Good

Cumbria Partnership NHS Foundation Trust

Community-based mental health services for older people

Quality Report

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Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RNNDJ	Voreda	Older Persons Community Mental Health Team, Dane Garth, Furness General Hospital, Barrow-In-Furness	LA14 4LF
RNNDJ	Voreda	Older Adults Community Mental Health Team, Carleton Clinic, Carlisle	CA1 3SX

Summary of findings

RNNDJ	Voreda	Older Adults Community Mental Health Team, Beacon Unit, Penrith Hospital, Penrith	CA11 8HX
RNNDJ	Voreda	Older Adults Community Mental Health Team, Westmoreland Hospital, Kendal	LA9 7RG

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

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

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

Summary of findings

Ratings

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

Overall rating for the service	Good
Are services safe?	Good
Are services effective?	Requires improvement
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Good

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

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

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

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

Summary of findings

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Summary of findings

Overall summary

We rated community mental health services for older people as good because:

- The service was fully staffed, with a sufficient skill mix to meet patients individual treatment needs. The trust set target times for referral to triage/assessment of 15 days and all four teams were meeting this target. Staff knew what they had to do to keep themselves and patients safe.
- Staff used evidence based tools and assessments to measure needs and risk. Outcome measures were used to assess the effectiveness of treatment and the services took part in audits to improve the quality of care. Staff had access to specialist training for their role and worked well with other services to meet all the needs of the patients.
- Staff treated patients and carers with dignity and respect. Appointments were rarely cancelled and patients reported that staff were very accessible. Patients were given time to ask questions and felt supported by staff. All of the patients and carers we spoke with felt positively about their care and treatment. Carers were offered support with identified carers leads based in each team.
- The CMHS had a commitment to quality improvement and innovation and was involved in research projects and innovative practices.

However:

- Patients' records were not always complete, accurate and up to date. They did not always reflect the involvement of the patient in planning their care and treatment.
- Staff had a variable understanding of the Mental Capacity Act in practice. Patients' records did not always evidence that a capacity assessment had been completed where required, or that consent to treatment had been sought.

Summary of findings

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

Are services safe?

Good

We rated safe as good because:

- All four community mental health services (CMHS) had on site facilities for patients to attend clinics. These areas were clean and well maintained.
- Teams had sufficient staff to meet patients' needs and caseloads were at a manageable level.
- Staff and patients reported good access to psychiatry.
- Patients were seen promptly and within agreed time limits as set by the trust.
- Staff undertook a risk assessment of patient's needs using an evidence based tool.
- Patients had a crisis contingency plan in place and staff knew how to respond to deterioration in a patient's physical or mental health.
- Staff had a good understanding of safeguarding processes and knew their responsibilities to protect patients from the possible risk of abuse and harm.
- Staff showed a good understanding of incident reporting.
- Staff followed the trusts' lone working policy and adhered to local protocols to keep themselves safe.

However:

- One piece of medical equipment was not tested for its accuracy, or recorded on a medical devices register.
- Fire safety information was missing in two of the offices we visited.
- Not all staff were up to date with required mandatory training.
- Risk assessments varied in quality and were not always reviewed in a timely manner.

Are services effective?

Requires improvement

We rated effective as requires improvement because:

- Patient records contained gaps and missing information and did not always have a current assessment of patients' needs.
- Care plans were not always personalised, holistic, or focussed on outcomes.
- Information in paper records did not always match electronic records.
- The CMHS was unclear whether a care programme approach (CPA) was being used for patients as detailed in trust policy.
- The appraisal rate for non-medical staff across the four teams was 48%, meaning over half had not received an appraisal.

Summary of findings

- Where capacity was in doubt, records did not always evidence how decisions had been made in the best interest of the patient.
- Staff did not document whether consent to treatment and/or interventions had been sought.

However:

- Staff used evidence based tools to measure patients' cognitive function and explained the results of these clearly to patients and carers.
- Outcome measures were used to assess the effectiveness of treatment.
- Staff had access to specialist training to further develop their skills.
- There was evidence of good inter-agency and multi-disciplinary team work.

Are services caring?

Good

We rated caring as good because:

- Interactions between staff and patients were positive. Staff were caring, kind and professional.
- Patients were given choices about their treatment and felt involved in their care.
- Patients felt supported and reported that staff listened to them and took them seriously.
- Staff offered support to carers and had identified carers leads within each team

However:

- Staff did not clearly record the involvement of patients in their care and the majority of patients and carers were not aware of their care plan.

Are services responsive to people's needs?

Good

We rated responsive as good because:

- The trust set target times for referral to triage/assessment of 15 days and all four teams were meeting this target. Patients were treated in a timely manner following assessment.
- The care home education and support service had been successful in reducing the number of admissions to inpatient wards, enabling patients to stay in their home.
- Patients told us that staff responded quickly when they contacted them and would normally return calls the same day where possible.

Summary of findings

- Patients were given a choice of whether a nurse or doctor informed them of their diagnosis
- Patients reported appointments were rarely cancelled.

However:

- Not all teams had sufficient interview rooms that were fit for purpose.

Are services well-led?

Good

We rated well-led as good because:

- Staff felt supported by managers at a team and service level and by their colleagues
- Morale was good, with generally low sickness and staff turnover levels.
- Staff participated in clinical audits and were able to inform practice and development.
- The CMHS had a commitment to quality improvement and innovation and was involved in research projects and innovative practices.

However:

- Lessons learnt from incidents were not always shared with staff.

Summary of findings

Information about the service

Cumbria Partnership Foundation Trust provide community mental health services (CMHS) for older people in six counties across Cumbria; Carlisle, Penrith, Barrow in Furness, Kendal, Allerdale and Copeland. Staff are employed from multiple healthcare disciplines, including mental health nurses, support staff, occupational therapists, psychologists and psychiatrists. The service accepts referrals for people of any age that have new or suspected dementia. This also includes the assessment, interventions and screening of people who have older age needs and a suspected functional mental health problem, to exclude the possibility of underlying dementia or to enable access to specialist age related interventions.

Following the publication of the Department of Health's National Dementia Strategy, Cumbria County Council in 2012 began to implement the Cumbria Dementia Strategy. In 2014 to support this implementation, the community mental health services for older people (CMHS) moved to a new way of working. This resulted in a 'one service' approach, rather than teams working differently in each county. The early memory pathway aimed to provide psychosocial intervention to patients with new or suspected dementia. This represented the highest number of referrals to the service. Staff conducted initial assessments and memory tests and referred patients for any necessary scans or tests. Staff informed patients of a diagnosis and offered any post diagnostic support. The complex needs pathway focused on patients with complex dementia. Patients often presented with behaviour that challenged others, co-morbid functional mental illness and multiple physical health needs. Staff would work closely with other services to provide therapeutic care and treatment, often involving medical interventions. The care home education and support service (CHESS) provided a rolling programme of mental health education and practical support to residential care homes. The aim was to improve the quality of life and well-being of patients and enable patients to remain in their chosen care home.

There had been no recent inspections of the community mental health services for older people in Cumbria.

Our inspection team

Chair: Paddy Cooney, Chief Executive (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 inspecting the specialist community mental health services for older people consisted of two inspectors, two registered mental health nurses, one Mental Health Act reviewer and one expert by experience that had cared for a relative with a mental health diagnosis.

Why we carried out this inspection

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

Summary of findings

How we carried out this inspection

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

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

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

During the inspection visit, the team:

- Visited four community teams and looked at the quality of the office environment.
- Spoke with 20 patients and 13 carers whose relatives or friends were using the service.
- Spoke with the managers of each team and the senior clinical service manager.
- Spoke with 37 other staff members; including doctors, nurses and occupational therapists.
- Attended and observed three multi-disciplinary meetings, four patient clinic appointments, one patient clinic in a care home and attended four visits with staff to see patients in their own home.
- Attended and observed a staff peer supervision session.
- Reviewed 24 treatment records of patients.
- Looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the provider's services say

We spoke with 20 patients and 13 carers, observed five clinics attended by patients and accompanied staff on four home visits. The feedback we received about the service was all positive. Patients and carers felt well supported and reported that staff were available when needed.

Good practice

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.

Summary of findings

Areas for improvement

Action the provider MUST take to improve

- The trust must ensure 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 CMHS.
- The trust must ensure all staff understand 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.

Action the provider SHOULD take to improve

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

Cumbria Partnership NHS Foundation Trust

Community-based mental health services for older people

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Older Persons Community Mental Health Team, Dane Garth, Furness General Hospital, Barrow-In-Furness	Voreda
Older Adults Community Mental Health Team, Carleton Clinic, Carlisle	Voreda
Older Adults Community Mental Health Team, Beacon Unit, Penrith Hospital, Penrith	Voreda
Older Adults Community Mental Health Team, Westmoreland Hospital, Kendal	Voreda

Mental Health Act responsibilities

We do not rate responsibilities under the Mental Health Act 1983. We use our findings as a determiner in reaching an overall judgement about the Provider.

In two of the teams we visited over 90% of staff were compliant with mandatory mental health legislation update training. The other two teams were not compliant, with 43% of staff in Penrith having attended and 35% in Carlisle.

At the time of inspections the teams had no patients being treated under a Community Treatment Order (CTO). A CTO is a legal order which sets out the terms under which a person must accept treatment whilst living in the community. We were able to review the records of a patient recently discharged from a CTO and the required paperwork was present. However it was unclear how the patient was informed of the discharge, or whether they had received a copy of their recovery plan.

Detailed findings

Advocacy information was available for patients in the teams we visited and staff were aware of how to support patients to access advocacy services.

Mental Capacity Act and Deprivation of Liberty Safeguards

In Furness, 76% of staff had undertaken training in the Mental Capacity Act (MCA). In Kendal this figure was 87% and in Carlisle and Penrith 100% of staff had received their training.

However, we concluded that not all staff had sufficient understanding of the MCA to put it into practice. Staff themselves reported a varied understanding of the MCA and acknowledged it was not documented well. Staff knew who to turn to for specialist advice on the MCA and who to contact to arrange a best interest assessment if they had doubts about a patients capacity. Staff felt they assessed capacity continually, yet there was little evidence of this in the notes. One staff member had a recent query about a patient's capacity and had made a judgement that the patient did have capacity, but acknowledged this was not documented anywhere in the patient's record. In one record, we found a recommendation from a doctor to arrange a best interest assessment. The case notes that followed on from this made no mention of capacity and three weeks later there had been no recorded attempt to arrange a best interest assessment.

Managers stated that the 'care pathways process record' in the front of each file acted as a checklist to ensure all necessary paperwork was completed. Staff had to sign to ensure they had informed consent to treatment and interventions. These documents were either missing, blank, or had gaps in information. Old paperwork did contain a 'consent to treatment and sharing of information' form, but staff informed us these were no longer in use. We reviewed the recording of consent in 16 care records, nine of which contained no evidence of informed consent to treatment and interventions. We did see evidence of verbal consent being obtained during staff appointments with patients and reflected upon during multi-disciplinary meetings (MDTs). In interviews with staff they made reference to the need to have patients' consent to treatment and interventions.

The Care Home Education and Support Service (CHESS) worked closely with staff in residential settings. They would conduct a monthly clinic at each care home, supporting the patient, family and staff. They would assist staff in initiating Deprivation of liberty safeguards assessments.

The trust did not audit compliance with the MCA.

Good

Are services safe?

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

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

Our findings

Safe and clean environment

All four community mental health services (CMHS) had on site facilities for patients to attend clinics. These areas were clean and well maintained.

The clinic rooms did not contain any medical equipment for carrying out physical examinations as physical healthcare checks were conducted by the patient's GP under a shared care protocol. In Penrith, the team had an electronic blood pressure monitor. The manufacturer recommended calibration every two years, which the staff were unaware of and confirmed had not happened. The manager was unaware of the requirement for it to be logged on a medical devices register.

The interview rooms at all four locations did not have alarms. Staff identified there were always other staff in the vicinity should they need assistance.

The offices were on hospital sites and the estates team were responsible for the buildings. Kitchen equipment had been PAT tested and the stickers were visible. Each team had a red file which contained information on fire safety. In two of the four teams there was some information missing from the file.

Safe staffing

Each patient had a risk assessment and risk management plan in place. These were completed at the start of the patient's involvement with the CMHS as part of the assessment process. The risk assessment tool used was older people's galatean risk screening tool (GRIST). This was an evidence-based tool that identified the individual risks associated with each patient, specific to older adults. The use of this tool is viewed as good practice. Staff updated patients' risk assessments when necessary and at a minimum every six months. In one patient's records there were concerns raised about potential domestic abuse and there were a number of partnership agencies involved. In this case the risk assessment had been reviewed five times in eight months, in response to each meeting or additional piece of information. Of the 24 care records we reviewed, four contained risk assessments that had not been reviewed in the last six months. One patient had been referred back into the service twice in an 18 month period due to increased risks to themselves and others. Their risk had not been re-assessed and therefore the GRIST did not reflect the current situation.

The risk assessments varied in quality and risk management strategies were not always evident for each identified risk. One patient had been assessed as at medium risk in terms of vulnerability, yet there was no management plan in place to reduce this risk. The risk assessment did not always correlate with other information in the patient record, such as the mental health clustering tool. An example of this was a patient whose clustering tool indicated a level 4 (high) for vulnerability, yet vulnerability was not recorded as a concern on the risk assessment. Clustering enables services to offer specific evidence based treatment interventions to patients and to assess the effectiveness of them.

All except one of the 24 care records we reviewed contained a crisis contingency plan. Staff knew how to respond if there was a sudden deterioration in the health of a patient. The crisis teams did not always support people with an organic illness such as dementia. To address this gap the teams would often give advance notice and additional information to the inpatient wards if they identified a patient may need assistance out of hours. Staff contacted emergency medical services for any physical health problems and the teams worked closely with the local General Practitioners via a shared care protocol.

Staff had a good understanding of safeguarding and their responsibilities in reporting concerns. All four teams had achieved above 80% compliance with basic safeguarding children training and three of the four teams had achieved the same with safeguarding adults training. During observation of one multidisciplinary team meeting a recent safeguarding concern was discussed and the actions taken were in line with the trusts policy and procedures.

Each community mental health team covered set areas. This included large geographical distances and some outlying communities. The trust lone working policy was out of date and should have been reviewed in April 2015. The CMHS had their own lone working protocols based on the trust policy, such as the use of a signing out board,

mobile phones and a phrase to use when calling the office to alert staff they were potentially at risk. Staff reported feeling safe at work and in each team they would work in pairs if they felt the patient posed a risk.

The CMHS did not store, transport or administer medication.

Assessing and managing risk to patients and staff

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The CMHS did not store, transport or administer medication.

Track record on safety

There were 43 recorded incidents between 1 July 2015 and 31 October 2015. Of these incidents, 19 were expected patient deaths, six were unexpected patient deaths, seven were safeguarding concerns and four identified lack of communication between services. The remaining seven raised concerns such as IT equipment not being fit for purpose, signage in the car park in Furness causing near miss accidents and a care provider being unable to access a patient's home.

There was evidence in the incident log of actions being taken to improve safety, but this was not always communicated to staff. For example, a staff member had concerns about inappropriate care being given to a patient in a nursing home. A safeguarding concern was raised about the patient, which was not shared with the rest of the team at the team meeting the following month. This is despite standing agenda items such as safeguarding alerts, risk and learning from incidents.

Good

Are services safe?

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

Reporting incidents and learning from when things go wrong

Staff felt confident in reporting incidents and raising concerns and the incident log indicates that this was happening across all four CMHS. What was not evident was how staff received feedback about these incidents.

The minutes of eleven team meetings that took place between July and October 2015 across the four teams were reviewed. They showed discussion of only one of the 43 incidents logged during that time in the team meeting. One set of minutes did reference the sharing of a trust wide learning lessons bulletin. One manager gave an example of a recent adverse event with a patient in a care home and identified the lessons learnt from this. When asked if these lessons were shared with staff they acknowledged this had not happened. They did identify that investigations are completed and fed back into senior management meetings.

Staff reported they had access to de-brief and were supported following incidents. Staff had a varied understanding of the meaning of duty of candour, however all staff knew of the importance of being open and transparent if things went wrong

Are services effective?

Requires improvement

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

Our findings

Assessment of needs and planning of care

Staff completed initial assessments of each patient's needs. A letter detailing the assessment would be sent to the patient's GP. The details included did vary between practitioners. The assessment would be reviewed and updated each time a patient was re-referred to the service following discharge. Twenty three of the twenty four care records contained an assessment. In one care record the assessment had not been updated in 18 months, despite the patient being discharged and re-referred twice during that time.

Staff undertook nationally recognised memory tests with patients, such as the mini mental state examination (MMSE) and the Addenbrooke's cognitive examination - revised (ACE-R). The MMSE is an 11-question measure that tests five areas of cognitive function: orientation, registration, attention and calculation, recall and language. The ACE-R is useful for detecting mild cognitive impairment and dementia and for differentiating the subtypes of dementia, such as Alzheimer' disease. These assessment tools were completed in all of the care records reviewed and repeated as required. It was not clear from the records how they informed the patient's treatment plan. In the letter to the GP following assessment, the test scores were provided with an explanation of their meaning. We also observed a home visit where a staff member informed the patient of their test results. The patient and carer were offered a clear explanation of their meaning and time was given for questions.

Twenty two of the 24 records that we reviewed contained a care plan and of those nine were personalised, holistic and recovery-oriented. Recovery-oriented means focusing on helping patients to be in control of their lives and build their resilience to avoid admission to hospital. The remaining 13 care plans contained generalised statements not individual to the patient, lacked specific review dates and were not focussed on outcomes. The operational protocol advocated the use of a person centred recovery care plan, however the actual document being used varied across the teams and care records. One document was much shorter in length and contained no section to identify the patient's strengths. The majority of patients and carers did not know about their care plan or have a copy of it. Most of the care plans in the care records were not signed by the patients. Staff in the early memory pathway used standardised care plans which were not person cantered. We saw one record where six monthly reviews had no evidence of review other than a date change.

The GRIST, health of the nation outcome scales tool (HONOS) and a crisis contingency plan were inputted onto an electronic system (IER). This allowed other teams to access this information out of hours. We compared two sets of paper records to the IER system to check they contained the same information and found that in both records the GRIST was in the paper file but not present on the electronic system. We also found that one patient's crisis contingency plan was not completed on the electronic system, or evident in the paper records. A further electronic system (IPM) was used to record any patient contact and again in the two records reviewed the contacts listed on the paper record did not match the electronic record. The trust is moving towards the implementation of an electronic care record system (RIO), which may address some of the discrepancies between the paper files and current electronic notes.

The Care Programme Approach (CPA) is a national approach which sets out how mental health services should help people with mental illness and complex needs. The CMHS worked under three pathways and the guidance for each pathway did not make reference to CPA. Managers and staff were clear in their views that CPA did not work for older people and that it was not in use within the teams we visited. However, we did find old CPA paperwork in some records and the dashboard system did flag patients who were overdue a CPA review. One manager stated this was old information that was not acted upon. There was confusion as some staff operated as lead professionals in a patient's care and others as care co-ordinators. When asked what would be the deciding factor, the response was whether the patient would meet the criteria for CPA. The paperwork had boxes to tick to identify whether the patient was on CPA and whether this was standard or enhanced, yet these were not used. The trust policy on CPA states that in relation to older adults, when a person's mental health and social care package is complex, predominantly mental health related, their care will normally be care co-ordination using CPA and a mental health lead care coordinator will be allocated.

All offices stored their patient data securely in lockable cabinets and the key was locked away at night. To ensure

Are services effective?

Requires improvement

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.

patient confidentiality, patient files were transported on trust premises using a trust approved red bag with security clips. A tracking number was documented and this was logged electronically. Staff were able to see where a file was located if it was not in their office.

Best practice in treatment and care

The CMHS followed the National Institute for Health and Care Excellence (NICE) guidance CG42, Dementia: Supporting people with dementia and their carers in health and social care. They followed an evidence based care pathway model and staff were allocated to a particular pathway with the exception of the occupational therapists, psychologists and psychiatrists who worked across the pathways.

We spoke with two psychologists during the inspection. NICE CG42 suggests that cognitive behavioural therapy may be considered as part of treatment for patients with dementia and comorbid emotional disorders. The psychologists identified the types of therapy offered to patients as; memory rehabilitation which involves supporting people with early onset dementia to learn new information and recover things they already knew; cognitive behavioural therapy which focusses on the connection between a person's thoughts, feelings and behaviours; and compassionate mind therapy which helps transform problematic patterns of cognition and emotion. Each team had access to psychological therapies for patients, although its use varied. In Barrow it was acknowledged they had limited access to psychological input, with one psychologist spending one day per week with the team. As a result the referrals into psychology seemed particularly low, which in turn reduced the amount of psychological therapy accessed by patients. In Penrith there was currently no psychology input due to absence, so patients were being added to a waiting list of a psychologist in another team.

The CMHS had a shared care protocol in place to ensure close working with GP's in the area. The psychiatrist would recommend medication to be prescribed and nursing staff would liaise with the patients GP for planned medication changes. All of the prescribing, administering and monitoring of medication was delivered by the GP.

If a patient diagnosed with dementia was prescribed anti-psychotic medication, a medication scrutiny tool was in use to ensure both the effectiveness of the medication and that reviews took place. We saw this tool in use in patients' records. The teams would check pulse rates of patients, but provided no other physical healthcare monitoring. The patient records contained evidence of regular communication with GPs and staff reported no delays in receiving the results of physical tests or medication monitoring. The psychiatrist would recommend an increase or decrease in memory medication and the nurse would request this through the GP. Some teams identified staff as a single point of contact for each GP surgery and in Barrow they had begun to deliver a clinic for patients at a GP surgery in an outlying community.

The services used the mental health clustering tool as a means of recording progress towards improved health and social functioning of patients. This allowed the teams to allocate patients to payment by results care clusters. The team monitored completion of the clustering tool via the electronic dashboard, which flagged when a patient was due to be reviewed. The Carlisle team had led on the use of a new outcome measurement for health-related quality of life for people with dementia (DEMQOL). This assessed health related quality of life for people living with dementia. Following its implementation in 2013 the service undertook an audit of its use. They found that staff were not completing the tool as often as required. They delivered further training on the measure highlighting the benefits to the patient and family of moving the focus away from the symptoms of dementia, to looking at the priorities of the patient and how staff can support them. DEMQOL was being rolled out across the other five community mental health services.

The occupational therapists undertook a clinical audit between 2013 and 2014, focussing on the use of the model of human occupation screening tool (MOHOST). They found that if they provided input for patients at home in the early stages of their illness, the outcomes were more beneficial for the patient. This resulted in additional funding to employ more OT's and staff were hoping to publish their findings.

There had been two clinical audits in early 2014 involving clinical staff; one entitled 'Compliance with guidance on physical examinations and blood investigations prior to starting antipsychotic' and the other 'Safe prescribing in Carlisle CMHT re-audit'. The first audit found that data was difficult to find in the notes and there did not appear to be an established format or protocol for recording data. The

Are services effective?

Requires improvement

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.

second audit noted an improvement in the recording of capacity to consent when prescribing medication. Both recommended a re-audit which were currently being undertaken by junior doctors.

Skilled staff to deliver care

Staff felt supported by their managers at both a team and service level. All staff reported to have received an appraisal in the last 12 months; however this did not match with data received from the trust. The appraisal rate for non-medical staff across the four teams was 48.37%. The clinical director provided supervision to all doctors every eight weeks and they met regularly for a continuing professional development peer group. The CHESS staff had a regular peer supervision session which we observed. There was a good group dynamic and staff wellbeing and workload was well supported by the manager. Safeguarding was discussed, along with risks to patients and staff.

All staff had a named managerial and clinical supervisor and supervision would be delivered every four to six weeks. The trust policy requires a minimum of 4 supervision sessions per year; Penrith was the only team from the four which did not meet this standard. Of six supervision files reviewed, four had a gap in supervision of one to two years. The other two had one recorded supervision each despite being in post for at least six months. A new manager was in place and had identified supervision as a concern and each staff member had supervision booked in over the coming weeks.

The move to a care pathways model had allowed staff to have more specific roles, for example occupational therapists (OT) had historically worked as care co-ordinators but were now able to provide a more therapeutic input to patients. MOHOST was used to gain a full assessment of patient's needs. The OT would liaise closely with adult social care to make recommendations about the care and equipment patients required. The aim was to restore occupational performance and enable patients to remain functioning in the community with assistance.

Staff had access to specialist training and a rolling 12 month training programme had been established following the implementation of the pathways. Staff attended for half a day every month, completing sessions such as 'differential diagnosis and predictors of an aggressive course in dementia' and 'nutritional status and needs' delivered by a dietician. Twelve staff in the last two years had completed advanced nurse practitioner training via the University of Lancaster. The teams also arranged internal training, for example, one of the psychologists had delivered formulation training on the assessment tools being used.

Multi-disciplinary and inter-agency team work

Services worked together to ensure that the care patients received met all their required needs. The team consisted of nursing staff, assistant practitioners, support workers, occupational therapists, psychologists and psychiatrists. They worked closely with colleagues in adult social care and GP's in their locality, along with staff on the inpatient wards.

Staff in Barrow had access to the acute hospitals electronic system allowing them to access results of screening tests and scans for their patients. They also had a hospital liaison post who worked closely with the local general hospital to ensure the transition of patients care. They would attend the weekly delayed discharge meetings and act as a point of contact for referrals from the hospital. A further post had just been appointed to, which would enable them to offer education to acute staff on caring for older people with mental health problems. There had been long standing difficulties in the working relationships with the mental health ward in Barrow. The CMHS manager and ward manager were working closely to resolve this. Staff from the community team now attended ward meetings and the plan was for staff from the ward to shadow visits in the community.

The Care Home Education and Support Service (CHESS) worked closely with staff in residential settings. We observed a CHESS clinic and a CHESS peer supervision session, both of which evidenced good inter-agency and multi-disciplinary team work.

Three multi-disciplinary meetings were observed during inspection. They involved all disciplines of staff engaging in thorough discussions of patients' treatment needs and identified next steps. The staff shared ideas for providing patients with additional support and were focussed on patient outcomes. In one meeting a patient was being transitioned from the early memory pathway to the complex pathway. The lead professional attended the complex care MDT, providing detailed information about the patient and it was agreed joint visits would take place to aid the transition.

Are services effective?

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Staff reported that they sometimes had guest speakers into team meetings to promote inter-agency work, a recent example of which was Age UK.

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

In two of the teams we visited over 90% of staff were complaint with mandatory mental health legislation update training. The other two teams were not compliant, with 43% of staff in Penrith having attended and 35% of staff in Carlisle.

At the time of inspection the teams had no patients on a Community Treatment Order (CTO). A CTO is a legal order which sets out the terms under which a person must accept treatment whilst living in the community. We were able to review the records of a patient recently discharged from a CTO and the required paperwork was present. However it was unclear how the patient was informed of the discharge, or whether they had received a copy of their recovery plan.

Advocacy information was available for patients in the teams we visited and staff were aware of how to support patients to access advocacy services.

Good practice in applying the Mental Capacity Act

In Furness, 76% of staff had undertaken training in the Mental Capacity Act (MCA). In Kendal this figure was 87% and in Carlisle and Penrith 100% of staff had received their training. However, we concluded that not all staff had sufficient understanding of the MCA to put it into practice.

Staff acknowledged use of the MCA was not documented well. Staff knew who to turn to for specialist advice on the MCA and who to contact to arrange a best interest assessment. Staff felt they assessed capacity continually, yet there was little evidence of this in the notes. One staff member had a recent query about a patient's capacity and had made a judgement that the patient did have capacity, but acknowledged this was not documented anywhere in the patients record. In one record we found a recommendation from a doctor that a patient receive a best interest assessment. The case notes that followed on from this made no mention of capacity and three weeks later there had been no recorded attempt to arrange a best interest assessment. We were shown a five question document titled 'assessing capacity', but this was not in use in the care records we reviewed.

Managers stated that the 'care pathways process record' in the front of each file acted as a checklist to ensure all necessary paperwork was completed. Staff had to sign to ensure they had informed consent to treatment and interventions. These documents were either missing, blank, or had gaps in information. Old paperwork did contain a 'consent to treatment and sharing of information' form, but staff informed us these were no longer in use. We reviewed the recording of consent in 16 care records, nine of which contained no evidence of informed consent to treatment and interventions. We did see evidence of verbal consent being obtained during staff appointments with patients and reflected upon during multi-disciplinary meetings (MDT's). In interviews with staff they made reference to the need to have patients consent to treatment and interventions.

The CHESS would conduct a monthly clinic at each care home, supporting the patient, family and staff. They would assist staff in initiating Deprivation of Liberty Safeguards assessments.

The trust did not audit compliance with the MCA.

Good

Are services caring?

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

Our findings

Kindness, dignity, respect and support

Interactions between staff and patients were positive. Staff were caring, kind and professional. They listened to patients, treated them with respect and offered plenty of time to answer questions. Patients were given choices about their treatment and felt involved in their care. Patients felt supported and reported that staff listened to them and took them seriously. One patient commented "I was very anxious before attending the first appointment as I didn't know what to expect, but she made me feel very relaxed and it was better than I thought".

In one doctors clinic a review was undertaken of the holistic needs of the patient, discussing their physical health, medication, sleep, diet, activities, mood and family support. The doctor ensured the patient was fully involved in discussions, summarising actions to be taken and consistently checking the patients understanding. Throughout all interactions it was clear that staff knew their patients and there was evidence of therapies being used and of discussions about patients care plans. This was reflected in positive feedback from patients, with comments such as "I'm understood as a person" and "I feel involved in my treatment".

To ensure patient confidentiality patient files were transported on trust premises using a trust approved red bag with security clips.

The involvement of people in the care that they receive

During our interviews with patients, the majority did not recall their care plan or have access to a copy. Patient's care records often did not evidence that patients had seen their care plan or received a copy of it. Patients verbally reported feeling involved in their care and treatment.

Staff undertook an assessment of patients' needs and ensured carers had an active part in discussions. We observed staff checking how carers were coping and one carer commented that staff were "very professional but very caring and understanding, they support us both". In Barrow, assistant practitioners would attend initial assessments with a nurse and would have an active role in supporting the carer. They would complete the carer strain index (CSI) while the patient underwent their memory test. They would then remain involved in the patient's care if required, supporting both the patient and carer. In Carlisle they had undertaken a project where they had identified a member of staff as a carer's lead. A carer's assessment had been developed and the carers lead would attend joint visits with the patients nurse. They would offer emotional support, information and education on the patients' diagnosis and signpost to other support services and groups in the area. They would also assist with practical issues such as attendance allowance and accessing respite care. In Carlisle the carers lead had made links with the local library and was using their space to meet with carers. This was now being rolled out across the other five CMHS and a carer's lead had recently been identified in each service.

The CMHS sought patient feedback via a questionnaire in an easy read format that was available in clinic rooms. The completed questionnaire was returned to the Patient Experience Team and collated at trust level.

Are services responsive to people's needs?

Good

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

Our findings

Access and discharge

The CMHS focused on assisting people to remain in the community and reducing admission into hospital where possible. Referrals to the service had doubled in the last five years. The trust set target times for referral to triage/ assessment of 15 days and all four teams were meeting this target. There were no delays in starting treatment following assessment, although no targets were set for this. The single point of access received and triaged all referrals. Where necessary, a patient would be seen as an emergency within four hours if they were acutely unwell or at risk. The community mental health services responded to urgent referrals within 24 hours. The teams operated a duty system and the allocated staff member on duty that day would respond to the emergency and urgent referrals. This would only be within the team's normal operating hours.

Out of hours, patients could be seen by the crisis team. However this was not consistent. As per Trust policy the crisis teams did not generally respond to patients with a diagnosis of an organic mental illness, such as dementia. Staff would use a flagging system with the inpatient wards if they felt a patient may need support out of hours. They would give the ward information about the patient and where possible provide the carer with a named contact on the ward. The CHESS staff worked flexibly, for example attending a residential home in the evening if the patient was regularly becoming unwell at certain times during the evening. This would be to observe behaviour and assist staff in understanding the best way to support the patient.

Patients were provided with a service based on their needs rather than their age; this meant that patients did not move from other community teams once they reached a certain age. The CHESS provided support to residential care homes to ensure that a patient's placement did not break down. They would take referrals for patients whose behaviour was deteriorating and impacting on the ability of staff to care for them. A holistic assessment would take place; this included blood tests to check for underlying physical health issues and a review of medication. They would then support the staff in identifying the best ways to meet the needs of the patient and once stabilised the patient was discharged and a letter sent to the GP. Based on admission data in the 12 months following the start of CHESS, this had reduced the number of patients having to be admitted to inpatient units from care homes.

Patients informed us that staff responded quickly when they contacted them and would normally return calls the same day where possible. The CMHS had undertaken a study, where patients could choose whether they received their diagnosis from the nurse or a doctor. A large number of patients were choosing to receive this from their nurse, given that they had already built a relationship with them. Nursing staff felt this helped their understanding through discussing patient diagnosis with the doctor. This reduced the waiting time for patients to receive a diagnosis and provided doctors with more available clinic time to see patients.

Patients reported appointments were rarely cancelled and they would be informed if the nurse was running late. A large number took place in the patient's home. If a patient did not attend an appointment, the CMHS would offer three further appointments. If these were also not attended, the team would contact the referrer to identify any potential risks to the patient. If risks were identified, they would continue trying to engage with the patient.

The facilities promote recovery, comfort, dignity and confidentiality

All four CMHS had access to interview rooms on site. In Kendal, staff reported difficulties accessing interview rooms and felt there were not sufficient rooms to see patients. In Barrow, the building where patients were seen was a shared resource and staff reported the reception was often unmanned which could be confusing for patients. The rooms were not soundproof which meant conversations could be overheard, making it difficult to protect patient confidentiality. Car parking was an issue, with a lack of spaces and staff waiting up to five years for a parking permit. This often led to staff spending additional time in their day searching for spaces.

At each team there was a wide range of information available for people to take away. This included a memory matters pack which was given to each patient and was tailored depending on their pathway and diagnosis. It contained information on what the diagnosis meant, drug treatment options, how to stay involved, active and

Are services responsive to people's needs?

Good

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

healthy, useful contacts and an Alzheimer's society memory handbook. Packs were available for those diagnosed with mixed type dementia, vascular dementia, mild cognitive decline and Alzheimer's.

In Penrith, one of the interview rooms had a number of memory boxes on the wall. These had been developed by staff within the team based on some of their own personal interests. They contained nostalgic items and followed themes such as sewing, music, pets, correspondence and mechanics. There was on old camera on the bookshelf and a pair of old hair clippers. They were used as discussion items with patients and assisted in making people feel at ease.

Meeting the needs of all people who use the service

All of the facilities we visited were accessible by people with a disability. Where the offices were on the first floor, a lift was available for patient use. Staff who worked with patients with limited ability to communicate would look for non-verbal cues and would speak to the patient's family. They would speak with others involved in the patients care, such as residential care home staff, to understand how best to communicate with each individual patient.

Although we did not see information leaflets and posters in other languages, large print, or braille, staff knew how to access these if required. They were also able to access interpreters and had used this service for a patient recently. They had initially had some difficulty arranging an interpreter in a particular language; this was quickly resolved following advice from the patient experience team.

Listening to and learning from concerns and complaints

The CMHS had received six formal complaints in the last 12 months, with one complaint upheld. None of these were referred to the ombudsman. All of the patients and carers we spoke with said they would feel confident to make a complaint should they need to. Managers dealt with informal complaints and staff would signpost any person wanting to make a formal complaint to the patient experience team.

The trust encouraged patients and carers to give feedback about the service they received in the following ways:

- Using an online survey.
- leaving a review via the 'iWantGreatCare' website
- completing the friends and family test
- general feedback from thank you cards and letters.

Staff had thank you cards displayed around the offices containing positive feedback from patients, however this was not reflected upon during team meetings.

Are services well-led?

Good

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

Our findings

Vision and values

Staff knew the senior clinical service manager and felt he was very accessible to the teams. All of the staff spoke very highly of this manager and of the focus that had been placed on community mental health services for older people in the last two years. In Barrow funding had been sought and an additional 6 staff were recruited in the last year. Staff were not aware of managers at a more senior level than this, although they did report that the chief executive had made contact with staff and was approachable.

It was clear that staff were working in line with the vision and values of the trust, although not all staff could remember what they were.

Good governance

Accessibility to mandatory training and e-learning was variable. Staff had at times travelled for two hours to attend a two hour training session. When registering for online training the process to get access could take up to three days for each session. By the time staff had access they no longer had time allocated in their diary to complete the training.

Staff felt the skill mix was sufficient to ensure good quality care and treatment. There was flexibility across the teams allowing staff to cover essential visits and clinics in the event of unexpected illness or holiday leave. Each team manager felt they had sufficient authority and administrative support.

Staff had a good understanding of the types of incidents and events that had to be reported. The team meeting structure allowed for regular discussion of governance issues, safeguarding, safety, risk and compliance. It was not clearly documented where lessons learnt had been shared with staff following an incident. Staff had a good understanding of safeguarding procedures. There was not always evidence of the application of the Mental Capacity Act in practice.

Key performance indicators were monitored via an electronic dashboard; however its use varied across staff and managers. The senior clinical service manager used it daily for monitoring key performance indicators. Other managers said it was meaningless and contained information that was not relevant, such as out of date care programme approach (CPA) reviews when patients were not under CPA.

Two meetings were held each month which involved managers from the wards and community services across the county; a clinical governance group and an operational management forum. The clinical governance group focussed on items such as service highlights, patient safety alerts, lessons learnt, medicines management and infection prevention. It was chaired by the clinical director and contained an action log that was reviewed each meeting. The operational management forum looked at factors such as performance monitoring, budgets, training, appraisals and the delivery of the clinical model. These meetings ensured that managers across the county took ownership of the whole service delivery and information was shared across teams and localities in team meetings.

Staff had the ability to submit items to the trust risk register. There were some standard risks active that applied to all teams, such as lone working and risk of staff absence.

Leadership, morale and staff engagement

Staff morale was high across all four teams. Staff felt supported by their managers, at both a team and service level and felt they operated an open door policy.

Until February 2015 Kendal had been without a manager in post for two years. This had impacted on staff morale. In response to this they arranged a team away day. Part one focussed on staff well-being and incorporated human factors training and part two on developing the pathways and the local team vision. Staff felt team morale had greatly improved following the appointment of the new manager. In Penrith there had been a new manager in place for almost two weeks at the time of inspection. Previously morale had been low and sickness levels higher than the rest of the teams. The new manager had a clear action plan focussing on staff wellbeing, training, improved internal systems and care records. Staff welcomed the change and could already see improvements.

Staff viewed the move to a care pathways model as positive, allowing them to specialise in certain areas and making caseloads more manageable and focussed. Managers actively sought feedback from staff on what could be improved and where possible action was taken.

Are services well-led?

Good

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

Staff knew how to raise concerns and felt able to do so if necessary. Staff were aware of the need to be open and transparent with patients if and when something went wrong, although not all recognised this as being their duty of candour.

Commitment to quality improvement and innovation

Staff in the community mental health team 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) comprises of a rolling programme of mental health education for care home staff, combined with a practical outreach service. The education programme consists of three modules covering dementia, depression and psychosis. The service provides 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 has had been recognised both locally and nationally with the service winning seven awards over the past six years.

A series of projects had been undertaken by the CMHS, such as the diagnostic study and the carers lead and further priority audits were planned for 2016. One will be a scoping exercise to ensure the services are compliant with NICE guidance and the other will review the implementation of the care pathways and how this is reflected in patient care plans. The Carlisle team had undertaken a study two years ago to explore how well the services informed patients of their rights and risks with regards to driving a vehicle and this was to be repeated in 2016.

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
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider did not maintain accurate, complete and detailed records in respect of each person using their service. This was a breach of Regulation 17(2)(c)

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent Patient's capacity and ability to consent to be involved in the planning, management and review of their care and treatment was not routinely documented. This was a breach of Regulation 11(1)