ensure staff feel supported, respected and valued and are able to speak to senior managers.
- The trust should ensure that all staff are aware of the Freedom to Speak Up Guardian.

Is this organisation well-led?

Our rating of well-led at the trust stayed the same. We rated well-led as requires improvement because:

- We rated 7 of the of the 14 core services provided by the trust as requires improvement and one as inadequate in well led. This takes account of the previous ratings of core services that we did not inspect this time.
- Not all of the governance systems at service level were effective in assessing, monitoring and improving care and treatment. Systems and audits had failed to identify issues such as patient observation following restrictive physical interventions, medicines management, mandatory training compliance, clear oversight of supervision, bed management, issues with staff experience and skill mix, care records or staff support following incidents.
- The trust board did not have a robust system to provide clear oversight of both quantity and quality of supervision. At our last inspection in 2016 we told the trust they must ensure that regular supervision was provided to in line with policy and that this was monitored to provide assurance of compliance to the senior management team. The trust only had local monitoring in care groups which recorded and monitored supervision. The trust planned to continue to audit on a quarterly basis and report this to the board until a more robust solution had been implemented.

Summary of findings

- Not all Fit and Proper Person checks were in place. The trust did not have an appropriate system or process in place to ensure that all existing directors continue to be fit and do not meet any of the unfitness criteria set out in Schedule 4 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
- Senior managers were not always visible in the trust. Although there was a programme of board visits to services, visits were less frequent in the mental health services. Few staff had seen or spoken with the senior managers of the trust.
- Not all staff felt engaged in the trust's vision, values and strategy. Not all staff in the core services were aware of the new values of the trust. Not all staff in the mental health services felt able to contribute to service developments or the strategy for their service. They did not know what the changes would mean for them going forward and staff in the east of the service had received little or no information regarding the changes.
- The trust had not fully implemented the role of the freedom to speak up guardian. There were areas within the core services where staff did not know who the freedom to speak up guardian was or their role. Staff were concerned that the guardian reported direct to the chief executive and was not independent.
- Not all staff teams had positive relationships or worked well together. The trust did not ensure that all staff working on Rowanwood ward felt supported, valued or respected following serious incidents. They did not assure that there were measures in place to protect them from reoccurrence of incidents.
- The trust board did not have effective systems in place to monitor operation and compliance of the Mental Health Act or its administration. Appropriate governance arrangements were not in place in relation to Mental Health Act administration and compliance. The trust had identified that the current structure of governance for the Mental Health Act was not effective and there were plans to address this.
- Not all areas of the trust provided patients with privacy and dignity. Oakwood wards had dormitory style accommodation and only a curtain between beds. Kentmere had dormitory style accommodation separated by a solid partition. The trust had not made any robust interim measures to asses or manage the risk of patients being accommodated in these areas.
- The trust had not completed work on the link between the risk register and board assurance framework. At our last inspection we told the trust it must ensure that the risk register is effectively reviewed and managed in line with the trust policy and that there is evidence of a clear link between the register and the board assurance framework. At this inspection the trust had only made some progress on this.

However:

- Senior leaders were new appointments in the last year and were skilled and experienced. The executive team were passionate and motivated to lead the work that needed to be done to move the organisation forward. There was an acknowledgement that progress had been made and there was a lot of work to do especially with the merge of the organisations.
- The executive team were able to identify most of the challenges the trust faced across their services, the plans in place to meet those challenges and the current strategic direction for the trust within the wider healthcare system in Cumbria.
- The trust aligned its strategy to local plans in the wider health and social care economy and had developed it with external stakeholders. This included active involvement in sustainability and transformation plans. The trust worked closely with local authority public health colleagues. There were good links with health and well-being strategy. The trust worked with partners to align strategies and plans for the system rather than individual organisations.

Summary of findings

- Staff generally felt positive and proud about working for the trust and their team. Most teams reported good morale, although acknowledged this could fluctuate in changing circumstances. The coming changes to the trust and merger had led to low morale from staff in some services.
- The trust recognised staff success by staff awards and through feedback. Staff awards and recognition were taking place. The trust was aware of the need to support and encourage staff through the changes. Over the past two years the Trust had increased its focus on staff recognition introducing Glimpse of Brilliance, weekly staff recognition, staff awards and offering leaders training in appreciative leadership.
- The trust applied duty of candour appropriately. At our last inspection in 2016 we found the trust were not fully applying the duty of candour requirement. At this inspection staff in the core services had a good understanding of duty of candour. Incidents meeting the duty of candour requirement contained an apology to the appropriate person. There was a trust 'being open and duty of candour' policy in place and in date.
- Staff had access to support for their own physical and emotional health needs through occupational health. The trust had a range of programmes to support staff's physical and emotional health needs. The trust provided access to complimentary therapies, counselling and stress management services occupational health service.
- Staff networks were in place promoting the diversity of staff. The trust had four staff networks that met quarterly and they had an executive board sponsor.
- There were organisational systems to support improvement and innovation work. The trust were working in partnership with organisations across North Cumbria through the Cumbria learning and improvement collaborative (CLIC) and had adopted a common approach to continuous improvement. A common toolkit of lean based improvement tools was available on the Cumbria learning and improvement collaborative website and cross organisational training was available through Cumbria learning and improvement collaborative. Staff in the core services felt engaged in quality improvements.

Ratings tables

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

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

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

Ratings for the whole trust

Safe	Effective	Caring	Responsive	Well-led	Overall
Requires improvement ➔➔ Sept 2019	Requires improvement ➔➔ Sept 2019	Good ➔➔ Sept 2019	Requires improvement ➔➔ Sept 2019	Requires improvement ➔➔ Sept 2019	Requires improvement ➔➔ Sept 2019

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

Ratings for a combined trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community	Requires improvement ➔➔ Jan 2018	Requires improvement ➔➔ Jan 2018	Good ➔➔ Jan 2018	Good ↑ Jan 2018	Requires improvement ➔➔ Jan 2018	Requires improvement ➔➔ Jan 2018
Mental health	Requires improvement ➔➔ Sept 2019	Requires improvement ➔➔ Sept 2019	Good ➔➔ Sept 2019	Requires improvement ➔➔ Sept 2019	Requires improvement ➔➔ Sept 2019	Requires improvement ➔➔ Sept 2019
Overall trust	Requires improvement ➔➔ Sept 2019	Requires improvement ➔➔ Sept 2019	Good ➔➔ Sept 2019	Requires improvement ➔➔ Sept 2019	Requires improvement ➔➔ Sept 2019	Requires improvement ➔➔ Sept 2019

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

Ratings for community health services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community health services for adults	Requires improvement Mar 2016	Good Mar 2016	Good Mar 2016	Good Mar 2016	Good Mar 2016	Good Mar 2016
Community health services for children and young people	Good Apr 2017	Good Apr 2017	Good Apr 2017	Good Apr 2017	Good Apr 2017	Good Apr 2017
Community health inpatient services	Requires improvement ➔➔ Jan 2018	Requires improvement ➔➔ Jan 2018	Good ➔➔ Jan 2018	Good ↑ Jan 2018	Requires improvement ➔➔ Jan 2018	Requires improvement ➔➔ Jan 2018
Community end of life care	Good Mar 2016	Requires improvement Mar 2016	Good Mar 2016	Good Mar 2016	Requires improvement Mar 2016	Requires improvement Mar 2016
Community dental services	Good Jan 2018	Good Jan 2018	Outstanding Jan 2018	Requires improvement Jan 2018	Requires improvement Jan 2018	Requires improvement Jan 2018
Overall*	Requires improvement ➔➔ Jan 2018	Requires improvement ➔➔ Jan 2018	Good ➔➔ Jan 2018	Good ↑ Jan 2018	Requires improvement ➔➔ Jan 2018	Requires improvement ➔➔ Jan 2018

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

Ratings for mental health services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Acute wards for adults of working age and psychiatric intensive care units	Requires improvement →← Sept 2019	Good ↑ Sept 2019	Good →← Sept 2019	Requires improvement ↓ Sept 2019	Requires improvement →← Sept 2019	Requires improvement →← Sept 2019
Long-stay or rehabilitation mental health wards for working age adults	Requires improvement Mar 2016	Good Mar 2016	Good Mar 2016	Good Mar 2016	Good Mar 2016	Good Mar 2016
Wards for older people with mental health problems	Good ↑ Sept 2019	Requires improvement →← Sept 2019	Good ↓ Sept 2019	Requires improvement ↓ Sept 2019	Good →← Sept 2019	Requires improvement →← Sept 2019
Wards for people with a learning disability or autism	Requires improvement →← Sept 2019	Requires improvement ↓ Sept 2019	Good →← Sept 2019	Requires improvement ↓ Sept 2019	Requires improvement →← Sept 2019	Requires improvement →← Aug 2019
Community-based mental health services for adults of working age	Good →← Jan 2018	Good →← Jan 2018	Good →← Jan 2018	Good →← Jan 2018	Good →← Jan 2018	Good →← Jan 2018
Mental health crisis services and health-based places of safety	Requires improvement →← Sept 2019	Requires improvement ↓ Sept 2019	Good →← Sept 2019	Requires improvement ↓ Sept 2019	Inadequate 2019	Requires improvement ↓ Sept 2019
Specialist community mental health services for children and young people	Requires improvement →← Jan 2018	Requires improvement →← Jan 2018	Good →← Jan 2018	Inadequate ↓ Jan 2018	Requires improvement →← Jan 2018	Requires improvement →← Jan 2018
Community-based mental health services for older people	Requires improvement →← Jan 2018	Requires improvement →← Jan 2018	Good →← Jan 2018	Requires improvement ↓ Jan 2018	Requires improvement →← Jan 2018	Requires improvement ↓ Jan 2018
Community mental health services for people with a learning disability or autism	Good Mar 2016	Good Mar 2016	Good Mar 2016	Not rated	Good Mar 2016	Good Mar 2016
Overall	Requires improvement →← Sept 2019	Requires improvement →← Sept 2019	Good →← Sept 2019	Requires improvement →← Sept 2019	Requires improvement →← Sept 2019	Requires improvement →← Sept 2019

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

Wards for older people with mental health problems

Requires improvement 

Key facts and figures

Cumbria Partnership NHS Foundation Trust provides inpatient services for people over the age of 65 and above with mental health conditions. The services provided are for both patients admitted informally and those detained under the Mental Health Act 1983.

Mental health wards for older people are based over two sites:

At Furness General Hospital based in the south of Cumbria

- Ramsey unit, a 15 bedded mixed gender assessment ward for adults with organic mental health problems.

At Carleton Clinic based in the north of Cumbria

- Ruskin unit, a 15 bedded mixed gender assessment ward for adults with organic mental health problems. The responsible clinician for this ward was a nurse consultant and it was a nurse led ward. On the day the inspection team visited the ward there were 14 patients on the ward.
- Oakwood unit, a 12 bedded mixed gender assessment ward for adults over 65 with functional mental health problems. Oakwood is the only functional older adult unit within Cumbria and is for older adults who have additional fragility needs for example poor mobility. Oakwood will also admit younger adults with additional significant physical health care needs. On the day the inspection team visited the ward there were ten patients on the ward, with two patients on leave.

The core service was last inspected in September 2017. The service was rated requires improvement overall. Safe and effective were requires improvement, responsive and well led good and caring was rated outstanding.

The trust were issued with two requirement notices for the core service.

Mental Health Act monitoring visits took place on Ramsey in June 2018 and Ruskin in February 2019. We found some issues with care planning, section 17 leave, scrutiny of detention papers on admission and access to independent mental health advocacy.

Our inspection on this occasion was unannounced. Staff did not know we were coming, which enabled us to observe routine activity.

During the inspection visit, the inspection team:

- Visited all three wards, completed a tour of the environment and observed how staff were caring for patients.
- Spoke with four ward managers.
- Spoke with two senior managers.
- Spoke with 15 other staff including a consultant psychiatrist, junior doctor, pharmacist, occupational therapists, activity co-ordinator, registered nurses and healthcare support workers.
- Spoke with two patients.
- Spoke with 12 carers or relatives of patients using the service and reviewed four comment cards.
- Looked at the care and treatment records of 11 patients.

Wards for older people with mental health problems

- Looked at the Mental Health Act paperwork of 11 patients.
- Looked at medication management and medication administration records.
- Reviewed four restraint records.
- Observed 12 meetings which included handovers, formulation meetings, and multidisciplinary meetings involving patients and families.
- Observed mealtimes on all three wards and a range of activities including gardening group.
- Looked at a range of policies, procedures and other documents relating to the running of the service.

Summary of this service

Our rating of this service stayed the same. We rated it as requires improvement because

- There were notable variations between the ward environments. Oakwood ward had not improved since the last inspection and dormitory accommodation was still in place. The ward was not fit for purpose and it was unclear when the relocation of the ward would take place.
- There were vacant nursing posts on Ramsey ward which could not be filled. This meant that the ward relied on bank and agency. Feedback from carers was mixed about the care and treatment on the ward.
- There had been a number of serious incidents on Ramsey unit. The trust had carried out investigations, but these continued to be areas of concern.
- Section 17 leave forms on Ruskin and Oakwood were generic and not patient specific.

However:

- There had been improvements since the last inspection in relation to the mental capacity act, the introduction of psychology onto Ramsey ward and staff supervision.
- Ruskin ward provided a dementia friendly environment with a good balance between patient safety and ensuring patients were comfortable.
- Staff assessed and managed risk well. They minimised the use of restrictive practices, managed medicines safely and followed good practice with respect to safeguarding.
- Staff developed holistic, recovery-oriented wellbeing diaries which were informed by a comprehensive assessment. They provided a range of treatments suitable to the needs of the patients and in line with national guidance about best practice. Staff engaged in clinical audit to evaluate the quality of care they provided.
- The ward teams included or had access to the full range of specialists required to meet the needs of patients on the wards. Managers ensured that these staff received training, supervision and appraisal. The ward staff worked well together as a multidisciplinary team.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, and understood the individual needs of patients.
- The service managed beds well so that a bed was always available locally to a person who would benefit from admission and patients were discharged promptly once their condition warranted this.
- The service was well led, and governance processes were in place to monitor the service.

Wards for older people with mental health problems

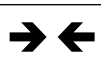
Is the service safe?

Good  

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

- All wards were safe, clean, well equipped, well-furnished and well maintained.
- The service had enough nursing and medical staff, who knew the patients and received basic training to keep patients safe from avoidable harm.
- Staff assessed and managed risks to patients and themselves well and followed best practice in anticipating, de-escalating and managing challenging behaviour. Staff used restraint and seclusion only after attempts at de-escalation had failed. The ward staff participated in the provider's restrictive interventions reduction programme.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse, and they knew how to apply it.
- The service used systems and processes to safely prescribe, administer, record and store medicines. Staff regularly reviewed the effects of medications on each patient's physical health.
- The wards had a good track record on safety. The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

Is the service effective?

Requires improvement  

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

- Section 17 leave forms on Ruskin and Oakwood were generic and not patient specific. Patients were not individually risk assessed to take leave. Families were not given copies of forms. This issue had been raised in the mental health act monitoring visit and was still an issue at the inspection.
- Patients on Ramsey ward did not have access to a dietician.
- There was some concern around the physical health care needs of patients on Ramsey. Families raised concerns that physical healthcare needs were not always identified and responded to in a timely manner.

However:

- Staff assessed the physical and mental health of all patients on admission. They developed individual care plans, which they reviewed regularly through multidisciplinary discussion and updated as needed. Care plans reflected the assessed needs, were personalised, holistic and recovery-oriented.
- Staff provided a range of care and treatment interventions suitable for the patient group and consistent with national guidance on best practice. They ensured that patients had good access to physical healthcare and supported patients to live healthier lives.
- Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives.

Wards for older people with mental health problems

- The ward teams included or had access to the full range of specialists required to meet the needs of patients on the wards. Managers made sure they had staff with a range of skills needed to provide high quality care. They supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.
- Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. The ward teams had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.
- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and discharged these well. Managers made sure that staff could explain patients' rights to them.
- Staff supported patients to make decisions on their care for themselves. They understood the provider's policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly for patients who might have impaired mental capacity.

Is the service caring?

Good ↓

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

- Staff treated patients with compassion and kindness. They respected patients' privacy and dignity. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.
- Staff involved patients in care planning and risk assessment. They ensured that patients had easy access to independent advocates.
- Staff worked with patients and family members to develop 'wellbeing diaries' for each patient. This meant that staff had detailed knowledge about patient's backgrounds, things that were important to them, personal strengths and the support they needed to maintain wellbeing. Staff proactively used this information to inform the delivery of personalised care.

However:

- There was a mixed response from carers. Patients and carers from Ruskin and Oakwood spoke highly of staff and felt that staff were kind and caring. However, we received information from three carers from Ramsey unit who were unhappy with care on the ward.

Is the service responsive?

Requires improvement →←

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

- Oakwood ward provided dormitory style accommodation with beds only separated by a curtain meaning that it was not fit for purpose. During the last inspection plans for the relocation of the ward had been agreed. However, the plans had been delayed and it was unclear when the move would take place. The ward discussed patients during bed management meetings to try and accommodate patients needing private rooms. However, the trust had not made any other interim measures to the ward.

- There had been some communication issues between the trust and the local authority safeguarding team in terms of staff attending safeguarding strategy meetings.

However:

- Staff managed beds well. This meant that a bed was available when needed and that patients were not moved between wards unless this was for their benefit. Discharge was rarely delayed for other than clinical reasons.
- The food was of a good quality and patients could make hot drinks and snacks at any time.
- The service met the needs of all patients who used the service – including those with a protected characteristic. Staff helped patients with communication, advocacy and cultural and spiritual support.
- The service treated concerns and complaints seriously, and investigations took place.

Is the service well-led?

Good 

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

- Leaders had the skills, knowledge and experience to perform their roles, had a good understanding of the services they managed, and were visible in the service and approachable for patients and staff.
- Staff knew and understood the provider's vision and values and how they were applied in the work of their team. Staff felt supported and informed about the upcoming transfer of services.
- Staff felt respected, supported and valued. They reported that the provider promoted equality and diversity in its day-to-day work and in providing opportunities for career progression. They felt able to raise concerns without fear of retribution.
- Our findings from the other key questions demonstrated that governance processes operated effectively at ward level and that performance and risk were managed well.
- Ward teams had access to the information they needed to provide safe and effective care and used that information to good effect.
- Staff engaged actively in local and national quality improvement activities.

However:

- Improvements had not been made to Oakwood ward. This had not changed since the last inspection and although plans had been agreed this had not been progressed and no timescales were in place.

Wards for people with a learning disability or autism

Requires improvement ➔ ➔

Key facts and figures

Cumbria Partnership NHS Foundation Trust's inpatient service for people with a learning disability or autism comprised one ward, Edenwood based at the Carleton Clinic in Carlisle. The service is a six-bed assessment and treatment unit for men and women with a learning disability who are currently experiencing a mental health crisis and require acute assessment and treatment.

The unit takes admission for people with a learning disability and autism, though not with just a diagnosis of autism. Individuals who have autism without a learning disability would have their needs met within generic mental health wards.

Following our last inspection in October 2016, we rated the service as requires improvement overall as we found two regulatory breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These are detailed below as well as another area for improvement:

- Training in some modules of mandatory training had compliance rates below the trust target of 80%, including Mental Health legislation training which was a breach of regulation 12, (safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
- There was no clear system in place to learn from incidents. Staff did not feel that they received any constructive feedback following incidents which was a breach of regulation 17 (good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
- Patients did not have access to occupational therapy support on the ward.

During this latest inspection, we looked at all of our key lines of enquiry in relation to the service. We reviewed the regulatory breaches and the other area for improvement identified in our last inspection.

To enable us to observe routine activity, our inspection was unannounced, so staff did not know we were coming.

Our inspection team comprised two Care Quality Commission inspectors, a specialist advisor nurse, a specialist advisor occupational therapist and an expert by experience. An expert by experience is a person who has personal experience of using or supporting someone using a learning disability and autism service.

During the inspection we:

- spoke with the network manager who was a senior manager of the service
- spoke with the ward manager
- spoke with the deputy ward manager
- spoke with nine staff members including a psychologist, an assistant psychologist, health care assistants and nursing staff
- spoke with three patients and two carers
- reviewed the care records for all five patients currently on the ward
- reviewed nine records of restraint, including the use of rapid tranquilisation
- attended a multidisciplinary team meeting and patient discharge planning meeting

Wards for people with a learning disability or autism

- looked at the medicines management arrangements for the service
- looked at policies, procedures and other documents relating to the running of the service.

Summary of this service

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

- Medicines management arrangements on the ward were ineffective. We found two unlabelled medicines in storage. There was no risk assessment in place in relation to the use of sodium valproate to treat a female patient of child bearing age despite there being known risks of birth defects and abnormalities associated with the drug.
- Staff did not carry out physical observations following the use of restraint and 'as required' medication was given after each of the nine restraint instances we reviewed without the rationale being recorded. Staff had not completed body maps for five of the nine incidents of restraint.
- Patients did not have access to sufficient therapeutic activities. There was no activities co-ordinator on the ward. We saw little evidence of activities on the ward which was having a negative impact on patients' morale.
- Staff on the ward had not completed their local induction or mental health legislation training. The provider reported that only 57% of staff had completed their local induction and 12.5% had completed their mental health legislation training. Ten other modules were below the provider's 85% compliance target.
- Staff did not receive regular supervision. Since August 2018, out of the 24 staff members on the ward, nine had not received any supervision and 14 others had only received supervision between one and three times.
- Governance systems for the ward were ineffective. Audits had failed to identify issues in relation to physical interventions, rapid tranquilisation, medicines management, confidentiality agreements, care records and a positive behaviour plan. The service had failed to address issues around mandatory training compliance that had been found during our previous inspection in October 2016.
- Staff had not reviewed the care plan relating to a patient's 'as required' medication since January 2018. A care record contained an incomplete positive behaviour support plan, lacked information about the patient's strengths, goals, needs and problems and their epilepsy plan did not contain steps to support a safe bathing process. The care record also referred to the patient using the wrong gender.
- We were told by staff that for physical healthcare emergencies during the night, staff used the NHS 111 system. However, we understood within the organisation that the agreed arrangements were to contact Cumbria Health On Call Limited when medical emergencies arose.
- There were no confidentiality agreements in place for two patients who had been deemed as having mental capacity. There was no nurse call system on the ward which made it more difficult for patients to call for assistance.
- Four members of staff lacked knowledge about the duty of candour and the role of the provider's freedom to speak up guardian.
- Two members of staff were unable to access suitable specialist autism training for their role and development needs.

However:

Wards for people with a learning disability or autism

- Staff treated patients and carers with kindness, dignity and respect and involved them in decisions about care and treatment. Staff used tools to communicate with patients with communication issues such as Makaton, flash cards, signers and translators. Staff undertook regular risk assessments of patients and put plans in place to mitigate risks. Staff ensured patients' physical health needs were met and monitored.
- Staff ensured patients had access to spiritual support and food choices to meet their dietary needs. The ward was accessible for wheelchair users.
- Staff adhered to the Mental Capacity Act and Mental Health Act and there were systems in place to monitor how the Acts were used on the ward. Staff carried out capacity assessments and we saw evidence that best interests' decisions were made appropriately if patients lacked capacity.

Is the service safe?

Requires improvement ➔ ➔

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

- Medicines management arrangements on the ward were ineffective. We found two unlabelled medicines in storage. There was no risk assessment in place in relation to the use of sodium valproate despite there being known risks of birth defects and abnormalities associated with the drug.
- Staff did not carry out physical observations following the use of restraint and there was no rationale recorded for why patients were given 'as required' medication after each of the nine restraint instances we reviewed. Staff had not completed body maps for five of the nine incidents of restraint.
- Four members of staff lacked knowledge about the duty of candour.
- We were told by staff that for physical healthcare emergencies during the night, staff used the NHS 111 system. However, we understood within the organisation that the agreed arrangements were to contact Cumbria Health On Call Limited when medical emergencies arose.
- There was no nurse call system on the ward which made it more difficult for patients to call for assistance.
- Staff on the ward had not completed their local induction or mental health legislation training. The provider reported that out of the 24 staff on the ward, only 57% of staff had completed their local induction and only 12.5% had completed their mental health legislation training. 10 other modules were below the provider's 85% compliance target.

However:

- Staff knew how to report incidents and made safeguarding referrals when required. Lessons learned from investigating incidents and safeguarding issues were used to improve the service.
- Staff carried out regular risk assessments of patients and put plans in place to mitigate risks. Staff knew how to identify sudden deterioration in patients' health and responded appropriately.
- The ward was clean and well-maintained, and staff followed infection control procedures.

Is the service effective?

Requires improvement ● ➔

Wards for people with a learning disability or autism

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

- Staff did not receive regular supervision. Since August 2018, out of the 24 staff on the ward, nine staff members had not received any supervision and 14 others had only received supervision between one and three times. The overall compliance rate for supervision at the time of our inspection was, therefore, only 43%.
- Only three out of the 24 staff (12.5%) on the ward had completed their mandatory mental health legislation training.
- Staff had not reviewed the care plan relating to a patient's 'as required' medication since January 2018. A care record contained an incomplete positive behaviour support plan, lacked information about the patient's strengths, goals, needs and problems and their epilepsy plan did not contain steps to support a safe bathing process. The care record also referred to the patient using the wrong gender.
- The care records for two patients assessed as having mental capacity did not contain confidentiality agreements to acknowledge they were aware of how information about their care and treatment would be shared.

However:

- Staff had the right levels of skills, experience and qualifications to carry out their roles. Staff monitored and addressed patients' physical health needs and ensured patients' hydration and nutrition needs were met.
- Staff adhered to the Mental Capacity Act and Mental Health Act and there were systems in place to monitor how the Acts were used on the ward. Staff carried out capacity assessments and we saw evidence that best interests' decisions were made appropriately if patients lacked capacity.

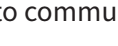
Is the service caring?

Good 

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

- Staff treated patients and carers with kindness, dignity and respect and involved them in decisions about care and treatment. Staff used tools to communicate with patients with communication issues such as Makaton, flash cards, signers and translators.
- Staff were able to raise concerns about disrespectful, discriminatory or abusive behaviour towards patients without fear of reprisals.
- Staff enabled patients and their families and carers to give feedback on the service they received via the use of comments cards, a 'thank you' board and the provider's complaints procedure.
- Staff understood the individual needs of patients, including their personal, cultural, social and religious needs and supported patients to understand and manage their care, treatment and condition.

Is the service responsive?

Requires improvement 

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

- Patients did not have access to sufficient therapeutic activities. There was no activities co-ordinator on the ward. We saw little evidence of activities on the ward which was having a negative impact on patients' morale.

However:

- Patients had access to spiritual support, food choices to meet their dietary needs and were supported by staff to access employment opportunities where appropriate. The ward was wheelchair accessible.
- Patients and carers knew how to complain, staff dealt with complaints appropriately and lessons learned from complaints were used to improve the service.
- Staff planned and managed discharge well. They liaised well with services that would provide aftercare and were assertive in managing the discharge care pathway. As a result, patients did not have excessive lengths of stay and discharge was rarely delayed for other than a clinical reason.

Is the service well-led?

Requires improvement 

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

- Governance systems for the ward were ineffective. Audits had failed to identify issues in relation to the lack of monitoring of patients following restraint, review of patients' observations after rapid tranquilisation had been administered, medicines management, confidentiality agreements, care records and a positive behaviour plan. Staff did not receive regular supervision. The service had failed to address issues around mandatory training compliance that had been found during our previous inspection in October 2016.
- Four members of staff did not know what the role of the provider's freedom to speak up guardian was.

However:

- Staff felt able to raise concerns without fear of reprisals and had access to the provider's whistleblowing policy. The provider's risk register included risks identified on the ward.
- Staff within the service were involved in accreditation schemes including leadership and management courses and Stopping the Over-Medication of People with a Learning Disability and Autism, also known as STOMP.

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

Requires improvement 

Key facts and figures

Cumbria Partnership NHS Foundation trust provide acute inpatient services for males and females from the age of 18. The services consist of one psychiatric intensive care unit and four acute wards. The wards are based across four locations in Whitehaven, Barrow in Furness, Kendal and Carlisle as follows:

- Carlton Clinic, Carlisle:

Rowanwood Psychiatric Intensive Care Unit, mixed sex with 10 beds

Hadrian Acute Unit, mixed sex with 22 beds

- West Cumberland Hospital, Whitehaven

Yewdale Unit, mixed sex with 16 beds

- Furness Hospital, Barrow in Furness

Dova Unit, mixed sex with 20 beds

- Westmorland General Hospital, Kendal

Kentmere Ward, mixed unit 11 beds

The service provides regulated activities for people who are detained for treatment under the Mental Health Act and for people who consent to admission as informal patients. The majority of patients were detained under the Mental Health Act at the time our inspection.

We previously inspected acute wards for adults of working age and psychiatric intensive care units between 13 February and 17 February 2017. The inspection report was published 20

July 2017 and we found some areas for improvement. At that inspection, we rated the services as requires improvement overall. We rated the service as 'requires improvement' in three

key questions safe, effective and well led and rated the service as 'good' in caring and responsive.

This inspection took place between 21 and 23 May 2019. The inspection was unannounced which meant that the service had no prior notice that we would be attending. We inspected the service using all the key lines of enquiry in the five domains (safe, effective, caring, responsive and well-led).

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

- visited all five wards, looked at the quality of the environments and observed how staff were caring for patients
- spoke with 18 patients who were using the service
- spoke with four carers of patients who were using the service
- spoke with 37 members of staff including the service lead, ward managers, consultants, junior doctors, pharmacists, nurses, healthcare assistants, occupational therapists and activity coordinators
- looked at the care and treatment records of 21 patients

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

- looked at 70 prescription charts
- reviewed medication management including a sample of patients' medication administration records
- attended and observed six meetings including four staff handovers, one patient community meeting and a seclusion review meeting
- attended and observed five patient activities or groups.
- looked at policies, procedures and other documents relating to the running of the service.

Summary of this service

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

- The governance systems and processes in place were not always adequate. Bed management did not ensure beds were always available locally. Staff on Rowanwood were not assured of the effectiveness of the serious incidents reviewed. Staffing and recruitment was an increasing issue, despite measures already in place to eradicate this.
- Staff did not do all that was reasonably practicable to mitigate risks to the health and safety of patients. Blanket restrictions were in place without being individually assessed. Staff did not always monitor patients' physical health needs following use of rapid tranquilisation and repairs to Dova Unit were ineffective to ensure a patient room was suitable for use.

However:

- Staff treated patients with compassion and kindness, respected their privacy and dignity, and understood the individual needs of patients. They actively involved patients and families and carers in care decisions.
- The ward teams included or had access to the full range of specialists required to meet the needs of patients on the wards. The ward staff worked well together as a multidisciplinary team and with those outside the ward who would have a role in providing aftercare.
- Staff understood and discharged their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005.

Is the service safe?

Requires improvement 

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

- Although measures were in place to ensure ward environments were well maintained, Dova ward had some areas where there was an ongoing issue with water leaks from the ceiling this was in several areas including a patient bedroom.
- Staff did not always monitor the physical health of patients after the administration of rapid tranquilisation in accordance with national guidance and trust policy.
- There were blanket restrictions on wards including phone chargers, aerosols, mirrors, plastic cutlery and crockery, and restrictions on patients having a key to their own bedroom. The service did not individually risk assess or review restrictions and there was no trust policy in place.

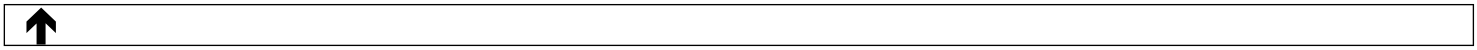
Acute wards for adults of working age and psychiatric intensive care units

- Fifty-six percent of eligible staff had completed the required Mental Health Act training. This was well below the trust target of 85%.
- Staff did not always ensure appropriate documentation was completed for medicines prescribed under the Mental Health Act.
- Patients at risk of violence and aggression did not have an individualised plan about the use of medication to calm, relax, tranquillise or to sedate them.
- Seclusion record entries were not always clear or complete.
- Incidents of rapid tranquilisation were not always reported as an incident in line with trust policy.
- The trust did not have a policy regarding the arrangements for children and young people who visit patients in hospital.

However:

- Environmental risk assessments had been carried out across all wards.
- The service controlled infection risk well. Staff kept equipment and the premises clean and used control measures to prevent the spread of infection.

Is the service effective?



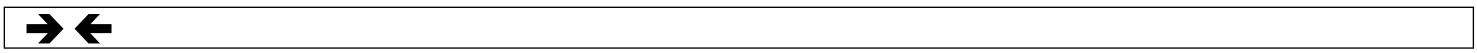
Our rating of effective improved. We rated it as good because:

- All patients had a care plan which was regularly reviewed and updated. Care plans were goal-orientated, and discharge focussed.
- Staff understood their roles and responsibilities under the Mental Health Act 1983 and knew how to support patients experiencing mental ill health.
- Staff of different kinds worked together as a team to benefit patients. Doctors, registered nurses and other healthcare professionals supported each other to provide good care. All wards had comprehensive daily multidisciplinary meetings which were recovery focused with the least restrictive options considered.
- Staff provided a varied set of activities for patients to engage in and enjoy all times of the day, seven days a week.

However:

- Not all staff were recording clinical supervision.
- Staff did not always provide information on patients' legal position and rights in line with the Mental Health Act Code of Practice.
- Physical health monitoring was not always completed as required.

Is the service caring?



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

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

- Staff were caring, kind and helpful to patients and knew the patients well. Feedback from patients and carers confirmed that staff treated them well.
- Staff involved patients and those close to them in decisions about their care and treatment. Carers told us that they felt informed and involved in the care being provided by the service.
- Staff helped to maintain patients' dignity and respected their confidentiality.
- Patients had information available about advocacy services and staff supported them to access these.

Is the service responsive?

Requires improvement 

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

- Bed management was poor which meant patients could not access the service when they needed it. As a result, patients were often on wards away from their communities and families and when they were recovering, if they had leave, they risked losing their bed whilst they were away. There were a high number of out of area placements.
- Dova Ward was not maintained to a reasonable standard in one patient bedroom and some communal areas.

However:

- Patients had a good range of activities available seven days a week, during the daytime and evening.
- The service took account of patients' individual needs. The service could access interpreters, translators and other services designed to meet individual needs. All wards were accessible for people with mobility issues.

Is the service well-led?

Requires improvement 

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

- The trust measures to ensure efficient bed management were not effective to meet the needs of people requiring the service. Therefore, patient beds were often not available when required for treatment or for returning from leave. Patients were often placed out of area away from communities and families.
- The trusts had insufficient measures in place to ensure they were able to deploy sufficient numbers of qualified, competent, skilled and experienced staff to meet the needs of patients care and treatment.
- The trust did not ensure that all staff working on Rowanwood felt supported, valued and respected following serious incidents or assured that measures in place, protected them from reoccurrence.
- Staff were not familiar with the updated trust vision and values.
- Systems and processes were insufficient to assess, monitor and improve care and treatment. This included identifying, individually assessing and reviewing, blanket restrictions, clear oversight of staff supervision and ensuring all physical health monitoring was completed as required.

However:

- Development opportunities were available for staff throughout the service.

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

- Local managers across the trust promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.

Mental health crisis services and health-based places of safety

Requires improvement 

Key facts and figures

Cumbria Partnership NHS Foundation Trust provides community health and mental health services across Cumbria. The trust has four mental health crisis teams and health-based places of safety at:

- Carleton Clinic, Carlisle
- West Cumberland Hospital, Whitehaven
- Dane Garth, Furness General Hospital, Barrow-in-Furness
- Westmorland General Hospital, Kendal

The mental health crisis services are defined into two pathways, access and liaison and home treatment.

The access liaison integrated service provides mental health assessment including Mental Health Act assessment and short-term support to adults of all ages. The liaison service are dedicated practitioners who are based at the accident and emergency departments in Carlisle, Whitehaven and Barrow-in-Furness between 8am to 8pm. They assess patients in accident and emergency who have presented with self-harm or other mental health problems within two hours and for those admitted to a medical ward within 24 hours between 8pm and 8am. They also provide ongoing support for patients and staff on the medical wards.

The home treatment team provides support between 8am and 8pm. The purpose is to try and prevent admission to hospital and can provide up to six weeks of intensive treatment. At the end of the treatment period patients are either discharged with strategies to help them manage their condition or they are referred to the most appropriate service for ongoing support.

The health-based places of safety are available over the 24 hour period and patients are admitted by the police. Once they have been admitted patients have an assessment of need by an approved mental health practitioner and a psychiatrist to determine what support they need.

We last inspected the crisis and health-based place of safety core service in March 2016 and we rated the service as good overall, with requires improvement in the safe key question and good in effective, caring, responsive and well led.

This inspection was completed between the 21 and 23 May 2019. We gave the service 24 hours' notice of the inspection so that practitioners and patients would be available during the interview. We inspected all the key lines of enquiry in the five domains (safe, effective, caring, responsive and well-led). Before the inspection visit, we reviewed the information we held about these services and the information requested from the trust.

During the inspection visit, the inspection team:

- looked at the quality of the environments
- observed how staff were caring for patients
- spoke with five patients who were using the service
- spoke with three service managers
- spoke with 25 other staff members including nurses, social workers, healthcare support workers, occupational therapists and doctors.

Mental health crisis services and health-based places of safety

- looked at the care and treatment records of 14 patients
- reviewed the medication management in the service
- attended and observed a handover meeting
- looked at policies, procedures, team meeting minutes and other documents relating to the running of the service
- reviewed 16 section 136 records
- attended four home visits
- spoke with two approved mental health practitioners and a police liaison officer.

Summary of this service

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

- The systems and processes established were not operating effectively to assess, monitor and improve the safety and quality of the service or assess monitor and mitigate the risks relating to the health safety and welfare of patients.
- The physical environment of the health-based place of safety at Kendal did not meet the requirements of the Mental Health Act Code of Practice.
- There was not always a dedicated member of staff to observe patients in the health-based places of safety.
- Some facilities in the health-based places of safety did not promote the privacy and dignity of patients.
- Not all staff supporting patients in the health-based places of safety were trained in the prevention and management of violence and aggression.
- There was not always a record on the electronic patient record system that patients had their section 136 rights explained when accessing the health-based places of safety.
- Care plans were not always completed on the right documentation and a record of whether all patients received a copy of their care plan was not evident.
- Staff managing patient care were not receiving supervision and appraisal in line with trust policy.
- Staff did not feel supported by senior management.
- Most staff did not feel respected, supported and valued. They did not feel able to raise concerns without fear of retribution. Not all staff were aware of the Freedom to Speak Up Guardian.

However:

- The mental health crisis teams included or had access to the full range of specialists required to meet the needs of the patients. Staff worked well together as a multidisciplinary team and with relevant services outside the organisation.
- Staff treated patients with compassion and kindness and understood the individual needs of patients. They actively involved patients and families and carers in care decisions.
- The mental health crisis service and the health-based places of safety were easy to access. Staff assessed patients promptly. Those who required urgent care were taken onto the caseload of the crisis teams immediately.

Mental health crisis services and health-based places of safety

Is the service safe?

Requires improvement 

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

- The physical environment of the health-based place of safety at Kendal did not meet the requirements of the Mental Health Act Code of Practice and were not safe to use for their intended purpose and used in a safe way.
- There wasn't always a dedicated member of staff to observe patients in the health-based place of safety based on the inpatient wards and staff relied on inpatient ward staff to attend in an emergency.
- Risk assessments were not always updated in line with policy. However a comprehensive risk assessment was completed for all patients and progress notes were completed including updates relating to risk and actions to be taken. This may mean it would be difficult to find this information urgently.

However:

- Staff assessed and managed risks to patients and themselves. They responded promptly to sudden deterioration in a patient's health. Staff monitored patients on waiting lists to detect and respond to increases in level of risk. Staff followed good personal safety protocols.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.
- The service used systems and processes to safely prescribe, administer, record and store medicines. Staff working for the mental health crisis teams regularly reviewed the effects of medications on each patient's physical health.

Is the service effective?

Requires improvement 

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

- Staff were not receiving supervision, appraisals or opportunities to update their skills and attend regular team meetings.
- Staff including managers told us that not everyone who were required to complete the prevention and management of violence and aggression as part of their role had completed this.
- Staff assessed patients mental and physical health needs but did not always complete the correct documentation however the information was recorded in the progress notes. A record of whether all people received a copy of their care plan was not evident.
- Not all the records we viewed showed that patients subject to a 136 section had been explained their rights as required under section 132 of the Mental Health Act.

However:

- Staff working in the access and liaison integration service and home treatment teams provided a range of interventions that were informed by best practice guidance and suitable for the patient group. They ensured that patients had good access to physical healthcare.

Mental health crisis services and health-based places of safety

- Staff working in the access and liaison integration service and home treatment teams used recognised rating scales to assess and record severity and outcomes.
- Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. The teams had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.

Is the service caring?

Good ➔➔

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

- Staff treated patients with compassion and kindness. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.
- Staff in the access and liaison integration service and home treatment teams involved patients and actively sought their feedback on the quality of care provided.
- Staff informed and involved families and carers appropriately

Is the service responsive?

Requires improvement ➔

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

- Facilities in the health-based place of safety in Kendal were not suitable for the purpose they were being used for and did not meet the code of practice; they did not have access to toilet facilities or outside space.
- Facilities in the health-based places of safety did not promote the privacy and dignity of patients. In Carlisle, there was an open space to the bathroom and no blackout curtains on the windows. In Whitehaven the viewing window to the suite formed part of another office which also affected the privacy and dignity of patients.

However:

- The home treatment team could visit patients until 8pm and after this time there was access to the service through a dedicated crisis telephone line. The referral criteria for the mental health crisis teams did not exclude patients who would have benefitted from care. Staff assessed and treated patients promptly. Staff followed up patients who missed appointments.
- Staff helped patients with communication, advocacy and cultural support.

Is the service well-led?

Inadequate ➔➔

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

Mental health crisis services and health-based places of safety

- The trusts systems and processes to assess, monitor and improve the health, safety and quality of the services were not always effective including effective audit, staff supervision, appraisal and the risks relating to the health-based places of safety and adequate staffing for observations.
- Systems and processes were not established to maintain the records of each patient accurately, completely and contemporaneously.
- The provider had not taken action as required in response to the previous inspection.
- Staff did not feel supported by senior management. Staff did not all feel respected, supported and valued.
- Staff did not feel able to raise concerns without fear of retribution and some staff were unaware of the Freedom to Speak Up Guardian.

However:

- There were effective, multi-agency relationships. Managers of the service worked actively with partner agencies (including the police, ambulance service, primary care and local acute medical services) to ensure that people in the area received help when they experienced a mental health crisis.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

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

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

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

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance

This section is primarily information for the provider

Requirement notices

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

Our inspection team

Jenny Wilkes, Head of Hospitals Inspection, led this inspection. Two executive reviewers, an equality and diversity specialist advisor, a safeguarding specialist advisor, and a Mental Health Act reviewer supported our inspection of well-led for the trust overall.

The team included two inspection managers, 11 inspectors, one assistant inspector, one pharmacy inspector, one enforcement inspector, ten specialist advisers, and one expert by experience.

Executive reviewers are senior healthcare managers who support our inspections of the leadership of trusts. Specialist advisers are experts in their field who we do not directly employ. Experts by experience are people who have personal experience of using or caring for people who use health and social care services.