

Cornwall and the Isles of Scilly Partnership NHS Foundation Trust

Inspection report

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

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

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

Ratings

Overall rating for this trust

Good 

Are services safe?

Requires improvement 

Are services effective?

Good 

Are services caring?

Outstanding 

Are services responsive?

Good 

Are services well-led?

Good 

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

Summary of findings

Background to the trust

Cornwall and the Isles of Scilly have a population of 545,000 with a higher than average aging population. This increases by an average of 300,000 during the summer holidays with a total of 41 million visitors per year. Cornwall and the Isles of Scilly is recognised as having the second weakest economy in England. 68,600 people live in the 20% most 'deprived communities in England'. The 2011 census showed ethnicity as 98.2% white and 1.8% non- white population.

Cornwall Partnership NHS Foundation Trust is the principal provider of community health, mental health and learning disability services to people living in Cornwall and the Isles of Scilly.

Following our inspection in 2015 we rated the trust as good overall. At the time the trust only delivered mental health, children's and learning disability services. At our last inspection in 2017 we rated community mental health service for adults of a working age and community based children and adolescent mental health services as requires improvement. All other mental health and learning disability services were rated as good and long stay or rehabilitation mental health wards for working age adults was rated as outstanding. Two other mental health services were rated as outstanding in caring.

On the 1st April 2016, the trust took responsibility for the delivery of community health services across Cornwall and the Isles of Scilly and works in coalition with Royal Cornwall Hospitals Trust, Royal Devon & Exeter, University Hospital Plymouth, North Devon District Hospital and Kernow Health (GPs) to provide these services. At our last inspection in 2017 we raised concern about leadership and culture in these services and rated community health services for adults, community health inpatient services, community end of life care and urgent care as requires improvement.

Following our inspection in 2017 the trust's rating overall was requires improvement. However, caring in the trust was rated as outstanding.

At this inspection, we found that the trust had made the majority of the required improvements although we had serious concerns about staffing levels, waiting times and senior leadership oversight of issues in two of the child and adolescent mental health teams.

Overall summary

Our rating of this trust improved since our last inspection. We rated it as Good ● ↑

What this trust does

Cornwall Partnership NHS Foundation Trust provides comprehensive mental health, learning disability and community health services to serve the people of Cornwall and the Isles of Scilly. These services include community hospitals, minor injury units, community services, district nursing, community mental health teams for adults, older people and young people, and a range of mental health inpatient services. The trust is currently building a new child and adolescent mental health inpatient service, the Sowenna unit which will open in 2019.

The trust has 370 inpatient beds across 13 community hospital and mental health sites. The trust employs 3,881 staff with an annual turnover of £184 million.

At the time of this inspection community health services for children, young people and families including health visiting and school nursing were transferring to the local authority.

Key questions and ratings

We inspect and regulate healthcare service providers in England.

Summary of findings

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

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

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

What we inspected and why

We plan our inspections based on everything we know about services, including whether they appear to be getting better or worse. At this inspection, we inspected seven core services out of the 13 that the trust provides.

We inspected specialist community mental health services for children and young people because they remained rated requires improvement for the past two CQC inspections with very high thresholds for young people to access services. We inspected community based mental health services for adults of working age because they were rated requires improvement previously and there had been continued concerns regarding staffing of those services. The older people's mental health ward was rated as good previously.

We inspected all the community health services at this inspection, including community hospitals, minor injuries units and end of life care. These were rated as requires improvement at the last inspection. The services are important to the whole system of care delivery in Cornwall and the Isles of Scilly and provide key support to the local acute trust.

Other services provided by the trust were previously rated as good and we had no information to suggest that the quality of those services had changed.

What we found

Overall trust

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

- We rated the trust as outstanding overall for the key question, 'are services caring' and as good for effective, responsive and well-led. We rated safe as requires improvement overall. At this inspection we rated one of the seven core services that we inspected as outstanding, five as good and one as inadequate. In rating the trust overall, we took into account the current good ratings for the six services not inspected this time.
- Staff in the trust had worked hard to address the concerns we had raised at our last inspection. Five services that had previously been rated requires improvement at the last inspection were now rated as good. Community health services including community hospitals and minor injury units had all improved, as had community mental health teams.
- We rated wards for older people with mental health problems as outstanding due to the way that the staff worked with patients and their families and how they ensured patients moved on to appropriate placements despite a challenging environment which had seen over 200 nursing home beds closed locally since 2016. Staff implemented creative solutions so they could get patients discharged home or into a care placement when there were limited placement options. The complex care and dementia nurse consultant who was also the responsible clinician, actively focussed on the discharge of patients through visiting and educating staff in nursing homes about settling patients post discharge. Occupational therapists supported patients on home visits to support the discharge process.

Summary of findings

- Effective leadership in the community health services and community mental health teams had led to improvements in those services. In particular the positive impact of a GP working as primary care director and a nurse consultant overseeing the pathway in the minor injury units. The consultant nurse for MIUs had reviewed the operating policy since the last inspection and had introduced the same one across all MIUs. This covered staffing, training, and scope of practice. The primary care director also worked as a GP and had helped improve links with other health providers.
- Recent growth of staff in the pharmacy team meant that clinical pharmacy support was more widely available across the trust in both community and mental health services.
- The trust had developed innovative approaches to improve dementia services for people who identify as LGBT. A specialist nurse had been awarded a Winston Churchill Fellowship and had visited Australia to learn from work completed there.
- Improvements had been made to how the trust learnt from deaths. A new suicide prevention training program and learning from how the trust engaged with families following deaths and during the investigation had been completed with a parent's involvement as part of the team.
- The trust had an experienced stable senior leadership team with the skills, abilities, and commitment to provide high-quality services. The executives and non-executives presented as a strong unified board.
- The board and senior leadership team had set a clear vision and values that were at the heart of all the work within the organisation. They worked hard to make sure staff at all levels understood them in relation to their daily roles. This was demonstrated by the work to change the culture of the enlarged organisation and bring the trust together as one following the transfer of the community health services contract to the trust in 2016.
- The culture of the trust had improved and staff morale was high in the majority of services. Staff felt respected, supported and valued by their managers and the trust.
- Senior leadership in the trust had improved relationships with partner organisations and were engaging positively in the wider health systems.

However:

- We had serious concerns about the safety of child and adolescent mental health services in the two of the six teams. The trust did not have clear oversight of the large number of children and young people waiting for treatment, the length of time they had waited nor the level of risks for each of those on the waiting list in the two teams. Despite improvements in other child and adolescent mental health teams the trust was not aware of the impact staff moves to newly developing teams had on the mid and east teams' ability to deliver a service in a timely manner. Concerns by staff about the level of risk in the service had not been escalated appropriately to trust senior team due to changes in the way the services were managed. As a result of the significant concerns identified on the inspection we issued a section 29a warning notice to the trust. The warning notice served to inform the trust that it must take immediate action to address the serious concerns. The trust responded positively and took immediate action to address the concerns and put plans in place to ensure children and young people received a timely, safe service.
- There were issues with staffing, cleanliness and infection control at three out of the 13 community hospitals. Not all wards had enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment. The trust took immediate action to address the concerns at the time of inspection.

Are services safe?

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

Summary of findings

- We had serious concerns about the safety of child and adolescent mental health services in the two of the six teams. The trust did not have clear oversight of the large number of children and young people waiting for treatment, the length of time they had waited nor the level of risks for each of those on the waiting list in the two teams. Despite improvements in other CAMHS teams the trust was not aware of the impact staff moves to newly developing teams had on the mid and east teams' ability to deliver a service in a timely manner. Concerns by staff about the level of risk in the service had not been escalated appropriately to trust senior team due to changes in the way the services were managed. As a result of the significant concerns identified on the inspection we issued a section 29a warning notice to the trust. The warning notice served to inform the trust that it must take immediate action to address the serious concerns. The trust responded positively and took immediate action to address the concerns and put plans in place to ensure children and young people received a timely, safe service.
- There were issues with staffing, cleanliness and infection control at three out of the 13 community hospitals. Not all wards had enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment. The trust took immediate action to address the concerns at the time of inspection.

However:

- Risk was managed well in the majority of the services that we inspected. For example, there were improvements in the way minor injury units triaged patients since our last inspection. There were clinical protocols for the recognition of a sick adult, sick child, and life-threatening conditions such as sepsis. The trust now had an agreement in place with the local NHS ambulance provider to prioritise these calls from the MIU's.
- Staff understood safeguarding and it was managed well across the trust.
- Recent growth in staff in the pharmacy team meant that clinical pharmacy support was more widely available across the trust in both community and mental health services. Where medicines safety risks were identified, they were actioned and shared appropriately within the trust and with external partners. Learning actions from medicines incidents and audits were shared across the trust.
- Improvements had been made to how the trust learnt from deaths. A new suicide prevention training program and learning from how the trust engaged with families following deaths and during the investigation had been completed with a parent's involvement.

Are services effective?

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

- Staff assessed the health needs of all patients. They worked with patients and families and carers to develop individual care plans and updated them as needed. Care plans reflected the assessed needs, were personalised, holistic and recovery-oriented.
- Staff provided a range of treatment and care for patients based on national guidance and best practice.
- Services included or had access to the full range of specialists required to meet the needs of patients under their care.
- The trust made sure staff were competent to undertake their roles. Staff demonstrated competence in their roles. Most staff received timely annual appraisals and regular supervision.
- The trust had robust arrangements to monitor use of the Mental Health Act from ward to board.

Are services caring?

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

Summary of findings

- At this inspection we rated Garner Ward, a ward for older people with mental health problems outstanding. This is the fourth service in the trust that we have rated outstanding for caring. Three other services we did not visit at this inspection were rated outstanding for caring at our last inspection.
- Staff treated patients with compassion and kindness. Staff were highly motivated and inspired to offer care that was kind and promoted patient's dignity and privacy.
- All staff demonstrated a strong visible person-centred culture. Staff were highly motivated and inspired to offer care that was kind and promoted patients' dignity. Relationships between patients who use the services in the trust, those close to them and staff are strong, caring and supportive. These relationships are highly valued by staff and promoted by leaders.
- Patient's emotional and social needs were seen as being as important as their physical and mental health needs.
- Feedback from patients who use the services in the trust, those who are close to them and stakeholders is continually positive about the way staff treat people. People said staff go the extra mile and the care they receive exceeded their expectations.
- Patients and carers were involved in decisions about their care. On Garner ward staff involved carers through newsletters and tea parties. Ward staff made regular telephone contact with carers to update them about patients' care.

Are services responsive?

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

- We rated Garner ward, a ward for older people with mental health problems as outstanding in responsive due to the way the nurse consultant and occupational therapist worked with the staff team and families to ensure appropriate placements to move on to despite a challenging environment which had seen 200 care home beds close locally. Staff implemented creative solutions they could get patients discharged home or into a care placement when there were limited placement options. The complex care and dementia nurse consultant who was also the responsible clinician, actively focussed on the discharge of patients through visiting and educating staff in nursing homes about settling patients post discharge. Occupational therapists supported patients on home visits to support the discharge process.
- The trust had developed innovative approaches to improve dementia services for people who identify as LGBT. A specialist nurse had been awarded a Winston Churchill Fellowship and had visited Australia to learn from work completed there.
- The trust planned and provided services in a way that met the needs of local people.
- Services were accessible to all who needed it and took account of patients' individual needs. Staff helped patients with communication, advocacy and cultural support as and when needed.
- The trust treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff.

However:

- The trust did not have a clear understanding of how many children and young people were waiting for treatment following assessment in two out of the six child and adolescent mental health teams. The trust took immediate action to address the issue when we raised this.

Are services well-led?

Our rating of well-led improved. We rated it as good because:

Summary of findings

- There was a culture of improvement across the trust. Staff at all levels in the trust had worked hard to address the concerns we had raised at our last inspection. Five services that had previously been rated requires improvement at the last inspection we have now rated as good and a service previously rated as good was rated as outstanding. Community health services including community hospitals and minor injury units had all improved as had community mental health teams.
- Effective leadership in the community health services and community mental health teams had led to improvements in those services. In particular, the positive impact of a GP working as primary care director and a nurse consultant overseeing the pathway in the minor injury units.
- The culture of the trust had improved with high morale in the majority of services. Staff felt respected, supported and valued by their managers and the trust.
- The trust had an experienced stable senior leadership team with the skills, abilities, and commitment to provide high-quality services. The executives and non-executives presented as a strong unified board. They recognised the training needs of managers at all levels, including themselves, and worked to provide development opportunities for the future of the organisation.
- The board and senior leadership team had set a clear vision and values that were at the heart of all the work within the organisation. They worked hard to make sure staff at all levels understood them in relation to their daily roles. This was demonstrated by the work to change the culture in community health services and bring the trust together as one organisation following the merger in 2016.
- The trust was committed to improving services by learning from when things go well and when they go wrong, promoting training, research and innovation. The positive culture of learning in the trust was embodied by the response to our warning notice. The trust accepted our findings in full and all levels of staff from the board to members of the CAMHs teams took responsibility, contributing to a comprehensive response detailing what went wrong and how the issues could be addressed.
- Despite the challenge of the geography, senior leaders made sure they visited all parts of the trust and fed back to the board to discuss challenges staff and the services faced.
- The trust had a clear structure for overseeing performance, quality and risk, with board members represented across the divisions. This gave them greater oversight of issues facing the services and they responded when services needed more support. There was excellent challenge from non-executive directors.
- The leadership team worked well with the clinical leads and encouraged divisions to share learning across the trust.
- The board reviewed performance reports that included data about the services, which divisional leads could challenge. There was strong rigour at board. Non-executive directors were able to act as critical challengers but be supportive at the same time.
- The trust recognised the risks created by the introduction of new IT and business systems in the services. Staff managed these risks well at ward level.

However:

- Although the trust had appropriate systems in place to gather data, it was not always presented in a way that would help senior leaders identify areas of concern. The trust board was aware of this and was in the process of looking at new systems and assurance framework to address the gap. Currently data was broken down to ward level for inpatient services which helped identify concerns, but community teams were presented at service level. This meant that the positive performance of four community CAMHs services had masked the issues in the east and mid teams.

Summary of findings

- We were concerned that, in contrast with other services, the local governance systems were not robust enough in the mid and east CAMHS teams to identify issues with waiting times and staffing levels. Local leaders were not able to interrogate systems so could not identify and act on issues; issues raised by staff were not escalated. Senior leaders did not have oversight of the issues in these two teams. The trust took immediate action following the warning notice to manage the risks and engage with staff.
- Not all of the board had a clear understanding of the level of financial challenge the trust faced despite good challenge from nonexecutive directors and positive action from the director of finance.
- No strategic overview of patient involvement in the trust was in place.

Ratings tables

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

Outstanding practice

We found examples of outstanding practice trust wide and also in the wards for older people with mental health problems.

For more information, see the Outstanding Practice section of this report.

Areas for improvement

We found areas for improvement including ten breaches of legal requirements that the trust must put right. These included concerns about leadership, staffing and management of risk in child and adolescent service, staffing and infection control in the community hospitals, care records in end of life care, and medicines management in podiatry and community mental health teams for adults of a working age. We found 42 things that the trust should improve to comply with a minor breach that did not justify regulatory action, to prevent breaching a legal requirement, or to improve service quality.

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

Action we have taken

We issued a section 29a warning notice to the trust due to our concerns about the safety of child and adolescent mental health services. We also issued ten requirement notices to the trust. Our action related to breaches of legal requirements in five services.

For more information on action we have taken, see the sections on Areas for improvement and Regulatory action.

What happens next

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

We will closely monitor the progress of the trusts action plan to improve child and adolescent mental health services and visit those services again to check that the changes are embedded.

Outstanding practice

Summary of findings

Staff on Garner ward, an inpatient service for older people with mental health problems had completed an innovative falls reduction project which showed that falls had reduced on the ward. Staff implemented creative solutions they could get patients discharged home or into a care placement when there were limited placement options. The complex care and dementia nurse consultant who was also the responsible clinician, actively focussed on the discharge of patients through visiting and educating staff in nursing homes about settling patients post discharge. Occupational therapists supported patients on home visits to support the discharge process.

The trust worked to develop new strategies and training on suicide prevention. The trust had a lead for suicide prevention who worked with a parent of a patient who had died by suicide whilst under the care of the trust in 2015. The views of the family member on risk, safety and treatment were included in the training. The trust also acknowledged the failings in their initial investigation and response to the family. The medical director, alongside the parent had recently presented at a national suicide prevention conference on the experience and how services could be improved. The parent is currently involved in developing more training and believes the trust has moved to a better understanding of the needs of families and of the unique perspective they can bring to learning.

The trust had developed innovative approaches to improve dementia services for people who identify as LGBT. A specialist nurse had been awarded a Winston Churchill Fellowship, had travelled to Australia to review LGBT dementia training there and had their research published. This had been a presentation to the board and the trust was now acting on the recommendations.

Areas for improvement

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

We told the trust that it must take action to bring services into line with ten legal requirements. This action related to five services.

Action the trust MUST take to improve

Specialist community mental health services for children and adolescents

The trust must have clear oversight of the large number of children and young people waiting for treatment, the length of time they have waited and the level of risks for each of those on the waiting list. The trust must have oversight of the quality of services being delivered, how complaints were being managed or whether incidents were being reported, addressed and learnt from. The trust must ensure it has sufficient systems and processes to enable them to assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity. They must be able to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who might be at risk which arise from the carrying on of the regulated activity. They must also evaluate and improve their practise in respect of the processing of the information referred to above (Regulation 17).

The trust must ensure there are enough, suitably qualified, competent, skilled and experienced staff deployed in the mid and the east teams to meet the needs of children and young people in a timely manner (Regulation 18).

The trust must ensure care plans, risk assessments and crisis plans are consistently in place across the service. The trust must work with the local general hospitals to ensure that children and young people presenting at the emergency departments in mental health crisis receive an appropriate mental health assessment outside of the crisis teams working hours. (Regulation 12).

The trust must ensure that all premises used by the service are well maintained and safe (Regulation 15).

Summary of findings

Community mental health services for adults of working age

The trust must ensure that all staff record the dispensing of medication appropriately and that medicines charts and care records have consistent and accurate information about medicines dispensed. Any errors or omissions must be reported as incidents and followed up appropriately. (Regulation 12).

Community health inpatient services

The trust must ensure there are sufficient numbers of suitably qualified, competent and skilled staff available to meet the needs of patients at all time and in all wards (Regulation 18).

The trust must ensure all premises are clean and follow infection prevention control practices (Regulation 15).

Community end of life care

The trust must ensure community hospital care plans and the documents used to support end of life care are individualised, consistently completed, signed and up to date (Regulation 9).

Action the trust SHOULD take to improve

Specialist community mental health services for children and adolescents

The trust should establish a consistent system across the service to investigate and learn from complaints from children, young people or their representatives.

The trust should establish a consistent system to investigate and learn from incidents across the service.

The trust should support the mid and east teams to have access to the full range of specialists required to meet the needs of young people.

The trust should check that all staff receive supervision and have a yearly appraisal.

The trust should support the CAMHS learning disability team to set up a participation group which enables children and young people to input into the development of the service.

The trust should check that staff members in the mid and east teams complete their mandatory training that is crucial to their job roles.

The trust should check that equipment such as weighing scales and blood pressure monitors are well maintained in the east and mid teams.

Wards for older people with mental health problems

The trust should check that training courses considered by the trust as mandatory are accessible to staff and that it should keep accurate records of attendance.

The trust should check it has oversight of restraint that takes place when personal care is being delivered.

The trust should check that a record is made of when staff receive supervision.

Community-based mental health services for adults of working age

The trust should check that all clinic rooms have the appropriate facilities to carry out physical health checks and that all appropriate checks of equipment (including fridge temperatures) are carried out.

The trust should review that all patients receive physical healthcare checks and have physical healthcare plans in place in line with National Institute for Health and Care Excellence guidance.

Summary of findings

The trust should check that all staff have access to and attend mandatory training and regular supervision and appraisal is given and recorded as having taken place.

The trust should check that patients are supported to be involved in their care plans, and record that they are offered copies of these.

The trust should check that patients who need psychology input have timely access to this.

The trust should review the purpose and effectiveness of the low intensity pathway to ensure this is fit for purpose.

The trust should check that allergies are recorded on patient medication charts.

Community health inpatient services

The trust should improve oversight and assurance for the management of equipment: storage, checks, cleaning and replacement.

The trust should support staff to access supervision, in line with the trust's supervision policy.

The trust should improve the completion and documentation of capacity assessments.

The service should check all risks identified are submitted to the trust's risk register.

The trust should review the electronic rostering system.

The trust should review locum doctor access to login information for the pathology results electronic system.

The trust should check that all staff are compliant with mandatory training.

The service should review ward environments to make sure they are dementia friendly.

Community health services for adults

The trust should continue to encourage staff to complete all mandatory training, including safeguarding and regular updates for staff who facilitate blood transfusion in people's homes, in a timely manner.

The trust should re-iterate the importance of following national guidance for hand washing procedures when staff visit patients in their homes.

The trust should improve processes for shared learning between the three geographical areas and between different locations.

The trust should continue to monitor the completion of risk assessments, share audit results across nursing teams and work to improve compliance in all localities. The trust should carry out risk assessments and education to ensure the right equipment is used in people's homes.

The trust should continue to embed the national early warning tool for vital observations and standardise processes to ensure contemporaneous recording.

The trust should work towards capacity and dependency scoring of all services (including acute care and home and specialist nursing services) to help inform regular review of establishment of all community services.

The trust should review processes to obtain consent for patients who lack capacity to consent to treatment.

The trust should review processes for consistent monitoring and review of referral to first contact or treatment for all services including community nursing services.

The trust should consider options to support staff with continuing post-graduate study including access for staff on the Isles of Scilly.

Summary of findings

The trust should plan regular team meetings in all teams across acute care services.

The trust should explore how to use patient feedback effectively across all community health services.

Community end of life care

The trust should work with commissioners to ensure it is able to provide the same level of responsive and accessible service across the county. The trust should check that care and treatment is consistently provided and is based on national guidance, for example, the Gold Standards Framework system.

The trust should check that nurses on the Isles of Scilly have opportunities for training in the use of syringe drivers and the verification of death.

The trust should review if staff feel engaged and clear about trust level involvement in end of life care.

Urgent care

The trust should review how patients can be observed while in the waiting room at Helston MIU, to ensure their safety.

The trust should check all relevant staff have signed the medicines patient group directions, to demonstrate that they know how and when to safely administer the medication.

The trust should review their business plan to make sure that there will be enough staff with the right skills and experience to deliver safe and effective care at Helston and St Mary's MIU's.

The trust should check that all staff in each MIU has access to supervision as detailed in the trust's policy.

Is this organisation well-led?

Our comprehensive inspections of NHS trusts have shown a strong link between the quality of overall management of a trust and the quality of its services. For that reason, we look at the quality of leadership at every level. We also look at how well a trust manages the governance of its services – in other words, how well leaders continually improve the quality of services and safeguard high standards of care by creating an environment for excellence in clinical care to flourish.

Our rating of well-led at the trust improved. We rated well-led as good because:

- There was a culture of improvement across the trust. Staff at all levels in the trust had worked hard to address the concerns we had raised at our last inspection. Five services that had previously been rated requires improvement at the last inspection were now rated as good and a service previously rated as good was rated as outstanding. Community health services including community hospitals and minor injury units had all improved as had community mental health teams.
- Effective leadership in the community health services and community mental health teams had led to improvements in those services. In particular, the positive impact of a GP working as primary care director and a nurse consultant overseeing the pathway in the minor injury units.
- The culture of the trust had improved with high morale in the majority of services. Staff felt respected, supported and valued by their managers and the trust.
- The trust had an experienced stable senior leadership team with the skills, abilities, and commitment to provide high-quality services. The executives and non-executives presented as a strong unified board. They recognised the training needs of managers at all levels, including themselves, and worked to provide development opportunities for the future of the organisation.

Summary of findings

- The board and senior leadership team had set a clear vision and values that were at the heart of all the work within the organisation. They worked hard to make sure staff at all levels understood them in relation to their daily roles. This was demonstrated by the work to change the culture in community health services and bring the trust together as one organisation following the merger in 2016.
- The trust was committed to improving services by learning from when things go well and when they go wrong, promoting training, research and innovation. The positive culture of learning in the trust was embodied by the response to our warning notice. The trust accepted our findings in full and all levels of staff from the board to members of the CAMHs teams took responsibility, contributing to a comprehensive response detailing what went wrong and how the issues could be addressed.
- Despite the challenge of the geography, senior leaders made sure they visited all parts of the trust and fed back to the board to discuss challenges staff and the services faced.
- The trust had a clear structure for overseeing performance, quality and risk, with board members represented across the divisions. This gave them greater oversight of issues facing the services and they responded when services needed more support. There was excellent challenge from non-executive directors.
- The leadership team worked well with the clinical leads and encouraged divisions to share learning across the trust.
- The board reviewed performance reports that included data about the services, which divisional leads could challenge. There was strong rigour at board. Non-executive directors were able to act as critical challengers but be supportive at the same time.
- The trust recognised the risks created by the introduction of new IT and business systems in the services. Staff managed these risks well at ward level.

However:

- Although the trust had appropriate systems in place to gather data, it was not always presented in a way that would help senior leaders identify areas of concern. The trust board was aware of this and was in the process of looking at new systems and assurance framework to address the gap. Currently data was broken down to ward level for inpatient services which helped identify concerns, but community teams were presented at service level. This meant that the positive performance of four community CAMHs services had masked the issues in the east and mid teams.
- We were concerned that, in contrast with other services, the local governance systems were not robust enough in the mid and east CAMHS teams to identify issues with waiting times and staffing levels. Local leaders were not able to interrogate systems so could not identify and act on issues; issues raised by staff were not escalated. Senior leaders did not have oversight of the issues in these two teams. The trust took immediate action following the warning notice to manage the risks and engage with staff.
- Not all of the board had a clear understanding of the level of financial challenge the trust faced despite good challenge from nonexecutive directors and positive action from the director of finance.
- No strategic overview of patient involvement in the trust was in place.

Use of resources

Colleagues from NHS Improvement joined the inspection and completed a review of how the trust uses its resources. They found that:

- The trust board is aware the trust is trading with an underlying deficit despite reporting a surplus in 2017/18 and 2018/19 and consistently quoted the delivery of the trust's cost improvement programme as one of its key risks. There

Summary of findings

is however a disconnect in practice between the board's awareness of the financial position, its ambition to invest to develop services and the pace at which the trust delivers efficiencies. The trust board must ensure that it collectively owns the trust's financial position and ensures the trust delivers enough efficiencies to finance its investments while improving its underlying financial position.

- Staff did not understand well the trust's underlying financial position as one-off income and financial adjustments have allowed the trust to deliver a surplus each year and the trust holds high cash balances. Senior management and the trust board did not provide a clear message during 2018/19 to budget holders on the need to deliver efficiencies at a time when the trust's ambition is to invest in services. Budget holders therefore prioritised investment in services resulting in lack of pace in delivering efficiencies. The trust must ensure there is a clear message to budget holders and staff regarding the trust's financial position and the need to deliver efficiencies at pace.
- The finance leadership team is clear that it needs to develop credible finance business partners who can effectively support clinical divisions in understanding their financial position and effectively plan and deliver efficiencies. The finance team is progressing in developing its business partner model and is providing training to budget holders to improve the level of financial understanding across the trust. However, the trust should accelerate the pace at which it embeds financial business partnering and financial understanding across the trust.
- The finance team is investing in the team's capability with several finance team members going through a financial qualification. The finance leadership team has the ambition to grow its own staff by providing the necessary training and experience, particularly to address recruitment difficulties at specific grades. However, we noted that there is no formal mandatory financial training programme for finance staff. The trust should consider the appropriateness and scope of financial mandatory training for finance staff.
- The trust has Standing Financial Instructions (SFIs) in place which define the financial responsibilities which apply to everyone working at the trust. Budget holders formally sign their budget and understanding of the SFIs each year. However, during our interviews with key members of staff, we heard of several examples where controls had not been followed resulting in costs being committed without proper approvals. The trust also ceased its Establishment Control Group which provided a forum to prioritise and approve new posts and changes to planned establishment. The PFI receives detailed service line information identifying the divisions which are overspending and underdelivering on CIPs. It is not clear however, what the consequences are for budget holders when they overspend or under deliver on CIPs. The trust must ensure that SFIs are adhered to, that additional controls are in place where required so that staff are clear and held to account on the consequences of not adhering to them and overspending on agreed budgets.

Ratings tables

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

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

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

Ratings for the whole trust

Safe	Effective	Caring	Responsive	Well-led	Overall
Requires improvement ↔ Apr 2019	Good ↑ Apr 2019	Outstanding ↔ Apr 2019	Good ↔ Apr 2019	Good ↑ Apr 2019	Good ↑ Apr 2019

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

Ratings for a combined trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community	Requires improvement ↔ Apr 2019	Good ↑ Apr 2019	Good ↔ Apr 2019	Good ↔ Apr 2019	Good ↑ Apr 2019	Good ↑ Apr 2019
Mental health	Good ↔ Apr 2019	Good ↔ Apr 2019	Outstanding ↔ Apr 2019	Good ↔ Apr 2019	Good ↔ Apr 2019	Good ↔ Apr 2019

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

Ratings for community health services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community health services for adults	Good ↑↑ Apr 2019	Good ↑ Apr 2019	Good ↑ Apr 2019	Good →← Apr 2019	Good ↑ Apr 2019	Good ↑ Apr 2019
Community health inpatient services	Requires improvement →← Apr 2019	Good →← Apr 2019	Good →← Apr 2019	Good →← Apr 2019	Good ↑ Apr 2019	Good ↑ Apr 2019
Community end of life care	Requires improvement ↓ Apr 2019	Good ↑ Apr 2019	Good →← Apr 2019	Good →← Apr 2019	Good ↑ Apr 2019	Good ↑ Apr 2019
Urgent care	Good ↑ Apr 2019	Good →← Apr 2019	Good →← Apr 2019	Good →← Apr 2019	Good ↑ Apr 2019	Good ↑ Apr 2019
Overall*	Requires improvement →← Apr 2019	Good ↑ Apr 2019	Good →← Apr 2019	Good →← Apr 2019	Good ↑ Apr 2019	Good ↑ Apr 2019

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

Ratings for mental health services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Acute wards for adults of working age and psychiatric intensive care units	Good Feb 2018	Good Feb 2018	Good Feb 2018	Good Feb 2018	Good Feb 2018	Good Feb 2018
Long-stay or rehabilitation mental health wards for working age adults	Good Feb 2018	Outstanding Feb 2018	Outstanding Feb 2018	Good Feb 2018	Good Feb 2018	Outstanding Feb 2018
Forensic inpatient or secure wards	Good Feb 2018	Good Feb 2018	Good Feb 2018	Good Feb 2018	Good Feb 2018	Good Feb 2018
Wards for older people with mental health problems	Good →← Apr 2019	Good →← Apr 2019	Outstanding ↑ Apr 2019	Outstanding ↑ Apr 2019	Good →← Apr 2019	Outstanding ↑ Apr 2019
Community-based mental health services for adults of working age	Requires improvement →← Apr 2019	Good ↑ Apr 2019	Good →← Apr 2019	Good →← Apr 2019	Good ↑ Apr 2019	Good ↑ Apr 2019
Mental health crisis services and health-based places of safety	Good Feb 2018	Good Feb 2018	Good Feb 2018	Good Feb 2018	Good Feb 2018	Good Feb 2018
Specialist community mental health services for children and young people	Inadequate ↓ Apr 2019	Requires improvement →← Apr 2019	Good →← Apr 2019	Inadequate →← Apr 2019	Inadequate ↓↓ Apr 2019	Inadequate ↓ Apr 2019
Community-based mental health services for older people	Good Feb 2018	Good Feb 2018	Outstanding Feb 2018	Good Feb 2018	Good Feb 2018	Good Feb 2018
Community mental health services for people with a learning disability or autism	Good Feb 2018	Good Feb 2018	Outstanding Feb 2018	Good Feb 2018	Good Feb 2018	Good Feb 2018
Overall	Good →← Apr 2019	Good →← Apr 2019	Outstanding →← Apr 2019	Good →← Apr 2019	Good →← Apr 2019	Good →← Apr 2019

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

Community health services

Background to community health services

Cornwall Partnership NHS Foundation Trust provides a wide range of community health services to people of all ages. The trust ran community health services from 15 locations across the county, including 13 community hospitals.

The trust provides the following community health services:

- Community health inpatient services
- Community health services for adults
- Urgent care services
- End of life care

We inspected all four community health services.

Previously, the trust also provided community health services for children, young people and families. However, these services were transferring to another provider from 1 April 2019 and we therefore did not inspect them.

Summary of community health services

Good ● ↑

Our rating of these services improved. We rated them as good because:

- Community health inpatient services improved and were rated good overall. Effective, caring, responsive and well-led were rated good. Safe was rated requires improvement.
- End of life care improved and was rated good overall. Effective, caring, responsive and well-led were rated good. Safe was rated requires improvement.
- Community health services improved and were rated good overall. Safe, effective, caring, responsive and well-led were rated good.
- Urgent care services improved and were rated good overall. Safe, effective, caring, responsive and well-led were all rated good.

Urgent care

Good ● ↑

Key facts and figures

Cornwall Partnership Foundation Trust provided urgent care at 10 minor injury units located across the county. Minor injury units (MIUs) provided treatment and advice on a range of minor injuries and illnesses not serious enough to require accident and emergency department treatment.

We visited nine out of the 10 minor injury units. Eight were on the Cornwall mainland at Newquay, Stratton, Helston, Falmouth, St Austell, Bodmin, Camborne and Redruth, and Liskeard. The other MIU was in St Mary's Hospital on the Isles of Scilly.

The minor injury units were nurse-led and provided advice and treatment for minor injuries. The full range of services on offer varied greatly, including the treatment of minor illness depending on the staff available and the setting the service was provided in. Primary care medical support was available from a General Practitioner at one minor injury unit, Camborne and Redruth, and the MIU at St Mary's Hospital had an on-call GP.

Services were provided without appointment to adults and children. Services were provided in most units seven days a week from 8am to 10pm (Helston 8am to 8pm). At St Mary's Hospital the service was available 24 hours a day. Stratton used to provide a 24-hour service but this was discontinued on the 07 December 2018. Each unit was staffed by registered nurses and/or paramedic practitioners, healthcare assistants and a receptionist. The MIUs employed band six and seven nurses, with band five nurse development posts. Not all units had access to a health care assistant and a receptionist outside of normal working hours and at weekends.

Of the 10 minor injury units, nine locations provided X-ray departments. These were open on weekdays from 9am to 5pm. Liskeard hospital had X-ray facilities open on a Saturday and Launceston Hospital was the only location with X-ray facilities on a Sunday. St Mary's Hospital had access to X-ray in the hospital each Wednesday.

Attendances at the minor injury and illness units fluctuated, with an increased demand during holiday seasons.

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

Our inspection was announced (staff knew we were coming) to ensure everyone we needed to talk with were available.

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

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

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

During the inspection visit, the inspection team:

Urgent care

- visited nine of the 10 minor injury units and looked at the quality of the environment and observed how staff were caring for patients;
- spoke with 32 members of staff across the units including: registered nurses, health care support workers, paramedics, administrators and a consultant nurse;
- spoke with 22 patients and one carer;
- looked at 18 patient records;
- looked at the medicines storage and medicines administration records at all nine sites;
- reviewed local policies, procedures and audits at all nine sites.

Summary of this service

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

- Staff in the minor injury units had received training to ensure they could keep patients safe. The staff team followed the correct procedures to keep the MIUs clean and reduce the spread of infection. Staff made sure all equipment was correctly maintained so it was ready for use. Staff recorded patient care and incidents following trust processes. Staff shared learning and apologised for mistakes.
- All the MIUs worked to the same policies and procedures. Staff assessed pain and gave effective pain relief promptly. The trust collected information from across the MIUs and used it to improve services. The teams worked well together and with other services. Staff considered patients' capacity before giving care.
- Staff treated all patients with dignity. Staff were professional when giving care. Staff had made reasonable adjustments to ensure all patients were involved in their care.
- The staff worked across the MIUs to ensure services were available where needed. Staff worked to meet the needs of all patients. Staff followed procedures so that if patients' needs changed they recognised this and met them. The trust had addressed the delays in acutely ill patients being transferred by ambulance from the MIUs to the local general hospitals. Patients were advised how to raise complaints with the trust and learning was shared.
- Staff felt supported by leaders at all levels in the trust. There was a vision for the MIUs and the trust was reviewing the services to ensure it met the community's needs.

However:

- Staff at the Helston MIU could not observe all patients as they waited in the waiting rooms due to the layout. Not all the units had separate staff teams and staff occasionally had to stop the treatment of one patient to triage another patient who had just come into the MIU to ensure they didn't need urgent attention. Not all staff had signed the patient medicines group directions to show they had read and understood them.
- Not all staff in each of the MIUs had received supervision.
- It was not clear on the trust's website when GPs were available at the Camborne and Redruth.

Is the service safe?

Good  

Urgent care

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

- Staff had received the training they needed to perform their roles and there were systems in place that encouraged staff to completed mandatory training.
- **Staff understood how to protect patients from abuse and the service worked well with other agencies to do so.** There were good processes in place to protect patients from abuse and staff understood and used them correctly.
- **The service controlled infection risk well.** The MIUs were clean and tidy and staff followed the trust's procedures to reduce the spread of infection.
- **The service had suitable premises and equipment and looked after them well.** Equipment, including emergency resuscitation equipment, was clean, maintained and checked correctly to ensure it worked when needed.
- There were systems in place to manage risks to patients. Receptionists were trained to recognise 'red flag' symptoms. Staff knew how to identify sepsis and other serious conditions and had processes to follow to escalate care if needed.
- **The service had enough nursing staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment.** The MIUs on the mainland had appropriate numbers of trained staff available to give care.
- **Staff kept detailed records of patients' care and treatment.** Staff made detailed notes recording appropriate information in patients' files.
- **The service followed best practice when prescribing, giving, recording and storing medicines.** The trust was carrying out a comprehensive review of medicines available on patient group directives.
- **The service managed patient safety incidents well.** Staff recognised what they needed to report on the trust incident system and apologised when things went wrong. Managers shared learning from incidents across the trust.

However:

- The trust had not provided us with training figures for individual MIUs. The staff in the MIU had not had not reached the trust's target for mandatory training completion.
- There were no dedicated MIU staff at St Mary's Hospital. Staff from the ward had to provide MIU cover when needed, reducing ward staffing and/or delaying triage and treatment of patients in MIU.
- Staff could not observe patients in the waiting room at the Helston MIU.
- Staff sometimes had to stop providing treatment to book-in and triage other patients when reception staff were not on duty.
- Not all staff had signed the medicine patient group direction register, to show the understood what could be given and when, at the Helston MIU.

Is the service effective?

Good   

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

- **The service provided care and treatment based on national guidance and evidence of its effectiveness.** There was a standard operating policy across all the MIUs and clinical policies were based on National Institute for Health and Care Excellence guidance.

Urgent care

- **Staff assessed and monitored patients regularly to see if they were in pain.** Staff provided patients with pain relief and assessed pain in ways that were meaningful to the patient.
- **Managers monitored the effectiveness of care and treatment and used the findings to improve them.** The trust monitored information about patient care in the MIUs and used this to improve the service.
- **Staff of different kinds worked together as a team to benefit patients.** There was good team working across the MIUs.
- **Staff understood how and when to assess whether a patient had the capacity to make decisions about their care.** Staff understood their responsibilities under the Mental Capacity Act.

However:

- Staff were receiving supervision but this was often as the trust policy recommended. However, all staff we spoke to felt they were supported by their senior staff.

Is the service caring?

Good   

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

- **Staff cared for patients with compassion.** Patients told us staff treated them with respect and compassion.
- **Staff provided emotional support to patients to minimise their distress.** Staff gave information to patients to help support their recovery and the MIUs used stickers, teddy bears, toys and tablet computers to support children whilst they were receiving care at the MIUs.
- **Staff involved patients and those close to them in decisions about their care and treatment.** They made reasonable adjustments to meet the needs of patients.

Is the service responsive?

Good   

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

- **The trust planned and provided services in a way that met the needs of local people.** The trust provided MIUs across the county and had plans in place to make sure the busiest units stayed open.
- Staff recognised and were sensitive to the needs of vulnerable groups of patients.
- **People could access the service when they needed it.** Staff observed patients and responded to their changing needs. There were systems in place for patients to alert staff if their needs changed. There was a system in place to prevent delays in staff transferring patients to local emergency departments by ambulance.
- **The service treated concerns and complaints seriously, investigated them, learned lessons from the results, and shared these with all staff.** The trust reviewed complaints and shared any lessons learnt throughout the MIUs.

However:

- It was not clear on the trust's website when GPs were available at Camborne and Redruth MIU.

Urgent care

Is the service well-led?

Good ● ↑

Our rating of well-led improved. We rated it as good because:

- **Managers at all levels in the trust had the right skills and abilities to run a service providing high-quality sustainable care.** Leaders were available in the MIUs and staff felt supported.
- **The trust had a vision for what it wanted to achieve and workable plans to turn it into action. These were developed with involvement from staff.** There was a vision for the MIUs and the trust was reviewing the service.
- **Managers across the trust promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.** Morale was good and staff were proud of the care they provided.
- **The trust used a systematic approach to continually improve the quality of its services and safeguard high standards of care by creating an environment in which excellence in clinical care would flourish.** There was a robust governance process in place at the MIUs to improve patient care.
- **The trust had effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected.** The trust had introduced procedures to ensure staff knew what they needed to do to shut the MIUs on time.

However:

- Some staff felt they had not had the opportunity to give their opinion on the development of the MIUs.

Areas for improvement

Action the provider SHOULD take to improve:

- The trust should review how patients can be observed while in the waiting room at Helston MIU, to ensure their safety.
- The trust should check all relevant staff have signed the medicines patient group directions, to demonstrate that they know how and when to safely administer the medication.
- The trust should review their business plan to make sure that there will be enough staff with the right skills and experience to deliver safe and effective care at Helston and St Mary's MIU's.
- The trust should check that all staff in each MIU has access to supervision as detailed in the trust's policy.

Community health inpatient services

Good  

Key facts and figures

Cornwall Partnership NHS Foundation Trust provided community health inpatient services at 10 community hospital sites across Cornwall and the Isles of Scilly. In total there were 14 open wards across these sites.

The majority of patients were moved to the community wards to continue their rehabilitation or care from Royal Cornwall Hospitals NHS Trust, University Hospitals Plymouth NHS Trust and Northern Devon Healthcare NHS Trust. General Practitioners also admitted patients directly into the community hospital beds.

The community hospital wards provided rehabilitation, inpatient nursing and medical care for people with long term, progressive and life limiting conditions. End of life care was delivered within all community hospital wards. Day case patients were seen within day case or outpatient units. Two dedicated beds were provided as part of the community hospital alcohol detoxification pathway; one on Anchor Ward at Bodmin Hospital and one at Helston Community Hospital. This was supported and delivered in partnership with GPs and Addaction. Stratton Hospital and Harbour ward at Bodmin had a day case bed in their inpatient ward. Stratton and Liskeard Hospitals had a dedicated minor procedures room where minor operations were performed by surgeons from Plymouth and Probus.

We visited eight community inpatient wards. Seven wards were on the mainland in Cornwall at Bodmin, Falmouth, Newquay, Camborne and Redruth, and Liskeard hospitals. The final ward was at St Mary's hospital on the Isles of Scilly.

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

Our inspection was announced (staff knew we were coming) to ensure everyone we needed to talk with was available.

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

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

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

During the inspection visit, the inspection team:

- visited eight of the 17 community inpatient service wards and looked at the quality of the environment and observed how staff were caring for patients.
- spoke with 43 members of staff across the units, including: registered nurses, health care support workers, paramedics, administrators and a consultant nurse.
- spoke with 22 patients and one carer.

Community health inpatient services

- looked at 48 patient records.
- looked at the medicines storage and medicines administration records.
- observed handovers, multi-disciplinary team meetings and bed flow discussions.
- review local policies, procedures and audits at all eight sites.

Summary of this service

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

- Staff recorded patient risks and completed comprehensive risk assessments. Staff understood safeguarding processes and knew how to report abuse. Staff reported incidents and learned from them.
- Staff across all wards followed national guidance when providing care to patients. The ward teams worked well together when planning, assessing and managing patient care.
- Staff were highly motivated and delivered compassionate care to patients. Staff treated patients with dignity and respect. There were good interactions between staff and patients. Feedback from patients and carers was positive. The trust sought feedback from patients and carers to improve service delivery. Staff were considerate of patients spiritual, cultural and religious beliefs.
- Each ward had clear admission criteria which staff understood. Patients were able to make choices about their care. Care and treatment were delivered in collaboration with health and social care providers to meet the needs of patients. Patients were able to raise concerns and staff reviewed and acted upon these appropriately
- Staff felt supported by the leadership within the trust. The trust had a vision and strategy which staff within the services understood and signed up to. The service had a system of governance in place to improve the quality of care provided to patients. The trust engaged well with staff, patients and carers.

However:

- Cleanliness on four wards at three hospitals was not good enough. There were gaps in cleaning rotas, poor compliance with infection control and unhygienic food standards. Equipment was not always maintained well.
- Staffing levels on two wards at two hospitals was not always met and shifts were unfilled. This created additional pressure on staff.
- There were some gaps in the recording of patients' capacity to consent.
- Staff found the electronic rostering system frustrating and time consuming to use.

Is the service safe?

Requires improvement ● → ←

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

- **The service provided mandatory training in key skills but did not always ensure everyone completed it.**

Community health inpatient services

- **The service did not always control infection risk well.** Cleanliness on four of the wards, at three hospitals, we visited was not sufficient. We found gaps in cleaning rotas, poor compliance with COSHH regulations and unhygienic food standards. We also found issues with infection control.
- **The service had suitable premises and equipment but did not always look after them well.** Equipment did not all have in-date service records and gaps in portable appliance testing. We found some tired equipment which was in need of replacement at two sites.
- **Not all wards had enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment.** Staffing levels on two wards, at different hospitals, were not always being met and some shifts were unfilled.

However:

- **Staff understood how to protect patients from abuse and the service worked well with other agencies to do so.** Staff knew how to recognise and report abuse. Staff understood their role in safeguarding and knew the procedures to report abuse.
- **Staff completed and updated risk assessments for each patient.** There were systems in place to assess and monitor patient risk.
- **Staff mostly kept detailed records of patients' care and treatment.**
- **The service managed patient safety incidents well.** There was an open culture of reporting incidents. Learning from incidents was shared by management within, and across, the service.
- **The service followed best practice when prescribing, giving, recording and storing medicines.** Medicines were stored safely. Emergency medicines were available and in date. Fridge temperatures and clinic room temperatures were monitored daily, and action taken if required.
- **The service used safety monitoring results well.**

Is the service effective?

Good   

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

- **The service provided care and treatment based on national guidance and evidence of its effectiveness.** The wards provided patient care and treatment based on national guidance. National Institute for Health and Care Excellence (NICE) guidelines were embedded in the trust's policies and procedures, which the wards followed.
- **Staff gave patients enough food and drink to meet their needs and improve their health.**
- **Staff assessed and monitored patients regularly to see if they were in pain.** Staff gave patients pain relief and assessed pain in collaboration with the patient.
- **Managers monitored the effectiveness of care and treatment and used the findings to improve them.** Information about patient outcomes was collected and monitored.
- **The service made sure staff were competent for their roles.** Most staff received regular supervision sessions and appraisals.

Community health inpatient services

- **Staff of different kinds worked together as a team to benefit patients.** The multi-disciplinary teams worked collaboratively when assessing, planning and implementing patient care. Professionals, including occupational therapists, physiotherapists, speech and language therapists, dieticians and social workers, worked cohesively to provide patient centred care.
- **Staff understood how and when to assess whether a patient had the capacity to make decisions about their care.**

However:

- Call bells were not always answered in a timely way on some wards.
- Staff supervision at St Mary's hospital was not always being completed in line with the trust's supervision policy.

Is the service caring?

Good  → ←

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

- **Staff cared for patients with compassion.** Staff were highly motivated and provided care which was compassionate to patients. We observed good interactions between staff and patients. Staff maintained patients' privacy and dignity at all times.
- **Staff provided emotional support to patients to minimise their distress.** Staff took into consideration patients' spiritual, cultural and religious needs and made adjustments where necessary.
- **Staff involved patients and those close to them in decisions about their care and treatment.** Patients and carers spoke positively about the way staff treated them and the attention and support staff offered. Patients said they felt involved in decisions about their care.

Is the service responsive?

Good  → ←

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

- **The trust planned and provided services in its community hospitals in a way that met the needs of local people.** There were clear admission criteria to the wards. Staff on each individual ward understood the criteria. Care and treatment was well co-ordinated with health and social care providers, such as GPs and social work teams, to meet the needs of patients.
- **People could access the service when they needed it.**
- **The service treated concerns and complaints seriously, investigated them, learned lessons from the results, and shared these with all staff.** Patients knew how to raise concerns or complaints and the trust reviewed these appropriately. The wards learned from complaints and improved services as a result.
- There was a good range of information available to patients and carers with leaflets about health conditions, treatment and other services.

However:

Community health inpatient services

- Dementia friendly environments varied between the wards.

Is the service well-led?

Good  

Our rating of well-led improved. We rated it as good because:

- **Managers at all levels in the service had the right skills and abilities to run a service providing high-quality sustainable care.** There was strong local leadership across all the wards. Staff were positive about their managers and local leadership and felt supported in their roles.
- **The service had a vision for what it wanted to achieve and workable plans to turn it into action. These were developed with involvement from staff, patients, and key groups representing the local community.** The service had a clear vision and strategy which staff were aware of and followed.
- **Managers across the service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.** Staff morale was high. Staff were proud to work for the trust and were passionate about their roles.
- **The service used a systematic approach to continually improve the quality of its services and safeguard high standards of care by creating an environment in which excellence in clinical care would flourish.** Staff undertook a number of audits and quality improvement projects to improve the delivery of services for patients.
- **The service had effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected.** The service had effective systems in place for identifying risks and plans to address such risks. The service maintained a risk register which was regularly reviewed and escalated to board level.
- **The service collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards.**
- **The service engaged well with patients, staff, the public and local organisations to plan and manage appropriate services, and collaborated with partner organisations effectively.** Staff were able to attend events with the executive team and patients and carers had opportunities to engage with the trust.

However:

- Areas of risk identified during the inspection were not reflected on the risk register.
- Staff in most wards found the electronic rostering system to be frustrating. It did not always accurately populate shifts, which meant managers spent more time making amendments to rotas.
- Locum doctors did not have access to login information for the pathology results electronic system.

Areas for improvement

Action the provider **MUST** take to improve:

- The service must ensure there are sufficient numbers of suitably qualified, competent and skilled staff available to meet the needs of patients at all time and in all wards (Regulation 18).
- The service must ensure all premises are clean and follow infection prevention control practices (Regulation 15).

Action the provider **SHOULD** take to improve:

Community health inpatient services

- The trust should improve oversight and assurance for the management of equipment: storage, checks, cleaning and replacement.
- The trust should support staff to access supervision, in line with the trust's supervision policy.
- The trust should improve the completion and documentation of capacity assessments.
- The service should check all risks identified are submitted to the trust's risk register.
- The trust should review the electronic rostering system.
- The trust should review locum doctor access to login information for the pathology results electronic system.
- The trust should check that all staff are compliant with mandatory training.
- The service should review ward environments to make sure they are dementia friendly.

Community end of life care

Good  

Key facts and figures

Cornwall Partnership NHS Foundation Trust delivered end of life care when required in the community hospitals and in patients' own homes. Care was provided by ward nurses, health care assistants, medical staff and by district nursing teams. In one locality there was a team of health care assistants, called Continuing Care at Home. This team worked with the district nursing team to provide care and support to patients in their own homes.

There were three specialist palliative care teams located across three localities in the county: east, central and west. These staff worked from the community hospitals and GP surgeries and linked with the other staff in their respective locality. The staffing compliment was 18.2 whole time equivalents. There were 5,415 face to face and clinically relevant activities undertaken by the teams between April 2018 and January 2019. Staff provided specialist support and advice for those patients with complex needs, and/or complex symptom management relating to end of life care. The team also provided advice on all aspects of palliative care and palliative care education and training.

An end of life care facilitator worked across the three locations. This staff member liaised with and supported ward staff and district nursing teams with all aspects of the Gold Standards Framework. This was the framework for end of life care that was in place across the whole service. This is a national accredited system and programme for the provision of end of life care.

A total of 230 deaths were recorded in the community hospital wards between 1 October 2017 and 31 March 2018. Cornwall had a lower rate of patients dying in hospital compared to the national average and a higher rate of patients dying in their own homes. An audit from the trust showed the specialist palliative care team cared for 1,139 patients between April 2017 and March 2018.

As part of this inspection we visited seven community hospitals. We also met with district nursing teams, the specialist palliative care teams, locality managers and health care assistants. We accompanied staff on seven home visits and attended seven community hospitals. We spoke with five patients, six relatives and 40 staff in total. We looked at a sample of 12 patient records. We looked at audits undertaken by the trust and policies and minutes from meetings.

Summary of this service

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

- Staff completed and updated risk assessments for each patient and responded when the patient's condition deteriorated. Community staff kept detailed records of patients' care and treatment. The services followed best practice when prescribing, giving, recording and storing medicines. Patients received the right medicines at the right dose at the right time. In the wards and community there was timely access to equipment to support patients at the end of life. Nutrition and pain needs were met. The service adjusted for patients' religious, cultural and other preferences.
- The community service had enough nursing and medical staff, with the right mix of qualification and skills, to keep patients safe and provide the right care and treatment. Doctors, nurses and other healthcare professionals supported each other to provide good care. Staff worked collaboratively with other health professionals and across healthcare disciplines to ensure continuity of specialist and individualised care for patients.

Community end of life care

- The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers monitored the effectiveness of care and treatment and used the findings to improve them. Audits were completed on the wards through the guidance of the end of life care facilitator, and in the community by the specialist palliative care teams.
- The trust set a target of 85% for completion of mandatory training. The compliance for mandatory training courses at 30 November 2018 was 78%. Of the training courses listed, 15 failed to achieve the trust target. End of life staff confirmed they had completed the mandatory training and found it relevant and helpful. Further specific training was provided to staff to support end of life care. Staff all confirmed they felt supported in their development and had supervision in the last year.
- Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. They followed the trust policy and procedures when a patient could not give consent. Since our last inspection in 2017 a review had taken place of the treatment escalation plan, this is a form for clinical guidance which includes mental capacity and agreed ceilings of care. Audit results showed an improvement in completion.
- Staff cared for patients with compassion. Patients gave feedback that staff treated them well and with kindness. Throughout our inspection we observed patients being treated with the highest levels of compassion, dignity and respect. Staff provided emotional support to patients to minimise their distress and involved patients and those close to them in decisions about their care and treatment.
- The trust planned and provided services in a way that met the needs of local people. The service took account of patients' individual needs. The trust worked with stakeholders, including commissioners and other providers, to promote end of life care across the county.
- The service treated concerns and complaints seriously, investigated them, learned lessons from the results, and shared these with all staff. Complaints were managed in an effective way.
- Leaders at ward level and in the community had the right skills and abilities to run a service providing high-quality sustainable care. The trust had a vision for what it wanted to achieve and was working on plans to turn it into action. In Cornwall the work on an end of life strategy was being implemented as part of a whole system approach.
- End of life leads across the trust promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values. We found there was a positive culture across the services we visited.
- The trust used a systematic approach to monitoring and improving the quality of its end of life services.
- There were systems to ensure end of life services were monitored and appropriate action taken to improve services. The service had systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected. The trust had recently implemented an end of life risk register.
- The end of life service engaged well with patients, staff, the public and local organisations to plan and manage appropriate services and collaborated with partner organisations effectively.
- The end of life service was committed to improving services by learning from when things went well and when they went wrong, promoting training, research and innovation.

However:

- At Camborne Redruth, Newquay, Helston, Bodmin, St. Mary's and Falmouth hospitals, end of life care plans were not consistently used and the care plans were not as personalised as they could have been.
- Care and treatment was not always provided in accordance with national guidance. The Gold Standards Framework system was in place across the service but was not used consistently. At Camborne, Redruth, Newquay, Helston, Bodmin, St. Mary's and Falmouth hospitals, staff did not fully complete the Gold Standard Framework care plans.

Community end of life care

- The Continuing Health Care Team provided by the trust was only available in part of the county. The trust was only commissioned to provide this service for part of the county. This meant that the team, that covered the middle of the county, could provide a more responsive and accessible service although good care was provided in all areas of the county. Training was not consistently provided across all areas of the county. Nurses on the Isles of Scilly required update training for both syringe drivers and verification of death.
- The trust leadership was not visible to all the end of life care service. Changes were planned following staff feedback, which would see the process being updated.

Is the service safe?

Requires improvement  

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

- **The records of care and treatment in the community hospitals were not consistently clear and up-to-date for staff providing care.** Camborne Redruth, Newquay, Helston and Falmouth hospitals did not fully complete the Gold Standard Framework care plans. End of life care plans were not consistently used and the care plans seen lacked individual content to enable staff to provide personalised care. Most care plans in use and planned reviews seen were not signed or dated.
- **The service provided mandatory training in key skills to all staff.** The trust set a target that 85% of staff should have completed mandatory and statutory training. As of November 2018, 78% of staff had completed this training. Although this was an improvement since our last inspection in 2017, for 15 of the courses listed compliance was below the trust target.
- **There was variable health care assistant provision for supporting patients in their own homes, depending on where they lived.** The Continuing Health Care Team (CHCT) provided by the trust was only available in the middle of the county. This meant that the service provided in the middle of the county was more responsive and accessible than other areas. The trust was only commissioned to provide the CHCT in the middle of the county. However, good care was provided across the county.

However:

- **Staff understood how to protect patients from abuse and the service worked well with other agencies to do so.** Staff had training on how to recognise and report abuse and they knew how to apply it.
- **The service controlled infection risk well.**
- **The service had suitable premises and equipment and looked after them well.** In the ward and community there was timely access to equipment to support patients at the end of life.
- **Staff completed and updated risk assessments for each patient.**
- **Except for health care assistants in the west and east and a consultant in the west and central teams, the service had enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment.** The community service had enough nursing and medical staff, with the right mix of qualification and skills, to keep patients safe and provide the right care and treatment. The trust had employed medical staff in nine of the 13 community hospitals.
- **Community staff kept detailed records of patients' care and treatment. Records were clear, up-to-date and easily available to all staff providing care.**

Community end of life care

- **The service followed best practice when prescribing, giving, recording and storing medicines. Patients received the right medicines, at the right dose and at the right time.**
- **The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately.** Staff felt confident in using the incident reporting system to raise concerns and told us they felt supported to raise and report issues. Incidents were investigated, and learning was shared with staff to prevent reoccurrence.

Is the service effective?

Good  

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

- **Staff gave patients enough food and drink to meet their needs and improve their health.** The service adjusted for patients' religious, cultural and other preferences.
- **Staff assessed and monitored patients regularly to see if they were in pain. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.**
- **Managers monitored the effectiveness of care and treatment and used the findings to improve outcomes.** Audits were completed on the wards through the guidance of the end of life care facilitator, and in the community by the specialist palliative care teams.
- **The service made sure staff were competent for their roles.** Staff had the right skills and knowledge to provide safe care and treatment for patients. Staff all confirmed they had supervision in the last year and appraisal targets had been met.
- **Staff of different disciplines worked together as a team to benefit patients.** Doctors, nurses and other healthcare professionals supported each other to provide good care. Staff worked collaboratively with other health professionals and across healthcare disciplines to ensure continuity of specialist and individualised care for patients.
- **Patients were encouraged to be involved in decisions about their own health and how to remain as independent as possible.**
- **Staff understood how and when to assess whether a patient had the capacity to make decisions about their care.** They followed the trust policy and procedures when a patient could not give consent. Since the last inspection in 2017 a review had taken place of the treatment escalation plan. Audit results showed improvements in completion.

However:

- **The service aimed to provide care and treatment based on national guidance, but this was not achieved consistently across the trust.** The Gold Standards Framework system was in place across the service but was not always used. The multidisciplinary team meetings in the west and central team had recently lost their consultant presence. This meant National Institute for Health and Care Excellence guidance was not met.
- **Training was not consistently provided across all areas of the county.** Nurses on the Isles of Scilly required update training for both syringe drivers and verification of death. The end of life education lead delivered this training but was not available until September 2019, by which time all staff would be out of date in terms of the training requirement. The trust was working to resolve this by finding another trainer to deliver the training to staff.

Community end of life care

Is the service caring?

Good ● → ←

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

- **Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness.** Staff were kind and supportive to patients and their relatives. Throughout our inspection, we observed patients being treated with the highest levels of compassion, dignity and respect.
- **Staff provided emotional support to patients to minimise their distress.** We observed staff providing emotional support to patients and relatives on many levels. All the relatives and patients we spoke with were positive about their involvement and understanding about their care, and the decisions that needed to be made.
- **Staff involved patients and those close to them in decisions about their care and treatment.** Support and information was provided to patients and those close to them, including carers and dependants, both in hospital and in the community.

Is the service responsive?

Good ● → ←

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

- **The trust planned and provided services in a way that met the needs of local people. The service took account of patients' individual needs.** The trust worked with other stakeholders, commissioners and other providers to promote end of life care across the county. There was a county-wide strategy group for end of life care.
- **The service mostly took account of patients' individual needs when they were in vulnerable circumstances.**
- **People could access the service when they needed it.** The specialist palliative care teams provided a service between 9am and 5pm seven days a week., with district nursing support being available until 10pm if needed.
- **The service treated concerns and complaints seriously.** Complaints were managed in an effective way.

Is the service well-led?

Good ● ↑

Our rating of well-led improved. We rated it as good because:

- **Leaders at ward level and in the community had the right skills and abilities to run a service providing high-quality sustainable care but** there appeared some disconnect between the trust leadership and end of life.
- **The trust had a vision for what it wanted to achieve and was working on plans to turn it into action.** In Cornwall, work on an end of life strategy was being implemented as part of a whole system approach in the wider health and social care setting.
- **End of life leads across the trust promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.** We found there was a positive culture across the services we visited.

Community end of life care

- **The end of life service used a systematic approach to monitoring and improving the quality of its services.** There were systems implemented to ensure monitoring of the services provided was undertaken and appropriate action taken to make improvements. The information gathered was used to monitor and manage quality and performance.
- **The end of life service had systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected.** The trust had implemented an end of life risk register.
- **The end of life service collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards.**
- **The end of life service was committed to improving services by learning from when things went well and when they went wrong, promoting training, research and innovation.**
- **However:**
 - There was limited end of life staff engagement. Changes were planned following staff feedback, which would see the process being updated. The trust leadership was not visible to all the end of life care service.

Areas for improvement

We found areas for improvement in this service. See the Areas for Improvement section above.

Action the service **must** take to improve:

- The trust must ensure community hospital care plans and the documents used to support end of life care are individualised, consistently completed, signed and up to date (Regulation 9).

Action the trust **should** take to improve:

The trust should work with commissioners to ensure it is able to provide the same level of responsive and accessible service across the county.

The trust should check that care and treatment is consistently provided and is based on national guidance, for example, the Gold Standards Framework system.

The trust should check that nurses on the Isles of Scilly have opportunities for training in the use of syringe drivers and the verification of death.

The trust should review if staff feel engaged and clear about trust level involvement in end of life care.

Community health services for adults

Good  

Key facts and figures

Cornwall Partnership NHS Foundation Trust provide a range of community health services to adults throughout Cornwall and the Isles of Scilly. The service provides care and treatment to a population of approximately 545,000 people. A quarter of the population (approximately 140,000 people) suffer from a long-term condition and a quarter of the population are aged over 65 years.

Adult community services deliver care and treatment in three area teams covering west, mid and north/east Cornwall and the Isles of Scilly. Community nursing teams, therapy teams and specialist nurses work from 34 different locations/clusters covering the whole of Cornwall and the Isles of Scilly.

Community nursing is delivered by district nursing teams and community matrons in 31 different locations throughout Cornwall and the Isles of Scilly. Teams are based in GP surgeries and community hospitals throughout the county.

Specialist nurse and therapy teams deliver a range of services, including:

- Acute care at home
- Adult speech and language therapy
- Bladder and Bowel Clinics
- Cardiac Services
- Diabetic Specialist Nurse
- Falls Practitioners
- Health for Homeless
- Home First
- Integrated Community Respiratory Team
- Musculoskeletal (MSK) clinics
- Neuro Rehab Service
- Parkinson Specialist Nursing Service
- Podiatry
- Rehabilitation Therapy Services
- Respiratory Nursing Services
- Specialist Stroke & Gastrostomy Nurse
- Tuberculosis Nurses
- Telehealth Services
- Tissue Viability Nurses

Community health services for adults

- Wheelchair Service

Our inspection was announced (the trust knew we were coming). During our inspection, we joined community nurses and matrons on home visits in community nursing services located in:

- Bodmin
- Falmouth
- Penryn
- Truro
- Newquay
- St Austell
- Cambourne & Redruth
- Isles of Scilly

We visited a range of specialist nursing and therapy services and spoke with staff and patients. We observed staff interact with patients receiving care in four different clinics held in community settings and we observed four multidisciplinary meetings.

We spoke with 70 nursing and therapy staff including leaders and managers at different levels. We spoke with 16 patients and seven relatives who told us about the care they received, and we reviewed 17 electronic patient records. We asked for data about how efficient the services were before and after the inspection and we spoke with four external staff who worked closely with the service.

The Care Quality Commission last inspected the service in September 2017 where we rated the service as requires improvement overall. Following our last inspection, we told the trust that they must improve on the completion of risk assessments and improve staff compliance with mandatory training and clinical supervision. We also told the trust they must ensure shared learning when things went wrong and provide staff with the tools to monitor patients who were at risk of deterioration.

We reviewed actions taken in response to the requirement notices we served and spoke with staff of different seniority about the changes that had been made.

Summary of this service

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

- There were systems and processes to protect patients from healthcare-associated infections. Staff completed risk assessments and the service mostly had suitable premises and equipment. However, the completion of patient records varied and learning from incidents were not always shared effectively across teams in different areas.
- The service delivered care based on current national guidance. Many specialist services used outcome measures to evaluate the effectiveness of care and treatment. There was good multidisciplinary working across all localities although it was a challenge to extend specialist services to the Isles of Scilly.
- Staff were compassionate, and patients told us staff were kind and delivered exemplary care. Staff supported patients' carers.

Community health services for adults

- Staff took account of each individual's care needs. Referral to treatment times were mostly met and referrals were triaged using effective processes. The service did not receive many complaints about care from patients and their relatives.
- Leadership and governance structured had strengthened. Managers promoted a positive culture and most staff told us they felt valued.

Is the service safe?

Good   

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

- **The service provided mandatory training in key skills to all staff and training compliance mostly met expected trust standards.** Overall mandatory training compliance has improved since our last inspection and met the trust's overall compliance target.
- **Staff understood how to protect patients from abuse and the service worked well with other agencies to do so.**
- **There were systems to prevent and protect people from healthcare-associated infections.**
- **The service had mostly suitable premises and equipment and looked after them well.** Staff had access to equipment to support patients in their home.
- **Staff completed and updated a range of risk assessments for each patient.** Compliance with risk assessments had improved.
- Staff were aware of signs and symptoms of sepsis. Staff had received sepsis training and were aware of signs and symptoms. The trust had recently introduced a sepsis toolkit to enable staff to take vital observations and escalate concerns.
- **The service had enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment.** Caseloads were managed well, although there were high caseloads across all services. There were enough staff, although recruitment was an ongoing challenge.
- **The serviced used safety monitoring results well.**
- **The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately.**

However,

- **The completion of detailed records of patients' care and treatment varied between locations.** The quality of patient care records was not regularly audited in all locations.
- Sharing of learning from incidents was not effective across areas, although there were effective processes for sharing of learning in local teams.
- Most but not all staff followed good practice for the prevention and spread of infection. Not all staff washed their hands following care interventions in patients' homes.

Is the service effective?

Good  

Community health services for adults

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

- **The service provided care and treatment based on national guidance and monitored evidence of its effectiveness.**
- **Staff assessed patients' food and drink needs to improve their health.** Assessment of patients' risk of malnutrition had improved since our last inspection.
- **Most staff assessed and monitored patients regularly to see if they were in pain.**
- **Managers monitored the effectiveness of care and treatment and used the findings to improve services.**
- **The service made sure staff were competent for their roles.** Staff demonstrated competence in their roles and received regular supervision. Most staff received timely annual appraisals.
- **Different staff worked together as a team to benefit patients.** There was effective multidisciplinary working and staff acknowledged the value of this for patient care.
- **Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. Staff understood how and when to assess whether a patient had the capacity to make decisions about their care.**

However:

- Consent processes did not always follow national guidance when seeking written consent for those who did not have capacity to consent to treatment. The Podiatry service did not use consent forms designed to obtain consent for procedures when patients did not have mental capacity to consent to treatment.

Is the service caring?

Good   

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

- **Staff cared for patients with compassion.** Patients and relatives told us care was “couldn't be better”.
- **Staff provided emotional support to patients and those close to them.** Staff took time to interact with patients and their relatives.
- **Staff involved patients and those close to them in decisions about their care and treatment.**

Is the service responsive?

Good   

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

- **The trust planned and provided services in a way that met the needs of local people.**
- **The service took account of patients' individual needs, including those in vulnerable circumstances.**

Most people could access community nursing services when they needed them. Referrals to community services were triaged using effective processes.

Community health services for adults

- **The service treated concerns and complaint seriously, investigated them, learned lessons from the results, and shared these with all staff.** The service received few complaints from patients and their relatives.

However:

- Some services did not meet referral to treatment times in line with national 18-week targets.

Is the service well-led?

Good  

Our rating of well-led improved. We rated it as good because:

- **Managers at all levels had the right skills and abilities to run a service providing high-quality sustainable care.** Most staff felt supported by their managers and most teams had regular team meetings.
- **The trust had a vision for what it wanted to achieve.** Senior management and leaders spoke of plans for integrated care models that were patient-focussed and involved working closer with voluntary sectors.
- **Managers across the service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.**
- **The trust had systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected.**
- **The trust collected, analysed, managed and used information well to support its activities, using secure electronic systems with security safeguards.**
- **The service engaged with patients, staff, the public and local organisations to plan and manage appropriate services. They collaborated with partner organisations effectively.**
- **The service was committed to improving services by learning from when things went well and when they went wrong, promoting training, research and innovation.**

However:

- Team meetings were not always held regularly and not always minuted. This meant there was inconsistent sharing of outcomes, actions and experiences.
- **The trust used a systematic approach to continually improve the quality of its services, but this was not embedded throughout the service.**
- Staff were not aware of the trust's values.

Outstanding practice

- The Health for Homeless provided person-centred support vulnerable people. For example, a nurse re-arranged their diary at short notice and drove a vulnerable person 55 miles in their own car, so they could receive a planned surgical procedure

Areas for improvement

We found areas for improvement in this service

Community health services for adults

Actions the trust SHOULD take to improve the service:

- The trust should continue to encourage staff to complete all mandatory training, including safeguarding and regular updates for staff who facilitate blood transfusion in people's homes, in a timely manner.
- The trust should re-iterate the importance of following national guidance for hand washing procedures when staff visit patients in their homes.
- The trust should improve processes for shared learning between the three geographical areas and between different locations.
- The trust should continue to monitor the completion of risk assessments, share audit results across nursing teams and work to improve compliance in all localities. The trust should carry out risk assessments and education to ensure the right equipment is used in people's homes.
- The trust should continue to embed the national early warning tool for vital observations and standardise processes to ensure contemporaneous recording.
- The trust should work towards capacity and dependency scoring of all services (including acute care and home and specialist nursing services) to help inform regular review of establishment of all community services.
- The trust should review processes to obtain consent for patients who lack capacity to consent to treatment.
- The trust should review processes for consistent monitoring and review of referral to first contact or treatment for all services including community nursing services.
- The trust should consider options to support staff with continuing post-graduate study including access for staff on the Isles of Scilly.
- The trust should plan regular team meetings in all teams across acute care services.
- The trust should explore how to use patient feedback effectively across all community health services.

Mental health services

Background to mental health services

Cornwall Partnership NHS Foundation Trust provides a wide range of mental health services to people of all ages.

The trust provides the following mental health services:

- community mental health services for adults of a working age
- specialist community mental health services for children and young people
- mental health crisis services and health based place of safety
- community based mental health services for older people
- community based services for adults with learning disabilities or autism
- forensic inpatient and secure wards,
- acute wards adults of working age
- wards for older people with mental health problems
- long stay / rehabilitation wards for adults of working age
- wards for people with learning disability or autism.

The trust is currently building a child and adolescent inpatient unit. This was not open at the time of this inspection, but we will inspect it in the future.

At this inspection we inspected community mental health services for adults of a working age, community based children and adolescent mental health services and wards for older people with mental health problems.

The other mental health services the trust provides were not inspected as they are all rated good or outstanding and we had no information to suggest this rating would change.

Summary of mental health services

Good   

Our ratings of these services stayed the same overall. We rated them as good overall because:

- Wards for older people with mental health problems improved and were rated outstanding overall. Caring and responsive were rated as outstanding. Safe, effective and well led were rated as good. Staff involved patients and carers in decisions about their care and they worked hard to enable patients to move to appropriate placements.

Summary of findings

- Community mental health services for adults of a working age improved and were rated good overall. Effective, caring, responsive and well led were rated as good. Safe was rated as requires improvement. New leadership in the service had addressed the concerns we had raised at the last inspection. However, there were issues with medicines management.

However;

- Specialist community mental health services for children and young people went down and were rated inadequate overall. Safe and well led were rated as inadequate. Effective and responsive were rated as requires improvement. Caring was rated as good. We had significant concerns about the safety of young people not being monitored on internal waiting lists in two of the teams.

Wards for older people with mental health problems

Outstanding  

Key facts and figures

Garner ward is a dementia ward on the site of Bodmin hospital, where there are other mental health wards. Garner ward is the only dedicated inpatient service for older people living with dementia in Cornwall. Garner ward supports people living with dementia and behaviours that challenge. Functional (complex care) older persons are admitted to a working age adult mental health ward. A functional mental illness is a type of illness that has a predominantly psychological cause. It may include conditions such as depression, schizophrenia, mood disorders or anxiety.

The ward admits both men and women and has 24 single bedrooms. Eight beds were closed at the time of our inspection due to the complex needs of patients being admitted. The trust had closed these beds in 2018. The ward had 16 patients at the time of our inspection, all 16 were detained under the Mental Health Act 1983 and there were no patients subject to a Deprivation of Liberty Safeguard (DoLS).

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

We last inspected Garner ward in September 2017, during this inspection we rated the service Good in Safe, Effective, Caring, Responsive and Well Led.

Our inspection was announced (staff knew we were coming) to ensure that everyone we needed to talk to was available.

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

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

Before the inspection visit we reviewed information that we held about these services, asked a range of other organisations for information, spoke with senior managers with service line responsibility for the older people's inpatient services and sought feedback from staff at focus groups.

During the inspection visit, the inspection team:

- visited the ward and looked at the quality of the ward environment and observed how staff were caring for patients
- spoke with one patient who was using the service
- spoke with four carers either on the telephone or in person
- interviewed the manager of the ward
- spoke with four other staff members
- attended a ward round
- reviewed six patients' care records

Wards for older people with mental health problems

- reviewed 13 prescription charts
- reviewed four patients' Mental Health Act records

Summary of this service

Our rating of this service improved. We rated it as outstanding because:

- All staff demonstrated a strong, visible, person-centred culture. Staff were highly motivated and inspired to offer care that was kind, compassionate and promoted patients' dignity. This was reflected in the way staff interacted with patients, patients care records and during multidisciplinary meetings.
- Patients were active partners in their care. Staff were fully committed to working in partnership with patients and supported patients to make decisions about their care for themselves. They understood the trust policy on the Mental Capacity Act 2005 and assessed and recorded capacity appropriately and clearly. Feedback from all carers was positive and all felt staff went the extra mile.
- Patients had comprehensive assessments of their needs, which included consideration of clinical needs, mental health, physical health and wellbeing, and nutrition and hydration needs. Staff developed holistic care plans informed by a comprehensive assessment.
- Patients' individual preferences and needs were always reflected in how care was delivered. They provided a range of treatments suitable to the needs of the patients and in line with national guidance about best practice. The expected outcomes were identified and care and treatment were regularly reviewed and updated. Staff engaged in clinical audit to evaluate the quality of care they provided.
- Staff actively and holistically focussed on the safe and supportive discharge of patients. Despite considerable difficulty in finding placements for patients following discharge staff worked together as a team and with other agencies to support the patients' safe and timely discharge wherever possible.
- Staff supported patients with family relationships. Families were encouraged to visit their relatives on the ward, there were no restrictions around visiting times. Patients were supported to visit their families at home as appropriate.
- The service provided safe care. The ward environments were safe and clean. The wards had enough nurses and doctors. Staff assessed and managed risk thoroughly. Staff managed medicines safely and followed good practice with respect to safeguarding adults at risk.
- The ward teams included, or had access to, the full range of specialists required to meet the needs of patients on the wards. Managers ensured that these staff received supervision and appraisal. The ward staff worked well together as a multi-disciplinary team and with those outside the ward who would have a role in providing aftercare.
- The service was well led and the governance processes ensured that ward procedures ran smoothly. Managers promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.

Is the service safe?

Good   

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

Wards for older people with mental health problems

- The ward was safe, clean, well equipped, well furnished, well maintained and fit for purpose.
- The ward had enough nursing and medical staff, who knew the patients and who kept people safe from avoidable harm.
- Staff completed and updated risk assessments for each patient and used these to understand and manage risks individually.
- Staff carefully and thoroughly planned all incidents of restraint during personal care. Staff reviewed and updated individual plans around restraint during personal care.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so.
- Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date and easily available to all staff providing care.
- Staff followed best practice when storing, administering, and recording medicines.
- Staff managed patient safety incidents well. When things went wrong, staff apologised and gave patients honest information and suitable support.

However:

- Training records on Garner ward showed that staff had not completed all the mandatory training that the trust required them to. Staff had not completed 20 out of the 43 trust mandatory training courses. The manager on the ward told us this was often due to courses not being available or the system had not updated recent training attendance.

Is the service effective?

Good   

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

- Patients had comprehensive assessments of their needs, which included consideration of clinical needs, mental health, physical health and wellbeing, and nutrition and hydration needs. The expected outcomes were identified and care and treatment was regularly reviewed and updated.
- Managers made sure they had staff with a range of skills needed to provide high quality care. They supported staff with appraisals, supervision, opportunities to update and further develop their skills.
- Staff from different disciplines worked together as a team to benefit patients.
- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice. Managers made sure that staff could explain patients' rights to them.
- Staff supported patients to make decisions on their care for themselves. They understood the trust policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly.
- Staff told us they received supervision every six to eight weeks and felt well supported by managers

However:

- Supervision records were not always kept up to date.

Wards for older people with mental health problems

Is the service caring?

Outstanding ☆ ↑

Our rating of caring improved. We rated it as outstanding because:

- Staff treated patients with compassion and kindness. They respected patients' privacy and dignity and supported their individual needs.
- All staff demonstrated a strong visible person-centred culture. Staff were highly motivated and inspired to offer care that was kind and promoted patients' dignity. This was reflected in the way staff interacted with patients, patients care records and during multidisciplinary meetings.
- Patients were active partners in their care. Staff were fully committed to working in partnership with patients. Staff showed creativity to overcome obstacles to delivering care. Patients' individual preferences and needs were always reflected in how care was delivered.
- Feedback from all carers was positive. All four carers we spoke with, said that staff were caring, professional and knowledgeable. Carers thought that staff went the extra mile and their care and support exceeded their expectations.
- Staff involved patients and those close to them in decisions about their care, treatment and changes to the service. Staff involved carers through newsletters and tea parties. Ward staff made regular telephone contact with carers to update them about patients' care. Relationships between patients, those close to them and staff were strong, caring and supportive.

Is the service responsive?

Outstanding ☆ ↑

Our rating of responsive improved. We rated it as outstanding because:

- Staff did all they could to support patients' discharge. Staff liaised with the local authority and care-coordinators to support patients' discharge. Despite a lack of appropriate placements in the geographical area and over 200 nursing home beds closed locally since 2016; staff liaised closely with funders to discharge patients in a timely and safe way. The complex care and dementia nurse consultant, who was also the responsible clinician, actively focussed on the discharge of patients whilst the occupational therapists supported patients on home visits to support the discharge process. Staff had the skills and knowledge to support a mix of complex acuity and longer stay settled patients that were awaiting discharge.
- Patients' individual needs and preferences were central to the planning and delivery of tailored services. The services were flexible, provided choice and ensured continuity of care.
- Patients had their own bedrooms where they could keep their personal belongings safely. There were quiet areas for privacy and where patients could be independent of staff.
- Staff supported patients with family relationships. Families were encouraged to visit their relatives on the ward, there were no restrictions around visiting times. Patients were supported to visit their families at home as appropriate.
- The ward was accessible to all who needed it and took account of patients' individual needs. Staff helped patients with communication, advocacy and cultural support.

Wards for older people with mental health problems

- Staff treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff.

Is the service well-led?

Good   

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

- Managers had the right skills and abilities to run a service providing high-quality sustainable care.
- The trust had a vision for what it wanted to achieve and workable plans to turn it into action developed with involvement from staff. This was reflected at ward level.
- Managers promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.
- The trust had effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected. Staff understood the risks on the ward and the plans in place to reduce them.
- The trust collected, analysed, managed and used information well to support all its activities, using secure systems with security safeguards.

Outstanding practice

Staff had completed a falls reduction project which showed that falls had reduced on the ward following the changes that were implemented. Simple changes had been made to reduce falls on the ward. For example, a line had been stuck onto the patients' walls to show the correct safe height that each bed should be set to for individual patients.

Staff worked as a team and thought creatively about how they could get patients discharged home or into a care placement when there were limited placement options. The complex care and dementia nurse consultant who was also the responsible clinician, actively focussed on the discharge of patients through visiting and educating staff in nursing homes about settling patients post discharge. Occupational therapists supported patients on home visits to support the discharge process.

Areas for improvement

We found areas for improvement in this service.

Action the provider should take to improve:

The trust should check that training courses considered by the trust as mandatory are accessible to staff and that it should keep accurate records of attendance.

The trust should check it has oversight of restraint that takes place when personal care is being delivered.

The trust should check that a record is made of when staff receive supervision.

Specialist community mental health services for children and young people

Inadequate ● ↓

Key facts and figures

Cornwall Partnership NHS Foundation Trust provides specialist community child and adolescent mental health services (CAMHS) for the whole of Cornwall. The service provides care and treatment to children and young people with emotional, behavioural or mental health issues. The service includes specialist mental health teams and specialist teams for children with a learning disability and eating disorders. The service also provides some primary care services. The service is divided into three geographically based teams the east, mid and west Cornwall teams. The three teams deliver services from seven bases across Cornwall.

Since the last inspection in 2017 the service has been reorganised. The crisis team has extended its working hours and expanded and has a small base at the Royal Cornwall Hospital. There is also a project to employ 31 new associate clinical psychologists based in each of the local schools and the local teams. From mid July 2019 Cornwall Partnership NHS Foundation Trust will deliver CAMHS inpatient services from the new unit Sowenna at Bodmin. The service was last inspected in 2017 when we rated the services as requires improvement overall. We rated the key questions, are services safe and are services responsive as requires improvement and the key questions, are services caring, effective and well-led as good.

At the inspection in 2017 we told the trust it must:

- ensure that the locations from where CAMHS services took place were well maintained and had a range of age appropriate items in the waiting rooms. We also required that the threshold for accepting children and young people into the service was reviewed as the threshold had been raised.

Before the inspection visit we reviewed information that we held about these services, and asked a range of other organisations for information.

During the inspection visit the inspection team:

- visited the west, mid and east local teams. We also visited the eating disorder service, the learning disability team and the crisis team
- interviewed a manager for each team and the overall service manager
- reviewed 28 care records
- spoke with ten young people
- spoke with 24 staff from all the teams
- spoke with four parents/ carers
- reviewed a number of policies, meeting minutes and assessments related to the running of the services.
- observed staff members plan therapy sessions.
- observed staff members in two multidisciplinary team meetings and a reflective practise meeting.

Summary of this service

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

Specialist community mental health services for children and young people

- We had serious concerns about the safety of young people in two of the six teams (the mid and the east local teams). The trust did not have clear oversight of the large number of children and young people waiting for treatment, the length of time they had waited nor the level of risks for each of those on the waiting list. The trust was not aware that risks were not being managed appropriately.
- The trust lacked an understanding of the impact that staff moving from the mid and east teams to newly developing teams was having on the mid and east teams' ability to deliver a service in a timely manner. Concerns by staff about the level of risk in the service had not been escalated appropriately to the trust senior team due to changes in the way the services were managed. The child and adolescent mental health services (CAMHS) had recently been transferred to the mental health directorate from the children's directorate but robust governance systems had not been put in place and information that could have identified issues had not been picked up.
- Some of the services did not provide safe care. The trust did not have enough staff with the right skills in the mid and the east team to see all the children and young people allocated to them for a first assessment following identification that they needed to be seen by the CAMHS. The risks were not being picked up or managed appropriately. Staff told us that they thought the service was unsafe. Local management was unable to provide an accurate record of current staff establishment and vacancies. Staff kept important information relating to patient care in several separate places, including the electronic record system and individual managers own spreadsheets. The electronic records could not be interrogated by the team managers, so they didn't fully understand which children and young people were allocated solely to them or to other team members (for example, the consultant) or were awaiting allocation for treatment. Following a review of records, we found that a number of children and young people whose mental health had seriously deteriorated and suffered harm because they could not be seen in a timely manner due to insufficient numbers of staff. Staff told us that they thought the service was unsafe. Staff had not ensured that all the premises were safe for the young people. The managers had not all completed ligature and environmental risk assessments on the premises. The waiting area on the Truro site had not been changed since the last inspection. Young people waited in an area that was not observed by reception and was stark and not child friendly.
- The mid and east CAMHS teams did not have robust governance systems. This meant that there was very little oversight of the quality of services being delivered, how complaints were being managed or whether incidents were being reported, addressed and learnt from. This meant that opportunities to identify issues and make improvements were being missed.
- Care plans and crisis plans were inconsistent across the sites we visited so did not support all the teams to deliver safe care and treatment to young people.
- Staff members did not consistently record incidents. Managers in mid and east teams could only see a list of incidents on the reporting system but did not have access to the analysis function to look at trends. Lessons learnt across the trust were not known to the mid and east staff teams as they were to the staff in the west teams. This meant that opportunities to identify issues and make improvements were being missed.
- The local governance meetings that had taken place when CAMHS was part of the children's directorate had been dominated by the risks and impact of the transfer of school nursing and health visiting to the local authority. As a result, concerns about CAMHS had not been adequately considered. Information presented to the trust board about CAMHS had not identified the issues in mid and east teams as the information was presented for CAMHS and was not broken down to individual team level; four of the teams were working effectively so this masked the poor performance of the mid and east teams. Following the inspection, the trust commenced governance meetings specifically dedicated to CAMHS to ensure clear oversight of the concerns and ensure all action required was addressed and monitored.

However:

Specialist community mental health services for children and young people

- Children and young people and their families were positive about the care and treatment from the staff teams. Staff treated children and young people with compassion and dignity. Feedback from young people confirmed that staff treated them well and with kindness.
- Staff provided an out-of-hours advice service to colleagues in other organisations should they be worried about the mental health of a child or young person. The crisis team had been developed into a large team and had a base at the local hospital and in local teams. They offered a more responsive service as they had extended their hours from a 5pm finish to an 8pm finish; with plans to ultimately have a 10pm finish.

Is the service safe?

Inadequate ● ↓

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

- We had serious concerns about the safety of young people in two (the mid and the east) of the six teams. The trust did not have clear oversight of the large number of children and young people waiting for treatment, the length of time they had waited nor the level of risks for each of those on the waiting list. The trust was not aware that risks were not being managed appropriately. The trust also lacked an understanding of the impact that staff moving from the mid and east teams to newly developing teams was having on the mid and east teams' ability to deliver a service in a timely manner. The trust did not have enough staff with the right skills in the mid and the east team to see all the children and young people allocated to them for a first assessment following identification that they needed to be seen by the CAMHS. The risks were not being picked up or managed appropriately.
- Staff were not all proactive at identifying and managing risk. Concerns by staff about the level of risk in the service had not been escalated appropriately to trust senior team due to changes in the way the services were managed. There were not consistent effective systems in place to ensure the management of young peoples' risks. Young people waiting for assessment following triage by the early help hub had not benefitted from the risk being considered adequately by the locality team. All young people did not have sufficient risk assessments to keep them safe. Staff did not all understand how to report incidents and near misses.
- Staff members had not ensured that all the premises were safe for the young people. The managers had not all completed ligature and environmental risk assessment on the premises.
- Staff members in the mid and east teams had not all completed their mandatory training.

However:

- The early hub teams and the learning disability team completed timely risk assessments to ensure young people's safe care and treatment.

Is the service effective?

Requires improvement ● ↓

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

- Care plans and crisis plans were inconsistent across the service so did not support all the teams to deliver safe care and treatment to young people.

Specialist community mental health services for children and young people

- In the mid and east teams, staff did not have the skills and experience to carry out their duties. They did not have access to the full range of specialists required to meet the needs of young people.
- The managers did not provide some staff with regular appraisals and managerial supervision (meetings to discuss case management, to reflect on and learn from practice, and for personal support and professional development).
- Meeting minutes in the mid and east teams were not fit for purpose. In the mid team they were single sentences next to a typed agenda written in pencil. There was no recorded consideration about learning from incidents or complaints.

However:

- Staff used recognised assessment tools to measure progress made by young people following treatment. The staff teams monitored the effectiveness of care and treatment and used findings to improve them. The service ensured analysis of outcome measures to inform service development.
- The learning disability team had a rolling continuous development training program in their team meetings, with different professionals in the team providing training to colleagues.
- The eating disorder service had an effective, evidence based six-week initial program to stabilise young people before ongoing therapy which young people and families said worked well.

Is the service caring?

Good   

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

- Staff treated young people with compassion. Feedback from children and young people, who were supported and treated by the teams, confirmed that staff treated them well and with kindness.
- Staff involved young people in decisions about their care and treatment.
- Staff ensured young people were involved in the recruitment of staff.
- All young people spoken with told us staff members described treatment options and gave them choices.

However:

- Young people's involvement in participation groups was not consistent across all teams, for example, there was no participation group in the learning disability service.

Is the service responsive?

Inadequate  

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

- The trust did not have a clear understanding of how many children and young people were waiting for treatment following assessment in the mid and east teams because information was kept in several places; including the

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electronic recording system and individual managers own spreadsheets. The trust could not provide accurate information that clearly identified the number of children and young people waiting for treatment following assessment, the risk levels of those on the waiting lists or a clear plan of when children and young people would be allocated to staff to provide treatment.

- In the east and mid teams there was not a clear system to understand the true nature of the waiting list. The electronic records could not be interrogated by the team managers, so they didn't fully understand which children and young people were allocated solely to them or to other team members.
- Young people who had self harmed and presented to the hospital after 8pm in the evening did not receive a full mental health assessment by members of the crisis team.
- Staff members did not have a consistent system to investigate and learn from complaints from patients or their representatives.
- The waiting area in Truro Health Park was the same as that seen at the last inspection. It was not child friendly or monitored by staff members, there was very small signage to the service and it was shared with other services. We noted there were plans to move the service but at the time of inspection they had not been completed. The waiting area in St Austell was small, not private and had multiple environmental risks which were not reviewed. There were plans in place to mitigate against their environmental risks.

However:

- The other teams like those in the west, the eating disorders teams and the learning disability team worked well and provided a service that met the need of the children and young people. The early help hub worked well in providing immediate triage and worked with partners to find alternative provision for young people who did not meet the criteria for CAMHS.

Is the service well-led?

Inadequate ● ↓

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

- Governance systems in the mid and east CAMHS teams were not robust with little oversight about the quality of services being delivered. We had serious concerns about the safety of young people in two (the mid and the east) of the six teams. The trust did not have clear oversight of the large number of children and young people waiting for treatment, the length of time they had waited nor the level of risks for each of those on the waiting list. The trust was not aware that risks were not being managed appropriately.
- The trust lacked an understanding of the impact that staff moving from the mid and east teams to newly developing teams was having on the mid and east teams' ability to deliver a service in a timely manner. Concerns by staff about the level of risk in the service had not been escalated appropriately to trust senior team due to changes in the way the services were managed. The child and adolescent mental health services had recently been transferred to the mental health directorate from the children's directorate but robust governance systems had not been put in place and information that could have identified issues had not been picked up.
- There was little oversight of the number of staff vacancies. The trust did not have enough staff with the right skills in the mid and the east team to see all the children and young people allocated to them for a first assessment following identification that they needed to be seen by the CAMHS. The risks were not being picked up or managed appropriately. Staff told us that they thought the service was unsafe. The trust was unable to provide an accurate

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record of current staff establishment and vacancies as information was kept in several places including electronic records and individual managers' own spreadsheets. Following a review of records, we found that a number of children and young people whose mental health had seriously deteriorated and suffered harm because they could not be seen in a timely manner due to insufficient numbers of staff.

- There was no oversight about how complaints were being managed or whether incidents were being reported, addressed and learnt from. Concerns raised by managers and staff were not escalated. Complaints were logged with patient advice and liaison service and managers in CAMHS did not see these. Complaints from families about the long waiting list were not escalated to the trust. The east team had paper records of complaints about waiting lists that were not logged onto the electronic complaints system. This meant that opportunities to identify issues and make improvements were being missed.
- The staff members had mixed views about the leadership team. Some teams felt local managers did not communicate with them well. For example, in the mid and east they felt they did not fully appreciate or act upon the concerns they raised about low staff levels and risk to young people. Senior managers in the trust were not fully aware of the risks to young people that we raised during our inspection via a random review of care files.
- Staff in the local teams were not involved in the redesign of the environments at St Austell and Truro.
- Staff morale was not good in all teams. In the east and mid teams staff were not confident in the leadership of the service. Staff in other teams expressed concern for colleagues in the east and mid.
- Whilst there were improvements and innovation in some areas like the new inpatient unit, the senior management team had lost sight of governance of risk in the mid and east teams.
- Staff members did not use the whistleblowing policy to escalate concerns to senior leaders in the trust. This was despite them expressing frustration to the inspection team that they knew risks were not being acted upon by leadership.

However:

- Staff, other than those in the east and mid teams, were enthusiastic and motivated.
- Leadership was more robust in the west than in the east and mid teams. In other teams including the west, the eating disorder team and learning disability teams there were more effective governance systems in place. They had oversight of the length of the waiting lists, how long children and young people had been waiting for allocation to a member of staff to commence treatment, the number of staff vacancies, the quality of services being delivered, how complaints were being managed or whether incidents were being reported, addressed and learnt from.

Areas for improvement

Action the provider MUST take to improve:

- The trust must have clear oversight of the large number of children and young people waiting for treatment, the length of time they have waited and the level of risks for each of those on the waiting list. The trust must have oversight of the quality of services being delivered, how complaints were being managed or whether incidents were being reported, addressed and learnt from. The trust must ensure it has sufficient systems and processes to enable them to assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity. They must be able to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who might be at risk which arise from the carrying on of the regulated activity. They must also evaluate and improve their practise in respect of the processing of the information referred to above (Regulation 17).

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- The trust must ensure there are enough, suitably qualified, competent, skilled and experienced staff deployed in the mid and the east teams to meet the needs of children and young people in a timely manner (Regulation 18).
- The trust must ensure care plans, risk assessments and crisis plans were consistently in place across the service. The trust must work with the local general hospitals to ensure that children and young people presenting at the emergency departments in mental health crisis receive an appropriate mental health assessment outside of the crisis teams working hours. (Regulation 12).
- The trust must ensure that all premises used by the service are well maintained and safe (Regulation 15).

Action the trust should take to improve:

- The trust should establish a consistent system across the service to investigate and learn from complaints from children, young people or their representatives.
- The trust should establish a consistent system to investigate and learn from incidents across the service.
- The trust should support the mid and east teams to have access to the full range of specialists required to meet the needs of young people.
- The trust should check that all staff receive supervision and have a yearly appraisal.
- The trust should support the CAMHS learning disability team to set up a participation group which enables children and young people to input into the development of the service.
- The trust should check that staff members in the mid and east teams complete their mandatory training that is crucial to their job roles.
- The trust should check that equipment such as weighing scales and blood pressure monitors are well maintained in the east and mid teams.

Community-based mental health services of adults of working age

Good  

Key facts and figures

Cornwall Partnership NHS Foundation Trust provides community-based mental health services for adults of working age across the county. The service offers people aged 18 to 75 years a range of community-based treatments, psychological support, medication and advice.

There are six community mental health teams providing multidisciplinary assessment and if appropriate, treatment throughout Cornwall for patients with severe and enduring mental health problems. The teams are based at Liskeard (Caradon), Bodmin (North Cornwall), Redruth (Kerrier), St Austell and Newquay (Restormel) and Truro (Carrick).

The services are available Monday to Friday between 8.45am and 5.15pm. All teams have an assessment team that complete assessments following referral to determine the level of need and subsequent interventions. The service also offers a low intensity pathway for patients who are in the service for therapy or ongoing medication support, but did not have an allocated care coordinator due to their low level of ongoing need, and are considered to be stable and low risk. While some patients are seen on site, many are seen in their own homes, nearby community facilities or trust buildings.

There are also ten resource centres based in locations across Cornwall that offer day care and treatment and support the community mental health teams. Each day resource centre works closely with its relevant integrated community mental health team and receives all new referrals via the weekly allocation meetings.

Cornwall Partnership NHS Foundation Trust is registered to provide the following regulated activities:

- Assessment or medical treatment for persons detained under the Mental Health Act 1983
- Diagnostic and screening procedures
- Nursing and personal care
- Treatment of disease, disorder, or injury.

We last inspected the community-based mental health services for adults of working age in 2017. At that inspection, we rated the service as requires improvement overall; with ratings of requires improvement for the key questions, are services safe, effective and well led and a rating of good for the key questions are services caring and responsive.

We told the trust it must take action to improve the unsafe staffing levels and poor environmental checks, the inadequate health checks and monitoring, the lack of incident reporting, the lack of quality risk assessments and care plans, the poor attendance by staff at training, and improve the way the service worked with other services for patients with a dual diagnosis.

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

Our inspection was announced (staff knew we were coming) to ensure that everyone we needed to talk to was available.

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

- Is it safe?
- Is it effective?

Community-based mental health services of adults of working age

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

Before the inspection visit, we reviewed information that we held about the service, asked a range of other organisations for information, spoke with senior managers with service line responsibility for the community-based mental health services for adults of working age and sought feedback from staff and patients at focus groups.

During the inspection visit, the inspection team:

- visited the six community mental health teams and one day resource centre, and looked at the quality of the environment
- spoke with 13 patients who were using the service and received written feedback from seven patients and carers
- interviewed the managers of each of the teams
- spoke with 40 other staff members, including consultant psychiatrists, nurses, support workers, psychologists, occupational therapists and social workers
- held three staff and one patient focus groups
- reviewed 36 patients' care records
- reviewed 73 medication records
- attended eight multidisciplinary meetings and observed six episodes of care and
- looked at a range of policies, procedures and other documents relating to the running of the service.

Summary of this service

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

- Staff completed and updated risk assessments for each patient and used these to understand and manage risks appropriately. The service responded well to safeguarding concerns and managed patient safety incidents well.
- Staff developed individual care plans and updated them when needed. Staff provided a range of treatment and care for patients based on national guidance and best practice.
- Managers ensured they had staff with a range of skills needed to provide high quality care. They supported staff with opportunities to update and develop their skills.
- Staff understood and discharged their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005, seeking support within the team as needed.
- Staff treated patients with compassion and kindness. They respected patients' privacy and dignity, and supported their individual needs.
- Teams had worked to reduce their waiting lists, and developed systems and processes to ensure oversight of all people waiting for allocation or support.
- Managers had the skills and abilities to run the service, and promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.

Community-based mental health services of adults of working age

However:

- Staff did not follow best practice when dispensing and recording medicines. We found a number of errors and omissions in recording information on patient medication charts. Staff did not always recognise medication errors as patient safety incidents and did not report these appropriately.
- Physical healthcare checks were not carried out for all patients in line with National Institute for Health and Care Excellence guidelines. Staff only carried out routine physical healthcare checks for high risk patients. The service acknowledged that there were improvements to be made in physical healthcare monitoring and support. There were plans in place and actions being progressed to address this at the time of the inspection.

Is the service safe?

Requires improvement ● → ←

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

- Staff did not follow best practice when dispensing and recording medicines. We found a number of errors and omissions in the recording of information on patient medication charts for patients who were receiving depot (slow release medication) injections. Staff did not always record patient allergies. Staff did not always recognise medicines errors as patient safety incidents and did not report these appropriately.
- Not all the premises from which services were delivered were well equipped. Some premises lacked equipment for undertaking basic physical health checks.
- Not all staff had completed their mandatory training. The overall number of staff completing mandatory training did not meet the trust's target, and some staff reported having difficulty accessing some training.

However:

- All premises were safe, clean, well-furnished, well-maintained and fit for purpose. While there were ligature anchor points, staff knew about these and took actions to mitigate risks to patients who might try to harm themselves.
- Staff understood how to protect patients from abuse and worked well with other agencies to do so.
- The service had recruited additional staff and had sufficient nursing and medical staff. Managers were supported to use vacancies creatively to support staff recruitment. For example, team managers were able to employ a part time band 6 nurse to a full time band 5 nurse vacancy if they were unable to recruit a band 5 nurse. Staff knew the patients and received training to keep people safe from avoidable harm.
- Staff completed and updated risk assessments for each patient and used these to understand and manage individual risks. Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date and easily available to all staff providing care.
- Those teams that had a waiting list monitored people on the list to detect and respond to increases in risks. This was put in place to address concerns raised at the previous inspection.
- The service managed patient safety incidents well. Managers investigated incidents and had a process in place to share lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

Community-based mental health services of adults of working age

Is the service effective?

Good  

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

- Staff assessed the mental health of all patients. They developed individual care plans and updated them when needed.
- Staff provided a range of treatment and care for patients based on national guidance and best practice.
- Managers made sure they had staff with a range of skills needed to provide quality care. They supported staff with appraisals, supervision, opportunities to update and further develop their skills.
- Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. Staff were keen to improve multidisciplinary relationships when working with people with dual diagnosis of mental health and substance misuse problems.
- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice. They would often joint work when needing support when working with patients under a Community Treatment Order.
- Staff supported patients to make decisions on their care for themselves. They understood the trust policy on the Mental Capacity Act 2005 and assessed and recorded capacity. While staff understanding of the Mental Capacity Act 2005 was variable, they knew where to access support and did so appropriately as and when needed.

However:

- Regular staff monitoring of patient physical health was offered to a target group of high risk patients only which was not in line with National Institute for Health and Care Excellence guidelines. The service acknowledged that there were improvements to be made in the physical healthcare monitoring and support, and had explored ways of improving this within the teams. There were plans in place and actions being progressed to address this at the time of the inspection.

Is the service caring?

Good   

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

- Staff treated patients with compassion and kindness. They respected patients' privacy and dignity, and supported their individual needs. We saw several examples of a holistic, compassionate and inclusive approach to care.
- Staff involved patients and those close to them in decisions about their care, treatment and changes to the service.
- Patients told us they were grateful for the support staff gave them and felt that had made a real difference to their lives.

However:

Community-based mental health services of adults of working age

- Patient and carer involvement in planning care for individual patients was inconsistent across the teams. It was not always clear when looking at some care records how much patients and carers were involved in their care planning. A small number of the care plans were less person centred and did not show the patient's voice. Staff did not give all patients copies of their care plans.

Is the service responsive?

Good ● → ←

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

- Patients accessed the service closest to their home when they needed it. Waiting times from referral to assessment and treatment, and arrangements to admit, treat and discharge patients from the service were in line with good practice. While there were some delays to access a clinical psychologist due to staff recruitment issues, the trust worked to ensure patients would receive some psychological input into their care while waiting to see a clinical psychologist.
- Where patients were seen on site, the design, layout, and furnishings of the service supported patients' treatment, privacy and dignity.
- Staff supported patients with activities outside the service, such as work, education and family relationships.
- The service was accessible to all who needed it and took account of patients' individual needs. Staff helped patients with communication, advocacy and cultural support as and when needed.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff.

However:

- Patients on the low intensity pathway were not clear about the input or support they would still be receiving and did not find the support offered met their needs.

Is the service well-led?

Good ● ↑

Our rating of well-led improved. We rated it as good because:

- Managers at all levels within the service had the right skills and abilities to run a service; providing high-quality sustainable care. The trust encouraged and supported managers to access specialist training to develop their leadership and management skills.
- The trust had a vision for what it wanted to achieve and workable plans to turn it into action developed with involvement from staff. Staff were invited to be a part of ongoing discussions about the strategy for the service.
- Managers across the service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values. Staff morale was generally good.

Community-based mental health services of adults of working age

- The trust used a systematic approach to continually improve the quality of its services. During our inspection of the community mental health services for adults of working age we saw examples of effective oversight of safeguarding, monitoring of waiting lists and patient risks. However, effective oversight was lacking with the management of medicines in the service.

However:

- Not all staff were aware of the visions and values and did not feel fully involved in these.
- Some staff teams told us they felt under pressure and at risk of burnout due to complex caseloads.
- The systems in place to monitor medicines management were not effective.

Areas for improvement

We found areas for improvement in this service.

Action the trust **MUST** take to improve

- The trust must ensure that all staff record the dispensing of medication appropriately and that medicines charts and care records have consistent and accurate information about medicines dispensed. Any errors or omissions must be reported as incidents and followed up appropriately. (Regulation 12).

Action the trust **SHOULD** take to improve

- The trust should check that all clinic rooms have the appropriate facilities to carry out physical health checks and that all appropriate checks of equipment (including fridge temperatures) are carried out.
- The trust should review that all patients receive physical healthcare checks and have physical healthcare plans in place in line with National Institute for Health and Care Excellence guidance.
- The trust should check that all staff have access to and attend mandatory training and regular supervision and appraisal is given and recorded as having taken place.
- The trust should check that patients are supported to be involved in their care plans, and record that they are offered copies of these.
- The trust should check that patients who need psychology input have timely access to this.
- The trust should review the purpose and effectiveness of the low intensity pathway to ensure this is fit for purpose.
- The trust should check that allergies are recorded on patient medication charts.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

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

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

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

Regulated activity

Regulation

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Regulation 18 HSCA (RA) Regulations 2014 Staffing

Diagnostic and screening procedures

Personal care

Surgical procedures

Transport services, triage and medical advice provided remotely

Treatment of disease, disorder or injury

Regulated activity

Regulation

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment

Diagnostic and screening procedures

Personal care

Surgical procedures

Transport services, triage and medical advice provided remotely

Treatment of disease, disorder or injury

Regulated activity

Regulation

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Regulation 9 HSCA (RA) Regulations 2014 Person-centred care

Diagnostic and screening procedures

Personal care

This section is primarily information for the provider

Requirement notices

Surgical procedures

Transport services, triage and medical advice provided remotely

Treatment of disease, disorder or injury

Regulated activity

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Diagnostic and screening procedures

Personal care

Surgical procedures

Transport services, triage and medical advice provided remotely

Treatment of disease, disorder or injury

Regulation

Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

Regulated activity

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Diagnostic and screening procedures

Personal care

Surgical procedures

Transport services, triage and medical advice provided remotely

Treatment of disease, disorder or injury

Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance

This section is primarily information for the provider

Enforcement actions

We took enforcement action because the quality of healthcare required significant improvement.

Regulated activity

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Diagnostic and screening procedures

Personal care

Surgical procedures

Transport services, triage and medical advice provided remotely

Treatment of disease, disorder or injury

Regulation

S29A Warning Notice: quality of healthcare

Our inspection team

Karen Bennett-Wilson chaired this inspection and Gary Risdale led it. An executive reviewer, Jan Bergman, supported our inspection of well-led for the trust overall.

The team included 23 inspectors, one executive reviewers and 13 specialist advisers.

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