Good

Peninsula Community Health C.I.C

Quality Report

Sedgemoor Centre
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Core services inspected	CQC registered location	CQC location ID
Community adults	The Sedgemoor Centre	1-303998621
Community inpatients	Camborne and Redruth Community Hospital	1-303925581
	Launceston Community Hospital	1-303946863
	Newquay Hospital	1-303947227
	St Austell Community Hospital	1-303962531
	Stratton Hospital	1-303985486
	Bodmin Hospital	1-303999240
	Fowey Hospital	1-303926348
	Helston Community Hospital	1-303946611
	Liskeard Community Hospital	1-303946965
	Falmouth Hospital	1-303926236
	St Barnabas Hospital	1-303984801
	St Mary's Hospital	1-303985084
End of life care	Camborne and Redruth Community Hospital	1-303925581
	Launceston Community Hospital	1-303946863
	Newquay Hospital	1-303947227
	St Austell Community Hospital	1-303962531
	Stratton Hospital	1-303985486
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	Falmouth Hospital	1-303984801
	St Barnabas Hospital	1-303985084
	St Mary's Hospital	1-303998621
	The Sedgemoor Centre	
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This report describes our judgement of the quality of care at this provider. It is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from people who use services, the public and other organisations.

Summary of findings

Ratings

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

Overall rating for community health services at this provider	Good 
Are services safe?	Good 
Are services effective?	Good 
Are services caring?	Good 
Are services responsive?	Good 
Are services well-led?	Good 

Summary of findings

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Overall summary

When aggregating ratings, our inspection teams follow a set of principles to ensure consistent decisions. The principles will normally apply but will be balanced by inspection teams using their discretion and professional judgement in the light of all of the available evidence.

We judged this provider to be providing good safe, effective, caring and responsive services that were well led. The organisation was operating in a unique setting as a community interest company delivering NHS services and operating at the heart of a wider NHS system that is challenged in terms of demand and performance. It was unique in having been set up in a way that left it with historical debt and risks that had not been mitigated. It had been formed in the teeth of opposition from the public and staff. There is also some uncertainty over the future with the current contract due to finish in March 2016. These challenges were being met. The leadership team was highly visible and trusted and were managing the significant risks and uncertainties in a measured way that protected the organisation and enabled staff to concentrate on delivering and developing services.

The organisation had a vibrant positive culture and a palpable “can do” attitude that existed at all levels and was recognised by external partners. Staff talked of a transformed culture and this had been externally recognised with the organisation being recognised by the Health Service Journal (HSJ) Best Places to Work awards. Staff were encouraged to be open and report and learn from incidents and near misses. Services had been developed and shaped by staff and some innovations had been recognised nationally, including the development of nutritional and hydration aids for patients. Patients and their families spoke highly of the services received and the team saw examples of outstanding care where staff had gone the extra mile to ensure patients received the care that they needed.

There were some areas for improvement that have been identified in individual reports. There was one service where requirements in aspect of leadership were needed and one service requiring improvement in safety. There are some areas to improve at corporate level but given the way challenges are being met and managed and the quality and safety of services that are being delivered the organisation has been judged as being good overall.

Summary of findings

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

We always ask the following five questions of services.

Are services safe?

Good

We judged good safe care was provided by across community inpatients, community adults, urgent care services and services for children and young people in all the places that we visited. Safety was judged as requires improvement for end of life care.

Incident reporting across all services was timely and part of routine activity with feedback and learning shared within teams. Staff were aware of their responsibilities for safeguarding and were supported by leads for adult and children safeguarding. Although the provider was unable to confirm that where a role required it, that the higher level of safeguarding training had been completed.

Management of medicines was generally good although access to a clinical pharmacist was not consistent in all the community hospitals. All equipment seen had been maintained and annual safety checks had been carried out. Staff had received training for the equipment they used in their roles. All clinical areas we visited were noted to be clean and maintained. Staff were supported to maintain knowledge through mandatory training and link staff for infection control and end of life care. There were vacancies in most of the services with cover arrangements varying: out of hours for community staff had variable cover arrangements and there was a gap in nursing hours on the Isles of Scilly. For staff working in the community it was a priority to ensure the safety of staff undertaking their roles in these settings.

We found concerns with completion of records for some patients receiving end of life care. The provider must ensure that all Allow Natural Death Orders (ANDO) were completed accurately to ensure the patients preferences, choices and best interest are accurately recorded. Regulation 20 of the Health and Social Care Act 2008.

Are services effective?

Good

We judged the effectiveness of the services provided as good. People's needs were met through the use of evidence based guidelines and multidisciplinary working.

Policies and procedures were developed in line with national guidance and were readily available for staff. There were assessments for patients' pain with appropriate medication being provided. The use of technology to enable patients to monitor their conditions at home via remote tele-health systems had a positive impact on them being able to remain in their own homes. Audit was used in services to monitor patient risks and outcomes to determine

Summary of findings

the effectiveness of care and treatment. There were good systems in place for multidisciplinary working with other internal services and external agencies in all of the core services. This was particularly good in the children's bowel and bladder services. However, the limited availability of physiotherapists and occupational therapists (OTs) in some of the smaller hospitals meant that falls management programmes, as part of a patient's rehabilitation, were not being carried out in line with accepted best practice.

We found concerns in some instances that mental capacity assessments were not always completed or reviewed where patients were identified as not having the capacity to make decisions around end of life care.

Are services caring?

Good

We judged the care provided by staff to be good across all the core services and in all the places that we visited. People were supported, treated with dignity and respect and were involved in their care. Patients, their relatives and carers spoke very positively about the compassion and care they received from staff in both in community hospitals and in the community. We saw staff taking time to talk to people in a supportive, kind and appropriate way. Patients and their relatives told us that they felt reassured and were confident to ask questions and make requests.

Are services responsive to people's needs?

Good

We judged the responsiveness of the services provided as good. People's needs were met through the way that services are organised and delivered. The services were organised in a way that took account of people's choices, enabled continuity of care and valued the importance of flexibility. People were offered services as close to home as possible. Where that was not possible, for example during temporary closure of inpatient services, options were discussed with people and patients told us they appreciated the efforts that were made to accommodate them. The needs of different groups of people, including vulnerable people, were taken account of. Teams were located throughout the county to be able to respond promptly to patients' healthcare needs and staff worked as part of multidisciplinary teams to ensure the patients' needs were met responsively. Changes had been made to venues where clinics were held to meet the needs of people in geographically isolated areas. The care delivered was holistic and individualised. Learning and changes as a result of complaints was achieved through reflection and cascade of information.

Summary of findings

Are services well-led?

Good

We rated the overall leadership of the provider as good although some improvements were needed for urgent and emergency care services. The overall leadership of the organisation is strong, highly visible and focused on the delivery of safe and high quality care. Although the organisation is challenged by a number of historical and current factors there was an inspiring shared purpose. Staff are proud of the organisation as a place to work and speak highly of the open culture. Staff feel valued and well informed and have confidence in the leadership team to deal with the challenges. The culture is vibrant and very focused on delivering the best care possible in a challenging environment. Staff told us that they could shape services to benefit patients and financial pressures were managed so as not to impact on care. Governance systems were in place to monitor the organisation's performance against local commissioning and nationally set targets although improvements were needed in aspects of these to ensure that the Board received and dealt with all appropriate information. The changes made over the last 12 months to frameworks and risk systems needed to be formalised and embedded.

Staff were aware the organisation may be going through some changes in the future but felt that the information about this was communicated to them appropriately. Staff told us that members of the executive team had visited their wards and taken time to speak to them and reassure them. All staff we spoke to felt the Interim Director of Operations, the Chair of the board and the Chief Executive Officer (CEO) were approachable and listened to their concerns. Staff were generally very happy with their local leadership arrangements and felt they could talk freely to their managers. The interim director of operations was new in post and had nursing leadership in their portfolio at board level. We saw the organisation encouraged personal development and initiatives and was open to new, innovative ideas and practices. There were several examples of innovations that had developed the service offered to patients.

Summary of findings

Our inspection team

Our inspection team was led by:

Chair: Dorian Williams, Assistant Director of Governance, Bridgewater Community Healthcare NHS Foundation Trust

Team Leader: Mary Cridge, Care Quality Commission

The team of 29 included CQC inspectors and a variety of specialists: district nurses, a community occupational therapist, a community physiotherapist, a community children's nurse, palliative care nurses, a director of nursing, a governance lead, registered nurses, a community matron and two experts by experience who had used services.

Why we carried out this inspection

We inspected Peninsula Community Health CIC as part of our comprehensive community health services inspection programme.

Peninsula Community Health CIC is an independent organisation providing NHS services and therefore we used our NHS methodology to undertake the inspection.

How we carried out this inspection

During our inspection we reviewed services provided by Peninsula Community Health CIC across Cornwall and the Isles of Scilly. We visited community hospital wards, minor injuries units and outpatient clinics. We accompanied district nursing teams on visits to people in their homes where they were receiving treatment.

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

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

Before visiting, we reviewed a range of information we hold about the core services and asked other organisations to share what they knew, this included Health watch. We carried out an announced visit on 21 – 23 January 2015. During the visit we held focus groups with a range of staff who worked within the service, such as nurses, doctors, therapists. We talked with people who use services. We observed how people were being cared for and talked with carers and/or family members and reviewed care or treatment records of people who use services. We carried out an unannounced visit on 29 January 2015.

Information about the provider

Peninsula Community Health CIC provides NHS healthcare services to a population of over half a million people in Cornwall and the Isles of Scilly. The demographics of Cornwall and the Isles of Scilly are broadly similar to England, although there is a slightly larger elderly population in Cornwall compared to England (6% higher in proportion). Deprivation in Cornwall and the Isles of Scilly is lower than the England average, although about 18.1% of Cornish children live in poverty. Life expectancy in Cornwall and the Isles of Scilly is slightly higher than the national average, standing at 79.5 for males and 83.5 for females compared with 79.2 and 83.0 nationally.

In 2013/14 there were 91,037 patients seen in the Minor Injury Units, Physiotherapists carried out a total of 91,132 outpatient appointments, and Community Nurses made 301,246 patient visits and there were 4,402 inpatients in the Community Hospitals.

It provides the following core services:

Summary of findings

- Community adults
- Community inpatients
- End of life care
- Urgent care services
- Children and young people's services

Peninsula Community Health CIC has a total of 16 registered locations, including 14 hospital sites: a service located at an acute hospital A&E and community teams registered at the headquarters.

Peninsula Community Health CIC was formed in 2011. The organisation has an income of about £88.8million, although was operating at a loss of £328,000 before tax as at March 2014, and employs 2,104 staff across its services.

Peninsula Community Health CIC community hospitals and community services have each been inspected twice since registration. At the time of this inspection all locations previously inspected were compliant.

What people who use the provider's services say

The 'friends and family test' was undertaken in all areas. The overwhelming number of patients responded that they would be 'extremely likely' or likely' to recommend the service to friends and family. On the stroke ward at Camborne and Redruth Hospital we were told "this is the only place I would choose to be, it's very clear that I am improving". Another patient told us they had made "considerable progress" since moving from the acute hospital.

Without exception patients who had received treatment at the minor injuries units were happy with the service at their current and previous visits to the service. Patients reported that the longest wait they had experienced was 30 minutes although a number commented that the waiting time increased in the summer months, but they all said they were given an idea when they arrived of how long the wait was likely to be.

In the children and young peoples' service parents who accompanied their children we spoke with felt they were treated with dignity and respect by staff. One child told us "the nurse was very kind"; a parent told us staff "were caring, kind and thoughtful". We saw that when a child became upset the staff responded in a kind and timely way.

Staff in the children's specialist bladder and bowel service were aware of the social, emotional issues related to these conditions. Parents and carers told us that they felt very supported emotionally by staff.

During our visits to patients receiving care in their own homes patients made positive comments to us regarding the care they received and the staff who provided it. We heard that staff were kind, helpful and caring. Patients were positive regarding their involvement in their care and the planning of any treatment. We were consistently told that staff informed them in detail of the plan of care and treatment and their consent was sought both verbally at each intervention and in writing in the planning stage.

Patients were clear that they were able to speak with their staff at any time and could telephone them regarding any worries or anxieties.

Concerns were expressed by a number of patients regarding the district nursing service. They voiced worries that the service was short staffed and on occasions nurses were late visiting them. We were told that nurses often rang the patient if they were going to be late to reassure them. Patients also added that the community staff were flexible regarding visit times to accommodate

On the stroke ward at Camborne and Redruth hospital patients said the information provided and discussion with the staff ensured they were well informed about their prognosis and discharge targets. A relative told us that they thought the care and treatment on the stroke ward was excellent, with the family fully involved, they said "there is not a bad word to say".

Good practice

We observed outstanding caring and professionalism from staff in Launceston Community Hospital MIU who

Summary of findings

were coping with two complex emergency situations and significant delays in attending by the ambulance service. Staff were calm and sensitive to the distress of the patient, but also the relatives, while also having an inspection in progress.

We witnessed outstanding caring and warmth shown to a child patient in St Austell Community Hospital MIU. Afterwards, the patient said their treatment had been "brilliant" and they now "want to be a nurse when I'm older."

There was an excellent ethos towards staff training and development in the MIUs. All staff were enabled and encouraged to maintain and improve their knowledge and develop new skills.

The specialist children's bladder and bowel service used national guidance and feedback from patients to shape and develop its services to best meet the needs of its patients. Staff attended national and regional forums and took up learning opportunities to optimise their skills. Together with performance activity the service had put forward business plans to commissioners to increase capacity to meet increasing demands. The staff team met monthly for supervision including reviewing cases and forward planning. Complaints were responded to promptly and learnt from and this learning shared with the person who made the complaint. This service was continuously striving for improvement.

The district nursing team had a high number of Queens Nurses. The Queens Nurse is an award presented by the Queens Nursing Institute to nurses who are deemed committed to delivering high standards of practice and patient centre care. This is a nationally recognised award.

We saw examples of where district nursing teams and the community rehabilitation therapy teams had provided individualised and holistic care to patients living in challenging environments which were potentially damaging to their health. The teams respected the patient's decisions and supported them to access services and health care as necessary.

The organisation had been part of a joint initiative that had been awarded a health journal publication - Managing Long Term Conditions award. This project enabled the staff to work with voluntary and Council workers to offer a combination of medical and non-medical support to develop a care plan which suited the person's life and helped them to maintain their health and wellbeing. This project had initially been developed in the Newquay and Penzance areas. Staff were positive about the outcomes they had witnessed and been part of.

The Health for the Homeless demonstrated holistic and individualised care for patients who required additional support to attend appointments to monitor their health and diagnose and treat medical conditions. The service had been working with the liver department at the acute trust to arrange a clinic to be held in local communities. This was to target homeless patients who were known to be non-attenders at the clinic at the acute hospital.

The tissue viability team were working on a project to make sure patients were provided with the correct pressure relieving equipment. This innovative project was also looking at the education of patients, staff and carers in how to manage pressure area care rather than relying on equipment. The tissue viability lead told us that since this has started in December 2014 they had found 50 pressure relieving mattresses which were not required.

The Early Intervention Service (EIS) had received an award for outstanding team contribution from the Cornwall Council Adult Care, Health and Wellbeing Department in 2014.

We observed and were told that the care and support provided by the Specialist Palliative Care Team was excellent. The care provided to patients at the end of their lives and receiving palliative care in the community was of a very high standard and we saw areas of excellent practice including the management, assessment and planning of care by the community SPCT and nursing staff.

In community hospitals all staff we spoke with or observed showed commitment to good care displaying caring and positive attitudes.

Launceston Hospital staff told us about working with the local Age UK team as part of their 'Living Well programme' aimed at identifying areas of a person's life they may like support with once they have left the hospital. They told us this had enabled patients to revisit hobbies they had enjoyed before becoming ill and Age UK had helped them to access transport to local clubs and provided staff to accompany them for example.

Summary of findings

Newquay Hospital had also recently held their first memory café. It was open to patients and members of the public. There were cream teas, music from a male voice choir and a rabbit whisperer performing during the afternoon. Following its success we were told the hospital would be running a memory café once a month.

Each morning the person in charge of each community hospital attended a teleconference along with acute hospital discharge teams that discussed potential discharges from the community hospitals and reviewed suitable admissions form the acute hospitals to the community hospitals. Staff reported these daily conversations as being useful and helpful with planning resources.

Locality managers told us to ensure trained nurses and health care assistants, who were new to the organisation, were able to work effectively soon after they had started with the organisation they were encouraged to attend a week of clinical skills training following their corporate induction. Topics covered included pressure ulcer care, continence awareness, venepuncture, A-Z of wound care and Falls, Frailty and Parkinson's awareness. Staff who had attended this week told us it was invaluable and "great to help me get started".

Areas for improvement

Action the provider MUST or SHOULD take to improve

Action the provider MUST take to improve:

- Develop an effective governance framework for urgent care and minor injuries services, including a comprehensive assurance system to monitor and report on activity, performance, quality, safety and effectiveness. The service must maintain a service level risk register and escalate serious risks to a corporate risk register.
- Ensure that all ANDO were completed accurately to ensure the patients preferences, choices and best interests are accurately recorded.

Action the provider SHOULD take to improve:

- Ensure there is a system for giving feedback to staff consistently on reported concerns and incidents.
- Ensure there are written prompts for staff to enable them to consider any suspicion of abuse of vulnerable adults patients when making initial assessments. The prompts should extend to enable staff to also consider if there is a child who might be at risk in the care of a patient visiting the unit.
- Ensure all medicines are stored in accordance with legal requirements and the provider's medicines management policy. This includes controlled drugs and other medicines stored inappropriately.
- Ensure information about and access to Newquay Hospital MIU for both patients and the ambulance service is clear at the entrance.
- Ensure the environment in St Austell MIU is reviewed for health and safety.
- Ensure patients are able to have private conversations, their records are kept securely and their confidentiality protected in Launceston and St Austell MIUs.
- Ensure that patients waiting to be seen in Newquay Hospital MIU are visible and adequately monitored to ensure they are safe at all times.
- Take steps to maintain staff's skills and confidence in units where patient attendance is low.
- Ensure staff working with children are supported by a structured programme of safeguarding children supervision.
- Ensure there is a system in place to identify and monitor which staff have undertaken safeguarding children training at level 3 where it is a requirement of their role.
- Ensure there are systems in place to review patients' records to ensure they are accurate and complete records of care and treatment.
- Ensure there are systems in place to review outcome measures in all services.
- Ensure robust arrangements are in place at all time to ensure the district nursing and community based service is adequately staffed.

Summary of findings

- Ensure patients in the community have access to replacement tele health equipment in the event of a failure of their device to ensure continuity of monitoring their health whilst at home.
- Ensure access for people with disabilities at Bodmin Hospital is adequate to enable people to be independent
- Ensure the current tools used to measure pain and inform pain management are consistently implemented and used. Current practice varies and a clear audit of monitoring and management of pain was not consistently available.
- Ensure guidance relating to the prescribing of anticipatory medicines in end of life care is available to all staff.
- Ensure all learning from incidents relating to end of life care is disseminated across the provider locations.
- Ensure monitoring of temperatures of all mortuary fridges is maintained and is seen to be at a safe level.
- Ensure that the electronic system 'System 1' enables staff to record and reference effectively. System 1 lacks capacity to capture multidisciplinary working needed for end of life care across the community.
- Ensure the roll out of the Five Priorities of Care of the Dying is implemented swiftly. Delays in roll out were evident since the withdrawal of the Liverpool Care Pathway in July 2014.
- Ensure that all documentation including the Allow a Natural Death Order (ANDO) which requires consent supported by a Mental Capacity Assessment is in place. This must be in place to ensure that the patient's consent and decisions around best interests are served.
- Continue to review staffing levels across the community hospitals including therapy staff.
- Ensure that there is a consistent multidisciplinary approach to the prevention and management of falls across the hospitals,
- Ensure pain assessment and review is always carried out and documented
- Ensure care records are always completed in full
- Ensure meals are served in a timely fashion so that all courses can be enjoyed at the pace of the patient and all course are hot.
- Ensure patient mealtimes are 'protected' in line with the organisations policy.
- Ensure staff receive an annual appraisal in line with the organisations policy.
- Ensure all pressure relieving equipment is checked to ensure it is still fit to use and the checks documented.
- Ensure access to a clinical pharmacist is consistent in all the community hospitals.

Peninsula Community Health C.I.C

Detailed findings

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

Summary of findings

We judged good safe care was provided by across community inpatients, community adults, urgent care services and services for children and young people in all the places that we visited. Safety was judged as requires improvement for end of life care.

Incident reporting across all services was timely and part of routine activity with feedback and learning shared within teams. Staff were aware of their responsibilities for safeguarding and were supported by leads for adult and children safeguarding. Although the provider was unable to confirm that where a role required it, that the higher level of safeguarding training had been completed.

Management of medicines was generally good although access to a clinical pharmacist was not consistent in all the community hospitals. All equipment seen had been maintained and annual safety checks had been carried out. Staff had received training for the equipment they used in their roles. All clinical areas we visited were noted to be clean and maintained. Staff were supported to maintain knowledge through mandatory training and link staff for infection control and end of life care. There were vacancies in most of the services with cover arrangements varying: out of hours for community staff had variable cover arrangements and there was a gap in nursing hours on the Isles of Scilly. For staff working in the community it was a priority to ensure the safety of staff undertaking their roles in these settings.

We found concerns with completion of records for some patients receiving end of life care. The provider must ensure that all Allow Natural Death Orders (ANDO) were completed accurately to ensure the patients preferences, choices and best interest are accurately recorded. Regulation 20 of the Health and social care act 2008.

Our findings

Incident reporting, learning and improvement

- Staff across all services provided by the organisation were aware of the incident reporting mechanisms and were confident in reporting relevant incidents in a timely

Good

Are services safe?

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

manner. Feedback and shared learning from incidents was reported to be in place with examples given of where changes to policies and practice had been made as a result of feedback.

- Staff predominantly said they received feedback from incidents although a small proportion reported that they felt feedback was not always given.

Duty of candour

- New fundamental standards and regulation for the provider will come into force in April 2015 regarding Duty of Candour (Regulation 20 of the CQC (registration) Regulations 2009). The duty of candour explains what providers should do to make sure they are open and honest with patients when something goes wrong with their care and treatment.
- We spoke with staff throughout our inspection, regarding their understanding and knowledge of The Duty of Candour in preparation for the new Regulation coming into effect in April 2015. The response was mixed, with some staff being fully aware of the implications for them following information disseminated within the organisations and discussions in team meetings. Others, whilst not aware of the term Duty of Candour were aware of some of the principles. We found senior staff were able to describe how the duty of candour was part of their working life and how openness and honesty related to their practice.

Safeguarding

- Staff working across all services provided had access to information and polices regarding identifying abuse and making appropriate referrals. This was supported by training at three levels dependent on the member of staff's role and whether they worked with children. There was a lack of information available to confirm which staff had received training at level 3. This meant that there was a lack of assurance that some staff working with children had received the required level of training which could place a child at risk.
- There was a named nurse and doctor for safeguarding children which staff told us they could seek advice from as they needed.
- In the minor injury units we visited there were reliable systems in place to protect vulnerable people from abuse. Information was displayed about how to progress concerns. Staff knew of their responsibilities for reporting concerns to the provider leads for safeguarding vulnerable adults and children, and the local authority. MIU staff used checklists within paediatric patient assessments covering any suspicions of abuse and what to do with any concerns. There were, however, no prompts for considering any abuse of vulnerable adult patients or dependents in the adult assessment notes.
- Staff who worked in the community hospitals demonstrated a good understanding of safeguarding and were confident in the support they received from the provider safeguarding lead for adults.
- Staff working in the community settings and people's homes, including district nursing teams, therapists and the health for the homeless service had all raised alerts for vulnerable adults who lived in their own homes, care homes and hostels. They demonstrated awareness of identifying abuse or neglect and acted appropriately by raising alerts.

Medicines management

- Medicines were stored appropriately in the majority of areas inspected including being refrigerated where required. Administration of medicine was found to be in accordance with the providers policies. Where appropriate, such as the MIUs the provider used Patient Group Directions (PGDs). These are written and approved instructions for the supply or administration of medicines to groups of patients which enabled nursing staff to administer, prescribe and supply medicines from an approved stock.
- There were pharmaceutical advisors employed whose role was to provide support to clinical staff, investigate medicine incidents, provide training for staff and produce a monthly newsletter which highlighted medicine issues and learning from the investigation of incidents. They also held regular meetings with ward nursing staff and matrons to discuss current medicine issues.
- Access to a clinical pharmacist was not consistent in all the community hospitals which meant there was no oversight of prescribing by a pharmacist at these locations. Four of the hospitals did not have a clinical pharmacist visit, at two of the other hospitals a pharmacist visited once a month and at the remaining hospitals a pharmacist visited once a week.
- Only three hospitals received a stock medicines top- up service. These arrangements had been identified as a risk by the organisation action was planned to employ a

Good

Are services safe?

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pharmacy technician to target areas that needed support. Staff were able to contact pharmaceutical advisors by telephone or access medicines information and an out of hour's service from the local NHS acute trust.

- Staff working in people's homes in the community setting had access to emergency medications and were trained in their use. To support patients to remain at home district nurses were trained to give intravenous medication (usually antibiotics), they were also trained and competent to use syringe drivers for the management of people's pain and as part of end of life care.
- Patients requiring end of life care had their needs for pain relief identified and were prescribed anticipatory medicines. These 'as required' medicines were prescribed in advance to ensure prompt management of increases in pain and changes in symptoms. When patients were discharged from hospital they were given information about the medicines to be administered. For those patients with support from the specialist palliative care team and the District Nurse teams this support remained ongoing to ensure medicines were administered safely.

Safety of equipment and facilities

- We looked at a range of equipment in all the hospitals we visited, including beds, hoists, wheelchairs, physiotherapy equipment and medical equipment. We found that all maintenance was up-to-date and recorded and annual safety checks had been carried out. Staff had received training for the equipment they used in their roles.
- Emergency equipment, including resuscitation equipment, was seen to be checked regularly in all the locations. Resuscitation equipment for children was available in the minor injuries units.
- Access to pressure relieving equipment such as mattresses and cushions either on wards or from the equipment store was reported to be good. However at weekends and bank holidays both hospital and community staff reported this could sometimes be more difficult.
- An emergency store was in place for community nurses to access equipment out of hours. It only included equipment that community nurses were able carry in their cars, for example, repose mattresses and commodes. There were some pressure relieving cushions that had 'bottomed out' meaning they were no longer able to give the required relief.
- Where clinics required sterilised equipment, a contract had been set up with the Royal Cornwall Hospitals Trust. Staff told us this worked well. If they required any additional equipment they telephoned to request this.
- Issues that related to the buildings at community hospitals often took longer to resolve as the organisation did not own any of the premises they provided services in. There was a backlog of estates' maintenance that the organisation had placed on their risk register. Staff told us they knew the organisation was in negotiation with the owners of the buildings about the outstanding maintenance issues.
- The provider had taken the decision to close Stratton Hospital to inpatients, for a short period of time (which included the time we inspected the organisation). This was to ensure the safety of patients was not put at risk whilst some important remedial building work was taking place.
- Access to the ambulance entrance door at Newquay minor injuries unit was locked to emergency ambulance crews arriving. When nursing staff were attending a patient they had to interrupt their treatment to admit ambulance personnel which took them away from the patients they were attending.

Records management

- The majority of patient care and medical records were of a good standard accurate and up to date and were stored to protect patient's confidentiality. Electronic recording systems were in place in the community teams where there had been some challenges in the initial implementation. Actions were in place to address the issues.
- We reviewed Allow Natural Death Orders (ANDO) and found there was a lack of space for recording of reviews of patients and discussions with the patient and/or their relatives and there was no space to identify if the patient was still in agreement with the previous decision.
- We reviewed 25 Allow a Natural Death Orders (ANDO) forms which were a record of the decision not to attempt cardio pulmonary resuscitation. Of the 25 forms we viewed, all had been signed by a GP in line with the organisational policy.

Good

Are services safe?

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

- Five of the forms we reviewed had not been completed correctly. We saw on two forms the term 'medical futility' was used instead of a clear summary of the main clinical reasons why cardiopulmonary resuscitation (CPR) was inappropriate. In two cases there was no detailed documentation of discussions with the patients' relatives and in another case we saw the use of an abbreviation on the form. This use of abbreviation may cause confusion about actual meaning.
- We saw in one hospital an ANDO had been completed which stated the patient did not have mental capacity to be included in discussion about that decision. However the mental capacity assessment noted that the patient had improved and now had capacity. The ANDO had not been reviewed and updated to reflect this change in mental capacity. This meant that the patient's choice for care may not have been accurately reflected and recorded.

Cleanliness and infection control

- All clinical areas we visited were noted to be clean and maintained. Policies and procedures for infection prevention and control were available to staff in all settings. Records and discussions with staff demonstrated that infection control training was provided during staff induction training and updated every year.
- We observed staff working in patients' own homes, inpatient wards, minor injuries units and clinics. All followed the policies and procedures relating to hand washing and use of personal protective equipment, for example, the use of antibacterial hand gel, gloves and aprons. Provision to isolate patients with, or at risk of infection was available in all the community hospitals we visited with side rooms being available for use.
- Hand hygiene audits were carried out on a monthly basis and results were reported back to staff. Records showed that the standard of hand hygiene within district nursing and therapy teams was high. Hand Inspection audits were carried out by inpatients, outpatients and community teams. This looks at the length of nails, absence of nail varnish / extensions and the permissible one ring only and ensures that any cuts and abrasions are cover appropriately.
- Clinical waste was managed in accordance with safe practice. All the units we visited had arrangements for the safe collection, removal and storage of clinical waste, including sharp instrument boxes and specific bins to segregate waste. Infection prevention and control link nurses from all areas were in post and attended quarterly meetings to discuss infection control issues and update other staff on practice.
- The infection control team provided a service across all community and hospital teams. Access to microbiology advice was via the acute hospitals departments. The provider had an infection control committee however there was no microbiology or infection control doctor representation on the committee. Reports to the committee provided overviews of hand hygiene and environmental audit scores however there was a lack of correlation of themes for areas where scores were not to the expected standard.

Mandatory training

- Mandatory training was provided for all staff with data produced by the provider stated 91% all of staff were compliant with the seven core mandatory training requirements. Staff confirmed that training provision was well managed and accessible. Recent changes to the mandatory training arrangements had enabled staff to access their annual training update in a single day. Staff reported that it was easier to be released and they were away from clinical roles for less time. They also said it was easier for them to ensure all of their mandatory training was up to date.
- The Specialist palliative care team provided both formal and informal training to staff, this included symptom control, communication and advance care planning.
- In community hospitals the percentage of staff receiving mandatory training had improved over the last few months. It had been recognised that staff shortages had led to staff sometimes having to cancel mandatory training sessions to provide cover on the wards.
- For three district nursing teams and noted that compliance for mandatory training was between 75% and 80% from October to December 2014. The provider was not able to supply data to show how the specific staff working across MIUs were up to date with their training. The information was only available showing staff by the hospital they were based at, and not the service they provided.

Assessing and responding to patient risk

- The therapy team gave examples of where patients were enabled to make informed choices regarding their

Good

Are services safe?

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rehabilitation and discharge home. We saw an outstanding example of risk management by the community rehabilitation team which demonstrated the support offered to one patient.

- Risk assessments were carried out for patients and plans were developed to manage identified risks. For example, if patient being visited at home had a pet which was considered to pose a risk. Known patient risks were discussed at team handovers to ensure all staff were made aware of the action they must take to reduce the risk.
- The National Early Warning Score (NEWS) documentation was used in all of the community hospitals (a standardised bedside chart that uses universally recognised terminology to make it easier for clinical staff to recognise and respond to a patient whose condition is deteriorating). We saw records that showed patients had been referred to the medical team appropriately based on changing scores.
- Care records we reviewed contained risk assessments. These provided guidance to staff on how to reduce or eliminate risks. For example, there was a falls risk assessment explaining what equipment a patient needed to use and how many staff were required to support them. Risk assessments were also completed for patients at risk of developing pressure ulcers and patients with vulnerable areas were checked regularly.
- Patients arriving at MIUs were responded to in accordance with the urgency of their complaint. As each patient arrived the receptionist, a nurse or healthcare assistant, would meet them and take some brief details of their injury or illness. If a patient talked about certain symptoms, such as chest pains, abdominal pain, breathing difficulties, or confusion following a head injury, they would get urgent attention. While we were visiting two of the MIUs we observed a calm and professional but urgent response to symptoms of this nature.
- We observed a multiagency meeting for a child with complex physical health needs in the community. Arrangements were put in place to manage the risks for this child. We observed protocols being amended to reflect changes in the child's condition and the care required.

Staffing levels and caseload

- Staffing levels were sufficient to ensure that patients received safe care and treatment in the end of life care team. A service was provided in the community hospitals and community seven days a week.
- Specialist Palliative care was provided from 8am to 5pm seven days a week. Outside of these hours and weekends, end of life care was provided by ward staff with access to specialist support from a local hospice.
- We reviewed the staffing and caseloads teams of district nurses and therapy staff. Each team leader had a good understanding of their staffing levels and service provision was monitored. The interim director of operations was aware of staffing vacancies, sickness and turnover throughout the services. Ongoing recruitment was taking place. District nursing teams were commissioned in localities to provide a service from 8.30am to 5.30pm each day, with a rota for one registered nurse per team to be on call from home from 5pm to 10pm. We found inconsistencies amongst teams in how this on call system operated.
- A workload assessment tool had been developed for district nursing in response to the Francis Report to ensure there were sufficient district nurses to meet the care and support needs of patients in their own homes across the geographical area. (The Francis report examined the causes of the failings in care at another health trust and made 290 recommendations of how the service could have been improved).
- The Isles of Scilly locality manager reviewed the staffing required to meet the needs of patients living in their own homes and in the Island's care home each week during the weekly multidisciplinary team meeting. This enabled sufficient resources to be allocated to the district nursing service.
- Most community hospitals had staff vacancies (nursing and healthcare assistant). Staff, including therapists, at all sites we visited and including St Mary's Hospital on the Isles of Scilly told us that staffing levels were a concern. We were told there was frequent use of agency and bank staff. The organisation continued to advertise for and recruit new staff. The clinical practice week, that trained nurses undertook following their induction, meant that they were able to work on the wards using the required skills quite soon after commencing employment. Staff told us the recruitment process for bank staff (including therapists) could be lengthy and had meant some people had found alternative employment due to the long wait.

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- We identified some concerns over the staffing ratios on certain wards at certain times at Helston Hospital and Camborne and Redruth Hospitals.
- In the minor injuries units there was a good skill mix of experienced and trained staff. The nursing staff were either trained to sister/staff nurse level, with further qualifications in minor injuries and illnesses, or were band five nurses in the process of completing their specialist training. The smaller units at Fowey and Helston were staffed by registered nurses, but they were not dedicated to the MIU as they worked on the inpatients ward and were called to the MIU when a patient rang or altered staff they were there.
- In the children's specialist bladder and bowel service as a result of a staff review a proposal had been put forward to ensure the staffing levels and skill mix reflected and met the patients' needs which had included an increase in administrative support. Previously a need for an additional nurse in the service had been identified on the risk register and this nurse had been recruited.

Managing anticipated risks

- Team leaders in the community told us it was a priority for them to ensure the safety of staff undertaking their roles in community settings. When working alone out of hours, staff were supported by the organisation's switchboard. Staff had a clear understanding of the lone working policy. They followed safe systems to ensure when working alone in the community they informed colleagues of their whereabouts and 'checked in' regularly.
- Staff in the community told us about plans in place to reach patients who were less accessible in the event of poor weather, such as snow or flooding. Hard copy records were maintained to enable staff to access records and so spread the workload to staff with more weather suitable vehicles. Staff told us that they were used to the inclement weather and would reallocate visits as needed to ensure priority patients were visited.
- In the minor injuries units there was no change to service provision to meet seasonal demand, but almost all patients were seen within a target time of two hours (65% target) and four hours (95% target) at most.

Major incident awareness and training

- The organisation's major incident plan was available for staff working in all areas on the intranet. Staff knew how to access the policy. Matrons and ward managers explained what would happen in the event of a major incident and were well informed.
- Some of the larger community hospitals had a major incident room where equipment and policies and procedures were kept. Ward managers at the smaller hospitals said they did not have a permanent major incident room, but had a room that would be allocated in the event of a major incident and a major incident pack to use as required.

Are services effective?

Good

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

Summary of findings

We judged the effectiveness of the services provided as good. People's needs were met through the use of evidence based guidelines and multidisciplinary working.

Policies and procedures were developed in line with national guidance and were readily available for staff. There were assessments for patients' pain with appropriate medication being provided. The use of technology to enable patients to monitor their conditions at home via remote tele-health systems had a positive impact on them being able to remain in their own homes. Audit was used in services to monitor patient risks and outcomes to determine the effectiveness of care and treatment. There were good systems in place for multidisciplinary working with other internal services and external agencies in all of the core services. This was particularly good in the children's bowel and bladder services. However, the limited availability of physiotherapists and occupational therapists (OTs) in some of the smaller hospitals meant that falls management programmes, as part of a patient's rehabilitation, were not being carried out in line with accepted best practice.

We found concerns in some instances that mental capacity assessments were not always completed or reviewed where patients were identified as not having the capacity to make decisions around end of life care.

Our findings

Evidence-based care and treatment

- Policies and procedures were developed in line with national guidance and were available for staff on the organisation's intranet. Staff in all locations and teams we visited were aware of the guidelines relevant to their area of work. The majority of staff across the district nursing teams were able to tell us about the clinical guidelines and National Institute for Health and Care Excellence (NICE) guidance which helped to inform their practice. For example, staff were familiar with the wound management formulary.
- The community based falls team worked in line with NICE guidance on the assessment and prevention of falls in older people.
- Staff in the community hospitals promoted skin integrity through the use of SSKIN, a five step model for pressure ulcer prevention (surface (of the bed/chair) – make sure your patients have the right support, skin inspection – early inspection means early detection (show patients and carers what to look for), keep patients moving, incontinence/moisture – your patients need to be clean and dry and nutrition/hydration – help patients have the right diet and plenty of fluids).
- Most of the hospitals provided some degree of rehabilitation for patients to help them to become more mobile or independent. However, the limited availability of physiotherapists and occupational therapists (OTs) in some of the smaller hospitals meant that falls management programmes, as part of a patient's rehabilitation, were not being carried out in line with accepted best practice.
- The Specialist Palliative Care Team delivered care in line with evidence based guidance such as Improving Supportive and Personal Care for Adults with Cancer developed by the National Institute for Health and Clinical Excellence (NICE).
- The provider used Allow a Natural Death Orders (ANDO). These records were used to document discussions with patients and their relatives about the 'ceilings of care' (which treatments would or would not be appropriate when a patient's condition deteriorates).
- Care and treatment was evidence based and staff accessed up-to-date information regarding good practice recommendations. Examples of this were the guidelines produced by the speech and language therapists (SALT) for the use of thickened fluids and the re-ablement care and treatment provided by the SALT and physiotherapists for patients with motor neurone disease

Pain relief

- There were tools in place to assess and monitor pain, and pain control was a priority in palliative care. Nursing staff used an assessment tool to provide a score to identify the severity of a patient's pain. There were prompts for staff to identify when patients were not able to articulate their needs, for example, if patients had a

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level of dementia or cognitive impairment. There was a specific Pain Assessment in Advanced Dementia (PAINAD) form in use for patients with cognitive difficulties.

- In community hospitals Patients were prescribed pain relief, as appropriate. Most hospitals received daily visits (Monday to Friday) from GPs, who were able to adjust prescriptions for pain relief as required. The out of hours service was able to alter or prescribe pain relief medication at weekends, evenings and bank holidays. A small number of pain assessment records were not completed.
- Across district nursing and therapy teams' patients' pain was being managed effectively through the use of a pain assessment tool. Patients were supported and/or enabled to take their pain relief prior to treatment and care being delivered. For example, we saw district nursing visits scheduled to coincide with the patient taking their pain relief.
- Patients presenting at MIUs were assessed for pain and offered analgesia as part of the triage process and treatment for patients. We observed nursing, health care and reception staff asking patients when they arrived if they were in any pain. Patients were asked to score their pain on a scale of 1-10 and this was recorded on the electronic patient record.
- Children were assessed differently for pain. In Bodmin MIU staff told us about pain scores for children. Younger children were given a picture of various 'smiley' faces and asked which face would describe their pain or how they felt.

Nutrition and hydration

- Patients' nutrition and hydration needs were assessed in line with their clinical condition and were recorded on their care records in all settings we visited. We saw evidence of where the Malnutrition Universal Screening Tool (MUST) had been completed for people at risk. When required specialist dieticians were available for advice from the local NHS trust.
- Mealtimes in community hospitals were protected to enable patients time to eat without interruptions from visitors or for treatment. Although at Launceston Hospital we saw lunchtime where domestic staff continued to clean the ward and some patients were left with their meals for 15 minutes before a staff member was able to help them. We also saw patients were given a hot dessert at the same time as their main course. We noted that by the time some patients had finished their main course their dessert was cold.
- We saw that patients in the last days of life were able to eat and drink as they wished. There was guidance for staff around this and the need for patients to be able to make informed choices even when a risk of choking had been identified

Use of technology and telemedicine

- Tele-health was in use throughout the region for patients seen by district nurses and other community based specialist teams. This was where a number of patients with long term health conditions could monitor their own health at home. Patients sent in details of certain vital signs at set periods of time, dependent on their illness, to a monitoring centre via a telephone line. If deterioration in their condition had taken place, the monitoring centre contacted the patient's relevant healthcare professional. Patients using this were able to commence treatment quicker and prevent hospital admission. The provider monitored the use of tele health activity and from records provided we found that from September 2013 to October 2014 the number of patients using this had increased by 28 to a total of 69 patients.
- The matron from St Mary's Hospital on the Isles of Scilly said they had a working group established to identify how the system could be best used on the Islands and to encourage consultants from the acute NHS trust to use it. She gave an example where it was used successfully with a patient on one of the other islands in the group and it had significantly reduced their hospital admissions.

Approach to monitoring quality and people's outcomes

- The district nurses were using a frailty tool which enabled the frail elderly to be continually assessed. We observed how one patient's medical condition had deteriorated and they were experiencing more frequent falls. The care team had used the falls pathway to assess the level of risk and had made reasonable adjustments to enable the patient to remain in their own home safely as they wished to do.

Are services effective?

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- In the MIUs there was a follow-up service to assess the minor illness service where reception staff were calling patients the day after their visit to check if they had received a good service or had any remaining concerns about their health or wellbeing.
- Outcomes of people's care and treatment were routinely collected in the children's specialist bladder and bowel service and the TB service. The specialist bladder and bowel service asked children and parents what improvements in their conditions they had experienced and the responses had been very positive.
- In the community hospitals each ward had to complete a number of local audits, which included ensuring food and fluid charts and medication administration records were completed and the number of falls were monitored. Any themes that emerged were bought to the attention of the staff to ensure quality and consistency of care was being maintained.
- For end of life care the use of the Gold Standard Framework (GSF) was audited and showed that in July 2014 62% of patients on the GSF were supported to make advance care plan decisions. Of the patients audited, 60% died with an end of life care plan in place and 80% of carers were offered bereavement information and support.

Outcomes of care and treatment

- Outcomes for patient care and treatment were routinely recorded. Eighty-one per cent of patients referred to Specialist Palliative CareTeam died in their preferred place of care, when this had been identified.
- The provider was working to reduce the length of hospital stay. The average length of stay (ALOS) of patients had reduced across the community hospitals. Staff told us this was due to improved communication with acute trusts, local social service teams, and the introduction of a discharge coordinator. They had been particularly helpful in organising complex packages of care.
  - In the north of the county the ALOS had reduced from 24.1 days in September 2014 to 22.6 days in October 2014.
  - In the mid region it had reduced from 24.1 days in September 2014 to 23.6 days in October 2014.
  - In the west it had reduced from 23.9 days in September 2014 to 23.1 days in October 2014. The organisation had set a 23 day length of stay target across the county.
- The bladder and bowel service reviewed complex cases at their monthly team meeting and through peer group supervision. Data was captured on patient outcomes when patients were discharged with staff and patients monitored improvements and diaries were used by patients, with goals being set and achieved.
- In the MIUs the number of patients who re-attended for unplanned further treatment was low. The provider had a target for unplanned re-attendance of less than 5%. In the period from April to December 2014, the average number of patients re-attending the units was just below 3%.

Competent staff

- Staff treating children in the specialist bladder bowel service, the TB service, respiratory nurse service, dermatology nurse service and physiotherapy service had specialist knowledge and skills to treat children with their presenting conditions. They had completed appropriate training and were encouraged to further develop their skills.
- Supervision for staff varied, with some having regular supervision and others not. Specialist staff we spoke with had annual appraisals that they found meaningful and useful.
- Staff in the MIUs were enabled to update their core skills on elements of the modular courses each year. Staff treating children and young people had received specific training to care for and treat children. Staff were trained to deal with life threatening emergencies. All nursing staff were trained to deliver intermediate life support (ILS) to both adults and children and in acute illness management. Health care assistants and administration staff were trained in basic life support.
- The provider was not able to supply data to show how the specific staff working across MIUs were up-to-date with their annual performance review. The information was only available showing staff by the hospital they were based at, and not the service they provided.
- Most staff working in the community hospitals had had an annual appraisal and had regular one to one meetings with their immediate managers to discuss their training needs and ongoing performance.
- End of life care and palliative care was provided by well trained and competent staff. The Community Specialist

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Palliative care Team produced a performance summary April 2013 to March 2014. This summary identified staffing levels, training and supervision records and patient experience.

- Ward and community staff we spoke with told us the specialist palliative care nurses acted as a resource and point of contact for advice and participated in delivering training in end of life care. Staff were able to contact a specialist palliative care consultant at the local hospice for advice around symptom management.
- There were end of life 'link' nurses and healthcare assistants who were based on the wards in the community hospitals. They provided information and support to their colleagues. We saw evidence of link meetings attended by the link staff and general ward staff told us that the link staff took a special interest in end of life care initiatives and communicating with other staff about these.
- The provider ensured staff working in the community had access to relevant update and clinical training from two clinical facilitators who worked throughout the county. Staff were positive about these members of staff and said they were approachable, supportive and always provided a prompt response. Staff were also encouraged and enabled to keep their skills and competencies up-to-date by spending time working with appropriate practitioners.
- Staff on the Isles of Scilly relied on e-learning for much of their training, with face to face training provided on the mainland. Staff had identified link roles and attended link meetings when possible and cascaded information to their colleagues.
- Arrangements for appropriate clinical supervision for clinical staff were in place. For example, the community matrons were supported monthly by the community geriatrician. Staff views on the appraisal system varied. The community therapy staff told us they had supervision sessions every six weeks with their line managers. All the therapy staff we spoke with were positive about these sessions

Multi-disciplinary working and co-ordination of care pathways

- The criteria were clear and we saw staff worked closely with other agencies to deliver care. There was proactive engagement with other health and social care providers and other bodies to coordinate care and meet children's needs.
- We observed a multi-agency meeting called a 'Team Around the Child' (TAC) to support a child with complex physical needs. The staff were working together to support the child. There was joined up work but it was a challenge to coordinate their support. We saw good examples of staff liaising with doctors and specialists, both within and outside of Peninsula Community Health.
- In the community hospitals we saw many examples of good multidisciplinary work to ensure patients were seen by the most relevant specialists during their stay in hospital. This included dieticians or speech and language therapists. Appropriate correct care and support was arranged for people once they were discharged.
- There was a good approach to multidisciplinary working in end of life care. The SPCT audit for 2013 demonstrated that the county had a lower rate of patients dying in a hospital setting and a higher rate of patients dying in other settings. To achieve this, coordination was required and the involvement of a wider multidisciplinary team.
- In the community the multidisciplinary meetings took place at the local hospice where the medical consultant attended and led the reviews. These were attended by the SPCT for Peninsula CHS.
- In the MIUs staff contacted GPs when a patient on their list had attended the unit, as were school nurses when the patient was in school and the health visitor if one was involved with the patient or family. There was a good relationship with the accident and emergency (A&E) departments in the local acute hospitals.
- The community matrons and district nurses worked closely together and reviewed caseloads to ensure all patients were seen by the appropriate staff teams and supported each other with patient visits as necessary. When patients required the support of additional professionals, the community nursing teams arranged joint visits whenever possible, to reduce the number of visits experienced by the patients. For example, when working with the Acute Care at Home team, tissue viability nurses, diabetes specialist nurse and GPs.

Referral, transfer, discharge and transition

- The services treating children in Peninsula Community Health also provided treatment for adults which meant that young people did not need to transfer to another service at the age of 16 or 18.

Are services effective?

Good

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- Patients receiving end of life care were referred and transferred appropriately. The discharge or transition to an alternative place of care was a multidisciplinary process which included the input of ward nurses and doctors, therapists and external support agencies who would be involved in providing end of life care at home.
- While we were at two of the MIUs we visited, patients arrived with conditions that required a transfer to the A&E department under the patient protocol. Staff ensured the patients were safe and provided appropriate treatment while an ambulance was called.
- Where patients receiving care in their own home required a referral to a specialist service the district nurses used the provider's electronic recording system make the referral. We saw evidence of referrals made to the tissue viability service, the learning disabilities nurse or the dementia service lead for the organisation.
- We saw evidence of joint discharge planning with the district nurses and community hospital detailed in patients' care records.

Availability of information

- For the community teams' staff were able to access records and information to deliver effective care and treatment. Records were stored securely at either staff bases or at a clinic where they worked. When clinics were held in other venues the records were couriered securely for these appointments.
- Records in the community were kept in both paper and electronic formats. The implementation of an electronic recording system was problematic for some staff and additional systems had been put in place to ensure safety for patients. These included the addition of paper records in patients' homes and a paper record being maintained in offices in case of poor weather.
- In the community hospitals patient information was available to all relevant staff in the form of medical records, care records and therapy care plans.
- We were told that information about the results of blood tests or imaging such as X-rays were available as expected. The electronic recording system in use by community staff did not link in to the system used in the hospital settings so paper information was used to pass information between the two settings as required. This was not reported as a problem within the community hospitals.
- Electronic systems for records varied across community services providing end of life care. The systems did not link to provide information for all staff involved. The hospital system did not link to the community system, which did not link to the GP system. This meant the duplication of records and increased work for staff. The Isles of Scilly were not linked electronically to the mainland and all information was in paper format.

Consent

- Consent from children, young people and families prior to commencing care or treatment was obtained in line with an assessment of competency/Fraser guidelines for children and young people. This framework was used when deciding whether a child or young person was mature enough to make decisions without parental consent.
- For end of life care nursing and medical staff were knowledgeable regarding the processes to follow should a patient's ability to provide informed consent to care and treatment be in doubt. We looked at three records at Edward Hain Hospital and Helston Hospital and saw that mental capacity and best interest processes had been followed and documented. We saw that records identified when relatives/representatives had been involved in decisions and these records highlighted who had been involved and the date of the best interest decision.
- In respect of end of life care medical staff we spoke with told us they did not routinely complete a mental capacity assessment for patients who they considered did not have capacity when making an ANDO/ CPR decision. This may mean that the decisions made may not be fully understood by the patient and decisions made may not be what they would want.
- We viewed four ANDO forms where decisions not to attempt CPR were recorded where the patients lacked mental capacity. We did not see completed mental capacity assessments for any of these patients.
- During our visits with health professionals to patients in their own homes, we saw verbal consent was consistently sought prior to carrying out any care or treatment and when staff planned to share the patient's information with another professional. We saw mental capacity assessments had been completed where there was concern around patients' ability to make informed choices and decisions.

Are services effective?

Good

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- In community hospitals we found patients were routinely asked for their consent before staff provided care. Staff recognised the need to ensure mental capacity assessments were carried out when appropriate. They ensured that where patients lacked capacity to take valid informed decisions about their care and support; these were made on their behalf in their best interests.
- Staff in the MIUs were aware that as the treatment they were providing was not high risk, they did not need written consent and verbal or implied consent was acceptable. Staff said patients were told what staff proposed to do and were able to ask any questions before treatment took place.

Staff understood and used the provisions of the Mental Capacity Act 2005 when an adult patient did not have the ability to provide valid informed consent. Staff described how they would consult with the patient's family or someone who spoke for them if the person did not have the mental capacity to give consent.

Good

Are services caring?

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

Summary of findings

We judged the care provided by staff to be good across all the core services and in all the places that we visited. People were supported, treated with dignity and respect and were involved in their care. Patients, their relatives and carers spoke very positively about the compassion and care they received from staff in both in community hospitals and in the community. We saw staff taking time to talk to people in a supportive, kind and appropriate way. Patients and their relatives told us that they felt reassured and were confident to ask questions and make requests.

Our findings

Dignity, respect and compassionate care

- Staff displayed an awareness of the importance of "community" in Cornwall and care was planned in a way to take account of personal, cultural and social needs. This meant that care was delivered as close as possible to people with every effort being made to ensure discharges from hospitals met the right geographical need of the patient.
- In all services and places we observed kind and compassionate interactions between staff, patients, relatives and carers, including with children and their parents. Staff took time to talk to people, to deal with questions, concerns and worries and to provide answers, information and kind reassurance. We observed that staff had a good rapport with patients, particularly those who had been inpatients for a period of time. Without exception, the patients and relatives that we met said staff were caring and sensitive. One patient spoke of how staff were empathetic with the pain they were experiencing, and another said told us about how staff had made sure they were able to get home safely.
- We observed that staff took steps to ensure that privacy and dignity was respected in conversations and during the provision of physical, personal and intimate care. The layout of some areas, for example in some clinics and minor injury units means that conversations could at times be overheard.
- The provider participated in the Patient Led Assessment of the Care Environment (January 2014 to June 2014). The scores in the 'privacy, dignity and wellbeing' category fell below the national average of 85%, with an organisation average of 75%, across nine community hospitals reviewed. Where there was a low score reported action plans were in place. We saw the action plans and current progress displayed on some of the wards we visited. In one hospital this included plans to make better use of communal space to give patients some privacy away from their bed space.

Patient understanding and involvement

- People using services, their relatives and carers were involved and included appropriately in discussions and decisions about care. This was observed in action across core services in all areas visited and was also seen in records of care where conversations and decisions were clearly documented. Staff told us about occasions when carers of patients with a learning disability, dementia or other cognitive impairment were supported to stay at the hospital to support the patient and minimise any distress. Visiting for families of patients receiving end of life care was unlimited and hospitality and support was provided by staff.
- Patients told us that they knew why they were in hospital and the expected outcomes. A patient told us "I have been given information to aid my choices, for example, about being discharged" and "I know my named nurse and she would tell me about my care".
- Staff followed up patients where they were concerned about their understanding of any after-care or making arrangements to see other professionals. Patients and carers were encouraged to make contact and to telephone for advice.

Emotional support

- Staff had a good knowledge of local support networks and were able to describe these and explain how they made contact on behalf of patients. Examples included bereavement counselling, advocacy services and Age UK, who could provide emotional support to patients when they were discharged home. Other examples included a local school support centre for children needing extra support or someone to talk with.
- Staff told us they felt they had the time to spend with patients to support their emotional needs. We observed

Good

Are services caring?

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

hospital and community staff spending time with patients and their relatives to establish emotional support needs and provide appropriate support and advice. Parents and carers told us that they felt much supported emotionally by staff.

- Staff were supported to meet the emotional needs of patients through enabling pets to visit their owners in hospital or through the involvement of the Pets as Therapy' (PAT) dog service. The team observed a PAT dog visiting one hospital and providing comfort for a number of patients. The team found recent examples in Falmouth Hospital where dogs had visited patients. These patients described the comfort they had from seeing them.
- Some staff told us they undertook psychological support training. We were told that group supervision/ support sessions were held for staff if they had experienced a distressing or difficult situation to "provide support and comfort for each other".

Promotion of self-care

- We observed care being provided within the community and saw that self-care was actively promoted. We saw patients and relatives being actively involved in developing their care plan. They were supported to ask questions, make suggestions and decline suggestions and treatment that they did not want. We saw that staff let the patient take the lead in decisions about issues such as diet, exercise and medication arrangements.
- We observed patients on the wards being supported to take the lead in their own care as appropriate. This included inclusion in decisions about staying in bed and bathing. We saw that parents and children were supported to manage their own health, care and wellbeing. Parents told us they felt confident in managing their children's needs.
- In a number of the community hospitals there were occupational therapy assessment kitchens to help and support patients regain or learn new skills in the kitchen to help their independence when they returned home. We saw staff taking a patient home for a home assessment as part of the discharge planning process.
- The provider had a policy on self medication to guide staff in supporting patients. Patients who could manage and were assessed as being able to manage their own medicines were supported to do so during their inpatient care.

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Good

Are services responsive to people's needs?

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

Summary of findings

We judged the responsiveness of the services provided as good. People's needs were met through the way that services are organised and delivered. The services were organised in a way that took account of people's choices, enabled continuity of care and valued the importance of flexibility. People were offered services as close to home as possible. Where that was not possible, for example during temporary closure of inpatient services, options were discussed with people and patients told us they appreciated the efforts that were made to accommodate them. The needs of different groups of people, including vulnerable people, were taken account of. Teams were located throughout the county to be able to respond promptly to patients' healthcare needs and staff worked as part of multidisciplinary teams to ensure the patients' needs were met responsively. Changes had been made to venues where clinics were held to meet the needs of people in geographically isolated areas. The care delivered was holistic and individualised. Learning and changes as a result of complaints was achieved through reflection and cascade of information.

Our findings

Planning and delivering services which meet people's needs

- There was evidence across the core services that information about the needs of the local population was used to inform the planning and delivery of services. Examples included the specialist services for children where analysis of information had enabled potential gaps to be identified and addressed with commissioners and relevant stakeholders. Information had been used to plan and deliver a service that had adhered to national guidance and had enabled it to achieve a vaccination programme. The services provided to people at the end of their life worked with patients and carers to identify their preferred place of care. The most recent information available showed that this had been identified for 77% of patients and had been achieved in 81% of cases. Services were evaluated and audited to help identify where needs were not being met and inform decisions on service development.
- The district nursing teams had been proactive in meeting the changing needs of patients and had piloted changes in working hours to include some members of staff working a 'late' shift. There was evidence that demonstrated how the community rehabilitation teams, community matrons and district nursing teams worked together to ensure the most appropriate staff provided care and treatment to patients with complex needs. This meant patients were not receiving duplicate care visits and instead received individualised care and treatment.
- Outpatient clinics were in operation around the county led by specialist nurses. These included continence, diabetes, stroke and cardiac care. Additional clinics had been set up in the more rural and isolated areas in the north and east of the county, to enable patients to attend more easily. Specialist nurses visited the Isles of Scilly to provide specialist care and treatment throughout the year and held clinics in the local hospital there. A cardiac nurse-led service was available on the Isles of Scilly each week with a support group in operation for patients to attend. A falls pathway was in place across all localities. Minor Injuries Units (MIUs) completed an initial falls check and referrals were provided to the community rehabilitation team through a single point of access. We saw a clear example of how this had worked positively for one patient who had attended the MIU following a fall and had been referred to the physiotherapy outpatients.
- The provider worked collaboratively with other providers and stakeholders in planning services and was part of a range of NHS and wider public sector networks although it was an independent provider. There was evidence of collaborative working with organisations such as the British Red Cross transport service, Age UK and social services.
- The provider's premises and facilities were largely appropriate for the services that were planned and delivered. The number of sites across a large geographical including the offshore Isles of Scilly presented a challenge, as did the variation in size and age of buildings. The provider did not own the sites that it occupied and so had to work through a third party in

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order to ensure the appropriateness and fitness of premises. Decisions on temporary closures were made in order to ensure that appropriate and safe facilities and premises were maintained.

Equality and diversity

- Staff had access to policies and procedures to ensure equality and diversity was respected during the provision of health services to patients. Staff had equality and diversity training during their induction which was updated every three years.
- As a major tourist area within England, staff in the minor injuries unit said they met and treated people from, for example, many different ethnicities and religions with a range of mental and physical abilities and varied social circumstances and backgrounds. Equality and diversity training was delivered at induction and then every three years. There were telephone translation services available for staff to use and information about these was on display. Staff who had used these services said they had found them easy to access and effective.
- Access for people with disabilities had been considered in all the community hospitals, clinics and outpatient departments that we visited and was generally good. One exceptions was the main reception area at Bodmin Hospital which was not accessible to people who used wheelchairs. This was because the reception staff were located behind a glass window which was too high to be accessible by people who used wheelchairs. The main entrance was accessed by an automatic opening door. Once through that door a second set of doors led into the reception area. This, however did not automatically open and therefore would be a barrier to some people with a physical disability.
- In the larger community inpatient facilities, for example at Bodmin and Liskeard Hospitals, there were multi faith rooms. These rooms were neutrally decorated to provide a space appropriate for the use of people from different faiths and contained a range of appropriate and relevant information.

Meeting the needs of people in vulnerable circumstances

- There was information for staff about people in vulnerable circumstances. This included records and guidance for making mental capacity assessments, how to get support from an independent mental capacity advocate (IMCA), the Royal College of Nursing guide to the use of restraint and using hospital passports for people with a learning disability. Information was available to staff and patients regarding advocacy services. Staff liaised and referred patients to external agencies if required for the support of independent advocates.
- The service had support and advice from a lead nurse for people with a learning disability. Staff had been trained in caring for patients with a learning disability. This included a guide for staff to refer to when discussing a person with a learning disability having a regular health check, information about autism and Asperger's syndrome, easy-to-read symbols or 'flash cards' to use with a patient for better communication and Makaton signing techniques.
- The provider had a matron leading on care for patients living with dementia. There were link nurses and liaison nurses in each hospital who also provided support to staff in the minor injuries units. All staff were trained to recognise the signs of dementia and the dementia liaison nurses had specialist knowledge. Nursing staff said if they had specific concerns about a patient with dementia or a person caring for a patient living with dementia, they would contact the patient's GP or social worker, or, if necessary, the safeguarding adults lead.
- The provider had implemented a training programme for staff regarding the care of patients living with dementia. Staff spoke positively of this training. Dementia care leads / dementia champions were in place in all teams across the community services. We saw evidence to support that the role of the dementia champions had been developed in areas where specific needs had been identified. For example, two members of the tissue viability team were dementia champions as a high number of patients had been identified as at risk of/or had developed pressure sores. The Isles of Scilly had also appointed a dementia champion who provided training and support for staff of all grades and roles regarding care of the people living with dementia in the community. This reduced the risk of harm to patients living in their own homes.
- We saw outstanding examples where community teams had supported and/ or provided care to patients in vulnerable circumstances. These included a team who stayed in touch with a patient who had refused care or support following their discharge despite returning to

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suboptimal accommodation. . A package of care was subsequently arranged to support the patient. This example showed the patient's wishes were respected and support offered appropriately when the patient was deemed to be vulnerable but had the mental capacity to make their own choices.

- The district nursing team demonstrated a strong and effective multidisciplinary approach to protect and care for a vulnerable family following the referral to their service of a patient with a long term medical condition. The team arranged a multidisciplinary meeting with a range of professionals who supported the family with the person's medical care, short term respite, housing issues, nutritional needs for the whole family and engagement with youth services.
- The district nursing service used a frailty tool which enabled frail elderly patients to be continually assessed. We observed how a person's medical condition had deteriorated and they were experiencing more frequent falls. The care team had used the frailty tool and the falls pathway to assess the level of risk and had made reasonable adjustments to enable the person to remain in their own home safely.

Access to the right care at the right time

- People were generally able to access the right care at the right time. Arrangements were in place to minimise waiting times and delays and to keep cancellations to a minimum. Services ran on time and people were kept informed of disruptions and delays. There were some challenges with weekend and out of hours cover. Performance information showed that demand for services had increased year on year and this was starting to impact on the timeliness of access. This was under discussion with commissioners.
- The movement of patients between acute and community care was actively managed through a daily teleconference call involving the community hospitals and the acute hospital discharge teams. Potential discharges from the community hospitals and suitable admissions from the acute hospitals to the community hospitals were discussed and reviewed. Staff reported these daily conversations were helpful when planning resources.
- The district nursing teams had exceeded their targets with patients being seen within zero to five working days, despite seeing an increased number of patients from previous years. The community stroke team had exceeded their target of patients being contacted within seven working days. Patients who were referred to the falls team were seen within about five working days at one of their clinics, although this may not have been the most local clinic to the patient. Patients who wished to attend their local clinic did at times experience a wait for an appointment.
- Some hospitals had therapy input at weekends, however, most only had physiotherapist and occupational therapist input from Monday to Friday. Whist some patients had therapy plans to promote the continuation of the therapy at weekends; this was not a consistent approach across all hospitals. This meant patients were at risk of not continuing their therapy regimes seven days a week.
- Arrangements were made for inpatients who had outpatient appointments at the local acute hospitals to ensure they were able to attend their appointments. This included booking the most appropriate form of transport for the patient and, if necessary, an escort for them or arranging for relatives to meet them at the relevant hospital.
- Minor injuries units were rarely closed. In December 2014 there were four days when services were closed early due to staff shortages but none were closed for a full day. In January 2015 the services in St Barnabas Hospital Saltash, were fully closed due to staffing issues. This was one of the smaller services and patients were redirected to services at Liskeard or Launceston. This was publicised on the NHS Choices website, through local media, and the PCH website. Staff said the local GPs and the ambulance service had also been informed.

Complaints handling and learning from feedback

- Patients we spoke with throughout the inspection told us that they would know how to make a complaint but had not had reason to. Not all services provided patients with information on how to make a complaint. However, patients told us they felt able to complain to the staff who visited them. In the outpatients departments' patients told us they would be able to raise any complaints with the staff but had not had the need to do so.

Good

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- Leaflets were available in the community hospitals explaining how to access the Patient Advice and Liaison Service. However, senior staff told us they always tried to talk directly with people who raised any concerns as they felt this helped to resolve concerns quickly and informally. Staff told us they received regular information from the Patient Advisory Liaison Service (PALS) about complaints and plaudits received. Patients were able to leave written cards in outpatient departments with suggestions or complaints. We saw action had been taken in one outpatient clinic in response to a complaint and chair raisers had been provided.
- Between December 2013 and December 2014 the organisation had received 90 complaints in relation to care provided by eight of the community hospitals (these may not all be related to inpatient care as the hospitals also provided outpatient and minor injury unit services). All had been dealt with using the organisation's complaints procedure. 'All aspects of clinical care" and 'attitude of staff' were the most common concerns reported.
- We saw that the services responded to complaints and feedback. We saw that outcomes from these complaints and feedback were shared with parents, carers and young people and that any changes that came about were shared with the person. One person had asked about hand hygiene between patients and was advised about the practice used. We saw a letter to a patient apologising about the service they had received and how this had been addressed. Where teams provided an integrated service complaints could be made to either the health or social care provider. The complaint would be assigned to the appropriate provider to be dealt with and learning shared with the whole integrated team.
- The patient experience manager had met with representatives of external agencies who supported the public to share their views of health and social care services. The purpose of these meetings was to discuss ways in which the organisations could engage with patients to capture their views of the services provided.

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.

Summary of findings

Instructions

We rated the overall leadership of the provider as good. The overall leadership of the organisation is strong, highly visible and focused on the delivery of safe and high quality care. Although the organisation is challenged by a number of historical and current factors there was an inspiring shared purpose. Staff are proud of the organisation as a place to work and speak highly of the open culture. Staff feel valued and well informed and have confidence in the leadership team to deal with the challenges. The culture is vibrant and very focused on delivering the best care possible in a challenging environment. Staff told us that they could shape services to benefit patients and financial pressures were managed so as not to impact on care. Governance systems were in place to monitor the organisation's performance against local commissioning and nationally set target

Staff were aware the organisation may be going through some changes in the future but felt that the information about this was communicated to them appropriately. Staff told us that members of the executive team had visited their wards and taken time to speak to them and reassure them. All staff we spoke to felt the Interim Director of Operations, the Chair of the board and the Chief Executive Officer (CEO) were approachable and listened to their concerns. Staff were generally very happy with their local leadership arrangements and felt they could talk freely to their managers. We saw the organisation encouraged personal development and initiatives and was open to new, innovative ideas and practices. There were several examples of innovations that had developed the service offered to patients.

Our findings

Instructions

Vision and strategy

The provider had captured their vision as "Quality care, closer to you…"

This vision was underpinned by five values as follows:

- Every patient matters
- Continual improvement through learning
- Challenge and innovation
- Flexibility and adaptability
- Enthusiasm and professionalism

- The provider had developed a strategy that dealt with the reality of the short and medium term situation and also looked to the future. The provider has stated their three strategic objectives as follows:

- Put patient safety and care at the heart of what we do by providing quality community healthcare services which meet need and benefit community.
- To lead, grow and develop a socially responsible and financially sustainable community business.
- To engage and empower employees to create a vibrant and inspiring workplace in which staff are proud to work, where innovation is encouraged and staff participate in the growth and development of the company.

- The provider had a contract to deliver NHS community services in Cornwall and the Isles of Scilly. This contract ran until March 2016. The provider was working with partners and commissioners to consider a range of options for the future. There was evidence of longer term strategic planning with partners across the community, for example the provider had influenced and was actively engaged with a five year strategy to develop a model for urgent care across the county.

- The provider had signed up to NHS England's three year vison and strategy, Compassion in Practice, based around six values known as the 6 C's; care, compassion, courage, communication, competence and commitment. One community rehabilitation team we spoke with said they had adopted a seventh C which was 'can do'. Staff told us they would do what was needed to ensure the patient received a person centred service which met their needs.

- There was evidence across the organisation and from external partners and stakeholders that the uncertainties over the future were not diverting the organisation from their purpose and focus. Other large providers in the south west, including NHS acute providers described the organisation as a dynamic leader within the system and a very proactive community partner.

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- Staff at all levels and across all services were aware of the strategy and their role in achieving it. Staff felt able to influence developments and shape services to benefit patients. Staff were aware of the uncertainties over the future but felt well informed and had confidence in the leadership of the organisation that they were acting in the best interests of both patients and staff. Staff were able to describe the values of the organisation and these were prominently displayed in the community hospitals. Staff told us they felt listened to and felt the welfare of the patients and wellbeing of the staff was very important to the organisation.

Governance, risk management and quality measurement

- The provider had governance arrangements in place that were appropriate for a community interest company and for the financial context within which the provider was operating. The Board met twice a month, once as a standard business meeting and once to deal specifically with financial reports.
- The provider was dealing with a very challenging financial situation. The company had inherited financial debt and so had been financially challenged from the start. It also appeared that not all legacy risks had been addressed or mitigated at the time the company had been formed. The current Board were addressing this situation with the support of a transformation director and at the time of the inspection it seemed that progress was being made. Dealing with these issues had absorbed considerable executive and non-executive time but had not detracted from the focus on quality and safety.
- The provider has risk management and quality strategies and policies in place and an assurance framework. The framework linked organisational objectives with identified risks. Responsibility for the management of the corporate risk register had transferred to the provider's Company Secretary in March 2014 who had reviewed the control framework and made improvements. Additionally an internal audit report on governance, risk and assurance had been undertaken and reported in January 2015. This had identified a number of areas for improvement including improving consistency of arrangements and formalising aspects of them.
- Risk registers were held at local team level across the core services Managers were aware of any risk on the register that applied to their service and the action being taken to reduce the risk. Team leaders used a number of tools to gather data needed to meet the organisation's governance arrangements. Incidents, accidents and near misses were recorded and investigated using the provider's electronic system. All staff we spoke with were aware of the system and were using it effectively. Improvements were needed in the consistent application of these arrangements in the urgent care services.
- The provider had a Clinical Quality and Safety Committee, chaired by a non-executive director that received reports and monitored performance on quality. The terms of reference for this committee had been reviewed during 2014 to include formal oversight of the corporate risk register. Further improvements were needed to strengthen Board oversight of corporate risk reporting.
- Quality measurement is reported to the Board through a monthly quality dashboard which summarises the main areas of quality measured. This is shared within the organisation and with commissioners. It includes information on infection control, nursing metrics, patients experience, complaints, safeguarding and incidents. This is reported alongside more detailed quality performance data.

Leadership

- The leadership team as a whole appeared strong and cohesive. At the time of the inspection there had been some changes with the retirement of a director and a new appointment. The opportunity had been taken to redefine roles. There were a number of interim appointments which was felt to be appropriate in the wider circumstances.
- The chair and chief executive had a close and effective working relationship. The non-executive directors demonstrated enthusiasm, knowledge and insight both of the organisation and the wider strategic issues. Staff across the organisation spoke highly of the chief executive who was visible and approachable and who had brought an energy, focus and an enthusiasm which they shared.

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- The board operated effectively and were supported by an experienced and legally qualified company secretary with extensive NHS experience. The board had invited external review of their arrangements and had acted on recommendations. Some arrangements, such as the reappointment of non-executives, had taken account of the future uncertainties. Quality and safety received appropriate coverage at board level and in the sub committees. The board was commissioning external specialist advice appropriate to their circumstances and was making decisions in the light of that advice.
- The positive impact of the leadership of the organisation had been recognised in the 2014 HSJ Best Places to Work award. The award measures seven areas including leadership and planning, corporate culture and communications, work environment and staff engagement and satisfaction. The citation for the award was as follows "Engaging and empowering employees to create an environment in which they are proud to work is a key value of the organisation. It scores highly, not only as staff recommending it as a place to work, but also on motivation, job satisfaction and support from immediate managers".

Culture across the provider

- At the time of the formation of the company 54% of staff had objected to the transfer. There had been concerned about leaving the NHS and what that would mean for staff and patients. It was apparent across the organisation that this situation has been transformed and that the culture was positive, open and supportive. All staff that we spoke to talked about how the culture had improved and the vast majority described how proud they were to work for the organisation and of the work that they do. All staff are members of the company and many talked about their sense of personal engagement with it.
- Staff told us that the organisation encouraged candour, openness and honesty. Matrons, nurse consultants and staff spoke of the importance of raising concerns and that action was taken when staff had concerns. There was a strong safety culture with staff talking about being encouraged to report both incidents and near misses. Some staff told us that this was "hammered home" in training and team meetings. Some staff talked about an undercurrent of bullying in some places but also that people were encouraged to report and that staff had confidence that action would be taken and there were a number of examples that staff cited as evidence of this. This had improved confidence further that issues would be tackled.
- Staff described the provider as "a good employer" and said that they felt valued, supported and listened to. The concept of a seventh C "can do" having been added was well embedded. Staff described their managers and leaders as having this attitude, managers and leaders referred to their staff in the same way and the term was used by a number of external partners and other providers when describing their views of the organisation to the inspection team.
- All staff were provided with information on a weekly basis from the provider through the electronic system. The information included policy updates, issues arising from the weekly executive meeting, staff wellbeing, important updates and a news round-up. Managers were encouraged to print this out to support staff who had limited computer access. Staff teams had monthly meetings with additional meetings in place for county wide staff of the same grade and role to provide consistency across the county, for example the community matrons and district nursing leads.

Fit and proper person requirement

- The organisation becomes subject to the requirements related to Fit and Proper Persons (where directors of organisations providing registered health and social care services must meet a fit and proper person test) in April 2015.
- The organisation was fully prepared to meet the new requirements both at the point of recruitment and on an ongoing basis. There had been a recent executive appointment and this had been conducted in line with the new requirement.

Public and staff engagement

- Public and staff engagement was taking place in a number of formal and informal ways reflecting the different settings where care is provided. The formal interface was through the Community Interest Forum which is chaired by a non-executive and is attended by the chief executive, company secretary and director of HR. There are staff representatives who are elected by their peers and also representatives from the trade

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unions and League of Friends. The public and stakeholders are invited to attend and individual staff are entitled to attend as members of the company. Meetings are rotated throughout locations in Cornwall to improve access for the public. The agendas and minutes of the forum showed that it was operating along the lines of a public section of a board meeting in an NHS setting and that more and more business was being dealt with by the forum.

- A number of the community hospitals had a very active League of Friends and fundraising committees. There was evidence of significant community investment in the community hospitals. Newquay Hospital had recently been donated £2000 from a local hotel to buy a 1950's style reminiscence pod to help encourage reminiscence, conversation and feelings of wellbeing amongst the patients, some of whom were living with dementia
- There were other internal systems in place to engage staff. The purpose of these was to ensure regular feedback on service provision for analysis, action and learning. The Team Focus monthly news sheet communicated provider wide information and invited feedback and input from staff and monthly team focus meetings had been introduced to facilitate discussion. Staff told us that there was a weekly staff bulletin available on the staff intranet that included business, operational, clinical, staff and organisation news which they found useful.
- Staff in non-clinical roles (mainly non-clinical managers and trainers) participated in the "Kinda Magic" project which is focused on gaining feedback from patients. The objectives were to promote the collection and use of feedback and to focus on the collection of patient experience from patients with communication and cognitive impairment. This was a wider NHS project with fourteen national partners including the acute and mental health trusts in Cornwall. The staff involved went out to care settings, spoke to patients and reported feedback in a consistent way. We spoke to staff who were part of the programme. They described the impact on them personally in operating out of their comfort zone and in gaining new insights into the work of the organisation and also gave examples of how services had been shaped in response to the feedback.
- Staff told us innovation was encouraged and recognised. There were many examples of innovation across the service. Examples a memory café being established at Newquay Hospital which invited members of the public to join in. Some initiatives were local to a specific hospital but in some cases, as with 'dementia friendly' environments and memory cafes, there was a plan for them to be rolled out at other hospital sites. There were a range of organised activities for patients, including cream teas, music from a male voice choir and a 'rabbit whisperer' performing during the afternoon.
- There was a clear view from staff that their focus was on patients and improving the quality of care and that they did not feel the organisation's financial pressures compromised care. Previous business plans had been successful in highlighting areas of need. In the TB service this had resulted in an increase in administrative support, while in the specialist bladder and bowel service, an additional nurse had been recruited. This resulted in an increased capacity to meet increasing demand.
- Launceston Hospital staff told us about working with the local Age UK team as part of their 'Living Well programme' aimed at identifying areas of a person's life they may like support with once they had left the hospital. They told us this had enabled patients to revisit hobbies they had enjoyed before becoming ill and Age UK had helped them to access transport to local clubs and provided staff to accompany them, for example.
- At Helston Community Hospital one bed was kept for the use of a locally run alcohol detoxification project, which was run in conjunction with a local GP service. Patients using the service were also supported by a worker from the project. Patients signed up for a course of treatment and a set of conditions for their stay. The ward sister said the project had so far been successful and had helped several patients move on to other therapeutic centres to continue with their treatment for alcohol related problems.
- The tissue viability team were working on a project to make sure patients were using the correct pressure relieving equipment. This innovative project was also looking at the education of patients, staff and carers in

Innovation, improvement and sustainability

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how to manage pressure area care, rather than relying on equipment. The tissue viability lead told us that since this had started in December 2014 they had found 50 pressure relieving mattresses which were not required.

- The sustainability of services and the organisation itself was a key focus for the leadership team given the contract situation. The leadership team were actively considering options with commissioners and a range of partners. The confidence of the staff in both the leadership team and the future of the services was notable.

Compliance actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision. How the regulation was not being met: People who use services and others were not protected against the risks associated with unsafe care and treatment by means of the effective operation of systems designed to enable the registered person to regularly assess and monitor the quality of the services provided in the carrying on of the regulated activities: The urgent care and minor injuries services did not have effective governance arrangements to monitor, manage and report on performance, safety and quality. The service had not elevated its risks to a corporate risk register; there was a lack of a routine programme of quality and safety audit or risk assessment that was analysed and reported upon; there was no analysis of incidents or complaints to ensure changes and improvements to services were made; Regulation 10 (1) (a).

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records Regulation 20 (1) HSCA 2008 (Regulated Activities) Regulations 2010 Records

Compliance actions

How the regulation was not being met: The registered provider did not ensure that patients were protected against the risks of unsafe or inappropriate treatment arising from a lack of proper information about them by means of maintenance of

An accurate record including appropriate information We saw six Allow a Natural Death Orders (ANDO) which were not completed correctly. Shortcomings included an unclear abbreviation and a lack of up to date information about the patient's current condition. In two cases a limited description of the reason for the decision having been made and in two instances discussions with the family were not recorded.

and documents in relation to the care and treatment.

Regulation 20 (a)