Centre for
Mental Health

**Centre for Mental Health**

**Review of Cumbria Partnership NHS Foundation Trust**

**Adult Mental Health Services**

**FINAL DRAFT v.5 (15 July 2014)**

Cumbria Partnership NHS
NHS Foundation Trust

NHS
Cumbria Clinical Commissioning Group

Cumbria
County Council

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# 1. Executive Summary

The review of adult mental health services was undertaken by Centre for Mental Health between March and June 2014.

Interviews were held with individuals and groups in each CMHT, inpatient unit and Crisis Team. Interviews were also held with staff from First Step, some Trust Directors, carers, people using inpatient services, external staff from NHS Cumbria CCG and a GP.

Most people interviewed expressed dissatisfaction with some of the community services delivered by the Trust; even people working in the services felt that they were not able to provide the service they aspired to. The Community Mental Health Teams (CMHTs) and crisis teams are under pressure due to high numbers of referrals and shortages of permanent staff.

In summary Centre for Mental Health highlights four broad areas of concern which need attention:

1. Workloads and waiting lists
2. Recruitment
3. Communication and patient records
4. Numbers of suicides and attitude to risk

**Workloads and waiting lists**
The Trust is failing to make inroads into the growing numbers of people waiting for a service. This needs urgent attention to implement short-term management plans and medium term solutions.

The review team found that crisis teams were supporting a high percentage of people with social care, housing and/or non-urgent causes of mental health problems but were experiencing delays from other parts of the system in providing the necessary support to discharge people from crisis caseloads.

**Recruitment**
Recruitment has been difficult for some time; the Trust and Local Authority experienced challenges finding permanent staff for many areas of the county apart from Carlisle, for Approved Mental Health Practitioner (AMHP) posts and consultant psychiatrists. The use of high proportions of agency and locum staff is costly, leads to discontinuity of care and constrains the implementation of strategic plans for recovery approaches in service provision.

### Internal communication

Video conferencing is a necessity in Cumbria due to the distances and travelling time between each of the districts, and locations of the team bases. The Trust recognises that travelling a distance for staff meetings is inefficient use of time to and it has already agreed targets to increase virtual meetings and reduce mileage expenses.

The unique skills of the adult social care staff and communication of the contribution they can make to personalisation and a recovery approach needs to be focussed and strengthened.

The Trust is working to a project plan for the launch of an electronic patient record. This is urgently needed and, once embedded, will save time, support informed risk management and provide staff with information to make the right decisions about care.

### Numbers of suicides and attitudes to risk

Numbers of suicides for people in touch with secondary mental health services have remained high in Cumbria compared with the rest of England over the last few years. The Trust and partner agencies have commissioned reviews and refreshed the multi-agency strategy, but the high numbers are unacceptable and the review team are concerned that the three areas above: waiting lists, recruitment and record keeping contribute to the risks of suicide.

A measured and balanced approach to risk management is offered by the work which the Trust is considering with the support of the Implementing Recovery Through Organisational Change (ImROC) Team.

Further detail on the background to the following recommendations is found in the full report.

## Recommendations

1. Temporarily increase staff resources to support CMHTs with long waiting lists to begin offering a service to those people within a short target time.
2. The creativity of the local CMHT managers should be nurtured and encouraged so that they trial and implement solutions to their waiting list problems, the best of which might eventually be replicated across the Trust.
3. Adult social care should drive the move towards pooled budgets as a vehicle to improve housing support, employment services and to facilitate peer-led support.
4. The crisis team should review their caseload and ensure that social care, housing and/or the CMHT are fully aware of the needs of the people they wish to

transfer, in order to facilitate planning for a seamless and timely transition from crisis support.

5. The very limited alternative to inpatient services and/or crisis house provision should be addressed by all three organisations commissioning this review.
6. The Trust should continue working through the ImROC model of the Team Recovery Implementation Plan to work with users and carers to devise and implement the models of service which people would like to use.
7. Devise new ways of attracting permanent staff to vacant posts and reduce the use of agency staff by 50% in six months.
8. Develop a structure which provides more peer support opportunities to address the professional and social isolation which consultants feel working in Whitehaven and Kendal.
9. Encourage the use of video-conferencing by measuring progress towards the target for reduction in mileage expenses.
10. Proceed as quickly as possible with the implementation of the electronic patient record.
11. Ensure that staff are supported to understand expectations and rationale for discharge and implement a team approach to timely discharge across all CMHTs.
12. Work with ImROC to review the culture and practice of risk assessment and management and ensure a recovery oriented approach.
13. The CCG should continue exploring options for future provision of adult ADHD services.
14. Review plans for the configuration of liaison psychiatry in the light of the national evidence describing services and outcomes.
15. The Trust should consult with service users and stakeholders with a view to becoming completely smoke-free across all its properties and estates.
16. The Local Authority and CCG commissioners should consider strategies to encourage third sector services to complement services provided by the Trust and to incentivise partnerships between organisations which can provide services more flexibly and cost-effectively.
17. The Local Authority should lead on the development of targeted social inclusion opportunities including housing support, education opportunities, consideration of a recovery education programme and Individual Placement and Support for employment.
18. The Trust should continue to train and monitor for staff competency in suicide prevention, and work with partner organisations to achieve the aims of the suicide strategy.

## Priorities for in-depth consultancy/research

I. **Recovery**
Work with ImROC on a suite of recovery focussed co-produced services; undertake a project to create peer support worker posts, and establish a measurable recovery approach in all teams and care plans.

II. **Liaison psychiatry**
Resource and support the liaison psychiatry service to focus on outcomes and provide a service in line with nationally recognised best practice.

III. **Social Care**
Propose and resource a model of social care which works effectively within all Trust community teams, clearly leads on personalisation and aspects of social care, social inclusion and Individual Placement and Support, champions the role of AMHPs and creates savings across the system by providing a more rapid response to solving housing and employment issues.

## 2. Commissioning of the review

Centre for Mental Health was approached by Cumbria Partnership NHS Foundation Trust 'the Trust' and Cumbria Clinical Commissioning Group 'the CCG' in November 2013 with a request for a review of the adult mental health services provided by the Trust.

The terms of reference were agreed and the review commenced in March 2014 with the intention of understanding and reporting on the quality of services through observation of systems, talking with staff, service users and carers to gain an understanding of the 'clinical culture' of the Trust.

Centre for Mental Health agreed to report back to the Trust, the CCG and Cumbria Council Adult Social Care 'the Local Authority' at regular intervals with written updates of activity and interim findings. Telephone conferences to discuss these updates were held approximately fortnightly.

## 3. Centre for Mental Health and the review team

Centre for Mental Health is an independent mental health charity aiming to improve the life chances of adults and children affected by mental health problems. The Centre promotes person-centred approaches to supporting good mental health, especially personal recovery action planning and service design which supports this.

The Centre is also widely recognised for its leading work to identify and promote evidence-based mental health services and interventions which are demonstrated to work effectively and provide value for money.

The Centre provided a team of four reviewers:

**Dr Jed Boardman** – Consultant Psychiatrist in recovery, South London and Maudsley, Senior Advisor to Centre for Mental Health, Lead for Social Inclusion at the Royal College of Psychiatrists and member of the ImROC project team since its inception

**Lawrence Moulin** – recently West Midlands Strategic Health Authority lead for Mental Health and Learning Disabilities, and a clinical psychologist by profession

**Dr Graham Durcan** – Associate Director at Centre for Mental Health, an experienced researcher and expert in practice development, author of a number of Centre for Mental Health publications, Senior Fellow, Institute of Mental Health, Nottingham and previously a mental health nurse

**Jan Hutchinson** – Director of Programmes at Centre for Mental Health, a qualified social worker with special expertise in social inclusion, equality and diversity.

The team shared the time visiting and observing aspects of the Trust's adult mental health services according to their specialisms.

## 4. Review method

The review team from Centre for Mental Health visited wards, community mental health team bases, crisis teams and First Step services to observe the work of frontline staff and to interview practitioners, medical staff, support staff and managers in order to understand the practices, challenges and cultures of the services being delivered.

The Trust and CCG believed that the key issues to review closely would be caseload management and transitions between services.

A number of previous review documents, survey results, inspections, feedback reports and strategies were made available by the Trust and the CCG to provide a context for the review. These documents were helpful to the review team in understanding

a) the context in which services are being delivered and
b) broader views of the Trust's clinical culture

The review endeavours to understand the culture as it is, to identify the strengths and difficulties inherent in the culture and to recommend priorities for change.

## 5. Level of Mental Health need in Cumbria.

There are a number of good summaries of public health reviews focussing on mental health morbidity and mortality in Cumbria, however any benchmarking should be considered within the service context. There is a mixed picture of mental health need in Cumbria. Compared with England the level of admissions for alcohol abuse is high, there are higher levels of long term illness and depression, but lower levels of mental health hospital admission despite higher rates of self-harm. Cumbria was in the highest quartile for the amount of antidepressant drugs prescribed by PCTs in England in quarter 3 of 2012/13.

### i. Resource allocated to mental health services in Cumbria

The 2012 finance mapping (the last data on resource allocation available) identified Cumbria PCT as being in the top quartile for England for investment in mental health services.

### ii. Resource for functional teams against NSF criteria

The National Service Framework identified staffing levels for the delivery of each of the specific NSF functions. While these are now somewhat outdated they give some resource comparisons.

Crisis Resolution/ Home Treatment

| Staff resource in place in Cumbria | Staff resource proposed in the NSF |
|---|---|
| 57wte | 49wte |

Assertive Outreach teams

| Staff resource in place in Cumbria | Staff resource proposed in the NSF |
|---|---|
| 12 wte | 19 wte |

Early Intervention

| Staff resource in place in Cumbria | Staff resource proposed in the NSF |
|---|---|
| 17 wte | 16 wte |

Overall the resource levels broadly match the NSF definitions, although some services are no longer delivered by stand alone functional teams.
(Source NSF documentation – Trust staff data)

### iii. Benchmark comparison

The NHS Benchmarking Network document *Benchmarking community based services, November 2012* is publicly available. Using data provided by the trust it has been possible to map Cumbria resources against the benchmark document.

Inpatient beds

| Number of acute inpatient beds in | Benchmarking average per |
|---|---|

| Cumbria per 10,000 population | 10,000 population |
|---|---|
| 1.58 | 1.79 |

CMHT caseload

| Cumbria caseload for Generic CMHTs per 10,000 population | Benchmark caseload for Generic CMHTs per 10,000 population |
|---|---|
| 86 | 75 |

Assertive outreach caseload

| Cumbria caseload for Assertive Outreach per 10,000 population | Benchmark caseload for Assertive Outreach per 10,000 population |
|---|---|
| 3.7 | 4 |

Crisis Resolution caseload

| Cumbria caseload for Crisis Resolution per 10,000 population | Benchmark caseload for Crisis Resolution per 10,000 population |
|---|---|
| 5.7 | 5 |

Early intervention caseload

| Cumbria caseload for Early Intervention per 10,000 population | Benchmark caseload for Early intervention per 10,000 population |
|---|---|
| 5.3 | 5 |

The pattern of lower bed use and higher caseloads in the community would match the context described in the first section, lower admission rates but higher levels of distress in the community indicated by antidepressant use, self harm and suicide. This leads to slightly higher levels of community services but with larger caseloads.

The figures do not deviate to a significant degree from the averages. The reviewers believe that in theory Cumbria has the resources necessary to provide a personalised and effective service, but we found that staff in most CMHTs and the Crisis Services are holding high caseloads and/or there are long waiting lists. These need to be reduced to a manageable level by addressing the inefficiencies which lie in the organisation and operation of services.

# 6. General findings from each group of interviews

## a) First Step (IAPT)

The reviewers found that First Step was well organised, and provided a service which responded quickly to need and was valued and appreciated by service users. Response to referrals was rapid, with people being clearly advised of the status of their referral and the plan for allocating them to a practitioner to receive treatment.

The First Step therapists demonstrated a highly skilled approach to people in distress relating to a range of situations and conditions, they were observed guiding people through the use of structured Cognitive Behavioural Therapy based interventions, demonstrating a thorough appreciation of the person's needs and an ability to adapt a therapeutic approach to each individual.

The views gleaned from information given by General Practitioners are that First Step has supported them effectively with short-term interventions for people with less complex problems. The reviewers are aware however that in the last three quarters the partial recovery targets have been missed resulting in the loss of the related CQIN payments. The First Step practitioners are also beginning to feel the pressures of referral numbers now experienced by other parts of the system, and there is growing concern over increasing risks of people harming themselves while having to wait for treatment.

In isolated cases it may be that some First Step clinicians are applying their acceptance criteria too rigidly. Although it is clearly not appropriate for the service to provide an intervention for people in crisis, and at immediate and genuine risk of serious self-harm, the reviewers were told by the crisis teams in two areas that anyone who expressed an intention to attempt suicide would be refused a service from First Step. The crisis team's view was that people whose current situation was causing them unbearable misery would find the First Step approach to rediscovering hope immensely beneficial. For instance, even the knowledge that they would be referred for intensive therapy could be enough for them to defer acting on suicidal thoughts, although those thoughts might still be present and would be articulated if they were questioned.

However the review team found evidence to suggest that the comments about First Step refusing to work with people who are at any risk of suicide, made by some staff of CMHTs and Crisis Teams, is not a widespread issue. A supervision session was witnessed where the client being discussed had attempted suicide on three occasions but was being seen by First Step.

The success of IAPT implementation was put down to:

- Strong and clear leadership
- Investment
- Clarity about the job, breadth of remit and what staff are meant to do
- The national impetus
- Formal clinical supervision
- Case management supervision
- Skills development
- Internal training 5 days per year for High Intensity, around the same for Psychological Wellbeing Practitioners
- Tight evaluation framework

Both First Step and the local GPs have a good shared understanding of how the service can help with certain types of problems, and the service has been very successful. In some ways First Step practitioners feel they have been victims of their own success because when other services have not coped with the volume of people needing help they have tried to use First Step as an extension of the CMHT, as a way of temporarily diverting people who would otherwise have to join the waiting list.

## b) CMHTs

Cumbria Community Mental Health Teams are probably the least effective part of its adult mental health services. The review highlighted a number of reasons for this, many of which can only be addressed by a wider review of the 'system' of mental health service provision. Some offices in which the CMHTs are housed do not facilitate supportive team working, Carlisle, for instance, is divided into a number of medium and small sized rooms with solid doors, spread over several floors, which does not make it easy for staff to discuss work with different colleagues or gain an understanding of the work of others through close contact with most of the team at least on a weekly basis – something which happens naturally in open plan team rooms such as Brookside.

Firstly it is important to state that the review identified some examples of strong and supportive leadership of the CMHTs which are contributing to a programme of service improvement. There are examples of CMHT managers who effectively support their team as individuals, and foster a culture of shared risk management by ensuring that there is a team approach to supporting service users facing complex situations. The case is held by an individual care co-ordinator, but the person's needs are discussed in team meetings so that a wider pool of knowledge and resource can be drawn upon and decisions relating to the management of risk are agreed by the group. This is helpful to less experienced members of the team and validates the skills and achievements of individual care co-ordinators.

Staff in two of the teams were feeling very overwhelmed by the work load and the reviewers felt that those teams were not functioning at all well. Staff told the reviewers that care co-ordinators had no capacity to accept new people onto caseloads, but a number of the existing service users were receiving very minimal support. This was often referred to as 'monitoring' or less positively as 'tea and sympathy'. Staff described an ongoing tension between managers and care co-ordinators in the team caused by managers reviewing caseloads and asking care co-ordinators to discharge people no longer in need of a specific intervention without enough support and training for caseload management and the process of discharge. On the other hand a manager claimed that care co-ordinators could be reluctant to discharge people who no longer required active intervention because they didn't want to be asked to take new people whose problems would require greater effort to address.

An example of good practice was described in Allerdale: monthly clinical supervision looking at caseloads and those difficult to move on, and a discharge group held every fortnight to identify people who should be helped to move on from services immediately. The Trust has a plan to implement a similar fortnightly discharge meeting in all CMHTs.

Some of the CMHT managers have considerable experience, gained from working in mental health services for many years, and in posts above their current grade. They described their feeling that some of their plans and ideas were not valued by their line-managers, and that they felt more senior managers were not using their experience sufficiently to benefit the work of the community mental health service. There were examples of ideas to reduce waiting lists being blocked and of the CMHT managers being told to implement new processes developed without their input which they felt would cause disruption to local service operation because they were evidently less useful than the local processes which the managers themselves had implemented. The feeling that line-managers are not open to ideas is borne out by a fairly low rate of 34.87% staff agreeing that the organisational culture encourages staff to contribute to changes that affect their team or service and 35.01% agreeing that managers and leaders seek staff views about how we can improve our service (Pulse Survey 2014).

There are advantages and disadvantages of the CMHTs having spit into psychosis and non-psychosis pathways. The vision that staff will benefit from increased skills and knowledge base, being able to offer specific therapeutic activities and gaining greater satisfaction from their work is being realised, although some staff said their training has as yet been less than adequate and that they do not feel they have sufficient time available to use therapeutic skills. A piece of work on 'job plans' which divides a practitioner's week into personal development, indirect clinical work and direct clinical interventions gave an example of less than half of

the available weekly hours being spent on direct clinical work (42.25%). If this could be improved to 53% of the week it would be a 25% improvement on the current situation, which would give staff enough time to work more quickly on effective discharge plans hopefully co-produced with service users.

Another consequence of splitting the team into two smaller teams was described in two of the teams which were trying to cope with a mismatch in the number of practitioners available and the number of people presenting with mental health difficulties of one type or the other. The challenge of dealing with long waiting lists and competing priorities is complicated by decisions about whether to work with someone needing one pathway, who is at the top of the 'risk list' when there is greater staff capacity to take instead someone from the other pathway whose needs are less urgent.

The reviewers noted that some CMHT staff were feeling overwhelmed by their workload, and some managers indicated that they felt high levels of stress caused by the large waiting lists, which had become unmanageable.

An example of the increase in referral rates was supplied by Allerdale Community Services, which although still less busy than Carlisle, has seen referral numbers grow by more than three quarters compared with the same month last year e.g.

| | January 2013 | January 2014 | Increase |
|---|---|---|---|
| Total Referrals | 34 | 60 | 76% |
| Seen by CMHT | 25 | 45 | 80% |
| Not accepted or referred to First Step | 9 | 15 | 67% |

The reviewers were particularly concerned about the model in one CMHT of having all the unallocated cases 'allocated' to the team leader which was felt to undermine any sense of organisational responsibility for the wellbeing of those people and potentially very discomforting in terms of perceived personal accountability for them. The Trust has made a commitment to identify and track all waiting times for every clinical service in order to work with commissioners to reduce waiting times. It is possible that the 'official' waiting times, according to this tracking is not wholly descriptive of the experience within the CMHTs because the reviewers found that people who, as far as they are concerned, are on the waiting list could have been allocated nominally to Team Managers, or have received a quick telephone call instead of a face-to-face assessment and in one case a service user was allocated to a worker who was about to leave and would have no opportunity to begin a useful piece of work before the case had to be handed over to someone else.

**Recommendation 1: Temporarily increase staff resources to support CMHTs with long waiting lists to begin offering a service to those people within a short target time.**

In one team there were clear gaps in the provision of staff managerial supervision, clinical supervision and caseload supervision. The Trust has been working with each CMHT to reduce large spans of management control, although it was claimed that this is still up to 44 people in one case, making it impossible to hold one-to-one sessions with any reasonable regularity.

The Trust has recognised the challenges of its current organisation into localities and resulting management structures. In the recent past the services have experienced a number of re-structures but it is hoped that the latest, 'A Case for Change', which has just completed the consultation phase, will provide a robust structure for the improvement of practice in mental health. A Case for Change re-aligns management with care groups rather than localities, i.e. changes back from Band 8 managers being responsible for both mental health and physical health services in a geographical locality to taking responsibility for either one or the other over a larger area.

The Centre recommends that the Trust should continue to use the expertise of ImROC to work with "The creativity of front line staff [which] can often be stifled by competing demands and directions coming from the top which are not aligned with recovery priorities."[1]

**Recommendation 2: The creativity of the local CMHT managers should be nurtured and encouraged so that they trial and implement solutions to their waiting list problems, the best of which might eventually be replicated across the Trust.**

Indeed encouraging innovation from each area has a number of benefits including:

- better staff engagement in identifying and implementing solutions
- starting from what they have achieved, not having to return to less effective processes
- the possibility of finding innovative solutions from within the Trust, which can more easily be introduced to other areas across the Trust, rather than those proposed or endorsed by external reviews and consultants

[1] Repper, J. & Perkins, R. (2013), *The Team Recovery Implementation Plan: a framework for creating recovery-focused services Implementing Recovery through Organisational Change Briefing Paper 6* London: Centre for Mental Health and Mental Health Network, NHS Confederation

The reviewers believe that the new management arrangements offer the Trust a rare opportunity, which should not be allowed to pass, for placing renewed trust and expectation on CMHT managers. If the Trust does not resolve to do this, it may find that CMHT management is further weakened through staff leaving or becoming too unwell to continue effectively in the role as a result of the stress of extended periods struggling but failing to cope with an impossibly heavy workload.

The social care provision within CMHTs has been lacking in visibility as the roles of social workers have become mostly indistinguishable from those of NHS care co-ordinators. Social care staff also feel they need more organisational support to identify and implement changes and improvements which will support personalised recovery plans and self-management strategies. A small number of examples of the use of personal budgets, for example the purchase of a boat, and innovative wellbeing strategies were described, but there is certainly scope and appetite for moving to a culture which better supports more creative co-produced recovery plans.

**Recommendation 3: Adult social care should drive the move towards pooled budgets as a vehicle to improve housing support, employment services and to facilitate peer-led support.**

The Local Authority should also review ways in which it could support the growth of third sector services in providing the above. The Local Authority has made a number of recommendations in the forthcoming renewed Section 75 agreement some of which relate to increasing the specialised nature and effectiveness of the input of the social care staff in CMHTs.

## c) Crisis Teams

There is national recognition that the way services respond to people in crisis needs to be more joined up, compassionate and flexible. The *Crisis Concordat* calls for local partnerships to develop their local approach under a co-ordinated mental health crisis declaration.

At the time of the review the crisis teams were expecting to be re-structured into separate Crisis Resolution and Home Treatment teams as a result of the RISCHES review. This re-structure had taken place in Carlisle but other staff were not sure of the timescales and details of changes to be implemented in their services. Directors said that there had been a deliberate decision not to send out any communication about the timings of the roll-out of RISCHES until they could be sure that information given would be clear and unambiguous. While the sense of

this can be understood, it would be a better approach to regularly share more of the detail of how the implementation of a strategy is progressing, for instance, to explain when the next milestone will be reached. This will help staff to feel involved in supporting the implementation of the Trust's vision.

The reviewers felt that Cumbria's challenge as a sparsely populated rural county with long travel times between the main towns is particularly felt by the crisis team. Crisis practitioners may be called to attend someone in crisis anywhere in a very large area, and some of the teams are very small in number to achieve this, especially at night when there may be only one or two workers available.

Although we spent time with all the crisis teams, the reviewers saw limited evidence of the teams responding to people in immediate and definite crisis. By far the majority of people being supported fell into two groups, a smaller group of people whose problems were acute, distressing, disabling and no doubt could have been effectively reduced by First Step, but the referral had come to the crisis team from First Step as a result of expressed suicidal ideation; or they were the larger group of people whose mental health problems had improved beyond the stage of requiring daily monitoring and support but remained complicated by issues such as housing, relationship difficulties, additional physical health problems or debt. Some of these people had been referred on to the CMHT, but while they remained on the waiting list, they also stayed on the caseload of the crisis team.

During the Centre's visit to one crisis team the current team caseload was discussed. This meeting progressed slowly and took over two hours (which tied up the consultant and all crisis team staff on shift). It highlighted to the review team that arguably all but one person among the current 'crisis' cases would have been more appropriately supported by either First Step or the CMHT. It was also concerning that during this meeting the ward sent a nurse to consult with the crisis team because an inpatient had not returned from planned leave. This situation felt confused because staff did not appear to have a clear protocol for expectations of the role of the crisis team in such a situation.

Another crisis team responded immediately to a call from a GP to see someone who had visited the surgery feeling very depressed, the information relayed was that he had been seen in the past by the CMHT but probably had been discharged. This event also demonstrated the way in which time may be wasted and people's needs not met as appropriately as they might be because staff do not have easy access to electronic patient records. The crisis team could not, or did not, quickly and easily check when the person last saw any mental health professional and whether there was any pertinent background information which would be likely to affect future response and intervention.

**Recommendation 4: The crisis team should review their caseload and ensure that social care, housing and/or the CMHT are fully aware of the needs of the people they wish to transfer, in order to facilitate planning for a seamless and timely transition from crisis support.**

## d) Wards

On the days when Centre for Mental Health reviewers visited, all the wards appeared to be offering a calm and therapeutic environment. However we agree with the CCG review of inpatient wards (2014) that while no significant problems were found there are also a number of inconsistences between the units and some deficits in staff skills.

The CQC inspection of the Dova Unit in October 2013 found that psychology input to the ward had increased to three days, but when Centre for Mental Health visited this had temporarily stopped because the psychologist was absent from work due to sickness.

The facilities are good in Carlisle, Barrow in Furness and Whitehaven but the South Lakes area really needs further investment to successfully provide all aspects of an inpatient ward, crisis team and home treatment team.
The facilities are of a high standard in Carlisle, Barrow in Furness and Whitehaven whereas the facility in South Lakes ideally further investment to successfully provide all aspects of inpatient, crisis and home treatment care.

The review team were impressed with a particularly good example of a handover at Rowanwood (Psychiatric Intensive Care Unit) which was multifactorial, thoughtful, challenging and identified the current situation of every service user on the ward. One carer raised concern that the unit staff's decision not to admit certain people who presented 'high risk' might be challenged as risk averse. The Trust is implementing a new strategy through the Acorn unit to provide the support necessary to bring some people with more challenging needs back into the county, although the service has only just begun to take referrals and still has many vacant beds.

The Centre felt that Oakwood responds flexibly to the needs of older adults with functional mental illness who cannot be supported to live at home during a period of acute illness. The ward no longer accepts younger adults but still takes some people in their early 50s if their particular needs (for example physical frailty) would be better met within the Oakwood environment than on a working age adult acute ward. Oakwood will also accept people with a diagnosis of

dementia where the admission is a short-term intervention for people generally able to cope well enough in their own home, who might be more distressed by admission to a specialist dementia ward.

Patients on the Kentmere and Yewdale wards do not have access to all the interventions that are expected by carers and service users: Occupational Therapy and Psychological Therapies are very limited, however the wards do provide a variety of activities, e.g. Yewdale was providing art, craft, baking and exercise on the week that the review team visited. The main concern described by both staff and service users was that care is often not able to be provided at the unit closest to the patient's home because there is no bed capacity or, often, people's needs are felt to be too complex for the staff numbers or skill-mix available.

Access to inpatient beds is a common concern for service users and carers but Centre for Mental Health's assessment is that there are currently enough beds. We feel that the challenges for the provider and the commissioner lie in how they are staffed, especially overnight and at weekends; we have concern over whether sufficient therapies are widely available, the capacity of the CMHTs, crisis teams and Home Treatment to keep people out of hospitals and sufficient alternatives to hospital admission for people in crisis.

**Recommendation 5: The very limited alternative to inpatient services and/or crisis house provision should be addressed by all three organisations commissioning this review.**

A recent consultation document proposes that "the Partnership Trust should work with stakeholders to identify appropriate, long term solutions for the Whitehaven and Kendal units". The Centre commends the intention to develop rehabilitation services with the third sector because this gives an opportunity to respond to service users' and carers' call for more emphasis on a recovery approach in rehabilitation services.

**Recommendation 6: The Trust should continue working through the ImROC model of the *Team Recovery Implementation Plan* to work with users and carers to devise and implement the models of service which people would like to use.**

Staffing numbers appeared to be adequate but staff are under some pressure to complete all the necessary physical health checks. These have to take priority over ward managers' ambitions to provide personalised opportunities which would support wellbeing, for example escorted community outings and self-

directed activities which require 1-1 support. However it was good to hear that efforts to provide more personalised support are continuing wherever possible.

The reviewers noted that smoking is still allowed within the open courtyards next to Yewdale Ward while many inpatient units around the country have now banned smoking anywhere on the hospital site and as a result staff have reported it has been a better environment in which to support and engage patients in interventions which promote recovery. Yewdale staff wear uniforms although this is not the case in other units; the Trust should consider the advantages and disadvantages of uniforms, making a decision to have consistency across all inpatient units.

Some of the medical staff feel that inpatient services should be focussed in two larger, better staffed units in the country able to develop excellence and a broad range of treatments, but concede that the move to this would be difficult and politically sensitive.

## e) Trust Directors

The Trust has a clearly articulated desire to improve services and the review team felt that the vision of the new Chief Executive is distinct, ambitious and encompassing of other staff and external innovations.

The Trust document *Strategic Vision for Mental Health and Learning Disabilities Care Delivery Group 2013* (based on information from workshops and vision events which were planned, attended and facilitated by users and carers, clinicians, managers, commissioners, people representing voluntary organisations, primary care, justice and social care) presents a helpfully extensive high level commitment to a number of important aspirations including:

- Adopting recovery concepts
- Enhancing compassion and reflection in mental health practice
- Increased access to reasonably adjusted information and materials to support prevention, self-management and access to services
- Increased support to primary care
- Clear and seamless pathways, supported by effective IT solutions.
- Provide safe, evidence based, individually tailored pathways to provide psychological, social and physical interventions.
- At times of crisis, there will be a range of alternatives to inpatient care
- Inpatient services will be configured to deliver safe, effective pathways of care.

It also describes the ambition to provide:

- competent secondary care clinical teams able to provide safe, evidence based, individually tailored, appropriately resourced, and multi skilled, cohesive pathways to provide psychological, social and physical interventions closer to home and focused on recovery
- competent, compassionate, highly skilled specialists for the most complex needs; delivered in a way that is easily accessible and empowers rather than engenders dependency
- suicide prevention through a multi-agency Cumbria wide strategy with clear leadership; communication and training.

Work to produce a detailed action plan to achieve the points above has begun.

Senior managers are quite clear about the range and degree of challenges facing the organisation. Directors described how the restructure of locality management to care group management will address the recent lack of leadership which has had the effect of diluting expertise, losing a real drive for targets and failing to provide appropriate challenge to poor practice. They also felt there had been insufficient focus on developing clinical skills.

## f) External staff, GPs, carer and service user views

People who use services and carers have given feedback to the Trust through surveys and consultations such as The *Patient Story Project 2013* which gathered full stories from 18 people who had used adult mental health services. The summary of the findings included:

- the majority of the patients felt very negative in relation to Care & Crisis plans
- they experienced particular difficulty in accessing Community Mental Health Team services
- although there were many positive comments about the interpersonal skills of individual staff, patients felt some of their knowledge was inadequate, not only about process and available services, but also around specific conditions
- general communication can be poor, letters were reported missing, being sent to the wrong place, and patients found that decisions had been made without their input
- patients' experiences on the wards varied, some were very good and people felt that the treatment they received was beneficial, others had very bad experiences where they said they were not treated with respect and felt confused and distressed by what was happening to them.

On a positive note the *Inpatient Heat Map* for all Trust wards published in the *Cumbria Patience Experience Report 2013-14 Quarter 2* highlights that people

using services are satisfied with many aspects of care on the ward and that 66.46% of patients are extremely likely to recommend the services to family and friends and a further 27.93% likely to recommend and only 1.56% unlikely or extremely unlikely to recommend.

Feedback from users and carers in *Working Together for Wellbeing and Mental Health: A Strategic Framework for Cumbria 2011-2014* raised the often-heard 'top four' complaints of:

- Some specialist services and staff are overstretched
- There are perceived difficulties accessing support in time of crisis
- There is a perceived lack of open access to high quality recovery focused support
- There are perceived difficulties related to transitions from young people's to adult services

Centre for Mental Health asked Carlisle and Eden Mind if they would like to encourage service users to speak to the review team. Due to their relocation they were unable to facilitate a group but did feedback that the biggest concern from service users and carers was difficulty in accessing help from the crisis service, that they didn't seem to have sufficient staff capacity to help and frequently didn't answer the telephone.

Discussions and sight of surveys completed by GPs highlighted that they remain highly critical of the community services because they experience inconsistency in response, which they say is often unhelpful, sometimes slow or perceived as defensive, and occasionally falls well below what is necessary, in their opinion, to keep people safe. They view the Trust as having a legacy of poor management and leadership across a number of mental health services and they are frustrated by the absence of joined-up systems leading to ineffective communication and poor customer care.

A specific criticism from GPs is that the Trust does not have an outward focus, and is not interested in looking at how its services can be made to compare favourably with the best services around the country and beyond.

# 7. Emerging themes

## a) Increasing workloads

Much has been said previously about the recent increases in referral numbers and waiting lists. Cumbria Partnership Foundation Trust is certainly not unique in experiencing pressures of increasing numbers of people needing to access mental

health services. Media reports show that these challenges could be widespread, but also that some Trusts are finding creative solutions by sharing knowledge and challenges beyond the organisation and that CCGs are working with their acute hospitals, community and mental health provider trusts, and GPs to turn situations around by taking immediate steps to reduce the current pressures along with longer-term actions to prevent re-occurrence.

## b) Recruitment and staffing issues

The Trust human resources strategy *An Enabling Workforce Strategy for a New Era 2013-18* aims for "high levels of staff motivation, engagement and performance, through providing meaningful work for staff who are empowered to act". The strategy fittingly states that the Trust should provide and foster a good staff experience and a sense of pride/belonging in the organisation. Many staff currently agree that there is much work to be done, less than half of staff (41.25%) would recommend the Trust to family and friends and less than a quarter (24.17%) feel that 'our organisational structures and process support and enable me to do my job well' (Pulse Survey 2014)

Staff are frustrated that Cumbria has had difficulty over recent years in being able to recruit sufficient numbers of quality staff. To add to the problem of disappointing responses to recruitment adverts, managers of wards and teams also reported long delays between appointment and staff being able to take up post. Reasons for this were often the wait for Disclosure and Barring Service clearance, but some felt that there has been inefficiency in Human Resources processes. It was mentioned that recruitment processes had improved of late, with the change to electronic rather than paper forms, but where there are ongoing vacancies, such as the chronic shortage of junior doctors, the procedures were felt to be unhelpful e.g. the need to gain authority for each individual recruitment was delaying advertisement and interviews. Staff suggested that a rolling recruitment for vacancies which reoccurred fairly constantly would be more efficient.

A current workforce project is focussing on ensuring recruitment into vacancies and reduction in use of agency staff as the arrangements for the new Mental Health Care Group become operational. The project mentions having a strategy in place to support the reduction in use of agency staff by 50% by the end of August 2014. This review team fully support this aim which will provide a number of benefits including a reduction of unnecessary spend, providing team stability and hopefully a more comprehensive skill mix, where this is needed.

**Recommendation 7: Devise new ways of attracting permanent staff to vacant posts and reduce the use of agency staff by 50% in six months.**

The operation of a local system of bank staff has been the responsibility of the individual ward manager, and staff reported that the supervision, performance monitoring and up-to-date training of bank staff has varied, depending on the attention paid to the quality of bank staff by the ward manager. However this is now said to be improving with more support coming from central HR.

Up to 55% of the out of hours AMHPs are agency staff. The Local Authority are responsible for providing the AMHP service and although there have been some plans and actions to increase the proportion of permanent staff it is not clear that this situation is improving and this requires a more targeted approach. A view expressed by an AMHP was that it would be hard to persuade competent, skilled and experienced staff to work in West Cumbria without the additional compensation of the higher agency pay rates.

The reviewers met several locum consultants, just three permanent consultants, and spoke to a group of consultants and staff grade doctors by telephone. The concern about recruitment of permanent medical staff was one of the top issues they raised, stating that recruitment has been extremely difficult anywhere but Carlisle, and there is also poor retention of new consultants for more than two years.

The reviewers agree with the staff view that the Trust must take steps to understand and address the professional and social isolation which consultants feel working in Whitehaven and Kendal. Without appropriate out of hours cover at night and weekends, and no middle grade doctors, consultants are the first on call, a configuration which is both unappealing to consultants and contributes to the level of risk experienced by staff and patients.

**Recommendation 8: Develop a structure which provides more peer support opportunities to address the professional and social isolation which consultants feel working in Whitehaven and Kendal.**

## c) Managerial support

A common theme in a number of interviews was that the Trust does not foster a supportive management culture, which demonstrates that middle management fully understand the difficulties and pressures faced by frontline staff. 29.06% of staff agree that the organisation communicates clearly with staff about its priorities and goals; 39.4% feel valued for the contribution they make and the work they do and 22.54% believe that communication between senior management and staff is effective (Pulse Survey 2014).

We noticed that some staff do not identify as belonging to a larger community of Trust staff and very rarely see colleagues in other areas. This is something that the Trust know could be addressed by better and frequent use of video-conferencing which they have made available in most units and on portable devices for senior staff.

**Recommendation 9: Encourage the use of video-conferencing by measuring progress towards the target for reduction in mileage expenses.**

Another important finding from the Pulse Survey (2014), which was also an outlier for the Trust against the rest of England in previous years' staff surveys, was the extent to which patient care is the top priority. 56.48% believe the Trust is providing high quality services to patients/service users, which is astonishingly low when this is actually why people go to work every day, and reflects the frustration they described to us about systems, inadequate support and other priorities hampering their efforts; 46.78% feel that the quality and safety of patient care is the organisation's top priority and just over a third (37.77%) feel able to prioritise patient care over other work.

The review team felt that co-operation between different teams and services needs to improve. Internal customer service is not always helpfully provided, i.e. understanding that within the organisation there are 'suppliers' and 'customers' of different parts of the whole operation. There were many examples of teams or departments putting the blame for delays, mistakes or inefficiencies on each other and few of supportive reciprocity in working together.

## d) Systems and communications

Middle managers commonly described how hard they find it to persuade some staff to change their ways of working and to adopt new systems and procedures. They felt that there is a great deal of resistance to change and unwillingness

a) to accept that new ways of doing things would make practice more efficient and productive
b) working enthusiastically with service users and learning to embrace recovery principles is a positive and innovative approach to improving services.

We are heartened that progress with the implementation of an electronic patient record was evidenced from staff interviews and posters displayed across the Trust. There are hindrances to efficient working which it would improve. The Pulse Survey revealed that only 28.21% of staff say the work environment,

facilities and systems enable them to do their job well. The electronic patient record is long overdue and the delay in having it has caused a huge waste of time through the duplication of effort required to complete two limited systems on computer and reliance on the paper records of care plus the need to keep personal diaries up to date – we noticed that some staff are using both electronic and paper diaries and have to spend more time than necessary keeping both current. Reduction in duplication would greatly assist in relation to practitioners keeping clinical records up to date and reducing risk through use of multiple systems.

**Recommendation 10: Proceed as quickly as possible with the implementation of the electronic patient record.**

## e) Attitude to risk

Individual attitudes to risk vary. While the majority of people felt that issues which put people at risk could be accurately assessed and services would in the most part be able to respond in a way that kept people safe, there were three comments which concerned the reviewers. Two comments, made in response to discussions about working to prevent suicides, were to the effect that "people do commit suicide – it's not our fault", and the third was about people with personality disorder who have used services for a long time with very little improvement in their condition. The clinician said that such people should be discharged because they had received everything that could be offered for a long time, but that there should be something written in the notes so that if a serious incident happened after discharge, that the service or individual clinicians would not be held responsible.

This raises issues which the review team suggest the Trust should consider:

- why some services are not helping some people with personality disorder and what more can be offered to them
- whether more of a 'team' approach can be taken when working with people with very complex needs
- whether staff have sufficient confidence and support in working through an intervention with people and bringing them to a point of discharge when a degree of recovery is recognised by the service user and they understand and agree with the reason for discharge

**Recommendation 11: Ensure that staff are supported to understand expectations and rationale for discharge and implement a team approach to timely discharge across all CMHTs.**

It is also shocking that an incident of hanging from a secure ligature point in Dova Ward happened as recently as 2013 when we would have expected that national concern about ligature points over the last decade would have motivated the Trust to take comprehensive action to improve the safety of the environment, and therefore it should have been second nature to all levels of ward staff to notice and remove the rails.

On the other hand, some staff of the Trust and CCG said that the Trust sometimes supports unnecessarily risk averse actions which mean that people are not managed at the lowest appropriate level of intervention. For example people we met when visiting with the crisis team definitely could be managed in lower intensity services.

Trust staff were not able to tell the reviewers much about a closer to home strategy to reduce the numbers of out of area placements and provide a more competent and confident service for people with complex needs, although some work to address social care spend on high cost packages is being undertaken.

Several ward staff told the reviewers that wards were working at their full capacity – both in terms of numbers and ability to meet the level of need. We felt that there are a number of indications that inpatient services in Cumbria are spread across the county too thinly such as:

- lack of access to anaesthetists for ECT,
- regular transfers of patients between units, often at night, with the aim of managing risks at the smaller units,
- no available junior doctors in all the units
- difficulty in recruiting permanent consultants outside Carlisle

This situation is recognised as potentially risky for staff and patients and is the reason why only moderate levels of need are supported in Kentmere and Yewdale.

In the community a response to previous incidents has resulted in local performance targets being set more strictly by the Trust and CCG than national expectations. The target of a maximum 15 days referral to assessment means that referrals for psychiatry and psychology are seen by CMHT only to deliver the target, despite the fact that the CMHT know that the wait for the actual assessment for treatment will be much longer.

ImROC supports the move towards a person-centred, 'safety planning' approach to assessing and managing risk which is already supported by current professional guidance, regulation and policy.

> "Risk assessment, even at its best, is generally poor at predicting or preventing untoward events (Langan, 2010; Royal College of Psychiatrists, 2008). Standardized assessment tools may have some value, but they should really only be used as part of a broader, systematic assessment which enables people to understand risk management through conversations (stories) about their lives and their personal contexts."[2]

At times, a number of staff shared with reviewers their profound sense of fear, guilt and frustration that people using services were being badly served and that people's quality of life was at such significant risk that incidents of serious self-harm or suicide were expected and dreaded all the time.

**Recommendation 12: Work with ImROC to review the culture and practice of risk assessment and management and ensure a recovery oriented approach.**

## f) Service criteria and transitions

The growing challenge for CMHTs is that they appear to be where the buck stops for an ever increasing number of people in need of ongoing mental health support. First Step have well defined criteria for interventions and refer appropriately to CMHT if people's problems are persisting or a there are complex social care and health needs to untangle and address. Wards and crisis teams quite rightly should be passing on to CMHT anyone whose condition no longer requires crisis management, but most of those people referred to CMHTs will still be very unwell and in need of fairly intensive support, at least for the first 2-4 weeks. GPs refer to CMHT anyone whose mental health problems are likely to need either the case management approach which underpins the CMHT model, or immediate support to bring back some stability, and to work with suicidal ideation.

The information gathered from users of services by the Best Life Wellbeing Network and the CQC points consistently to a generally held view that CMHTs are difficult to access and are not currently providing a service which people consider to be satisfactory and timely.

There is some evidence that people's needs and difficulties may be exaggerated in order to persuade a particular service to accept the referral. This becomes an escalating problem and is frustrating and presents a risk for people in genuine urgent need of support and treatment.

[2] Boardman, J. & Roberts, G (2014) *Risk, Safety and Recovery. Implementing Recovery through Organisational Change Briefing Paper 9.* London: Centre for Mental Health and Mental Health Network, NHS Confederation

**Young people in Transition**

The trust is implementing flexibility, rather than strict age-related criteria in providing services to young people in transition to adulthood to ensure that services are appropriate for individual needs.

The CCG and Trust are aware that there is a large gap in services for adults with ADHD. The CAMHS team is able to support young people with ADHD but once they become too old for children's services there is no service they can be referred to within the Trust. Adult ADHD services are available in the North West, but not to the South of Cumbria, so young people in Barrow and South Lakes are likely to be left without any appropriate service for their needs, once they transition from children's services. Consideration of this issue is being addressed as part of the 2014/15 contract agreement between commissioners and the Trust although it will be limited in terms of the interventions that can be provided.

**Recommendation 13: The CCG should continue exploring options for future provision of adult ADHD services.**

## g) Service configurations

### i. RISCHES and Liaison Psychiatry

An acknowledge of the need to respond better to people with Personality Disorder has led to the establishment of the access, liaison, intervention service (ALIS) and increased capacity for Home Treatment.

**Psychiatric liaison**
It is understood that the current psychiatric liaison team is to be integrated into a larger crisis team as part of the RISCHES work, and they will all be based at the Carlton Clinic site.

The review team is concerned that the Trust is not implementing the clear evidence around effective psychiatric liaison. The liaison team needs to be present on the acute hospital site, have open access across the hospital, and have a key role in training, supporting and liaison with acute staff. The proposed change in structure is likely to make the service less clinically and financially effective and would be expected to increase the overall cost.

The change to Liaison Psychiatry proposed by the RISCHES project is not universally welcomed by clinicians. Centre for Mental Health believes that the changes being made to the liaison psychiatry service will result in a less effective service which no longer provides the cost-effectiveness which is part

of the rationale for these services. The proposed full scale relocation of the psychiatric liaison service within the CR/HT team base may have been temporarily halted during the review, but the liaison team is already managed as part of the CR/HT team, and liaison staff are being asked to cover CR/HT cases. This is an erosion of the service and falls out of line with the evidence discussed in a number of recent Centre for Mental Health publications.

The targets for the service are being met, but they have been set on the hard components of delivery such as referrals accepted and assessments completed. A better quality measurement of the service would be obtained by the inclusion of two further key areas: acute staff training, development and support. Evidence from a review of the Rapid, Assessment, Interface and Discharge (RAID) service, a specialist multidisciplinary mental health service within all acute hospitals in Birmingham, suggests this is the essence of liaison psychiatry's contribution to the system and is possibly more important than counting the face to face contacts. The targets also miss any measures of outcome such as early discharge or reducing readmission from which the RAID model was able to show substantial cost savings.

The Liaison Psychiatry team had begun the process of achieving formal accreditation in the Psychiatric Liaison Accreditation Network but this was stopped in September when the proposal to assimilate into the CR/HT was imposed.

**Recommendation 14: Review plans for the configuration of liaison psychiatry in the light of the national evidence describing services and outcomes.**

### ii. Early Intervention in Psychosis (EIP)

The county EIP service has now split into localities and re-located as part of the CMHTs. An EIP practitioner said that re-joining the CMHT was helpful for the other members of the CMHT, but less so for the EIP staff because they have lost much of their peer support through being split up and have not had a dedicated consultant for EIP lately, although this was being addressed at the time of the review.

Centre for Mental Health champions the importance of Early Intervention services and recommends that the Trust recognises the risks of staff losing their specialism through the pressure of workloads within the CMHTs and reduced peer support from a wider team of EIP practitioners.

## h) Commissioning vision and ambition

The joint plans for commissioning and mental health service delivery in Cumbria echo many of the elements described by Centre for Mental Health in the 2006 publication *The future of mental health: a vision for 2015*. These are:

- Extend the availability of psychological therapies on wards and in community teams
- Strengthen the mental health workforce with strategic approaches to workforce planning and early thought to possible sources of future staff.
- Supporting carers through a range of individual and group recovery oriented services.
- Develop the use of individual budgets making these much more widely available.
- Better comprehensive shared care planning using a fully integrated electronic record system.
- Invest in the development and sustainability of service user groups.
- Invest further in housing support.
- Tackle smoking through appropriate psychological and physical support to help people quit smoking and implement a total ban on smoking in the vicinity of psychiatric wards.

**Recommendation 15: The Trust should consult with service users and stakeholders with a view to becoming completely smoke-free across all its properties and estates.**

One example of a specific plan which Centre for Mental Health endorses is the 2014/15 CQUIN plan to incentivize a comprehensive and structured roll out of education and the delivery of psychological therapies in CMHTs and wards. There are important overarching ambitions too in the Trust Quality plan: *Improving Quality through Partnerships 2013 – 2015* acknowledges that commissioners are looking for quality services at the right cost, which meet patient needs and:

- are clinically safe
- are evidence based
- manage safeguarding well
- are welcomed as those which people want to use
- are those which staff have pride in delivering
- have strong clinical leadership
- demonstrate learning lessons
- listen and act on patient experience
- are open and transparent
- are efficient and provide value for money

A comment from a Trust manager was that the reason that some of the mental health services are still delivered through traditional models is that commissioners have not given detailed descriptions of how they expect modernised services to look. If both the providers and commissioners are uncertain of what is needed there will be nothing to spur on a strategy for modernisation.

The reviewers also heard complaints about the effectiveness of the relationship between the CCG as commissioners and the Trust, from both sides, one of the medical staff said that the relationship was felt to be competitive rather than collaborative.

Centre for Mental Health supports the Trust's plans to work with ImROC, to go further than the aim to "listen and act on patient experience" by working with service users and carers to implement services which are co-designed and co-delivered.

Much of the support which service users want relates to their social care needs and the Local Authority and has an important role in working with the Trust and supporting the commissioners in the development of more third sector services to ensure sufficient availability of carer support, housing support, employment support, links with local colleges, with sports facilities and volunteering. There are few well-established third sector services in Cumbria able to support people with mental health difficulties. They are not evenly spread across the county; with concentration in certain relatively affluent areas while more deprived areas have very little in place. A number of third sector services have closed due to the ending of their grant funding.

**Recommendation 16: The Local Authority and CCG commissioners should consider strategies to encourage third sector services to complement services provided by the Trust and to incentivise partnerships between organisations which can provide services more flexibly and cost-effectively.**

The Trust has a patient experience team which facilitates service user and carer involvement in mental health services and the governors have established a mental health service users group. Initial recovery focussed work has begun with ImROC but the review team were hoping to see evidence of other initiatives such as:

- emerging recovery college
- arts in health;
- expert patient programme;
- comprehensive carers' support service

- IPS (or similar) employment support service

Employment is a concern as there is no Occupational Therapy group focussed on vocational rehabilitation either. The Cumbria Mental Health and Wellbeing Strategic Framework 2011-2014 includes an action for Cumbria Council Adult Social Care to introduce a county wide employment & support service accessible for all, and for the Trust to develop a vocational strategy for mental health service users. The Employers Bridge project made a promising start in developing an IPS service, but is no longer in operation.

A poor score compared with other mental health trusts was reported in the *NHS Mental Health Community Survey 2013* for service users saying they were 'not given enough support with finding or keeping work'. It is unfortunate that the momentum of the Employers Bridge project has been lost. This is definitely an area which needs the attention of commissioners and providers.

The *Cumbria Mental Health and Wellbeing Strategic Framework 2011-2014* also identifies aspirations to improve access to debt advice and to undertake more anti-stigma projects but these were not mentioned in any of the interviews.

**Recommendation 17: The Local Authority should lead on the development of targeted social inclusion opportunities including housing support, education opportunities, consideration of a recovery education programme and Individual Placement and Support for employment.**

## 8. Suicide benchmarking

Across the North West the death rate from suicide is higher than the rate for England, and in Scotland the difference is statistically significantly higher. In 2001-2006 the suicide rate in Scotland was 79% higher than in England. It is important to remember that the majority of people who commit suicide are not in contact with services.

The Trust supplied information on serious incidents to the review team for the purpose of comparing suicide rates against other providers. The following draws together a summary of data on suicides by people receiving secondary mental health services from mental health providers in the West Midlands between 2005 and 2011, and compares those figures with data for people receiving secondary services from Cumbria Partnership NHS Foundation Trust.

The data was extracted by considering all incidents of deaths due to suicide or other causes recorded in the 24 hour reporting system. Based on the circumstances, including evidence of means and recent history of suicidal ideation or intent, and in accordance with the findings of the National Confidential Inquiry into Suicide and Homicides, all suicides were identified.

The data reviewed was restricted to people who at the time of their death were receiving secondary care adult mental health services. Those identified as users of older people's services, Substance Misuse Services, and those receiving support from only Primary Care Services, Prison Healthcare, CAMHS, Forensic Services or IAPT (First Step) were excluded from the count.

The data in Appendix 1 shows that the suicide rate for people receiving adult mental health services for Cumbria fell at or outside the control limits in 2006, 2008, 2009 and 2011.

There could be many reasons for this. While the comparator area, the West Midlands, includes a number of Shire counties and one of the most sparsely populated counties in England, there could be number of factors such as geography which makes Cumbria sufficiently different to create this effect.

As mentioned, the suicide rate in Scotland has been 79% higher than that in England, and it would be surprising if this did not 'spill over' into Cumbria, although the West Midlands also has a long border with Wales, which also has a higher suicide rate.

It is expected that commissioners would review safety with any provider who fell outside the control limits in any one year, and that an external review would be instigated of any provider who fell outside the control limit for two or more years.

Cumbria clearly has not turned the tide yet on higher than average numbers of suicides but the review team notes that the County has recently launched a refreshed suicide strategy: *suicide is everyone's business* and much work has taken place in the Trust over recent months including:

- launch of a suicide prevention plan in November 2013;
- creation of the role of suicide prevention champion;
- membership of the multi-agency suicide prevention group chaired by public health;
- clinical staff taking part in a web chat with partners on suicide prevention where the public could get in touch;
- an ST4 doctors completed a review of all unexpected deaths in the county with public health and this includes people in contact and not in contact with the trust

- oxford learning events;
- clinically led review of our approach to assessment and training in suicide prevention

Staff also pointed out that some suicides of people in touch with secondary mental health care have occurred when people had most recently been seen by other services such as Accident and Emergency or the police, and there could be questions about whether staff across the broader partnership of organisations are sufficiently skilled in their response to potential suicidal intentions, hence the title of the new strategy *suicide is everyone's business*.

The review team nevertheless feels that many of the issues which have a strong probability of contributing to the suicide rate being higher than in other areas can be addressed within the remit of the Trust. So while it is not possible from this data to explain with certainty the higher rate of people in receipt of services in Cumbria who commit suicide it confirms that there is a heightened risk and we feel this is as a result of the high waiting list numbers in some areas, lack of availability of some therapies, examples of incomplete or inaccessible record keeping and a conservative attitude to risk management which focusses more on objective ratings rather than working to support the individual's own strategies for keeping themselves safe.

Centre for Mental Health believes these figures demonstrate continuing and significant cause for concern and urges the Trust and the partner organisations to continue their efforts to reduce these tragic incidents.

**Recommendation 18: The Trust should continue to train and monitor for staff competency in suicide prevention, and work with partner organisations to achieve the aims of the suicide strategy.**

# 9. Recommendations

## a) Full list

1. Temporarily increase staff resources to support CMHTs with long waiting lists to begin offering a service to those people within a short target time.
2. The creativity of the local CMHT managers should be nurtured and encouraged so that they trial and implement solutions to their waiting list problems, the best of which might eventually be replicated across the Trust.
3. Adult social care should drive the move towards pooled budgets as a vehicle to improve housing support, employment services and to facilitate peer-led support.

4. The crisis team should review their caseload and ensure that social care, housing and/or the CMHT are fully aware of the needs of the people they wish to transfer, in order to facilitate planning for a seamless and timely transition from crisis support.
5. The very limited alternative to inpatient services and/or crisis house provision should be addressed by all three organisations commissioning this review.
6. The Trust should continue working through the ImROC model of the Team Recovery Implementation Plan to work with users and carers to devise and implement the models of service which people would like to use.
7. Devise new ways of attracting permanent staff to vacant posts and reduce the use of agency staff by 50% in six months.
8. Develop a structure which provides more peer support opportunities to address the professional and social isolation which consultants feel working in Whitehaven and Kendal.
9. Encourage the use of video-conferencing by measuring progress towards the target for reduction in mileage expenses.
10. Proceed as quickly as possible with the implementation of the electronic patient record.
11. Ensure that staff are supported to understand expectations and rationale for discharge and implement a team approach to timely discharge across all CMHTs.
12. Work with ImROC to review the culture and practice of risk assessment and management and ensure a recovery oriented approach.
13. The CCG should continue exploring options for future provision of adult ADHD services.
14. Review plans for the configuration of liaison psychiatry in the light of the national evidence describing services and outcomes.
15. The Trust should consult with service users and stakeholders with a view to becoming completely smoke-free across all its properties and estates.
16. The Local Authority and CCG commissioners should consider strategies to encourage third sector services to complement services provided by the Trust and to incentivise partnerships between organisations which can provide services more flexibly and cost-effectively.
17. The Local Authority should lead on the development of targeted social inclusion opportunities including housing support, education opportunities, consideration of a recovery education programme and Individual Placement and Support for employment.

18. The Trust should continue to train and monitor for staff competency in suicide prevention, and work with partner organisations to achieve the aims of the suicide strategy.

## b) Priorities for in-depth consultancy/research

**I. Recovery**

Work with ImROC on a suite of recovery focussed co-produced services; undertake a project to create peer support worker posts, and establish a measurable recovery approach in all teams and care plans.

**II. Liaison psychiatry**

Resource and support the liaison psychiatry service to focus on outcomes and provide a service in line with nationally recognised best practice.

**III. Social Care**

Propose and resource a model of social care which works effectively within all Trust community teams, clearly leads on personalisation and aspects of social care, social inclusion and Individual Placement and Support, champions the role of AMHPs and creates savings across the system by providing a more rapid response to solving housing and employment issues.

## Appendices

### Appendix One – Suicide benchmarking

### Appendix Two – Contract for the review

### Appendix Three – Terms of Reference

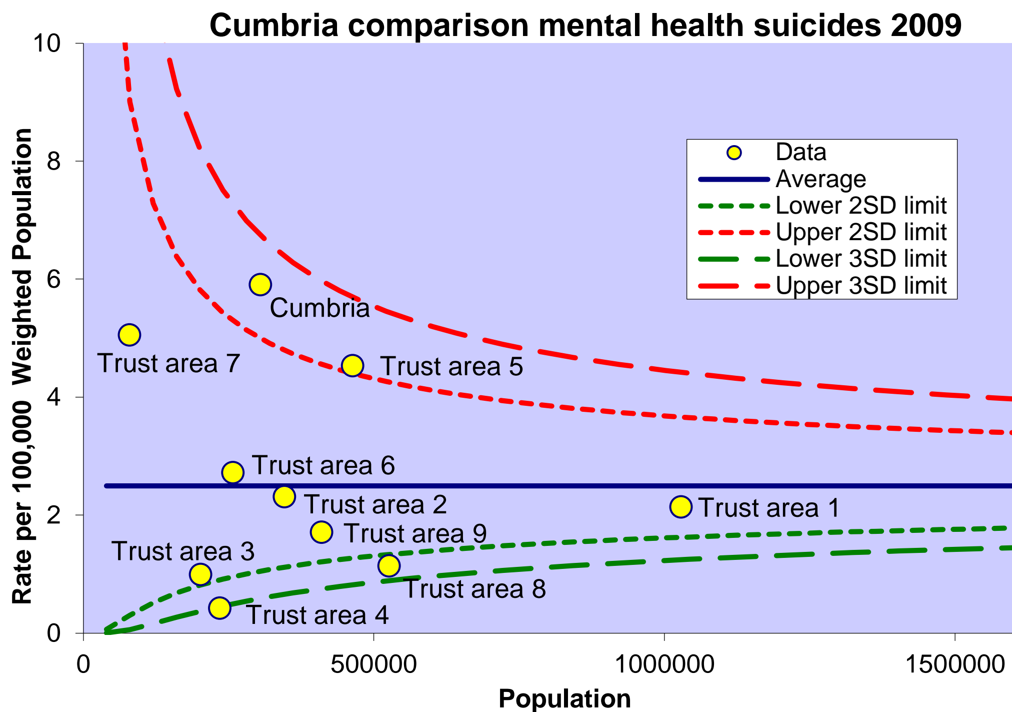
### Appendix Four – Description of timescales and location of visits and interviews

# Appendix 1

## Suicide Benchmarking

**Table 1**
**Count of Suicides per MH Provider Trust based on Selection Criteria**

| | **Count of Suicides** (Includes the counts of suicides include reports by other relevant NHS bodies) | | | | | | |
|---|---|---|---|---|---|---|---|
| **Provider Trust** | **2005** | **2006** | **2007** | **2008** | **2009** | **2010** | **2011** |
| Trust area 1 | - | 6 | 12 | 13 | 22 | 7 | 22 |
| Trust area 2 | - | 2 | 8 | 11 | 8 | 6 | 8 |
| Trust area 3 | 5 | 5 | 8 | 4 | 2 | 0 | 2 |
| Trust area 4 | - | 3 | 3 | 1 | 1 | 1 | 1 |
| Trust area 5 | - | 14 | 6 | 23 | 21 | 13 | 21 |
| Trust area 6 | - | 5 | 8 | 16 | 7 | 5 | 7 |
| Trust area 7 | - | 8 | 4 | 2 | 4 | 10 | 4 |
| Trust area 8 | - | - | 6 | 12 | 6 | 1 | 6 |
| Trust area 9 | - | 2 | 5 | 11 | 7 | 2 | 7 |
| Cumbria | 7 | 11 | 10 | 16 | 18 | 9 | 22 |



## Data Analysis

The data was analysed using mental health weighted population data, and standard errors calculated using the Wilson Score Method rather than the traditional method.  The Wilson Score Method produces fewer statistical anomalies where $n$, the actual number of incidents, is less than 5. The usual interpretation of control limits within Statistical Process Control is that items above 2 sigma should be observed and those above 3 sigma require attention.

# Appendix 2

## Cumbria Partnership NHS Foundation Trust Adult Mental Health Services Review

### March 2014

Cumbria CCG (the commissioners) in partnership with Cumbria Partnership Foundation Trust (CPFT - the providers) and the Local Authority have commissioned the 'Centre for Mental Health' - Dr Jed Boardman, Dr Graham Duncan, Lawrence Moulin, Jan Hutchinson and Professor Sean Duggan (the review team) to support improvement processes in CPFT adult mental health services by providing an independent view of the ways in which CPFT's staff can achieve their own goals, creating more effective teams, processes and improvement in care and recovery experiences of service users.

### Methodology

The Centre for Mental Health will commence the review week commencing the 10th March 2014 and will include visits to CPFT adult mental health community and inpatient services. This will include observation of systems, talking with staff, service users and carers to gain an understanding of the 'clinical culture' of CPFT adult mental health services, reporting back on those services requiring further in-depth review. Findings will be triangulated with current information to include:

- Review of service user and care surveys
- Review of staff surveys
- Feedback from Care Quality Commission surveys
- Interviews / focus groups with staff including frontline clinicians and managers
- Interviews with service users / carers
- Review of learning from serious incidents (including suicides)
- Review of patient flow: from wards to community and from secondary to primary care
- Comment on service focus on recovery, quality and safety
- Staff access to training, support and supervision
- Opportunities for staff to lead and shape changes within the organisation
- Overview of service design

### Reporting timescales

An oversight group will be established to include a senior clinician and manager from Cumbria CCG and CPFT and a senior manager for the Local Authority.

The Centre for Mental Health will provide fortnightly update reports to the oversight group either via face to face meeting or teleconference using the Interim reporting template (Appendix 2)

The review team will provide its final report to the oversight group week commencing 26th May 2014.

### Governance

The review will be overseen by the oversight group.

### Intellectual property ownership

The content of the report and all its drafts will at all times remain the intellectual property of Cumbria CCG and will not be published, or shared with a third party, without their prior approval.

If however, in the course of their research, the review team identify behaviour or clinical practice that exposes patients or their families to a risk of harm they will take action, in line with Cumbria safeguarding policies and report their concerns to the Cumbria CCG Quality meeting.

### Contract management

Any significant service issues will be escalated into the Cumbria CCG joint contract review meeting.

## Appendix 3

## Appendix to CPFT Board report

# Independent Review of Cumbria Partnership NHS Foundation Trust Adult Mental Health Services

### 1 Purpose of the Review

Cumbria Partnership NHS Foundation Trust (the Trust), NHS Cumbria Clinical Commissioning Group (CCG) and Cumbria County Council (the Local Authority) have jointly agreed to commission an independent review of the delivery of the Trusts adult mental health services.

The review is anticipated to focus on quality, clinical leadership, clinical skills and most importantly clinical culture.

### 2 Stages of the Review

The review will take place in three stages:

| Stage | Review Activity | Output |
|---|---|---|
| 1 | A broad, rapid assessment of the overall clinical culture of the organisation based on assessments provided from Trust clinical leaders and direct observation and interviewing of a broad range of clinical staff in the clinical environment. | Overarching assessment of the clinical culture of the organisation and services requiring further review on a risk based approach. |
| 2 | A deeper review of specific services identified in stage 1 | Recommendations for service improvement. |
| 3 | Medium term external challenge and support in developing quality services through the Excellence Programme. | Verification and challenge of service models. |

### 3 Scope of the Review

The review will consider all working age adult mental health services including First Step. The review will not consider learning disability, substance misuse and older adult services other than where there are issues of co-morbidity or transition planning. The review will not focus on financial issues, Trust income, expenditure, or overall efficiency. However, the

review will need to be set within the context of finite resources, and any arising recommendations will need to be realistic within a value for money framework.

## 4 Indicative Composition of the Review Team

The review team will need access to the following skills/competencies:

- A Chair and a report writer
- Credible, experienced, expertise from Psychiatry, Psychology, Nursing, Social Care and Managerial
- Service User & carer Representation

## 5 Timetable for the review

The first stage of the review should be completed by December 2013. The timetable for the second and third stage will be agreed at that point.

## 6 Governance Arrangements

The review is undertaken jointly on behalf of the Trust, the CCG, and the Local Authority. The review will be overseen, and ultimately received, by a joint team comprised of Two Trust Directors, a CCG Director and the Associate Director of Adult Social Care.

The review team will be supported by a senior Nurse and Manager from the Trust, the CCG Lead Nurse for Quality and Safety and a senior Manager from the Local Authority.

## 8 Outputs of the Review

The outputs from the review will be:

- A presentation to the joint team and stakeholders
- If required a presentation to the Cumbria Quality Surveillance Group organised by NHS England
- At each stage an Executive Summary
- At each stage a full report, with findings and recommendations

All reports will be accessible to the public.

# Appendix 4

## Description of timescales and location of visits and interviews

Visits took place during March, April and May

| Date | Site visited |
|---|---|
| 11/03/2014 | Kentmere Ward |
| 13/03/2014 | First Step South Lakes |
| 17/03/2014 | CMHT South Lakes |
| 19/03/2014 | Crisis Team South Lakes |
| 20/03/2014 | Oakwood Ward Carlisle |
| 21/03/2014 | Hadrian Ward Carlisle |
| 24/03/2014 | Rowanwood Ward Carlisle |
| 25/03/2014 | Dr Alan Edwards, GP, Carlisle |
| 25/03/2014 | CMHT Carlisle |
| 26/03/2014 | CMHT Eden, Penrith |
| 31/03/2014 | Crisis Team Carlisle |
| 01/04/2014 | Yewdale Ward, Copeland |
| 01/04/2014 | Crisis Team West, Whitehaven |
| 02/04/2014 | CMHT Allerdale (Brookside) |
| 07/04/2014 | First Step West, Workington |
| 07/04/2014 | CMHT Allerdale (Park Lane) |
| 07/04/2014 | CMHT Copeland, Whitehaven |
| 15/04/2014 | CMHT Barrow in Furness |
| 15/04/2014 | Dova Unit, Barrow in Furness |
| 15/04/2014 | Crisis Team, Barrow in Furness |
| 29/04/2014 | Hadrian Unit Carlisle |
| 30/04/2014 | Paul Beales, Human Resources |
| 30/04/2014 | Sara Munro & Joanna Forster Adams |
| 07/05/2014 | Claire Molloy |
| 08/05/2014 | Tom Le Gassicke, Liaison Psychiatry |
| 08/05/2014 | Richard Thwaites, First Step |

In addition face to face interviews were held with:
Dr Alan Edwards
Cindy Daltioni, Self-harm Awareness for All Cumbria (SAFA),
Laura Carr and Andy Airey.

Telephone interviews were held with:
Dr Karen Johl
Nigel Maguire

Ruth Gildert
Trever Thompson
Rachel Chapman
Tania Desborough
Teresa Waleboer
A group of psychiatrists
Professor Dave Dagnan
Jim Bradley
Members of the Mental Health Special Interest Group