Cumbria Partnership NHS Foundation Trust

Quality Report

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Core services inspected	CQC registered location	CQC location ID
Acute wards for adults of working age and psychiatric intensive care units	The Carleton Clinic Dova Unit Kentmere Ward Yewdale Unit	RNNBJ RNNFG RNNWG RNNBX
Long stay/rehabilitation wards for adults of working age	The Carleton Clinic	RNNBJ
Wards for older people with mental health problems	The Carleton Clinic Ramsey Unit	RNNBJ RNNY2
Wards for people with a learning disability or autism	The Carleton Clinic	RNNBJ
Mental health crisis services and health based places of safety	Voreda Dova Unit The Carleton Clinic Kentmere Ward	RNNDJ RNNFG RNNBJ RNNX5
Community based mental health services for adults of working age	Voreda	RNNDJ
Specialist community mental health services for children and young people	Voreda	RNNDJ

Summary of findings

Community based mental health services for older people	Voreda	RNNDJ
Community mental health services for people with a learning disability or autism	Voreda	RNNDJ
Community end of life care	Voreda	RNNDJ
Community health services for children, young people and families	Voreda	RNNDJ
Community health services for adults	Voreda	RNNDJ
Community health inpatient services	Penrith Hospital Brampton War Memorial Hospital Ruth Lancaster James Community Hospital Abbey View Workington Hospital Langdale Unit Victoria Cottage Hospital Cockermouth Hospital Wigton Community Hospital	RNNBE RNNX3 RNNX6 RNNX2 RNNY1 RNNX5 RNNX7 RNNCB RNNX9

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

Summary of findings

Ratings

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

Overall rating for services at this Provider	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** 

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

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

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

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

Summary of findings

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Summary of findings

Overall summary

We found that the trust was performing at a level which resulted in a rating of Requires Improvement because:

- In some services, the assessment of patients' needs was not always holistic and there was limited evidence of the patients' participation in developing their plan of care.
- The trust has both electronic and paper care records in use across services. Not all staff had access to current, complete and contemporaneous care records to support the care and treatment of patients. The trust had a project in place to move to a single electronic care record across services. However, its implementation was delayed with the implementation taking place through 2016.
- The trust did not have a named nurse for children's safeguarding at the time of the inspection, although we were told that this post had been filled. A duty rota was in place to give advice and support to staff. The systems and frameworks for safeguarding procedures and safeguarding supervision were in early development. Safeguarding supervision had been incorporated into managerial supervison and training for managers was taking place.
- The requirements of the Mental Capacity Act (2005), including deprivation of liberty standards, were not being met in some services. Patients' capacity and ability to consent to their care and treatment was not routinely documented in care records.
- Managers and staff did not have a clear understanding of Mental Capacity Act (2005) including deprivation of liberty standards. The trust did not have a system to monitor how they meet the requirements of the Act.
- The trust did not have a restrictive interventions reduction programme in place to meet Department of Health guidance.
- The environment of the health based places of safety in Carlisle and Kendal did not meet the expected standard to meet national guidance. This placed people who used these services at risk and did not provide an environment which supported good care and treatment.
- On Kentmere ward, and Victoria Cottage hospital the environment did not meet all the requirements of the Department of Health guidance on same sex accommodation.
- Mandatory training compliance in the trust was variable across services and 63% overall. This was below the trust target of 80%. The trust's appraisal rate was 49% for non-medical staff. This was below the appraisal rate we would expect in an NHS trust.
- The trust did not have a robust system in place to record staff training and appraisal. Individual and team records did not match centrally held trust records on training attendance. Therefore the trust could not be assured staff had received training to maintain their skills and knowledge to carry out their roles safely and effectively and were up to date with changes to best practice.
- In some services, national best practice and guidance was not being followed in relation to the availability of suitably trained or skilled staff. In other areas, we found vacant posts within multidisciplinary teams such as consultant psychiatry and occupational therapy.
- The trust did not have a robust process in place to ensure that trust policies and procedures were reviewed within agreed timescales. The meant that policies and procedures may not always reflect current good practice or changes in legislation.
- Participation in clinical audit and the learning and improvement from these audits was variable across services.
- Within community health services for children and young people, there was no paediatric resuscitation equipment in areas where children attended for treatment for minor injury and illnesses. In addition, there were no paediatric trained staff at these centres.

However:

- The trust had a clear strategy, which established its long term vision and strategic goals, underpinned by the values of the organisation.

Summary of findings

- Staff treated patients and their relatives with kindness, dignity, respect and compassion.
- Most patients shared positive experiences of care and treatment from the services they used.
- There was evidence of good communication between professionals involved in providing care and treatment to patients through structured handovers and multi-disciplinary meetings in most services.
- In community health services for adults, the referral to treatment times in relation to physiotherapy, diabetes and neuroscience were similar or better than the national target.

Summary of findings

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

We always ask the following five questions of the services.

Are services safe?

Requires improvement

We rated safe as requires improvement because:

- Within community health services for children and young people, there was no paediatric resuscitation equipment in areas where children attended for treatment for minor injury and illnesses. In addition, there were no paediatric trained staff at these centres, nor had staff who worked in the treatment centres undertaken training in paediatric life support.
- The trust did not have robust safeguarding systems and processes in place. The trust had recently appointed a named nurse for children's safeguarding but this post remained vacant at the time of the inspection. Staff did not have access to a framework for safeguarding supervision in line with national recommendations.
- The health based places of safety in Carlisle and Kendal were not fit for purpose and did not meet current guidance.
- There was no psychiatric junior doctor medical cover supporting the consultants on call, after 5pm or at weekends on Dova unit, Kentmere ward and Yewdale unit. There was no psychiatric junior doctor medical cover after 12 midnight onweek days and weekends at Hadrian unit and Rowanwood.
- In mental health rehabilitation services the patient bedrooms located on the first floor did not have a nurse call system and there was no identified staff routinely present in this area. The blind spots were covered by parabolic mirrors.
- Within community inpatient services there were concerns regarding medicine management and checking of resuscitation equipment.
- Staff we spoke with were aware of infection control procedures and there were infection control policies on the trust's intranet for staff to access. However, infection control training compliance was variable across services and some of the infection control policies, which were relevant to community based staff, were out of date and had been due for review in 2012-13.
- The trust do not meet all the requirements of the Duty of Candour.

Summary of findings

- There was evidence of blanket restrictions through the routine locking of some doors on Ramsey, Ruskin, Kentmere and Hadrian units.
- In the learning disability and mental health services where restraint was used there was evidence of prone restraint. The trust did not have a restrictive interventions reduction programme in place.
- In community inpatient services, the wards displayed information about the number of nurses on duty at the time but did not display planned numbers versus actual staffing levels. There is national guidance from NHS England which states staffing levels should be displayed in all in patient areas.
- The trust mandatory training rate at August 2015 was 63%, which was below the trust's target of 80%.
- On Ruskin unit, there was no permanent support from a doctor to assist with meeting the physical health needs of patients.
- Over a third of health visiting staff we spoke to expressed concerns that they could not always complete records in a timely way. Some staff we spoke with told us they took clinical records home to complete them during their days off.
- Patient records were a combination of paper based and electronic records. Neither system held all the clinical information. There were delays accessing paper files when patients were transferred between services.

However:

- There had been no never events in community health services. Never events are serious, preventable safety incidents that should not occur if the available preventive measures had been implemented.
- Staff told us they were encouraged to report incidents and were able to explain the procedure.

Are services effective?

Requires improvement

We rated effective as requires improvement because:

- In learning disability services, community services for older people and specialist children and young people's mental health services, assessments of need, risk assessments and care plans did not demonstrate that a comprehensive, holistic and person centred approach had been taken in providing care and treatment to patients. In specialist children and young

people's services, some care documents were not present in the clinical records. However, in other services inspected there was good evidence of assessment, risk assessment and care planning which was holistic.

- Not all services had access to sufficient dedicated time from the full range of professionals required to ensure that a patients received care in line with their assessed need.
- In community and inpatient learning disability services, there was no formal approach to monitoring the outcomes for patients who received care and treatment from services.
- The trust did not hold UNICEF Baby Friendly accreditation. The UNICEF Baby Friendly Initiative is a global accreditation programme developed by UNICEF and the World Health Organisation it was designed to support breast feeding and promote parent/infant relationships.
- Staff had a variable understanding of the Mental Capacity Act 2005 in their practice. The trust policy on the use of the Mental Capacity Act had not been reviewed since 2013 and provided limited guidance to staff. Compliance with mandatory training in relation to the Act was below the trust's target. Patient's capacity to consent and participate in planning their care and treatment was not documented consistently across all services.
- Manager's we spoke to did not have a clear understanding of the MCA, DoLS or how these were managed and monitored across the trust.
- The trust appraisal rate at the time of inspection was 49%, which was below the appraisal rate we would expect in an NHS Trust.
- There was limited evidence of participation in clinical audit to monitor the quality of clinical care and associated improvements from the outcome of audit within specialist children's and adolescent mental health services and community mental health services for working age adults.
- The trust did not have a robust system in place to record staff training and appraisal. Individual and team records did not match centrally held trust records on training attendance. Therefore the trust could not be assured staff had received training to maintain their skills and knowledge to carry out their roles safely and effectively and were up to date with changes to best practice.

Summary of findings

- The trust did not have a robust process for the regular review of trust policies and procedures. As a result, a significant number of trust policies had not been reviewed within the stated timescale.

However:

- There was evidence in all services that the physical health needs of patients were assessed and any identified needs met by appropriately trained staff, with the exception of patients using the health based places of safety. Patients with learning disabilities had health action plans in place to meet their physical health needs.
- Staff in most services received regular supervision to support them in their role and had access to appropriate training to maintain and develop their skills.
- There was good evidence of communication between the professionals involved in providing care and treatment to patients through structured handovers and multi-disciplinary meetings to plan patient care.
- The specialist child and adolescent mental health service were participating in the children and young people's improving access to psychological therapies programme with the aim of increasing the availability of evidence based interventions within this service.

Are services caring?

Good

We rated caring as good because:

- Across community services, we saw patients and their relatives being treated with kindness, dignity and respect, and saw compassionate care being delivered.
- Staff understood and respected patients' personal, cultural, social and religious beliefs and considered them when planning care and treatment.
- Patients were given information about the services they were receiving and how to make comments or raise a concern or complaint if this was necessary.
- Most of the patients, carers and parents we spoke to made positive comments about the care and treatment they received from services.

However:

Summary of findings

- In working age adult services, some patients told us that they were not involved in planning their care. In other services the patient's involvement in the planning of their care and their views were not evidenced within the care records.
- Information about services, care and treatment was not always available to people with learning disabilities in a format that they would be able to understand.

Are services responsive to people's needs?

Requires improvement

We rated responsive as requires improvement because:

- In community health services for children and young people, the trust was not achieving the national target of 95% of children being seen within 18 weeks in out-patients departments across the services provided. Access to community paediatricians following referral was also below the 18 week national referral to treatment target. The trust reported the decline in meeting the target to be linked to capacity and increased demand for assessments, particularly for autistic spectrum disorder.
- In mental health acute wards for adults of working age, average bed occupancy levels over the period April to September 2015 ranged from 80% to 108% with the service average being 92%.
- In health based places of safety patients waited longer than the nationally recognised target between being taken to the health based place of safety and their assessment being commenced.
- In the learning disability inpatient service, there were limited activities available to patients. Those activities that were available had a limited focus on increasing skills and independence.
- In wards for older people with mental health problems, the Oakwood unit had dormitory style accommodation, which compromised patient privacy and dignity.

However:

- In community health services for adults, the referral to treatment times in relation to physiotherapy, diabetes, and neuroscience were similar or better than the national target.
- In community health services for adults, people with urgent care needs were prioritised for treatment and their needs were met in a timely way. Patients could contact the service out of hours by telephone for advice if needed.

Summary of findings

- In community end of life services, patients in vulnerable circumstances, such as those with dementia and learning disabilities, were referred through their GPs to the palliative or end of life care consultants.
- In most mental health services, patients were assessed in a timely manner and teams took active steps to engage with people who used the service.
- Services were accessible for people with disabilities and offered an environment conducive for mental health recovery. The environments were spacious, pleasantly decorated and calming in the majority of services.
- Patients we spoke to knew how to make a complaint about the services they received. Staff were able to describe how complaints were dealt with, including their responsibilities under duty of candour.
- Patients' spiritual and faith needs were met with the support of the trust chaplaincy service where this was needed.

Are services well-led?

Requires improvement

We rated well-led as requires improvement because:

- There was a lack of assurance regarding the information being presented to the board by the senior management team through governance meetings. Systems and processes agreed between the board and the senior management team (referred to as the triumvirate by the trust) were not always in place in services at a local level.
- The corporate safeguarding team was under development. The deputy director of quality and nursing had recently been given responsible for this. A safeguarding committee had been established and an improvement plan was in place. The trust did not have a named nurse for safeguarding children, although the post had recently been filled. Safeguarding supervision had been incorporated into managerial supervision.
- The trust did not ensure that staff received the necessary mandatory training and appraisal that was required.
- There was inconsistency across services in relation to participation in clinical audit and there was limited evidence of learning and improvement from audit activity.
- There was no robust process for reviewing policies and procedures in the trust. We found a number of policies to have exceeded their planned review dates.

Summary of findings

However

- The trust had a clear strategy, which established its long term vision and strategic goals, underpinned by the values of the organisation. Staff in the areas we visited was able to talk about the values of the trust and importance of the care and treatment they provide patients.
- The trust met the fit and proper persons requirements.
- There was evidence of an improving culture across the trust; both staff in services and stakeholders described this.

Summary of findings

Our inspection team

Our inspection team was led by:

Chair: Paddy Cooney, Retired

Head of Inspection: Jenny Wilkes, Care Quality Commission

Team Leaders: Brian Cranna, Inspection Manager (Mental Health) Care Quality Commission

Sarah Dronsfield, Inspection Manager (Acute) Care Quality Commission

The team included CQC inspectors and a variety of specialists: consultant psychiatrists, experts by experience who had personal experience of using or caring for someone who uses the type of services we were inspecting, health visitors, Mental Health Act Reviewers, a social worker, pharmacy inspectors, registered nurses (general, mental health and learning disabilities nurses), a school nurse and senior managers.

Why we carried out this inspection

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

How we carried out this inspection

To understand the experience of people who use services', we always ask the following five questions of every service and provider:

• Is it safe?

• Is it effective?

• Is it caring?

• Is it responsive to people's needs?

• Is it well-led?

Before visiting, we reviewed a range of information we hold about Cumbria Partnership NHS Foundation Trust and asked other organisations to share what they knew. We attended a council of governors meeting and a board meeting. We carried out announced visits to all core services on 10, 11 and 12 November 2015.

During the visit, we held focus groups with a range of staff, such as nurses, doctors, allied health professionals and support staff. We also held focus groups at main hospital sites for detained patients prior to and during the inspection. We also interviewed key members of staff, including the chief executive, chairperson, medical director, director of nursing, director of finance, Mental Health Act manager.

During the inspection we also:

- spoke with over 140 patients who shared their experience of the services they had received and reviewed the feedback contained in 309 comment cards
- observed how patients were being cared for in the services we visited
- spoke with more than 68 carers and or family members
- spoke with over 335 trust employees
- met with representatives from the local authority and commissioners of health services
- reviewed care or treatment records of 211 patients
- attended more than 50 clinical meetings which included multi-disciplinary meetings and handovers
- met with parents of children and young people with autism or autistic spectrum disorder and representatives of a charity that supported them.

We also used a Short Observational Framework for Inspection (SOFI) on the learning disability and older

person's wards. The SOFI is a tool used to help us collect evidence about the experience of people who use services where they may not be able to fully describe their experience due to cognitive or other problems.

In addition to the announced inspection, we carried out unannounced visits to Ruskin unit on 17 November 2015, Isel ward and Victoria cottage hospital on 23 and 24 November 2015.

We also carried out a further announced visit to Edenwood unit on 27 November 2015.

Information about the provider

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

Cumbria Partnership NHS Foundation Trust provides mental health, learning disability and community physical health services across Cumbria to a population of approximately half a million people.

Cumbria is rural county, which is sparsely populated in some areas. Cumbria had 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 made up 21% of the population. Infant and child mortality rates in Cumbria were similar to the national average. The level of child poverty in Cumbria was better than the national average with 14% of children under 16 years of age living in poverty. Rates of family homelessness were also rated better than the national average.

The trust provides services commissioned by Cumbria Clinical Commissioning Group, works with NHS England specialist commissioners and local authority commissioners.

The trust's total income in the financial year 2014/15 was £173.7 million and had an operating expenditure of £177.9 million. A deficit of £4.2 million against the planned deficit of £6.1 million in the trust's five-year plan. The trust employs more than 3,800 staff to deliver its services.

The trust had 20 locations registered with the CQC. All the trust community teams were registered to trust headquarters at Voreda, Penrith.

At the time of the inspection, the trust had 100 inpatient beds across 10 wards or units within its mental health and learning disabilities services. In community health services, the trust had 204 inpatients beds across 13 wards.

The trust was also commissioned to provide a range of community services in both community health services and mental health and learning disabilities services.

There had been 22 inspections across 11 registered locations carried out under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

At the time of inspection the following compliance actions remained from previous inspections:

- Dova unit, outcome 21 in relation to records.

This inspection was the first inspection of the trust under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The Care Quality Commission is responsible for protecting the interests of people detained and treated under the Mental Health Act 1983 in England, for making sure they are cared for properly, and for ensuring that the Act is used correctly. We do this by monitoring the use of the Mental Health Act and by visiting hospitals and speaking to patients. We appoint Mental Health Act Reviewers to do this and they visit every place were patients are detained on a regular basis. They also meet patients placed on supervised community treatment. We carried out Mental Health Act monitoring visits and detained patient focus groups prior to and during the inspection.

The trust provided the following core services that we inspected:

Mental Health Wards

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

Summary of findings

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

Community Health Services

- Community health services for adults
- Community health services for children and young people
- Community end of life services
- Community health inpatient services

We did not inspect the following services which the trust provided:

- Acquired brain injury service
- First Step (Improving access to psychological therapies)
- Physical health psychology services
- Prison health services
- Specialist dentistry

What people who use the provider's services say

We received 309 comment cards from people who use services. Of these comment cards the majority (87%) contained positive comments regarding the service. The remaining comments were either mixed in their comments (7%) or contained negative comments regarding the service provided (4%).

We received most comment cards from community health services for adults (50%); the lowest number of comments cards was from mental health wards for adults of working age and the psychiatric intensive care unit (3%).

Themes from positive comment cards and the phrases used were identified as follows:

- Staff attitude – kind, caring, professional, approachable, attentive.
- Environment – safe, clean, hygienic and good food.
- Service – excellent, outstanding, brilliant, would recommend to friends, waiting times were ok.
- Treatment – brilliant care, appointments well organised, access available out of hours.

Negative comments included:

- Lack of alternative care options, no counselling service
- Unsafe staffing, low morale
- Food sometimes cold
- Long wait from referral to treatment, lack of consistency and gaps in service

We met with patients who were detained under the Mental Health Act (1983) and their carers both individually and in groups. Feedback from these patients and carers was mainly positive regarding staff, environment and the care and treatment they received. Patients also told us that they understood their rights under the Act. However, two family members told us about the difficulties they had experienced accessing mental health support prior to their relatives being admitted. We also found issues in relation to patients' access to independent mental health advocates on one ward.

During the inspection, we spoke to patients and their carers in mental health services about the care they received. Most feedback was positive with staff being described staff as being caring, friendly, approachable and polite. Patients felt safe on the wards or had been able to approach staff for support when they felt unsafe. However, we did receive some negative feedback regarding some services. This included:

- Waiting time for specific therapies like cognitive behaviour therapy (CBT).
- A lack of support and treatment following the diagnosis of autistic spectrum disorder.
- Inconsistencies in care and treatment due to staff turnover.

Summary of findings

- Two patients told us they did not like being cared for on mixed sex wards.

In community health services, almost all patients and carers we spoke to were positive about the service they received. Patients and carers told us that staff were professional, respectful and supportive of their needs.

Within community mental health teams for adults of working age, the friends and family test results showed that 92% of people who used mental health services were likely or extremely likely to recommend the service. The service had a questionnaire that was given to patients to complete following initial assessment, however, this was not routinely used and we could see no evidence of how feedback was routinely gathered and used to improve services.

Good practice

Community health services for adults

- The South Lakes community respiratory staff had produced 'self-management' booklets/ plans for patients who had bronchiectasis or chronic obstructive pulmonary disease (COPD).

Community health services end of life care

- Patients and families told us that staff continuously assessed the level of pain and discomfort so that patients received appropriate and sufficient treatment to promote comfort. Treatment was not always medication as patients received alternative therapy such as massage to relieve anxiety and help with relaxing and easing pain.

Anticipatory medication prescriptions for pain relief were in use to avoid delays in treatment.

- Multidisciplinary meetings were patient focused, discussions were open, transparent and all attendees' views were considered when reaching decisions about the management of patients. At each meeting, inpatients and community patients were discussed so that staff knew the latest conditions of patients nursed in their homes.
- Patients were given information in a way it was easy to understand. Consent was sought only when patients were able to understand and discuss. In order to gain valid consent staff revisited discussions when patients found difficulty to concentrate or wanted their family members to be present. Staff gave patients time to understand and did not rush them to make decisions.

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

- The Hadrian unit provided a carers group on a Saturday. This was open to all carers and carers' assessments could be undertaken.

Wards for older people with mental health problems

- The memory matters and later life services designed and implemented the '#seethePERSON' model of care. This model moves the focus of care away from a patient's diagnosis or symptoms and onto their needs. Its steps focus on staff and aim to: raise their competencies in person-centred recovery practice; empower their innovation and creativity; and support their well-being. Managers complete all staff appraisals within the service in line with the model. The National Patient Safety Congress and Safety Awards 2015 shortlisted the services '#seethePERSON' model and awarded it a 'highly commended' rating.

Long stay and rehabilitation wards for working age adults

- The ward was completely self -catering. All patients had a weekly budget for their food shopping and staff supported them to make a shopping list and go out to buy the ingredients. The patients maintained a vegetable and herb patch in the outside area and this was used in their cooking
- The ward staff went out and engaged with the staff teams taking over their patients' care on discharge. For example, both the occupational therapist and the psychologist had gone out and provided training with a supported living accommodation provider in order for them to understand the way they work with that particular patient.

Mental health crisis services and health based places of safety

Summary of findings

- The ALIS South crisis team proactively attended the wards on a daily basis to facilitate patients' discharge through the acute admission pathway process. This had led to reduced in-patient stays and patients were supported on discharge to help with the transition between hospital and returning home.

Community mental health services for working age adults

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

Community mental health services for older people

- Staff in the community mental health service had developed an innovative project for older people in Cumbria. This was called ?seethePERSON and aimed to put more focus on an individual's personal well-being and their self-esteem. This was in order to aid better care, rather than focusing on the illness as the object of a person's treatment. Aims of this were an improved patient experience, improved quality and safety, increased staff competencies and keeping the focus on the person receiving care. The project was shortlisted in the changing culture category of the patient safety awards and is now embedded in practice across the county.
- The care home education and support service (CHESS) comprised a rolling programme of mental health education for care home staff, combined with a practical outreach service. The education programme consisted of three modules covering dementia, depression and psychosis. The service provided comprehensive recovery based mental health assessment and practical support to back up the education programme. In the 12 months immediately prior to the commencement of CHESS Outreach service within Carlisle, 52% of patients admitted to inpatient wards came from care homes. Six years later, this had fallen to only 5%, meaning that 95% of admissions did not come from care homes. The success of CHESS had been recognised both locally and nationally with the service winning seven awards over the past six years.

Areas for improvement

Action the provider MUST take to improve

Action the provider MUST take to improve

An action that a provider of a service MUST take relates to a breach of a regulation that is the subject of a regulatory breach by the Care Quality Commission.

Trustwide

- The trust must ensure that there are robust systems and frameworks for safeguarding children procedures and supervision, with oversight from a senior nurse with safeguarding children experience.
- The trust must ensure that policies and procedures are amended or created in order to adhere to the revised Mental Health Act Code of Practice, which was issued in April 2015.

Summary of findings

- The trust must ensure that staff are trained and implementing the principles and requirement of the Mental Capacity Act (2005) including the Deprivation of Liberty Safeguards.
- The trust must ensure that they have a plan in place to reduce restrictive practices and meet the Department of Health guidance, Positive and Proactive Care: reducing the need for restrictive interventions (April 2014).
- The trust must ensure that policies and procedures are regularly reviewed to include current good practice and changes in legislation.
- The trust must ensure that all staff have completed mandatory training, role specific training and receive an annual appraisal in line with trust policy and national guidance.

Community health services for adults

- The trust must ensure that at all times there are sufficient numbers of suitably skilled, qualified and experienced staff in line with best practice and national guidance taking into account patients' dependency levels.
- The trust must ensure that all staff have completed mandatory training, role specific training and had an annual appraisal.
- The trust must ensure that policies and patient group directives are updated and a system put in place to review these in a timely manner.
- The trust must ensure when using two forms of care records they both contain the same information to provide continuity and safe care for patients.

Community health inpatient services

- The trust must ensure that staff are trained and are implementing the principles and requirement of the Mental Capacity Act (2005) including the Deprivation of Liberty Safeguards.
- The trust must ensure that the resuscitation and emergency equipment is ready for use at all times and have robust systems in place for the checking and replacement of emergency equipment.
- The trust must ensure that systems and processes are in place and followed for the safe storage, security, recording and administration of medicines.
- The trust must ensure that all patients identified at risk of falls have appropriate assessment and review of their needs and appropriate levels of care are implemented and documented.
- The trust must strengthen the systems in place to regularly assess and monitor the quality of care provided to patients.
- The trust must ensure that where actions are implemented to reduce risks these are monitored and sustained.
- The trust must ensure at all times that there are sufficient numbers of suitably skilled, qualified and experienced staff in line with best practice and national guidance taking into account patients' dependency levels.
- The trust must ensure that all staff have completed mandatory training, role specific training and had an annual appraisal.

Community health services end of life care

- Systems and processes must be established by the trust and operated effectively to ensure good govenance.
- The trust must ensure that all relevant staff are trained and the principles of the Mental Capacity Act (2005) including Deprivation of Liberty Safeguards are embedded within the trust.
- The trust must ensure proper and safe management of medicines is followed.

Community health services for children, young people and families

- The trust must ensure that there is appropriate paediatric resuscitation equipment in locations where children attend for treatment for minor injury and illnesses.
- The trust must ensure that there are improvements in referral to treatment times for children and young people accessing children's community health services.

Summary of findings

- The trust must ensure that there are robust systems and frameworks for safeguarding procedures and supervision, with oversight and leadership provided by a senior nurse with child protection expertise.
- The trust must ensure that staff complete records within the timeframe expected by Nursing and Midwifery Council guidelines.
- The trust must ensure that where actions are implemented to reduce risks these are reviewed monitored and sustained.
- The trust must ensure that policies and patient group directives are updated and a system put in place to review these in a timely manner.
- The trust must ensure that all staff have completed mandatory training, role specific training and had an annual appraisal. For example: paediatric life support, safeguarding children

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

- The trust must review the out-of-hours medical cover available across the wards to ensure there are sufficient staff to meet the needs of all patients.
- The trust must ensure that arrangements for single sex accommodation are always adhered to in order to ensure the safety, privacy and dignity of patients. Clear signage should be in place at the entrance to each gender area informing patients who could enter.
- The trust must ensure that all staff understand the application of the Mental Capacity Act in practice. Documentation should contain evidence of recording of any decisions made about a patient's capacity.
- The trust must ensure that mandatory training is completed for all staff to achieve the trust target of 80%.
- The trust must ensure that staff attend basic life support with defibrillator training.

Wards for older people with mental health problems

- The provider must ensure that all staff understand the application of the Mental Capacity Act (MCA). MCA documentation should record evidence of patients' informed consent to treatment as well as any decisions made about a patient's capacity.
- The trust must review the out-of-hours medical cover available across the wards to ensure there is adequate psychiatric medical cover.

Wards for people with learning disabilities or autism

- The trust must ensure that care and treatment is planned and delivered in line with best practice guidance.
- The trust must ensure that care plans are holistic, person-centred and treatment focused.
- The trust must ensure that patients' communication needs are adequately assessed.
- The trust must ensure that patients have a discharge plan in place.
- The service must ensure that there is a plan in place to reduce physical interventions and restrictive practice.

Long stay and rehabilitation wards for working age adults

- The trust must ensure that the first floor of the building has clear lines of sight and an alarm call system that can be easily accessed to summon assistance.

Mental health crisis services and health based places of safety

- The trust must improve the environment of the health based places of safety (HBPoS) through a credible improvement plan and ensure that the HBPoS can be immediately available at all times in the event of a psychiatric emergency. In the interim, the trust must mitigate the risks of the current environments of the HBPoS and equipment used in the HBPoS.

Community mental health services for older people

- The trust must ensure that all patients have a full assessment of their health and social care needs. This must include a person centred care plan and a regular review of the patients need, treatment plan and risk. This must be documented clearly and consistently in each patient's care records across all community mental health services and all required documents must be completed on the electronic record. The information on the electronic system must correspond to that in the paper record.
- The trust must ensure that all staff understands the application of the Mental Capacity Act in practice.

Documentation should contain evidence of informed consent to treatment and record any decisions made about a patient's capacity and any best interests decisions.

Community mental health services for people with learning disabilities

- The trust must ensure that all staff have an annual appraisal.
- The trust must ensure that care plans are person-centred, holistic and presented in a way that meets the communication needs of people using services that follows best practice and guidance.
- The trust must ensure that staff complete and record patient's risk assessments consistently evidencing contemporaneous care records for patients who use services.

Specialist community mental health services for children and young people

- The trust must ensure that risk assessments are completed fully and regularly reviewed and maintained for all people who use the service. This must include a system for monitoring risk for young people waiting for first treatment intervention.
- The trust must ensure that complete, accurate and contemporaneous records are maintained in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided.
- The trust must ensure that feedback from people who use the service is evaluated and used to make improvements.
- The trust must ensure that an appropriate system of audit is in place to assess, monitor and improve the quality and safety of the service.

Action the provider SHOULD take to improve

Action the provider SHOULD take to improve

Actions that we say a provider SHOULD take relate to improvements that should be made but where there is no breach of regulation.

Trustwide

- The trust should ensure that the out of hours doctor cover is adequate and doctors providing cover are skilled in assessing the mental health needs of patients.
- The trust should ensure that the single electronic care record system is implemented in line with the strategy and timeline the trust have set out.
- The trust should consider what further actions can be taken to improve the assurance that is provided to the board.
- The trust should consider additional pharmacy resource to support multidisciplinary teams, medicines reconciliation, training and wider support to services.
- The trust should continue to proactively recruit to vacant posts within services to ensure that the range of skills and professional disciplines are available to deliver the assessed needs of their patients.
- The trust should ensure that it meets all the requirements of Duty of Candour.

Community health inpatient services

- The trust should ensure that care records accurately reflect the assessment of patients' needs, care planning, treatment and the care delivered.
- The trust should ensure that patients have facilities such as toilets and bathrooms that are gender specific so that male and female patients do not need to share.

Community health services for children, young people and families

- The trust should promote the sharing of good practice across teams and work towards a cohesive workforce to promote equity of service across the county.

Community health services end of life care

- The trust should establish an EoLC Pathway to enable patients to be placed in an appropriate timeframe, move progressively through care based on evidence based practice.
- The trust should ensure that all staff receive appropriate training, support, development opportunities, supervision and appraisal.

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

Summary of findings

- The trust should ensure that medicines are stored safely in rooms that do not exceed the recommended temperature range.
- The trust should ensure that care plans are personalised and that patients are fully involved in their care planning.
- The trust should ensure that positive behaviour support plans are developed for patients receiving restrictive interventions.
- The trust should ensure that patient bedrooms and bathrooms in the Hadrian unit are fitted with nurse call alarms.
- The trust should ensure that the clock in the seclusion room on Rowanwood is replaced.
- The trust should ensure that all staff have an annual performance appraisal.
- The trust should ensure that all episodes of seclusion on Kentmere ward are correctly recorded.
- The trust should ensure that all episodes of restraint on Kentmere ward are reported on the incident reporting system.
- The trust should ensure that all acute and PICU wards display notices both on the inside and on the outside of locked entrance doors to inform informal patients of the reason for the ward being locked and their right to leave at any time.
- The trust should review patients' access to ECT.

Wards for older people with mental health problems

- The trust should ensure that it promotes patient privacy and dignity on all wards.
- The trust should ensure that there are enough staff to meet staffing requirements.
- The trust should continue to monitor the requirements of patients with physical healthcare needs and ensure it fully supports and trains all staff to complete the associated tasks.
- The trust should consider how the blanket restriction of locked bedroom doors impacts patients with limited verbal communication. It should ensure there are systems to review the restriction for each patient.
- The trust should consider whether better access to psychology could benefit the recovery of individual patients.

Wards for people with learning disabilities or autism

- The service should ensure that mandatory training is kept current and ongoing.

Long stay and rehabilitation wards for working age adults

- The trust should ensure that all staff have an annual performance appraisal
- The trust should ensure that mandatory training is completed by all staff to achieve the trust standard of 80% staff trained.

Mental health crisis services and health based places of safety

- The trust should continue to address the mandatory training levels of staff within the crisis teams; including crisis staff who support the supervision of patients in the health based place of safety receiving appropriate training in the prevention and management of violence and aggression training.
- The trust should ensure that patients detained using section 136 of the Mental Health Act are given their rights in a timely manner and ensure the recording of episodes of section 136 are improved.
- The trust should continue to work with other agencies to ensure that assessments in the health based place of safety are not unduly delayed due to the availability of assessing doctors and approved mental health professionals.
- The trust should monitor the need for the fuller range of primary care mental health services (for example, longer term condition management of mild to moderate mental health needs) and the impact on its current services (such as crisis teams) as evidence towards any future commissioning strategy.
- The trust should ensure that when patients are first brought into the HBPoS, they are routinely assessed for any ongoing physical health problems which requires follow up investigation.

Community mental health services for adults of working age

Summary of findings

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

Community mental health services for older people

- The trust should ensure that all medical equipment is fit for purpose and records are kept to ensure it is well maintained.
- The trust should ensure that fire safety records are kept up to date to ensure the safety of patients and staff when on site.
- The trust should ensure that training is accessible for all staff, that all staff attend mandatory training and that the identified training requirements for their teams are accurate.
- The trust should ensure that risk assessments are thorough and current and reflect the patient's needs.
- The trust should ensure that lessons learnt from incidents are shared with staff.
- The trust should ensure that it is following recommended national guidance and its own policy on the use of CPA in secondary mental health services.
- The trust should ensure that patients and carers are aware of their care plan, are offered a copy of it, and that care records evidence the patients involvement
- The trust should ensure that all staff receive an annual appraisal and this is documented.

Community mental health services for people with learning disabilities

- The trust should ensure that people can access treatment in an effective and timely manner following assessment in accordance with national guidance.
- The trust should ensure that people have access to a full range of multi-disciplinary professionals to meet their care and treatment consistently across all of the service in line with best practice.
- The trust should ensure that environmental risk assessments are dated on completion.

Specialist community mental health services for children and young people

- The trust should ensure that mandatory training is kept current and ongoing.
- The trust should monitor waiting times between assessment and first treatment intervention.
- The trust should provide the full range of evidence based interventions recommended by NICE to support people using the service.
- The trust should seek to implement the full range of recommendations as set out in the CAMHS review 2012.
- The trust should seek to develop a comprehensive CAMHS service including tier two and out-of-hours provision.

Cumbria Partnership NHS Foundation Trust

Detailed findings

Mental Health Act responsibilities

The trust had clear governance systems in place for meeting its responsibilities under the Mental Health Act. There was a Mental Health Act (MHA) office based in each locality and a team of Mental Health Act administrators was based at each of these locations and was responsible for the administration of the MHA and Deprivation of Liberty Safeguards (DoLS). The team reported to the head of the legal services who was also responsible for providing legal training updates and advice to trust staff.

We could not find any evidence that policies had been amended or created in order to adhere to the revised Mental Health Act (MHA) Code of Practice which was issued in April 2015. The revised Code sets new standards and increased the good practice expectations for existing areas covered in the Code for providers and professionals when making decisions about care and treatment for people affected by the Act. CQC stated on the publication of the revised Code that it would expect services to have such policies and procedures in place by October 2015.

Detention papers on files were in good order. We found there were effective systems in place for the administration of the Act. Where people were detained under the MHA, evidence of their detention could easily be found on patients' files. This included the approved mental health professional (AMHP) report and section 19 transfer orders where appropriate.

However, we found one patient had been detained under section 2 of the MHA at a location not registered for the care and treatment of detained patients (Keswick hospital). We also found a patient subject to section 5(4) on one ward (Kentmere) for which there was no paperwork.

In most services, the trust ensured that detained patients were given information about their legal status and rights on admission in accordance with section 132. We found that there was a very effective independent mental health advocacy (IMHA) service in operation with an auto referral system in place on all but two wards.

We had some concerns regarding adherence to the procedural safeguards in relation to seclusion and the recording of restraint on Rowanwood. We were informed that the stand alone wards used domestic staff and porters who had been trained in the prevention and management of violence and aggression for restraint. We were concerned about how this met with the requirements of the Code of Practice in terms of de-escalating and restraining patients in accordance with positive behavioural support plans.

Mental Capacity Act and Deprivation of Liberty Safeguards

The trust had a policy for the Mental Capacity Act 2005 (MCA) which had been ratified in October 2011 and was a joint policy with the Cumbria Safeguarding Adults Partnership. The policy was due for review in October 2013

but had not been reviewed. The manager responsible for this policy told us that this was due to the policy being a multi-agency joint policy and this was causing a delay in the process of the review.

The policy had very limited guidance for staff to follow and was not specific to the needs of the patients in the trust. The forms contained in the policy for assessing capacity and recording best interests were generic and not specific. There was no guidance for staff to follow informing them when capacity assessments or best interest decisions carried out or how to record these in patient's clinical records. As a result, some services had developed their own assessments and recording systems at a local level. While some of these were very comprehensive, there was no organisational overview for their use or quality.

The MCA policy did not refer to the complexities of the Supreme Court decision in relation to the deprivation of liberty and there was no reference to the interface with the Mental Health Act 1983.

The trust hosted the Deprivation of liberty safeguards management on behalf of the local authority. They coordinated requests for authorisation, assessments and associated administrative processes. There was no policy in the trust for the Deprivation of liberty or how the trust managed this process.

Requires improvement

Are services safe?

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

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

Summary of findings

Our findings

We looked at safety incidents from three sources: incidents reported by the trust to the National Reporting and Learning system (NRLS) and to the Strategic Executive Information System (STEIS) and also serious incidents reported by staff to the trust's own incident reporting system.

Trusts are required report all patient safety incidents of any severity to the NRLS. The trust reported a total of 3,426 incidents to the NRLS between 1 September 2014 and 31 August 2015. Of the incidents reported to NRLS the majority had been classified as resulting in "no harm" 41% or "low harm" 37%, "moderate harm" 19% and "severe harm "1%.

When compared to similar NHS trusts this trust was the highest reporter of incidents. The NRLS considers that trusts that report more incidents than average and have a higher proportion of reported incidents that are no or low harm have a maturing safety culture.

Of the incidents reported to NRLS, 33% were related to the implementation of care and ongoing monitoring / review (including pressure ulcers) and 28% were associated with patient accidents (including patient falls).

The trust is also required to report serious incidents to STEIS. These include 'never events' which are serious patient safety incidents that are wholly preventable. The trust reported 109 serious incidents between 1 September 2014 and 31 August 2015. Of these 109 incidents, 27% were classified as 'unexpected death of community patient

(receiving care)', 19% were incidents relating to 'category 3 pressure ulcers' and 11% were of the 'slips, trips and falls' type. None of the incidents reported to STEIS were classified as "never events".

On the trust's incident reporting system, staff reported 98 serious incidents between 24 March 2014 and 21 June 2015. Of these, 50 incidents involved the death of a patient. The commonest type of serious incidents were the unexpected death of a community patient who was receiving care, followed by incidents classed as 'other' and slips, trips and falls.

We found 16 child deaths had been reported. Of these, five were from natural causes and were expected and 11 were unexpected.

The number of the most serious incidents recorded by the trust incident reporting system was different to those reported to STEIS, although it should be noted that these are covering different time periods.

The NHS Safety Thermometer measures a monthly snapshot of four areas of harm including falls and pressure ulcers. The safety thermometer prevalence rate for new pressure ulcers fluctuated throughout the 13 month period between August 2014 and August 2015. The rate was highest in August 2014 at 1.5% (26 pressure ulcers) and was at its lowest in June 2015 at 0.1% (2 pressure ulcers).

Between August 2014 and August 2015, the safety thermometer results show that most falls with harm occurred in February 2015 with a total of 16 followed closely by January 2015 with 14.

In community health inpatient services 676 falls were reported between 1 January and 31 October 2015 which equated to 2.4 falls every day in the service. On a number of incident reports low staffing and/or high patient acuity and dependency was recorded by staff as a contributory factor to patient falls during this period.

Across the four areas of harms collected within the Safety Thermometer the service delivered Harm Free Care to 92.4% patients compared to the national average of 90.6%.

Some of the responses to questions in the NHS Staff Survey 2014 can be linked to the culture of safety and incident reporting in a trust. The trust results were in the worst 20% of mental health and learning disability trusts for the question related to fairness and effectiveness of incident reporting. However, staff could describe the incident reporting procedure and there was no significant evidence of incidents not being reported.

Learning from incidents

Our intelligence identified that the investigation of the oldest serious incident on STEIS had been ongoing since September 2014 and only 41% of the serious incidents had been closed on STEIS. All of the open incidents on the STEIS 2 system had passed the deadline.

The trust used an incident reporting system, which was easy to navigate for general information, and could generate reports. The system collected comprehensive information on duty of candour but safeguarding information was limited. Trust managers received notifications within 24 hours and then had 72 hours to complete an investigation. Risks were assessed in line with the risk policy using a scoring matrix. Relevant directors received information regarding high level incidents for their information or action where appropriate. Staff reported that they knew how to report incidents and were involved in learning from these.

A serious incidents policy was in place with an accountable officer at director level who was the director of quality and nursing. Incident management underpinned the trust risk management and board assurance. The trust had learning lessons leads that supported the care groups by embedding a culture of learning and continuous improvements across team. The leads facilitated learning lessons events, delivered coaching and training to staff to increase confidence and competence.

A review of six serious incidents found inconsistencies across the care groups. The standard of the investigation detailed in serious incident reports was not consistent. The level of analysis of information and identification of a root cause varied across the reports. Witness statements were not always attached to serious incidents. Action plans varied in content and only one had any timescales. A trust wide template was in place for serious incidents although not all services followed this. The director of nursing reviewed serious incidents monthly but did not sign them off on completion.

We also reviewed four investigations that had been carried out following serious incidents in community health services which resulted in patient harm. There was limited

evidence of learning being cascaded to staff at ward level. For example a review of the ward meeting minutes from across the service showed that not all referred to recommendations made in May 2015 regarding learning and actions required from a patient fall.

The trust had learning lessons leads who aimed to support the care groups to develop a culture of learning and continuous improvements across team. The leads facilitated learning lessons events, delivered coaching and training to staff to increase confidence and competence.

Examples of communicating learning included:

- Learning reviews
- Presentations at team meetings
- E bulletins and newsletters
- Trust intranet and public web page
- Public board papers
- Reports to quarterly safety committee and clinical governance forums

A mental health lessons learnt bulletin went to staff monthly. We received feedback in focus groups was that staff felt supported by managers and had attended learning events and team meetings to look at serious incidents. They also discussed complaints and other ways of working within team meetings. However, there was a lack of evidence in some areas that changes were being made as a result of lessons learned. This suggested that the process had not fully embedded across all services.

In children and young people's community health services, an updated 'transfer in' policy guided staff on what to do when a patient moved into the area, following learning from an incident. However, when staff were asked about meeting the needs of patients who had moved into the area, they were not using best practice guidelines of the five day target to contact the referrer and the ten day target to visit patients with universal needs. This was the recommendation in the National Health Visitor Service Specification 2014/15 published by NHS England.

We found overall incident reporting at the trust to be good. However, investigations were not completed to a high standard in all cases and the process for sharing lessons learned was not effective across all services.

Safeguarding

The trust safeguarding policy had a children's focus and did not provide a robust document to guide staff in relation to adult safeguarding. The policy had not been amended following the introduction of The Care Act 2014.

The trust had a dedicated safeguarding team, which was lost when the care groups were formed. A corporate safeguarding team was under construction. The deputy director of quality and nursing had recently taken responsibility for this and plans were in early development. The trust had two specialist practitioners in safeguarding whose roles were clear but both had children's backgrounds with limited understanding of adult services and safeguarding adults. The practitioners met quarterly with the designated named nurses and clinical commissioning group leads. They were managed and supported by the deputy director of quality and nursing.

The trust had recently appointed a named nurse for children's safeguarding but this post remained vacant at the time of the inspection. The annual childrens safeguarding report had identified risks and an implementation and training plan had recently been put into place.

A duty system was in place with a central contact number for staff to access for advice and guidance. However, the trust did not provide robust safeguarding supervision to staff working with children, young people and families in line with national service specifications and best practice. An audit undertaken with health visitors found that they did not have access to safeguarding supervision. Safeguarding supervision had been incorporated into managerial supervision although not all managers had been trained, the training was ongoing. The adult care groups had developed standard operating procedures, which were currently with the safeguarding committee but this work had not been done across all care groups.

Although there was provision of support with safeguarding issues, staff told us the lack of dedicated teams was an area on concern for them.

No safeguarding alerts had been raised with CQC since 1st September 2014. A safeguarding alert is where the CQC are the first agency made aware of a safeguarding concern. However, ten safeguarding concerns were raised with the

CQC. A safeguarding concern is where another agency is already addressing the concern. In five of the 11 child unexpected child deaths reported safeguarding concerns were identified.

The trust was involved in ten ongoing serious case reviews. Serious case reviews are multi agency investigations, which occur when a child has suffered serious harm or death. They provide lessons to be learned for services involved in promoting the health and wellbeing of children.

Whistle blowing

The trust had a "Raising Concerns" policy and procedure dated May 2015 which described the process staff should follow if they had concerns about poor care, risks, malpractice or wrong doing that affects patients, staff or the trust.

Two whistleblowing enquiries had been raised with the CQC regarding the trust since 1 September 2014 regarding Ramsey Unit and Voreda. The trust responded appropriately to these whistleblowing concerns.

Staff told us they knew how to raise concerns or report incidents in the services we inspected.

Assessing and monitoring safety and risk

The trust had a risk register in place which identified the owner of the risk and the timescales for completion of identified actions. However, there were a large number of risks on the register and not all information was not completed on the register. Incident reports were reviewed by ward managers and senior managers and investigations were carried out when identified as required. In most areas, patients received an individualised risk assessment which was regularly reviewed.

Safe and Clean Environments

In the 2015, patient-led assessments of the care environment the trust scored higher (92%) than the national average of other mental health/community health service trusts (90%). However, they scored lower than the national average for 'condition, appearance and maintenance' and 'dementia friendly environment'.

Wards and community team bases visited during the inspection were clean and appeared to be well maintained. However, previous Mental Health Act reviewer visits had highlighted issues with environmental constraints or facilities, for example, carpets needing replacing. All areas had environmental risk assessments completed. Except in older peoples and working age adult community services, where some information was incomplete or missing.

The health based places of safety in Carlisle and Kendal were not fit for purpose and did not meet current guidance. This meant that there was a potential risk to patients and others who used the service. The rooms were small, poorly furnished and would not comfortably accommodate the patient and the number of staff required to assess and observe the patient. Rooms in the suite were used for other purposes such as child visiting. This meant that the rooms were not always available for use in a psychiatric emergency. In Carlisle, there were no washing or toilet facilities and patients used the public toilet in the adjoining corridor. We found that risk assessments had not been carried out in relation to patients using toilets outside the health based place of safety.

In acute wards for adults of working age, children and young people under the age of 18 were not allowed to visit the ward and no specific visiting areas were identified for visiting to take place. We found that 136 suites were being used as visiting areas for children and young people when they were not in use. This meant that visits could be cut short if they were required for their intended use. In addition, guidance states that 136 suites should be available at all times for use as a place of safety.

There were blanket restrictions on some mental health wards. These included:

- In wards for older people with mental health problems, Ramsey and Ruskin wards had bedroom doors, which locked on closing. Patients' had to ask a member of staff to access their bedrooms. Individual care plans and risk assessments did not reflect this restriction on accessing bedrooms.
- In wards for working age adults with mental health problems, some doors to bedrooms and other communal areas were locked on Kentmere and Hadrian units. Individual care plans and risk assessments did not reflect these restrictions.

There was evidence that the trust was working to reduce blanket restrictions. Patients were able to keep their own mobile phones and internet access was provided on most wards. Patients had unrestricted access to outside space, opportunities to smoke and make drinks for themselves.

In the mental health rehabilitation unit, patients' bedrooms were located on the first floor. There was no staff alarm or nurse call alarm on in this area and lines of sight were obstructed. These were mitigated by the use of parabolic mirrors. However, staff did not routinely work on the first floor, the only staff presence was during hourly observations. This meant there patients had no means of summoning staff help or support in an emergency.

Kentmere ward and Victoria Cottage hospital were not compliant with the Department of Health's guidance on eliminating mixed sex accommodation. In Kentmere ward male patients had to pass a female side room to access a bathroom. Female patients had to pass male patients bedrooms, a lounge and day room to access the female toilet and bathroom. There was no risk management plan in place to minimise any potential risks. In Victoria Cottage hospital, there was one bathroom and two shower rooms between 13 patients. This meant both male and female patients would use the same bathroom.These facilities were not labelled for each gender's specific use.

Seclusion

The trust had only one seclusion room. This was located on the Rowanwood psychiatric intensive care unit. The room was subject to a seclusion review by a Mental Health Act reviewer in August 2015 and actions required following this visit were still ongoing at the time of the inspection. There was evidence that four hourly medical reviews were not always taking place in accordance with the requirements of the Code of Practice. We were also concerned that we were unable to find any evidence of positive behavioural support plans for those patients at risk of seclusion or other restrictive interventions on this ward.

Window blinds had been ordered to allow patients to control the daylight in the room but had not been fitted. A mirror had been fitted to eliminate blind spots in the rooms. There was no working clock in the room to allow patients to remain orientated to time, staff told us that it had recently been broken by a patient and had not yet been replaced.

Trust records showed that there had been 17 episodes of seclusion in the 6 months prior to the inspection.

Restraint

The trust had a policy on the prevention and management of violence and aggression which was dated August 2015.

Managers from the learning disability service told us that the trust had no plan in place to reduce restrictive practices and meet the Department of Health guidance, Positive and Proactive Care: reducing the need for restrictive interventions (April 2014). The prevention and management of violence and aggression policy did not refer to the guidance and there was no reduction programme to meet the guidance at trust level. Trust's are required to have a restrictive interventions reduction programme led by a board level executive in place to meet the Department of Health guidance.

On the learning disability ward trust information showed that restraint had been used 198 times in the period 1 May 2015 to 31 October 2015. Of these 198 incidents of restraint, 12 were in the prone position. Prone restraint is where a person is restrained face down and guidance states this should not be used.

In acute wards for adults of working age trust information showed that there were 115 incidents of restraint in the period 1 May 2015 to 31 October 2015, 35 of these involved prone restraint. We had concerns regarding the accurate recording of restraint on Rowanwood and the practice of restraint in one case on Kentmere ward.

We were informed that the stand alone wards used domestic staff and porters who had been trained in the prevention and management of violence and aggression (PMVA) for restraint. We were concerned about how this met with the requirements of the Mental Health Act Code of Practice in terms of de-escalating and restraining patients in accordance with positive behavioural support plans.

Medicines Management

The trust commissioned an independent review of pharmacy services in April 2014. This found a significant shortfall in pharmacy staffing and a lack of senior pharmacists to support the chief pharmacist in developing a strategy for medicines optimisation. A medicines optimisation strategy had not yet been drafted and linked to trust's business plan for pharmacy services. Additionally, the trust described difficulties in recruitment, with vacant posts being re-advertised and a reported 59% pharmacy vacancy rate. However, an action plan was in place and there had been recruitment to two of the three new senior pharmacists' posts linking directly with the specialist and mental health care groups. Locum pharmacy support was being used to support the service.

The trust had agreed a new contract for the supply of medicines to be implemented across the north of the region in January 2016. There were plans to complete baseline audits prior to the implementation of this service in order that it could be effectively monitored at implementation.

New arrangements for the supply of Clozapine were implemented ahead of this in November 2015. Recognition had been given to the need for further pharmacist support during this period and the potential reduction in pharmacy support to wards during implementation was included on the risk log.

Plans were being developed for greater pharmacist involvement in local governance groups to strengthen medicines governance across the care groups. However, we found that the trust's Rapid Tranquilisation policy ratified in September 2015 was revised by the clinical care group with reference to NICE guidance (NG25) that had been superseded in May 2015. The trust's medicines management committee identified this in October 2015 to be raised with trust wide clinical governance, with a recommendation for review in April 2016. This is almost a year after the publishing of new NICE guidance Violence and aggression: short-term management in mental health, health and community settings NICE guidelines [NG10].

There were trust wide medicines policies. However, we found a lack of robust governance arrangements of the role of nurse non-medical prescribers [NMPs] in transcribing onto discharge prescriptions in the trust's community hospitals. We found this transcribing role was not defined as distinct from their prescribing role within the Trust's prescribing policy and so did not fully support them in this function. Pharmacy advisors have informed us that the trust's non medical prescribing guidance Additionally, community managers had reported that Medicines Management policy does not reflect community requirements; this was being progressed with support from the care group's pharmacist lead.

The NHS England Medicines Optimisation Dashboard recorded that a higher than average proportion of the trust's reported medicines errors resulted in harm. The majority of these were reported as low harm. The use of summary care record and medicines reconciliation was not reported upon for this trust. Medicines reconciliation was not audited but current pharmacy provision did not allow for this to be promptly completed across the trust. Further pharmacist and technician provision would facilitate greater pharmacy involvement in multidisciplinary team meetings, medicines reconciliation, training delivery and wider support to the community teams.

Within community health inpatient services, there were concerns regarding medicine management. Some locations were not storing medication in the appropriate way and the recording of drug fridge temperatures was not consistent across the service meaning that medication effectiveness could be affected.

In the Hadrian unit, the clinic room temperature had regularly been recorded above 25 C. High temperatures in rooms where medication is stored can compromise the stability of some medicines. The trust pharmacist had advised staff to regularly open the window to cool the room.

We spoke with three non-medical prescribers [NMP] about their prescribing roles. The nurses were independent prescribers, legally allowed to prescribe virtually any medicine. Good practice guidelines, however, state that prescribing must only be within the clinical competence of the NMP. We saw that when NMPs started treatment this was within an area that they were competent. However, the NMP role also included prescribing all the patient's current medicines onto their inpatient chart on admission to the ward and then onto a discharge prescription when patients were discharged. The trust's NMP prescribing policy did not support this practice.

In some units, there was evidence of resuscitation equipment not being properly checked and some equipment had been on order for a number of months and had not been replaced.

Safe Staffing

Since April 2014, all hospitals have been required to publish information about staffing levels on wards, including the percentage of shifts meeting their agreed staffing levels. This initiative was part of the NHS response to the Francis report, which called for greater openness and transparency in the health service. The trust had published information about staffing levels on its website.

In community health inpatient services, the wards displayed information about the number of nurses on duty but did not display planned numbers versus actual staffing levels. National guidance from NHS England states staffing

levels should be displayed on all in patient areas. The trust had developed a dependency and acuity tool in order to determine safe staffing levels and skill mix on the wards. However, we found some units were not updating the dependency and acuity tool daily so were contacted by managers individually to undertake this.

The Trust was aiming for a 1:8 registered nurse to patient ratio during the day and at night a ratio of 1:12. This target was not met in some units, particularly at night when there was one registered nurse on a ward for up to 15 patients. On these wards additional health care support workers were used.

We asked the Trust how staff were covered for breaks when there is only one registered nurse on duty; they informed us there were arrangements with the local district nursing service to cover for breaks or staff were paid for missed breaks. This did not reflect what staff told us or how the staff cover was provided on night shifts when there was a very limited district nursing service provided across the county overnight.

There were no paediatric trained staff in areas where children attended for treatment for minor injury and illnesses. This posed a risk for children whose health may deteriorate whilst at a nurse-led treatment centre. There were no qualified decision makers at the nurse led treatment centres at Alston or Maryport hospitals. These nurses with additional training can assess, diagnose and treat a number of minor ailments and conditions.

An on call consultant psychiatrist for the south of the region and an on call consultant psychiatrist for the north of the region provided psychiatric medical cover out of hours and at weekends. Psychiatric junior doctor cover was provided up to 5pm weekdays on Dova, Kentmere and Yewdale ward and up to 12 midnight, seven days a week at Hadrian unit and Rowanwood. Physical screening examinations on admissions were conducted by nursing staff with the requirement for a full physical examination to be completed within 24 hours during core working hours or when the patient consented. Cumbria Health on Call Limited (CHOC) were contacted for medical queries and prescribing psychiatric medication out of hours (after 5pm weekdays and weekends at Dova, Kentmere and Yewdale ward and after 12 midnight at Hadrian unit and Rowanwood). The Primary Care Assessment Services (PCAS) was also used for any medical emergencies at Kentmere ward. This meant that psychiatric emergencies were dealt with by the on call consultant psychiatrist.

Staff in adult mental health services, told us that consultants would usually only go to the wards out of hours and at weekends for MHA assessments. Prescribing of medications out of hours was usually done over the telephone. Whilst some staff acknowledged this was manageable, particularly for known patients, some felt it was not ideal for new patients and that access to consultants and psychiatric cover out of hours was not sufficient.

In wards for older people with mental health problems, Ruskin unit was a nurse led unit with no dedicated full time doctor. Junior doctors from Oakwood unit provided support with physical health care needs during the week. A general practitioner also worked on the ward for two sessions a week. Staff told us that the out of hours psychiatric medical cover could cause difficulties for out of hours admissions. For example, CHOC doctors were reluctant to write up the medication charts for new admissions. In this situation, the nurse would request a verbal order from the consultant on call.

The trust had a monthly report of staffing levels on all wards. This included an explanation of any sickness, use of agency or incidents. Most teams reported that staffing levels were good and where there were vacancies the trust were attempting to fill them.

We found a number of posts that had remained vacant for long periods of time but managers told us there had been ongoing attempts to recruit to most of these posts. Services used locum or agency staff to minimise the impact of these vacancies on patient care. However, where agency or locum staff covered vacancies, some patients told us that there were issues with consistency in their care.

The trust had a staff turnover rate of 11% and a 6% vacancy rate on 30 June 2015. The trust described an ageing workforce and that students tended to move on after placement. The trust told us that they were talking to student nurses on placement in the trust to improve the recruitment of newly qualified nurses. However, in our focus group with student nurses they told us they would like to stay with the trust but positions had not been made aware of employment opportunities.

Detailed findings

Within community adults services in June 2015 there were a total of 603.80 whole time equivalent (WTE) staff in post there was a total of 64WTE (37.98 qualified staff and 26.03 care staff) vacancies across services. There was an average staff turnover rate of 15.5% the 'Out of hospital care' team had the highest rate of vacancies with 42.28%, followed by the Community Respiratory team in Kendal with 17.74%. The overall sickness rate reported for this time period was 5% for the trust however, we saw in some of the community teams this was higher. For example in the Penrith community nursing team, there was a sickness rate of 6.86%, in the Rapid Response Team, Carlisle, there was a sickness rate of 5.16% and in Eden Allied health professionals there was a sickness rate of 7.48%.

Staff told us there was poor career progression for administration staff and the recruitment process took too long. The trust were looking at this issue and staff told us that the system had been improving.

The trust had appointed an executive Human Resources lead to deal with capability issues, as there had previously been limited use of the capability process within the organisation.

There was evidence that the trust followed disciplinary processes and provided support to staff. However, the process had often taken several months with no timescales for completion.

Mandatory Training

The trust had set a target for compliance with mandatory training for all staff at 80% to be achieved by 31 March 2016. At the time of inspection the trust reported their overall mandatory training rate to be 63%.

The mandatory training compliance rate by core service was:

Community health services for adults 75%

Community health services inpatients 58%

Community health services children, young people and families 32%

Community health services end of life care

Acute wards for adults of working age and psychiatric intensive care units 59%

Wards for older people with mental health problems 57%

Wards for people with learning disabilities or autism 71%

Long stay / rehabilitation mental health wards for working age adults 60%

Mental health crisis services and health based places of safety 54%

Community mental health services for adults of working age 67%

Community mental health services for older people 71%

Community mental health services for people with learning disabilities and autism 82%

Specialist community child and adolescent mental health services 63%

The trust had a total of 34 mandatory training courses on its programme for staff. The trust was reviewing the mandatory training programme with the aim of reducing the mandatory training requirements on staff and making the training more accessible to staff. To support the changes taking place, the director of workforce had divided the department into two sections, one to focus on organisational learning i.e. career progression and the other to focus on the workforce in terms of meeting mandatory requirements.

The trust were meeting their target compliance in the areas of corporate and local induction for new staff joining the organisation. As reflected in the overall trust compliance rate, the rates for all other mandatory training topics were below the trust target.

Staff we spoke with were aware of infection control procedures and there were infection control policies on the trusts intranet for staff to access. However, infection control training compliance was variable across services and some of the infection control policies, which were relevant to community based staff, were out of date and had been due for review in 2012-13.

The trust did not have a robust system in place to record staff training individual and team records did not match centrally held trust records on training attendance. Therefore the trust could not be assured that staff had received training to maintain their skills and knowledge to carry out their roles safely and effectively and were up to date with changes to best practice.

Potential risks

Detailed findings

Within community health services for children and young people there was no paediatric resuscitation equipment in areas where children attended for treatment for minor injury and illnesses. This posed a risk for children whose health may deteriorate whilst at a nurse-led treatment centre.

At Victoria Cottage hospital minor injuries unit a five year old child had attended the unit between our announced and unannounced inspection and was treated despite the trust informing us during the inspection that children were not treated in these units. There was confusion amongst the staff about whom they were able to treat at the unit.

During the inspection 38% of health visiting staff we spoke to expressed concerns that they could not always complete records in a timely way. Nursing and Midwifery Council guidelines state that nursing records should be completed within 24 hours of contact with the patient. Some staff we spoke with told us they took clinical records home to complete them during their days off.

Some teams were using both paper and electronic patient records. Not all information held in the paper record was available electronically. This meant that staff could not always access contemporaneous information. In community mental health teams for working age adults, when patients transferred between services there were delays in accessing paper records.

Duty of Candour

The trust had a duty of candour policy but had failed to identify who was responsible for the implementation of the policy. The trust was not monitoring the compliance of duty of candour. The risk and safety policy was out of date and the audit trail in respect of management of incidents not fully developed particularly around duty of candour.

Staff in most services we visited told us about Duty of Candour or its principles.

Overall, the trust were not meeting all the required standards of Duty of Candour.

Requires improvement

Are services effective?

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

Summary of findings

Our findings

Assessment and delivery of care and treatment

In services for people with learning disabilities, assessments were not always comprehensive, holistic and person centred. There was limited evidence of specialist assessments such as functional analysis, communication assessments and sensory assessments to inform the care planning process. Individual care plans did not reflect best practice guidance in areas such as positive behaviour support and autism. In some community health and mental health services, not all patients had a clear individualised care plan, which reflected their assessed needs. In specialist community mental health services for children, not all children had a current risk assessment. Staff told us that delays could occur between the electronic system being updated and a paper copy being placed in the care record.

However, within other services we found that staff assessed the needs of patients and that these assessments were comprehensive, holistic and person centred and supported the planning of appropriate recovery focused care and treatment. Within mental health services there was limited evidence that care plans had been developed in collaboration with patients and carers although patients were able to talk about their care plan.

There was evidence across all services, with the exception of health based places of safety, that the physical health needs of patients were being assessed and identified needs being met by appropriately trained and skilled staff. Within the health based places of safety, there was no evidence that baseline checks were carried out to identify any physical health needs that may require follow up.

Best practice in care and treatment

NICE guidance was not always being followed within mental health services. NICE guidance in relation to rapid tranquilisation had not been fully implemented although the trust had a plan to address this in place.

Patients had access to psychological therapies in most mental health services although there were waiting times in some services.

Staff assessed the physical health needs of patients who used mental health services and provided appropriate care and treatment or made referrals to other services to meet any identified need. In learning disability services, patients had physical health plans identifying their individual physical healthcare needs. Junior doctors expressed concerns to the trust regarding their support and training to meet the complex physical health needs of patients in the Ruskin unit. The trust had arranged for a meeting to take place with the doctors and had put measures in place, such as providing training to nursing staff to carry out physical healthcare procedures and care to ensure patients' physical healthcare needs were being met. We carried out an unannounced inspection to the Ruskin unit and were able to confirm that confident and skilled staff were meeting patients' physical health care needs.

Trust staff were monitoring side effects to minimise any potential adverse effects of medication being prescribed by doctors in the service.

Outcome measures to inform the assessment and monitor the outcome of interventions were not being used routinely in the delivery of care. In some services, outcome measures were present, including health of the nation outcome scales in services for people with learning disabilities.

Participation in clinic audit and learning from these was found to vary significantly between services. In mental health services for children and young people there was no evidence of clinical audit taking place and staff could not recall when they were last involved in audit. However, in other areas there was clear evidence of participation clinical audit and action planning from these.

Requires improvement

Are services effective?

The trust had recently introduced a more robust system to register and monitor progress and actions from clinical audit. Each care group had also identified an audit lead with a responsibility to engage services in the audit process and take actions to address any issues found.

Staff skills

Services operated within a multi-disciplinary team framework. This included nurses, doctors, psychologists and allied health professionals. The skill mix of the teams varied across services. The community learning disability service did not have the range of allied health professionals to support the development of comprehensive care plans and effective evidence based interventions.

Within the south child and adolescent mental health team, consultant psychiatrist input had been provided through the use of a locum psychiatrist. Since April 2015, there had been five different locum consultant psychiatrists working in the service. Staff told us this had negatively affected continuity of care for young people who used the service. The trust had been attempting to recruit permanently to this post for some time.

In three services, there were occupational therapy posts vacant which meant that patients did not receive the benefits of occupational therapy intervention. In the learning disability inpatient service, this vacancy had existed for over 2 years and the trust had no clear strategy in place address this.

Staff employed within services were qualified to carry out their roles and registered with the appropriate professional bodies. However, in community health services for children, young people and families, specific paediatric life support training had not been provided to community and nurse led treatment centre staff.

There was a preceptorship programme for newly qualified staff, which provided a framework to develop competencies in their area of practice. Local induction programmes within services supported new members of staff.

Staff reported that training opportunities beyond the mandatory requirements were good and that further training enhanced the delivery of care and development of staff.

The trust had been developing its appraisal process to focus on a more values based approach.

The trust business plan included the golden thread. This aimed to link individual, team, department, and trust priorities to the outcomes framework, strategic goals and vision. The organisational development team aimed to ensure that all staff had clear job objectives and personal development plans, linked to the trust business plan. Feedback from staff was that this had improved the appraisal system.

Information provided by the trust showed the trust's appraisal rate overall was 48%. In some services, local records showed a higher rate of appraisal than reported on trust systems. The lowest rate for annual appraisal was 5% (Ruskin Unit, wards for older people) with other services showing higher rates:

Community health services for adults 56%

Community health services inpatients 58%

Community health services children, young people and families 54%

Community health services end of life care 22%

Acute wards for adults of working age and psychiatric intensive care units 49%

Wards for older people with mental health problems 17%

Wards for people with learning disabilities or autism 41%

Long stay / rehabilitation mental health wards for working age adults 32%

Mental health crisis services and health based places of safety

Community mental health services for adults of working age 38%

Community mental health services for people with learning disabilities and autism 30%

Specialist community child and adolescent mental health services 69%

Staff within the majority of services told us that they had management supervision monthly and we saw supervision records, which confirmed this. However, in community health services end of life care and community mental health service for adults of working age staff did not regularly access formal management or clinical supervision.

Requires improvement

Are services effective?

Medical practitioners had undergone professional revalidation. Qualified nurses told us they had been supported by the trust to prepare for their professional revalidation through revalidation awareness workshops. There was evidence of staff accessing specialist training relevant to the services in which they worked including training provided by external providers.

The trust was working with the Cumbria Learning and Improvement Collaborative to provide training sessions in addition to the available mandatory training.

Multi-disciplinary working

Across the trust, we found evidence of effective multi-disciplinary team working through regular multi-disciplinary meetings and handovers of care.

We attended more than 50 clinical meetings or handovers across the trust during the inspection. Multidisciplinary meetings were held regularly and attended by professionals from other services where this was appropriate to assist with patients care. Within the Ruskin unit, multi-disciplinary meetings were arranged flexibly based on patient need and to allow carer's and relatives to attend where they were the main carers.

The discussion within meetings focused on patients' needs and included risks such as safeguarding concerns. The outcomes of these meetings were documented within care records. The learning disabilities inpatient service was an exception. Here, we found poor recording of multidisciplinary meetings.

All staff starting shifts attended handovers. In the majority of services, the discussion was comprehensive, focussed on patient need and referred to patients in a positive and respectful manner. Staff leaving handovers told us that the discussion made it clear what was expected from them during their shift.

We observed services working with other agencies in the planning of patient care. In community health services for children and young people, staff worked collaboratively with children centres and schools in providing care and treatment.

In community health services inpatient areas we were told of joint working taking place with the ambulance service to reduce admissions to hospital. The project had reduced admissions to hospital by providing appropriate assessment to patients in their own homes and as a result, an estimated that 50 patients had not required admission who would have been admitted for assessment prior to the project.

The trust had signed the joint declaration making a commitment to improve crisis services across Cumbria to meet the guidance set out in the crisis care concordat.

Information and Records Systems

There were three electronic patient record systems in use across the trust, as well as paper based records. In some services, this resulted in clinical staff not having access to current, accurate clinical records, particularly outside normal office hours.

In some services, staff used both paper based and electronic records, which did not always have the same up to date information on a patients' care. Staff told us that this affected the continuity of patient care. Access to electronic records was variable across the trust with some areas able to access more comprehensive information than others.

In community services for children and young people, staff told us that they had difficulty in accessing paper based records in a timely manner. This may impact on the planning of patient care or cause a delay in the record of care and treatment that had been provided.

Within crisis services and health based places of safety, staff did not have timely access to all the clinical records for patients. This may lead to important information not being available about a patients care or treatment.

There was evidence in the majority of services of record keeping audits being carried out to monitor the quality of record keeping.

The trust had recognised the potential risks of having multiple record systems and had an information technology strategy. This included a programme to replace the existing systems with a single electronic record system. The programme had been delayed and a revised implementation plan showed an intention to roll out the new systems through 2016.

Consent to care and treatment

The trust had a Mental Capacity Act (MCA) policy in place. However, this had exceeded its planned review date and as a result did not reflect more recent changes in practice. The

policy and accompanying procedure provided limited guidance to staff on the use of the Act and the relationship between the Act, the Mental Health Act and deprivation of liberty safeguards (DoLS).

A number of additional guidance documents for both MCA and DoLS had been issued by the legislation department. These included assessing capacity; referrals for DoLS, process for DoLS requests. However, many of these had no author identified, version control, date published or issued or a governance structure. These documents were also not available on the trust's intranet. Staff were advised to contact the legislation department should they need advice or guidance in relation to MCA or DoLS.

There was a mandatory training programme across the trust for MCA and DoLS. 77% of staff in the trust were up to date with this training in August 2015.

Staff understanding of MCA and DoLS was variable across the trust. Staff in some services had a good understanding of their responsibilities under the MCA and DoLS. In others, understanding was poor. Managers of the trust we spoke with did not have a clear understanding of the MCA, DoLS or how these were managed across the trust. The trust did not have a system of monitoring the trust's adherence to the MCA or DoLS.

Assessment and treatment in line with Mental Health Act

The trust had a clear governance structure in place for meeting its responsibilities under the Mental Health Act. There was a Mental Health Act (MHA) office based in each locality at Whitehaven, Carlisle and Barrow. A team of Mental Health Act administrators were based at each of these locations and were responsible for the administration of the MHA and Deprivation of Liberty Safeguards (DoLS). The team reported to the head of the legal services who was also responsible for providing legal training updates and advice to trust staff. Staff we spoke with told us they felt well supported by the MHA offices and legal services unit.

There was no evidence that policies had been amended or created in order to adhere to the revised Mental Health Act (MHA) Code of Practice, which was issued in April 2015. The revised Code sets new standards and increased the good practice expectations for existing areas covered in the Code for providers and professionals when making decisions about care and treatment for people affected by the Act. CQC stated on the publication of the revised Code that it would expect services to have such policies and procedures in place by October 2015.

We were informed that staff received regular legal update training and that training on the revised Code had been provided. However, staff on the wards informed us that they were not familiar with the requirements of the Code and we were therefore concerned about how they would be able to meet their legal duty to have regard to the Code in their actions. We were concerned about how effective any training could be in the absence of revised policies to support practice.

Detention papers on files both on the ward and in the MHA offices were in good order. We found there were effective systems in place for the administration of the Act. We were informed that MHA administrators went onto the wards and audited a sample of patient files every three months. Where people were detained under the MHA, evidence of their detention could easily be found on patients' files. This included the approved mental health professional (AMHP) report and section 19 transfer orders where appropriate.

However, we found one patient had been detained under section 2 of the MHA at a location not registered for the care and treatment of detained patients (Keswick hospital). We also found a patient subject to section 5(4) on one ward (Kentmere) for which there was no paperwork.

We were informed that the use of section 4 had doubled in the preceding 12 months and this included conversions from section 5(2) and section 136. This indicated some difficulties in the availability of section 12 approved doctors to provide the second medical recommendation.

We reviewed the detention documents in MHA offices and had some concerns regarding the community treatment order (CTO) conditions on some of the files. We also examined the hospital managers' review of CTO patients and were concerned to find that the decision to continue a patient's CTO did not record the power to recall in any of the sample we checked.

The trust ensured that detained patients were given information about their legal status and rights on admission in accordance with section 132. We found that there was a system in place to represent rights where patients had not initially understood them and at regular intervals thereafter. However, this system was not always

adhered to and we found some problems with providing patients with information about their rights on two wards (Rowanwood and Kentmere). There was an effective independent mental health advocacy (IMHA) service in operation, with an auto referral system in place on all but two wards. (Edenwood and Ruskin). As these wards accommodated some of the most vulnerable patients, we were concerned that these patients who may lack capacity would not automatically be referred to the IMHA.

The documentation relating to the use of section 17 leave was clear on files on the ward. There was a system for authorising section 17 leave which was linked to risk assessment. We reviewed the leave forms and found that the parameters of leave were clearly recorded in most cases. However, it did not appear that patients and carers were provided with copies of their leave forms on one ward (Oakwood). There was evidence that some wards (Kentmere and Ruskin) were not always able to facilitate agreed section 17 leave due to staffing issues.

In relation to section 58, we found that all prescribed medication was authorised by a form T2 or T3. However, there were some instances where the form T2 or T3 did not match the prescription chart. We were unable to find any evidence that patients' capacity to consent was being assessed at the point that medication had first been administered. However, there was evidence across all wards that capacity was being assessed at the three month point. We found some examples of patients erroneously having multiple forms of authority in place and staff confirmed they were not clear on the authority under which they were treating patients in these cases.

Good

Are services caring?

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

Summary of findings

Our findings

Dignity, respect and compassion

During our inspection, we saw interactions between staff and patients in every service we visited. We saw that patients in all services were treated with dignity, respect and compassion.

Patients and carers told us that staff were professional, approachable and caring. We saw staff spending time with patients in communal areas and being attentive to patient's needs.

Staff knew their patients well and could discuss their individual needs, likes and dislikes. Staff were also able to discuss patients' recent history, which was relevant to their care, and support they were providing.

In the mental health rehabilitation ward we saw a debrief session taking place following an incident. In the discussion, the relationship between members of staff and the patient were discussed to identify the most appropriate member of staff to lead the patients' care at that time.

In learning disability services, patients told us that staff helped them understand difficult situations and gave them time to understand their care and treatment.

Involvement of people using services

Most patients and carers we spoke to told us that they were involved and understood their care. In some services, we found that the involvement of patients in the planning of their care was not recorded clearly in care records and patients did not receive copies of their care plans.

In learning disability services, care plans were not all person centred and did not demonstrate interventions to increase people's skills and independence. Care plans did not reflect patient's individual assessed communication needs, which meant that information was not always available in a format that could be understood.

In the mental health rehabilitation ward there was a structured induction and assessment period which required staff to work with patients collaboratively towards a shared outcome. This period also included expected standards regarding orientation to the ward and introduction to staff and other patients.

In Ramsey and Ruskin units, staff used software with patients to promote engagement and develop life stories which were used to gain a better understanding of patients' and inform the care they received.

There was evidence of patients participating in the running of wards. Community meetings were held on wards where patients were encouraged to give feedback regarding their experience of the care they received. From observation of meetings and evidence from records kept, we saw that changes were made to services because of the feedback given at community meetings.

In all areas, information on how to access advocacy services was available and advocates regularly attended community meetings on wards. In all areas except Ruskin and Edenwood, all patients detained under the Mental Health Act were referred for an independent mental health advocate.

In some areas, such as the mental health rehabilitation ward and crisis services, patients were involved in the recruitment of new staff.

We saw that services also considered the needs of those who support patients. Within services for older people, relatives and carers were supported to continue to provide care and support to their relatives where appropriate. We saw an example of this with a wife of a patient continuing to help her husband shave.

On Ruskin unit, an identified nurse carried out carer assessments where appropriate and acted as a link between the service and carers. A carer's support group was also available for carers of patients admitted to the unit. Community teams for older adults also had identified carer's link nurses who carried out assessments and worked with other agencies to improve support for carers. In Carlisle, the link nurse ran a support group for carers in the local library.

Good

Are services caring?

On Hadrian unit, a carer's group was held on a Saturday where carers could be supported and carers' assessments were carried out at this time.

Requires improvement

Are services responsive to people's needs?

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

Summary of findings

Our findings

Access and Discharge

In a number of services, the trust was not meeting targets for waiting times from referral to assessment and / or treatment.

In community health services for children and young people the trust was not achieving the national target of 95% of children being seen within 18 weeks in outpatients departments across the services provided. The trust had its own target of 92% of children receiving an outpatient's appointment from the time of referral; however, services were still not achieving this.

In the speech and language therapy service, only 50% of referrals were seen by 18 weeks. The trust had a recovery plan in place to reduce waiting times for children; however the trust trajectory report showed the waiting times would increase over time, due to lack of available appointments.

In community health services for adults, patients with urgent care or treatment needs were prioritised for treatment and their needs were met in a timely way. They were given the out of hours bleep number so that they could contact the service directly when needed. This ensured they received timely care from the service, by staff that had access to their care plans and be able to meet their individual needs. This helped prevent unnecessary admissions into hospital and receiving care that had not been planned to meet their needs.

In community health services for adults, the referral to treatment times in relation to physiotherapy, diabetes, and neuroscience were similar or better than the national target of 95% referral to treatment times within 18 weeks.

The trust did meet waiting time targets in some of its core services. In specialist mental health services for children and young people, the trust had set a target for waiting time from referral to first assessment of 35 days or 48 hours in the event of an urgent referral. The north and south children's service were meeting these times.

There was however no maximum waiting time from initial assessment to the start of treatment or intervention. In the south team, trust records showed that 50 children send young people were waiting for treatment, some of those for period in excess of 4 months.

For children and young people waiting for treatment there was no arrangement in place to review risk and prioritise intervention. Parents or young people were asked to contact the service if their needs changed whilst on the waiting list.

Children and young people who did not have a level of need that required intervention from a specialist service did not have good access to alternative care from other agencies. To address this with the support of commissioners the trust was inviting tenders to provide a targeted mental health service for children and young people across Cumbria.

Access to community paediatricians following referral was below the 18 week national referral to treatment target. Only 77% of referrals were being seen by 18 weeks. The trust's target was to see 92% of patients by 18 weeks against a national target of 95%. The trust reported the decline in meeting the target was linked to capacity and increased demand for assessments, particularly for autistic spectrum disorder.

In health based places of safety, a trust audit showed the patients were waiting longer than the nationally recognised three hour target between being brought to the health based place of safety and their assessment being commenced. The audit showed that the majority of these waits were following patients being detained by the police in the late afternoon or early hours of the morning. At this time the availability of approved mental health professionals and section 12 approved doctors was limited and resulted in long waits in health based places of safety and without appropriate facilities in Carlisle and Kendal.

Requires improvement

Are services responsive to people's needs?

Within community health inpatient services, we saw bed occupancy levels over the period April to September 2015 were high across the whole service ranging from 77% to 97% with the service average being 89%. In mental health acute wards for adults of working age, the average bed occupancy levels over the same period ranged from 80% to 108% with the service average being 92%.

The optimum bed occupancy rate for hospital beds are context dependent and vary between organisations. The National Audit Office suggested that hospitals with average bed occupancy levels above 85% can expect to have regular bed shortages, periodic bed crises and increased numbers of health care-acquired infections.

In most inpatient areas, there was evidence of discharge planning taking place. However, there were delays in patients being discharged in some services. In Yewdale and Hadrian units, acute wards for adults of working age, there had been a total of five delayed discharges during the period April 2015 to September 2015; these delays were due to a lack of suitable housing or placements.

In the learning disability inpatient service, no clear discharge plans were in place although staff were working to support patients discharge from the ward. There had been no delayed discharges from the service in the previous 6 months but two patients had been re-admitted to the ward within 28 days of their discharge.

The children's service had a transition protocol in place to guide a young person's transfer of care from children's to adult mental health services. Staff and parents described problems with transitions. These related to the criteria to access adult services or no specialist provision in the case of adults with attention deficit hyperactivity disorder.

The facilities promote recovery, comfort, dignity and confidentiality

Most ward areas and community bases had comfortable environments with access to quiet spaces and rooms for activities and therapy. The trust's overall patient led assessments of the care environment score for privacy, dignity and wellbeing was 83%, which was below the 87% national average for this type of trust. Patients' also had access to outdoor space. However, on Kentmere ward this space was some distance from the ward, which was on the second floor of a district general hospital.

The health based places of safety in Kendal and Carlisle did not provide an appropriate environment for patient care. The entrance to the place of safety was not discrete and the toilet and washing facilities were located outside the suite. The rooms within the suites were bare with limited furniture that was not appropriate to the needs of patients using the suite.

The Oakwood unit had seven single bedrooms and two shared dormitories. The beds within the dormitory areas had curtains, which pulled around each of the bed spaces. Patients had a wardrobe next to their bed; however, these wardrobes did not have doors. Patients' privacy and dignity was compromised due to the layout of the two dormitory areas.

In wards where patients stayed for longer periods of time, patients were encouraged to personalise their rooms by bringing in personal possessions and selecting pictures for walls.

An interpretation service was available where this was required. This was a telephone service which could be booked by staff where English was not the patients' first language. Services identified the need for an interpreter before the first appointment so that suitable arrangements could be made.

Most patients made positive comments regarding the quality and quantity of meals provided on wards and had access to drinks and snack outside meal times. In some wards where patients were working to increase their independence, patients were able to access kitchen areas and prepare their own meals. Patients were given a choice of meals and staff told us that that meals were available that took account of people's cultural or physical needs.

A range of therapeutic activities were available for patients on wards. In some services activity coordinators were employed who delivered the programme of activities and supported patients to access activities that were appropriate to meet their needs. On the learning disability ward patients participated in a range of activities, many of which were within the local community. However, these activities were not linked to patient care plans and no process was in place to measure the therapeutic outcome of the activities.

Meeting the needs of all people who use the service

Requires improvement

Are services responsive to people's needs?

Wards areas and community bases were accessible to people with disabilities. On wards, there were fully accessible bathrooms or shower areas available to allow patients to meet their personal care needs.

In most services, the patients' religious or spiritual needs were identified during the initial assessment. The trust provided a chaplaincy service to support the spiritual or religious needs of patients who used the service. The trust chaplain could arrange for support in relation to particular faith needs where this was required. The rehabilitation unit had a multi faith room that could be used to hold small ceremonies if a patient was unable to attend their usual place or worship.

In community end of life services, we saw examples of patients in vulnerable circumstances, such as patients with dementia or learning disabilities, being cared for in the community through joint working between the patients' GP and palliative or end of life care consultants.

Learning from concerns and complaints

The patient experience team (PET) incorporated complaints and patients advice and liaison services. The complaints policy had passed its planned review date. A review of the complaints process had taken place in April 2015, which was being used to inform the development of the new policy, which was not yet available. The trust had recognised gaps in staff training on complaints and a formal staffing structure for the patient experience team had been developed in July 2015 in response to this. The trust were not meeting key performance indicators around investigation and response to complaints, this was mainly in relation to mental health. The average length of time to respond to complaints was 21 days against target of five days. The time taken to investigate formal complaints was 52 days against target of 25. An action plan was in place to address this and meet the response targets.

The trust received 498 complaints during the period 1 August 2014 to 31 July 2015. Of these complaints, 85 were upheld. None of the complaints were referred to the parliamentary ombudsman.

Community based mental health services for adults of working age and community health services for adults received the most complaints in comparison to other services.

Staff in most services could describe how patients could make a complaint and the service provided by PALS (patient advice and liaison service). Information about how to make a complaint was widely available across services in leaflets, on notice boards and on the trust website. In some areas, information on how to make a complaint was given to patients on admission to the service.

Most of the patients and carers we spoke to knew how to raise concerns or make a complaint they had regarding their care and treatment. Most patients and carers we spoke to also told us that they felt able to raise concerns or issues with staff and that staff were approachable.

A consistent process was not being followed to ensure learning from complaints across the trust. In some services, complaints were discussed within team meetings and this discussion included any learning from the issues raised. In specialist services for children and young people, we saw no evidence of how the outcomes of complaints were used to change how services were delivered.

The trust board had introduced a patient story at each of its meetings. We saw a patient attend a board meeting and tell their story of the care and treatment they received from a community health service.

Requires improvement

Are services well-led?

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

Summary of findings

Our findings

Vision, values and strategy

The trust had a strategy for 2014-2019, which established its long-term vision and strategic goals, and the outcomes framework to measure its progress. A business plan for 2015-16 set out the trust wide priorities for 2015-16, from the service level improvement and development objectives.

The trust evidenced detailed engagement with staff around the vision and values of the trust. This had been a priority setting comprehensive plans to engage staff around trust vision and values and how to define the behaviours that would be expected when working to these values.

The trust had four values to underpin their work, which were:

- Kindness
- Fairness
- Ambition
- Spirit

The trust had identified three key strategic goals to help bring the values into their interactions with each other, with patients and the public, these were:

- Consistently delivering the highest possible quality of service we can achieve
- Realising the full potential of everyone we work with and the talent of all our staff
- Transforming our services to improve them for the people we serve

The strategy was embedded across the trust's four care groups. Staff acorss the trust knew and understood the trust visions and values and demonstrated showed these in their work.

Governors had been involved in the development of the trust vision and values and now felt more involved.

Good governance

A new divisional care group structure had been established in July 2014 to support services to develop their quality governance effectiveness. The care groups were:

- Children and families
- Community health
- Mental health
- Specialist services.

The following programmes supported the care groups:

- Participation plan
- People and OD plan
- Quality plan
- Estates and facilities strategy
- Child health strategy
- Market development plan
- Financial plan and recovery plans
- IM&T plans

The financial plan reflected the trust pressures arising from external factors, and local issues.

The trust board of directors were accountable for the running of the trust. They provided the overall strategic leadership. The senior leadership team provided executive oversight and decision making at an operational level. Non-executive directors made up part of the board and had noted a change in ways of working and felt that the culture of the trust had changed in a positive way since the current chief executive had joined the trust.

The trust had six committees, which reported directly to the board, which were:

- Executive management group
- Audit committee
- Quality and safety committee
- Finance investment and performance committee
- Strategy planning group
- Remuneration committee

Requires improvement

Are services well-led?

We attended and observed a board meeting prior to the inspection and reviewed minutes of the previous four trust board meetings. The minutes indicated that there had been financial pressures, staffing issues, engagement with stakeholders and better involvement of governors. A development day was held for the board in December 2014, with a greater focus on the importance of patient experience. Board meetings now heard patient and staff stories and we observed a patient telling their story of the positive experience of care and treatment they had received from a respiratory care team.

A council of governors provided a link between the local communities and the board of directors. A staff governor and lead governor also sat on the board. A formal process had been established for raising questions to the board and receiving a response in a timely manner. The council of governors felt that the progress the trust had made had been positive, with a shift to work in a more coordinated way. However, they felt that there was still work to be done on how the trust engaged with patients. There was an improvement in information for new governors including a new buddy system, improved induction programme and the support of a governor's assistant.

The trust identified finding a cross section of governors to reflect the demographics of the population as a challenge.

A special interest group of governors was in place for each of the clinical care groups, which was in addition to the formal governor's council committees.

Each care group had a management team, which was referred to as the triumvirate. Each triumvirate reported to the executive leads and down to the care groups.

The trust was in the second year of a new governance structure, which aligned clinical expertise into the care groups. Strong leadership teams consisted of clinicians, operational managers and quality governance leads. While the governance structure was in place, there was a lack of assurance about information to the board from the care groups about what was happening at an operational level. It was very difficult to see how assured the board were in relation to the information they were receiving.

We found that there was a disconnect between the policies and processes within services at a local level and the assurance provided to the board by the triumvirate of each care group. We also found that there was not a consistent application of the processes described within trust wide corporate services at an operational level in services. An example of this was the process for monitoring clinical audits and tracking action plans with a lead for audit in each care group. However, we saw that participation and learning from clinical audit was inconsistent across services.

The membership of the board had significantly changed and was still in a development stage. Governance structures were in their second year and at an early stage, with the infrastructure in place and resources committed. The senior management team were actively working to embed the management and governance structures across the organisation and this work was a different stages across services.

The trust had a clinical governance structure in place, which sat under the quality and safety committee. There were clear lines of communication from team clinical governance meetings, which fed into network clinical governance meetings, then into the trust wide clinical governance group, and into care group clinical governance meetings.

The trust was rated as 'Satisfactory' in the 2014/15 Information Governance Toolkit.

The trust had been developing the appraisals system to make the process values based. This revised appraisal system focused on personal goals, development objectives and to ensuring each member of a team understood their role. At the time of inspection, the trust reported its overall appraisal rate for non-medical staff as 47%.

The trust's own target for mandatory training for all staff was set at 80%. At the time of inspection, the trust reported its overall mandatory training rate as 63%. However, an element of the training did not require to be completed until 31st March 2016. This was below the trust target and the trust had action plans in place to increase compliance. Compliance rates within core services varied from 32% in community health services for children, young people and families to 75% in community health services for adults.

The participation of staff at an operational level in clinical audit, varied across services with one area reporting no participation and other areas providing evidence of active participation and learning from audit. There was limited evidence that changes had been made at an operational

level because of learning from clinical audit. We found that audit was nationally driven rather than being locally led as a tool to evaluate and improve the quality of care and treatment provided by the trust.

Recruitment of staff was a significant issue for the trust. The trust described the challenges, which it faced which included the rurality of the area as well as the location and type of services provided. The trust had an active recruitment campaign to try and recruit to key posts through both national and international advertising.

A number of trust policies and procedures exceeded their stated review dates and revised policies were not available. Regular review of policies and procedures is necessary to ensure that they reflect current good practice or changes in legislation. The trust had a process in place to review and update polices with timescales for completion.

The chief executive and director of quality and nursing were members of the childrens improvement board which provided assurance to ministers about the safeguarding children and children looked after improvement work in Cumbria. The director of quality and nursing was a member of the local safeguarding childrens board, the safeguarding adults executive board and chaired the multi-agency safeguarding adult operations group. However, there were a number of concerns in relation to the safeguarding policies and processes internally within the trust. The safeguarding policy was published in December 2014 and needed updating. Although the trust was making progress this was still in development A safeguarding committee had been established and sub groups had been agreed. The named safeguarding specialist for children was currently vacant. The safeguarding committee meetings from October 2015 showed that this post had recently been filled but had not yet started.

Staff did not receive specific safeguarding supervision. This had been incorporated into managerial supervision. However, we were told that not all managers had received additional safeguarding training to support safeguarding supervision. A policy for supervision and guidance was available and team managers were in the process of being trained in safeguarding supervision.

The trust had a number of electronic clinical record systems and some services were using paper-based care records. There were plans to move to a single electronic clinical record system but this project was taking a considerable amount of time to deliver with a delayed implementation plan to deliver the system across 2016. Staff told us that basic information technology (IT) issues such as access to equipment as well as the lack of a single clinical records system caused them some problems.

The trust information systems did not allow the easy reporting of accurate data and information on the performance of services. Reports requested from the trust contained conflicting or inaccurate information regarding the services provided.

Although relationships with the CCGs had improved, there was feeling on both sides that further work was needed to strengthen this. Relationships with the local authority had improved at a strategic level but the impact had not been seen at an operation level.

The trust felt that their were some issues in relation to external stakeholders expectations of the services which the trust delivered. These were related to specific services which were not provided as they had not been commissioned such as, forensic or perinatal services.

Engagement with external stakeholders was a challenge due to the rural geography of the area and some localities did this better than others. There were also links with the police through a police liaison post.

Other agencies working with the trust, felt that the culture of the trust had changed over recent years and the trust was now more open and transparent. The recognised that the trust had worked hard to develop closer working relationships with partners. The relationship with GPs was a trust wide priority in order to integrate working practices.

The board had identified the strategic risks, which might affect business and had developed a board assurance framework. The board of directors actively reviewed the board assurance framework (BAF) on a quarterly basis. Work activities of the board and board-level sub-committee were aligned to significant risks identified within the BAF.

There were eight risks highlighted in the April 2015 board assurance framework, of which four had been described as ‘severe’ risk ratings.

These were:

- being unable to use partnerships to deliver sustainable Cumbria health and social care system

Requires improvement

Are services well-led?

- unable to deliver leadership, workforce capability and capacity improvements to deliver modernised and transformed services;
- the trust not using their differentiating strengths or unique selling points to maximum advantage, nor to reach their full potential;
- The inability to balance financial sustainability with maintaining high quality, safe services.

The April 2015 board assurance framework reported that there was an implied assumption that board-level assurance on strategic risks were being effectively mitigated because risk control processes and procedures were in place. An internal audit of risk led to a review of the risk management strategy. Further plans had been developed to strengthen risk management and risk registers had been reviewed.

The trust risk register was in place as required by the trust risk policy and procedure. However, not all domains were completed on the risk register and some review dates had passed making it unclear whether these had been reviewed. Risks were assessed using a matrix and those scoring above 15 were reported to the governance quality and safety committee.

Leadership and culture

We held focus groups with staff representatives. Staff spoke passionately about the work they did and felt supported in their roles. Staff spoke about positive changes within the organisation. The care group staff felt more involved through 'Listening into action groups' and felt that recent changes had improved dialogue between staff and management. Staff told us that they enjoyed their jobs and morale was good.

The NHS Staff Survey 2014 showed that the trust performed worse than the national average and in the worst 20% of all mental health trusts for questions related to support from immediate managers and communication between senior management and staff.

The trust compared favourably to the national average and in the best 20% of all mental health trusts for five of the 29 questions. These five questions related to staff making a difference to patients; suffering from work related stress; experiencing physical violence from staff; feeling pressure to attend work when feeling unwell in the last 3 months and experiencing discrimination in the last12 months.

The trust scored below the national average for job satisfaction, but above the national average for staff motivation.

Staff friends and family test data showed 59% of respondents were either 'likely' or 'extremely likely' to recommend the trust as a place to work (England average 62%).

There was evidence of the reported change in the culture of the trust and that the the chief executive was supportive and had made positive improvements in the leadership of the trust.

The introduction of the new branding had made the trust more visible and had created a sense of the trusts vision.

Fit and Proper Person Requirement

The fit and proper person's requirement (FPPR) is one of the new regulations that applied to all NHS trusts, NHS foundation trusts, and special health authorities from 27 November 2014. Regulation 5 says that individuals, who have authority in organisations that deliver care, including providers' board directors or equivalents, are responsible for the overall quality and safety of that care. This regulation is about ensuring that those individuals are fit and proper to carry out this important role and providers must take proper steps to ensure that their directors (both executive and non-executive), or equivalent, are fit and proper for the role.

Directors, or equivalent, must be of good character, physically and mentally fit, have the necessary qualification, skills, and experience for the role, and be able to supply certain information (including a Disclosure and Barring Service check and a full employment history).

We reviewed the personnel records of four executive directors and three non-executive directors. All were found to be compliant with the requirements of the regulation. The FPPR guidelines were comprehensive and senior directors in the trust were in line with FPPR.

Ten staff files were reviewed which all had evidence that the required checks and trust processes had been followed and completed prior to staff taking up post. However, the recruitment and selection policy was out of date and referred to Criminal Records Bureau checks rather than Disclosure and Barring Service checks.

Requires improvement

Are services well-led?

Engaging with the public and with people who use services

There was evidence of the trust engaging with the public and those who used or may use services. Governor's held meetings in local areas to encourage public involvement and social media was used to share information with the public.

The patient experience team provided a confidential advice and information service. The team would listen to those that use the services, their carers and relatives. Their views were used to enable the trust to improve services. The service was available Monday – Friday 9.00 – 5.00pm and could be contacted by free phone, text, email or in writing; an answer machine was available during out of hours. However, governors felt that the trust could do more to engage with patients especially in relation to mental health.

The patient experience team had developed questionnaires regarding patient experience for the teams within the care groups. These were given to patients and their carers after each contact. Completed questionnaires were sent directly to the PET, which collated responses into monthly reports for each service. We found inconsistencies in the use of this questionnaire among the operational teams.

Although the PET told us that the reports were widely used we found little evidence to support this and limited examples of where service users and carers had been actively engaged in service improvements. The trust had a policy that a service user would sit on the panel for all band six and above posts and we found examples of this taking place. Service users, carers and third sector providers had been involved in the process of reviewing the 136 policy and procedures as part of the crisis concordat action plan group.

Quality improvement, innovation and sustainability

The trust had the following five quality priorities for 2015/16:

- Preventing people from dying prematurely because of suicide.
- Treating and caring for people in a safe environment and protecting them from avoidable harm.
- Building health resilience in children and young people
- Ensuring patients have appropriate and timely access to services based on need
- Ensuring people have a positive experience of care through better use of feedback and patient involvement and engagement

The trust quality strategy 2014-17 sets out the organisation's quality improvement priorities. The strategy sets out its commitment to working in partnership towards improving quality. Improving quality was a trust priority in 2013-14 and the strategy builds on work previously undertaken. Organisational development workshops and feedback from listening into action engagement events, helped to shape the strategy.

Care groups and support services had developed their improvement and development plans for 2015-16 and had identified top priority pieces of work.

The trust was working to become more efficient by eliminating waste within the organisation and had developed plans and systems to sustain improvements.

The trust had introduced a balanced scorecard to measure their strategy and action plans. The domains within the scorecard were aligned to the strategic aims, to improve outcomes for quality, services, people, and efficiency. For each aim, a set of outcomes had been identified. Key performance indicators had been agreed at both trust and care group levels in line with the outcomes and performance framework.

Clinical dashboards had been implemented across the care groups to share the performance measures with staff and the public. The system looked at quantitative rather than qualitative data. In addition, a suite of reports had been developed to share performance within the organisation and with stakeholders. The board received a corporate performance report, which contained a high level summary of the key performance indicators from across the trust. However, staff understanding of the dashboards and their relevance to their service was inconsistent across the trust. There was a requirement for greater accountability and performance management within the care groups.

The trust had employed quality leads for each care group. However, these were new posts and from discussion within a focus group with these staff, it was unclear if they understood the trust expectations of their roles including the responsibilities that they held in relation to quality. Two quality leads had been aligned to each care group.

Requires improvement

Are services well-led?

The trust participated in external peer review and accreditation schemes including:

- Accreditation for inpatient mental health services (AIMS). This is a standards based accreditation programme designed to improve the quality of care in inpatient mental health wards.
- Rowanwood unit was a member of the National Association of Psychiatric Intensive Care units and were benchmarking themselves against other psychiatric intensive care units.
- Specialist mental health services for children and young people were participating in the children and young people's improving access to psychological therapies programme.

Staff had opportunities to be involved in inprovements at work. The NHS Staff Survey 2014 showed that the trust performed in line with the national average for staff being able to contribute towards improvements at work; however, they scored in the worst 20% for the use of patient feedback to make informed decisions in directorates or departments.

There were some examples of good practice throughout the trust in relation to innovation and service improvements. There was a need to ensure that this was consistent across the trust and staff are supported to make improvements.

The trust had produced a mental health crisis care concordat action plan. The actions have been identified as key to improving the interagency response in relation to people in crisis because of their mental health condition:

A Cumbria triage model had been developed to provide a service available to all patients (of all ages and diagnosis), carers, and service providers, which is available 24/7 to provide access to mental health professional advice and support.

The south of the trust is in an NHS England Vanguard area, This programme named Better Care Together will develop a new model of care which will join up GP, hospital, community and mental health services. The trust is working with other NHS trusts, local authorities, clinical commissioning groups and an ambulance trust with the aim of achieving a system that will take responsibility for the whole health and social care needs of the population within a single budget.

The trust are also included in the Success Regime. This is a national initiative designed to support health and care systems in the country, which have been identified as "the most challenged". It has some similarities to the Better Care Together programme in its aim to have local health and care organisations working together with a common approach and ambitions. The Success Regime covers the areas of west, north and east Cumbria where organisations have had long term difficulties in recruitment and financial challenges.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Family planning services Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The trust must ensure that they have a plan in place to reduce restrictive practices and meet the Department of Health guidance, Positive and Proactive Care: reducing the need for restrictive interventions (April 2014). **This was a breach of regulation 12 (1) (2) (a) (c)**

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Family planning services Surgical procedures Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment The trust must ensure there are robust systems and frameworks for safeguarding procedures and supervision, with oversight and leadership provided by a senior nurse with child protection expertise. **This was a breach of regulation 13 (1) (2)**

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Family planning services Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The trust must ensure that all policies and procedures are regularly reviewed to include current good practice and changes in legislation. The trust must ensure that policies and procedures are amended or created in order to adhere to the revised Mental Health Act (MHA) Code of Practice, which was issued in April 2015. **This was a breach of Regulation 17 (1)**

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 Diagnostic and screening procedures Family planning services Surgical procedures Treatment of disease, disorder or injury	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment **The trust must ensure all staff have completed mandatory training, role specific training and had an annual appraisal.** The trust must ensure that staff are trained and are implementing the principles and requirement of the Mental Capacity Act (2005) including the Deprivation of Liberty Safeguards. **This is a breach of Regulation 18 (1) (2) (a)**

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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