Cornwall Partnership NHS Foundation Trust

Quality Report

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Core services inspected	CQC registered location	CQC location ID
Acute wards for adults of working age and psychiatric intensive care units (PICUs)	Bodmin Community Hospital (Fletcher Ward) Bodmin Community Hospital (Harvest Ward) Longreach House (Perran Ward) Longreach House (Carbis Ward)	RJ866 RJ866 RJ863 RJ863
Forensic inpatient / secure wards	Bodmin Community Hospital (Bowman Ward)	RJ866
Long stay / rehabilitation mental health wards for working age adults	Bodmin Community Hospital (Fettle Ward)	RJ866
Wards for older people with mental health problems	Bodmin Community Hospital	RJ866
Community-based mental health services for older people Community-based mental health services for adults of working age Community-based services for adults with learning disabilities. Specialist community mental health services for children and young people. Community health services for children, young people and families	Trust Headquarters	RJ8X7

Summary of findings

Mental health crisis services and health-based places of safety	Bodmin Community Hospital	RJ866
	Longreach House	RJ863

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

Summary of findings

Ratings

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

Overall rating for services at this Provider	Good
Are Mental Health Services safe?	Good
Are Mental Health Services effective?	Good
Are Mental Health Services caring?	Good
Are Mental Health Services responsive?	Good
Are Mental Health Services well-led?	Good

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

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

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

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

Summary of findings

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Summary of findings

Overall summary

We rated Cornwall Partnership NHS Foundation Trust as Good overall because:

- Patients were protected from abuse and avoidable harm. There where systems in place to report when things go wrong with lessons learned and improvements made.
- Some teams were staffed to their complement and where there were vacancies, the trust had contingency plans in place with the use of regular bank and agency staff who received training and supervision.
- We found across most core services that risk assessments were in place, comprehensive and holistic. Staff understood the local safeguarding procedures, what their responsibilities were and how they could raise concerns.
- Most services could demonstrate they used evidence based practice and followed national guidance.
- Teams where multidisciplinary and worked collaboratively to provide care and treatment. There was a high level of adherence to mandatory and statutory training across all the core services.
- On Fettle ward and across the learning disability community services we found care provided at an outstanding level. We observed staff across all the core services providing skilled interventions in a caring and respectful way.
- Services were organised so that people's needs were met. We saw that trust premises were, in the main, accessible for patients. Interpreters were available and staff knew how to access the service if needed. The inspection team noted that information was available to patients and carers in a range of languages.
- Most teams and services worked within the targets agreed by the trust and there were systems in place to monitor compliance with waiting and response times in most core services.
- The inspection recognised that the trust was well led with leadership, management and governance systems in place. The trust supports learning and promotes and an open culture.
- Staff had been involved in the development of the trusts' vision and values and all teams recognised the values and vision held by the trust
- There were strong systems of governance in place across most teams which ensured that the senior management had an understanding of the strengths and weaknesses of the service and was able to ensure that information was shared and learnt.
- We saw a wide range of audits to inform and improve service development. Some of these were being used to inform the redesign.

However;

- There were notable problems on Harvest ward with ligature risks identified in audits and it was not clear when these risks would be reduced. In the seclusion facility the toilets were not easily accessable, there were blind spots which restricted the observation of patients and the intercom was broken.
- The cleanliness on Harvest wards was poor and patients privacy and dignity was not protected.
- In some teams we found there were difficulties in appointing to key staff groups. There was no access to psychological therapies on the Garner ward and no psychology input available across the ward.
- Across the home treatment teams there was a lack of multi-disciplinary working. There was no psychology or dedicated medical input across this core service. This has resulted in delays for physical health care checks to being undertaken.
- In Garner ward consent to treatment and information sharing was not consistently recorded and when do not attempt resusitation status was in place individual assessments were not recorded.
- There was often a shortage of beds for acute admissions in the trust. Patients needing admission were sometimes admitted out of the area. We were unable to judge if patients needed readmission were placed out of area as this information was not available.
- Adults with learning disabilities, child and adolescent mental health services and older people who experience a mental health crisis outside of office hours had limited access to specialist expertise and support.

Summary of findings

- Support provided to staff in the community learning disabilities teams during the service redesign process was poor.
- Many of the nurses interviewed reported that they did not feel they had a strong voice and there was confusion about who held the executive lead nurse role.

Throughout this inspection process, we found that patients, their relatives, staff and senior managers all willing to engage in an open and frank way.

Summary of findings

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

We always ask the following five questions of the services.

Are services safe?

Good

Overall we rated safe as **good** because:

- In the main we found that risk assessments were in place, comprehensive and holistic.
- Staff understood the local safeguarding procedures, what their responsibilities were and how they could raise concerns. Additional safeguarding supervision arrangements were in place for most staff in the children and families health teams.
- We found suitable arrangements in place for the management of medicines in most cases. This included the receipt, storage, administration and recording of medicines. Fettle ward provided a well-structured support system for people to look after and self-administer their medicines. Of particular note was the continued support given to patients when they left this service.
- Some teams were staffed to their complement and where there were vacancies, the trust had contingency plans in place with the use of regular bank and agency staff who received training and supervision.
- In some community teams caseloads were monitored centrally to ensure that they were maintained at a level which ensured the safety of people who used the service.
- Staff were aware of how to report incidents and displayed a good understanding of learning from incidents through the service and the trust.
- Infection control procedures were in place and staff had completed the appropriate training.
- Mostly, equipment was correctly serviced and maintained with minor exceptions.

However;

- On Harvest ward ligature risks had been identified in audits but it was not clear when these risks would be reduced. Plans did not show staff how to mitigate these risks.
- The seclusion rooms on Harvest ward contained blind spots and patients needing toilet and washing facilities had to be taken out of seclusion which would pose a safety risk. The intercom in one seclusion room did not work which meant that communication between a patient in seclusion and staff was limited.
- The cleanliness on Harvest ward was poor and patients privacy and dignity was not always protected.

Summary of findings

- Aggression towards staff on Garner ward had increased recently and the behaviour of some patients was severely challenging. The trust had taken steps to address this escalation and seek appropriate solutions.
- Although there were some plans in place to address the shortfall, in all the integrated community mental health teams we visited, staffing levels were below the establishment set by the trust.
- Staff in the child and adolescent mental health teams told us their caseloads over the last twelve months were between 45-55 and had been in excess of this in some cases.

Are services effective?

Good

Overall we rated effective as **Good** because;

- Most services could demonstrate they used evidence based practice and followed national guidance.
- There was a multidisciplinary and collaborative approach to care and treatment in most core services.
- Staff were appropriately trained and competent to carry out their role with a high level of adherence to mandatory and statutory training. Most staff received supervision and appraisal. Records reviewed and data seen confirmed overall adherence to mandatory training of over 95% across most disciplines.
- We observed appropriate sharing of information to ensure continuity and safety of care across teams.
- Physical health checks were carried out across most core services with the exception of the home based treatment team were delays patients receiving physical health checks were noted.
- The use of the MHA was mostly good across the teams. During the inspection MHA monitoring visits were undertaken to Bowman, Garner, Harvest and Fettle wards.

However;

- Do not attempt resuscitation (DNAR) status records in place on Garner ward were not always individualised and five records of patients with DNAR status did not have a DNAR capacity assessment.
- On Garner ward patients had only recently began to access independent Mental Health Advocacy (IMHA) services as the service had recently been commissioned.

Summary of findings

- In some teams we found there were difficulties in appointing to key staff groups. There was limited access to psychological therapies on Garner ward and no psychology input available across the ward.
- In some teams care plans and risk assessments varied in detail and quality. Consent to treatment and information sharing was not consistently recorded. Within the home treatment team, the majority of care plans did not include sufficient details to ensure the safety of patients, for example in relation to crisis/ relapse plans. The trust had identified areas for improvement in relation to quality of care records.
- In the day resource centres some patients who attended the "open access" sessions did not have a trust care coordinator, and so did not have care plans or risk assessments in line with the published operating model.
- Difficulties caused by a lack of integration and work with social services for older adults meant that people did not always receive a seamless service.
- Across the home treatment teams there was a lack of multi-disciplinary working. There was no psychology or dedicated medical input across this service.
- We saw some up-to-date physical health care plans within the home treatment teams, for example in relation to lithium or clozapine medication, but many others were either absent or out of date.

Are services caring?

Good

Overall we rated the care provided as **good** because:

- We were particularly impressed with how caring the staff were on Fettle ward and across the learning disability community service. This was clear from both the care records and the feedback we heard from patients and their carers.
- Most carers and patients spoke highly of staff and the care provided. Across the services we saw that staff demonstrated a good understanding of their patients.
- We observed staff within the services providing skilled interventions in a caring and respectful way. This included on the visits we undertook in the community settings and in the ward environments.
- There was access to advocacy across all the wards and the service was widely promoted.

Summary of findings

- In child and adolescent mental health services and child health there was good participation work in partnership with a local advocacy service to ensure the voice of young people was heard in service design.

However;

- We were concerned that in some core services patients, including young people and families, did not always receive copies of their care plans.
- In addition we found that the care plans did not reflect the patient voice or in some instance the carers' views clearly.

Are services responsive to people's needs?

Good

Overall we rated responsive **good** because;

- On Fettle ward plans for accommodation were identified in discharge care plans with clear actions identified.
- Staff attempted to ensure that services were as accessible as possible to the widespread community.
- Most teams and services worked within the referral to treatment targets agreed by the trust and there were systems in place to monitor compliance with waiting and response times in most core services.
- Trust premises where, in the main, accessible for patients. Interpreters were available and staff knew how to access the service if needed. The inspection team noted that information was available to patients and carers in a range of languages.
- Across all core services staff knew how to support people who wanted to make a complaint. Learning from complaints was embedded in service wide governance systems.

However;

- There was often a shortage of beds for acute admissions in the trust. Patients needing admission were sometimes transferred out of the area.
- There was a lack of clarity regarding funding and commissioning requirements in the community learning disabilities service.
- Adults with learning disabilities, child and adolescent mental health services and older people who experience a mental health crisis outside of office hours had limited specialist support available.
- There was limited room for any disabled patients within the day resource centre, with no specific toilets and wheelchair access was very limited space throughout.

Summary of findings

- The trust did not collate details of any delays in access to services from health based place of safety and 136 suites, but we were told that delays could happen at times.
- There were clear arrangements in place for young people under 16 experiencing a delay when requiring admission to an inpatient child and adolescent facility. There were no clear arrangements for young people aged 16 and 17 experiencing similar waits.
- Bodmin Hospital scored 74% for 'food' in the 2014 PLACE survey and steps were being taken to address the shortfalls. We saw that in one case staff had difficulty accessing appropriate meals for a patient with specific dietary requirements. Bowman ward had an ongoing issue with the quality of the food provided. Both wards form part of the Bodmin hospital site.

Are services well-led?

Good

Overall we rated well led as **good** because:

- Staff had been involved in the development of the trusts vision and values and all teams recognised the values and vision held by the trust.
- Services were well led, with good managers, who were clear about the trusts core values and strategic intentions.
- Staff knew how to use the trust's whistle-blowing process and a culture of openness and transparency was promoted by the executive team. Some staff told us that they felt able to raise with the trust any concerns they might have about patient care or treatment.
- There was evidence of learning from feedback and complaints, appropriate audits were undertaken and staff knew what types of incidents to report and how to report them.
- We saw a wide range of audits to inform and improve service development. Some of these were being used to inform the redesign.
- The trust has a clear structure of relevant committees and sub committees. There were strong systems of governance in place across most teams which ensured that the senior management had an understanding of the strengths and weaknesses of the service and was able to ensure that information was shared and learnt.

However;

- Staff supervision was provided inconsistently in some core services.

Summary of findings

- Staff in child and adolescent mental health services and learning disabilities services did not feel they would be able to raise concerns with the executive or senior management team.
- Nursing staff across the trust reported that they did not feel they had a strong voice and there was confusion about the lead nurse role.
- Despite intervention by the chief executive there were ongoing issues with the PFI arrangement at the Bodmin site and the trust remained in legal dispute.

Summary of findings

Our inspection team

Our inspection team was led by:

Chair: Michael Hutt**,** independent consultant

Head of Inspection: Pauline Carpenter, head of MHA and Peninsula inspection, CQC

Team Leader: Serena Allen, inspection manager, CQC

The team included 16 CQC inspectors as well as a pharmacy inspector, MHA reviewers and a second opinion appointed doctor (SOAD).

There were a variety of specialists from the relevant core services that included consultant psychiatrists, registered mental health nurses operating at a range of grades in current practice, social workers, psychologists, one health visitor and a school nurse. We had 5 experts by experience that had lived experience of mental health services.

Why we carried out this inspection

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

How we carried out this inspection

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

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

Before visiting, we reviewed a range of information we hold about Cornwall Partnership NHS Foundation Trust and asked other organisations to share what they knew.

Before the inspection we asked members of the public, patients and carers to tell us what they had to say about the trust.

All the information was collated and analysed forming a data pack which was used to guide and inform our enquires.

We carried out a series of announced visits between 14 -16 April 2015 inclusive across a range of times.

During the visit we held focus groups with 110 members of staff from a range of disciplines and services. In addition we interviewed staff from a range of disciplines across all the core services we inspected.

We observed how people were being cared for and talked with carers and/or family members and reviewed care or treatment records of people who use services. During the visit we met with in excess of 100 people who use services and carers, who shared their views and experiences of the core services.

Information about the provider

Cornwall and the Isles of Scilly have a population of 532,300 with a higher than average aging population. Cornwall is recognised as having the second weakest economy in England. Although not a deprived area there are neighbourhoods with consistently high levels of deprivation. The 2011 census showed ethnicity as 98.2% white and 1.8% non- white population.

Summary of findings

Cornwall Partnership NHS Foundation Trust (CFT) is the principal provider of mental health, children's and learning disability services to people living in Cornwall and the Isles of Scilly.

The trust was approved as a Foundation Trust on 1 March 2010 by Monitor. The Foundation Trust supersedes the Cornwall Partnership NHS Trust which was established on 1 April 2002

The trust employs more than 1,900 whole time equivalent staff and has an annual income of £87.2 million with total expenditure of £85.7 million.

As a foundation trust they have 10,494 members and there are 83 active volunteers.

The trust is commissioned to provide service by NHS Kernow Clinical Commissioning Group, Cornwall Council and NHS England

Cornwall Partnership NHS Foundation Trust delivers care from three 3 three registered locations and 85 other sites. There are five service lines; children and families, adult learning disability, inpatient mental health, complex care and dementia and community mental health and they provide the following services

- community health services to children and young people
- community mental health teams for:
  - adults of working age (including day services)
  - mental health crisis intervention and health based places of safety
  - children, adolescents and their families /carers
  - older people
  - people with a learning disability
- inpatient wards for:
  - forensic mental health
  - adults of working age
  - older person inpatient care
  - rehabilitation / long stay

They also provide specialist services including:

- community veterans service
- early intervention in psychosis
- eating disorder service
- community forensic mental health team
- perinatal mental health team
- personality disorder service
- psychiatric liaison service
- supported housing

We did not look in any detail at these specialist services.

At the time of the inspection there were 122 inpatient beds in operation. Cornwall Partnership NHS Foundation Trust has a total of three registered locations serving mental health and learning disability needs.

Cornwall Partnership NHS Foundation Trust has been inspected nine times since registration. We have previously issued 13 compliance actions against two locations. There were no outstanding compliance actions at the time of the inspection.

What people who use the provider's services say

Prior to the site visit we aim to work with partners and to seek the views of members of the public.

We became aware of an event being hosted by Healthwatch and the trust. However, Healthwatch did not feel it was appropriate for CQC to attend these events but agreed they would share feedback. We did not get any output from the trust or Healthwatch following these events.

Questionnaires were sent out via the Mental Health Providers Forum & SEAP Advocacy service. 17 questionnaires were sent out to people who had used services within the past 12 months, and 12 completed questionnaires were received back. Respondents had used a variety of community and acute inpatient services we used this information to make further enquires in the core services.

Information about the inspection was sent out across the voluntary and community sector to encourage feedback about the trust.

We use this feedback and other data collected to guide or our enquires and investigate further.

During the visit we spoke with more than 100 patients and carers currently using services. Most patients told us the care they received was good. In the rehabilitation and

Summary of findings

long stay service and community learning disability teams' patients viewed the care they received as excellent. Carers we spoke to told us they were happy with services provided.

Good practice

- Pro-active training and support given to a range of health and social care providers, including voluntary and private organisations, to ensure that people with learning disabilities get the right support at the right time
- At the Trelil Court day resource centre we saw how they had developed and just introduced a scheme to "help improve potential and personal opportunities". This provided IT training which was aimed at helping patients return either to work or further study.
- We saw specific projects aimed at improving the services for patients using the community services for adults. One example was the development of a new approach to dealing with psychosis called "open dialogue". This had involved getting a small team from Finland to provide training in this approach for staff. We also saw a supervision session for psychologists via a "Skype" system from London. This enabled them to access specialist supervision which would not have been available locally.
- Medicine management in the rehabilitation and long stay ward (Fettle) was very good. The ward provided a well-structured support system for patients to look after and self-administer their medicines. There was ongoing support and assessments of the person at each stage to ensure they were safe to continue the scheme. Of particular note was the continued support given to a person when they left the service.
- The Royal College of Psychiatrists' quality network for forensic mental health services had recently published an article in its newsletter, highlighting the effectiveness of Bowman wards recovery model in supporting patients in successful discharge.
- During the course of the inspection we visited the community forensic team and it was of note that there was documented evidence of the positive impact on patient experience since the inception of this service. There has been a 33% reduction in police time spent with individuals.
- The complex care and dementia community service has a strong and proactive approach to research in the care of people with dementia. It has shared this research and interest through the publication of journal articles to ensure that learning and best practice is disseminated.

Areas for improvement

Action the provider MUST take to improve

The provider **must:**

- Ensure that all staff and team managers have access to well-structured and effective support and supervision through the re-design process within the learning disability service line. There must be a clear plan to monitor and undertake impact assessments on staff health and wellbeing.
- Ensure all staff working in the acute wards and psychiatric intensive care unit (PICU) are clear about the steps they need to take to reduce the risks of ligature points to patients
- Take action to reduce the blind spots in the seclusion rooms in Harvest ward so that staff can observe patients at all times when secluded.
- Ensure the repair of the intercom in the seclusion room in Harvest ward to ensure staff and patients can communicate when patients are in seclusion.
- Ensure the cleaning and maintenance of the wards at Bodmin hospital is improved to reduce the risk of infection to patients and staff and improve the environment.

Summary of findings

- Ensure that there are sufficient competent staff in child and adolescent mental health services to meet the needs of the population safely; particularly out of hours.
- Engage with local commissioners to review child and adolescent mental health teams' staffing provision, in particular the out of hour's crisis provision.
- Ensure that physical health assessments, crisis plans and care plans reflect patients' needs and contain specific plans to manage or mitigate any risks in the crisis services and health based place of safety.
- Ensure that all individual mental capacity assessments for do not attempt resuscitation status are completed for all relevant patients on Garner ward.
- Work with commissioners to ensure that robust and lasting arrangements are in place for IMHA input into Garner ward

The provider **should:**

- Ensure caseloads of all integrated community mental health teams are managed to ensure they are in line with department of health guidance, to maintain effective services.
- Develop a long term recruitment strategy for integrated community mental health teams.
- Review privacy and security in the interview rooms within integrated community mental health teams
- Evaluate the current model of the day resource centres to assess how it meets the needs of patients.
- Establish clear plans for assessing and monitoring current buildings and facilities, in particular the East resource centre, which has been identified as unfit for purpose.
- Continue to improve working relationships with the adult social care service in order to develop an effective model of care in line with current and projected population changes, including out of hours provision.
- Continue to improve care records, in particular that mental capacity assessments, consent to treatment and information sharing is clearly and consistently recorded.
- Due to the unsuitable design of the current seclusion suite, the trust should consider improvements being made so that patients' do not have to be removed from the seclusion room in order to use toilet facilities.
- Consider how on Bowman ward ligature risks are monitored and how actions are addressed in the event of admission of patients with a higher risk of self harm. Patients currently resident on Bowman ward were settled and were identified as low risk of self harm through ligature use.
- Consider how to address the unresolved concerns regarding the quality of food on Bowman ward and ensure that, when escalated to a more senior level, feedback to patients is given and actions agreed are completed.
- Consider how access to crisis support can be delivered effectively for older people and that people who use services and carers have access to crisis support plans.
- Consider on Garner ward how staff access to support from clinical psychology.
- Ensure that clinical records are up to date, reflect the views of people who use services and carers (where appropriate) and ensure that decisions around capacity, where relevant, are documented in line with the Mental Capacity Act Code of Practice and the Mental Health Act in all care areas.
- Evaluate, monitor or audit the assessment process within the place of safety suite, including length of stay, delays, and admission into an acute ward.
- Work with its multi-agency partners, including the police, ambulance service and commissioners, to review how it assesses and monitors the crisis services it delivers in the place of safety suite.
- Consider the risks and ensure it fully complies with same sex accommodation guidance for the ward bathroom facilities on Garner ward.

Cornwall Partnership NHS Foundation Trust

Detailed findings

Mental Health Act responsibilities

Mental Health Act responsibilities

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

Mental Health Act (MHA) governance was led by the MHA managers committee that reported quarterly to the trust board. The committee met quarterly and was chaired by a non-executive director (NED). All other non-executive directors were members of the committee as were two out of three executive directors, with the MHA Advisor and the trust solicitor in attendance. Until recently it had been predominantly concerned with facilitating the work of NEDs in carrying out their hospital managers' functions. Recently, the committee had been strengthened by the establishment of a MHA working group which included the trust's manager of approved mental health professionals.

At the time of our inspection information reported to the committee and the board on performance in relation to the MHA was limited. We were told the MHA working group are developing performance indicators so that trends will be identified and performance monitored.

The MHA managers committee did not have a clear role in relation to the trust's adherence to the Code of Practice. One example of this was the lack of scrutiny by the committee of the trust's work with independent mental health advocacy (IMHA). Very few hospital manager reviews were attended by an IMHA although a proportion were attended by a solicitor. We also understand that Garner ward did not have access to an IMHA for a lengthy period of time. It appeared that this lack of IMHA involvement was not addressed by the committee, although we were told that it would be in future through the new reporting mechanisms.

The responsibilities of the NEDs as hospital managers under the MHA were supported by the appointment of a number of associate managers who carried out many of the hospital managers' reviews. At a time of increasing numbers of detentions, we were told that the number of reviews undertaken by hospital managers had gone down over the years, but it was not known why this was.

The associate managers attended the associate managers' forum, which met quarterly and was both a business and training meeting. This forum was also attended by NEDs. The associate

managers were very clear about their roles and responsibilities and spoke highly of their experiences in the trust in relation to the support, training, and annual appraisals they received. They told us they could turn to any of their colleagues, the MHA team, directors or the chief executive if they had any concerns or queries. We were told that recent training included the Mental Capacity Act and the new Code of Practice.

There were plans for further training on the new Code of Practice at trust level and throughout the organisation, and we were shown a presentation and training materials on the new underpinning principles. Although training was being pursued on a number of fronts, it was unclear whether there was a trust-wide strategy for implementation of the new Code.

Good

Are services safe?

The MHA administration team comprised five members of staff. The process of admission document scrutiny appeared to be robust and timely. One team member had particular responsibility for training and audit of MHA processes and documentation. The team maintained a database of detentions within the trust and monitored deadlines, organised hearings and liaised with the tribunal service. There was no record of detentions of Cornwall patients in out-of-area placements.

We were shown an information leaflet on consent to treatment and a checklist for ward staff on explaining a detained patient's rights under section 132 of the MHA, both of which had been developed by the MHA administration team.

A summary of MHA practice across the core services is detailed later in the report.

Mental Capacity Act and Deprivation of Liberty Safeguards

The governance arrangements for the Mental Capacity Act (MCA) were led by the Mental Health Act Committee and the Mental Health Act administration team.

The trust had a policy on the application of the MCA and the process of applying for deprivation of liberty safeguards (DoLS). In services where this was most relevant staff appeared to be familiar with this policy.

We found evidence that staff had undertaken training on the MCA with mandatory training compliance at 95% across the trust. We were able to review training records which confirmed that training had taken place.

Staff told us that they understood the MCA and the application process for DoLS and were able to describe what they would do in the event of needing to apply for DoLS.

Staff knew where to seek advice regarding the MCA and DoLS within the trust and there were well established links with the Mental Health Act office and administrator.

A summary of MCA practice across the core services is detailed later in the report.

Good

Are services safe?

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

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

Summary of findings

Please refer to the summary at the beginning of the report

Our findings

Track record on safety

A total of 2,102 incidents were reported to the National Reporting and Learning System (NRLS) between 1 February 2014 and 31 January 2015.

Good

Are services safe?

The majority of incidents resulted in no harm (53.1%) or low harm (39.9%) to the patient. 5.5% of incidents resulted in moderate harm and 0.1% resulted in severe harm.

The incident category that was most frequently reported was 'patient accident' (16.1%) followed by 'medication' (14.5%) and 'self-harming behaviour' (12.5%).

Fifty five incidents were reported to STEIS between 1 February 2014 and 31 January 2015. The majority (21.8%) of the incidents relate to the 'unexpected death of community patient (in receipt of care)'.

Three hundred and eighteen incidents of restraint were reported, 157 occurred in Garner Ward. 95 occurred in Harvest ward with six being restrained in 'prone position' of which five resulted in rapid tranquilisation. We were told that, on Garner ward, all incidents including holding patients arms and escorting were reported as restraint.

There were no 'never events' reported during this time.

Learning from incidents

We found that the trust had an electronic reporting system that staff said was easy to use. The inspection teams saw evidence that incidents were reported, and staff were clear about the types of incident that needed to be reported.

On receipt of an incident an investigator was sourced from a bank of staff trained in root cause analysis. The investigation team included a clinical advisor and facts were corroborated with the relevant associate clinical director. The final report was provided to the executive clinical risk group who monitored and cascaded leaning and actions as necessary.

Staff received feedback from investigations carried out when things went wrong and the inspection team reported that, in some areas, there was evidence that services made necessary adjustments to care based on this learning. Messages and themes were shared across the service lines in team meetings, newsletters and the intranet. Staff of band 5 and above, hear lessons learnt from investigation via specific learning events.

Arrangements were in place to ensure that medicine incidents were documented and investigated. We found that there was an open culture of reporting medicine errors when they were identified in order to change practice and learn from lessons. Overall trends in medicine errors were reported directly to the medicine management committee.

Safeguarding

One safeguarding alert had been raised with CQC in the past 12 months. There had been many more raised through the national reporting and learning system. There was some confusion about CQC reporting expectations and this has led to a reduction in the frequency of notifications and information being passed directly to CQC. The trust had been told by CQC, and produced evidence to support, that, safeguarding information should be shared only via the national reporting and learning system in all cases. The trust has internal safeguarding systems in place and from April 2014 to February 2015 there were 156 safeguarding alerts raised by staff. Of these, 121 met the threshold for further investigation and action through formal safeguarding processes. 35 did not meet the agreed threshold and were managed by care coordinators.

The safeguarding team provided one to one advice for staff with a safeguarding concern. In addition they offered advice, support and training to all staff. They also represented the trust at a strategic level and informed the trust on all safeguarding issues.

In the core services staff were able to describe what actions would constitute abuse. They were able to apply this knowledge to their work with patients and described in detail what actions they were required to take in response to any concerns. There were clear safeguarding policies and procedures in place that staff understood and were easily accessible. Staff knew who they should speak with if required. Staff received training on safeguarding adults and children at the required level for their role and responsibilities. At the time of our inspection, 95% of staff had received safeguarding adults and children's training.

Assessing and monitoring safety and risk

CQC's intelligent monitoring had flagged Bodmin Hospital as an elevated risk in the patient led assessment of care environments for cleanliness and food. During the inspection we found cleanliness on some wards fell below acceptable standards. On Harvest ward we discussed our concerns with managers and we were told that there was always a problem getting repairs and maintenance completed in a timely way which meant the environment on the ward often looked uncared for. A consequence of this was that ward staff carried out some of the

maintenance and decorating themselves because those tasks were not being done through the formal channels. After we raised these issues with management, steps were taken to address some of the immediate concerns.

All services had risk recording systems in place and most staff knew how to escalate risk to the risk register if necessary.

Across the core services we found risk assessment and planning in place. There were recognised risk assessment tools used for assessing patient risks. Across the inpatient ward ligature risk assessments had taken place and action taken to address issues. However, on Harvest ward ligature risks had been identified in audits but it was not clear when these risks would be reduced. Plans did not show staff how to mitigate these risks.

There were blind spots on some wards and the seclusion room on Bowman ward had blind spots that could pose a risk when patients were in there. The design of the ward meant that there were not clear lines of sight and meant the staff had to carry out regular checks to ensure the safety of patients.

Staffing was managed through the e- rostering system for ward based staff which some staff reported did not take into account the nuance of some services. We found, with the exception of Harvest ward, staffing to be well managed and the staff rotas matched the required needs identified across the inpatient estate. When bank or agency staff are used these were sourced from a regular pool of staff and provided with the necessary training with the exception of Harvest ward were we it was unclear how temporary staff received induction.

We found that in some child and adolescent mental health services and across the integrated community mental health teams, caseload management was problematic with demand for services outweighing the staff available. Across the children and families health teams they had recruited and trained its full complement of health visitors in response to the national "call to action" initiative started in 2011, which was designed to ensure the appropriate levels of trained health visitors were available in the community.

The trust recognised the challenge to recruit staff and had made attempts to fill vacancies however there remained some unfilled posts and this was being managed through locum, bank and agency staffing.

Potential risks

Emergency equipment, including automated external defibrillators and oxygen, was in place in clinical areas. With the exception of Harvest ward, staff checked the emergency equipment in line with the trust policy to ensure it was fit for purpose and could be used effectively in an emergency. Staff were trained in its use and local systems were in place to maintain staff safety.

We were concerned that the alarm system on Harvest ward did not alert staff in the vicinity to a serious incident, and this had resulted in the police responding to an incident on the ward rather than staff in neighbouring wards providing a response.

The pharmacy team provided an efficient clinical service to ensure people were safe from harm. The pharmacy team also provided training to nurses on safe medicine administration. Nursing staff told us that the pharmacist team were a good support and if they had any medicine queries they always had access to pharmacist advice including out of hours.

Across the core services we found suitable medicines management. However, there are some notable examples that included; the pharmacy team had undertaken an audit on the use of 'rapid tranquillisation'. They found that the 'rapid tranquillisation' policy had not always been followed. In particular people had been treated with medicines for rapid tranquillisation which had not been documented as rapid tranquilisation in people's records. They also found that the benefit of the treatment following rapid tranquillisation was not always recorded.

Arrangements were not fully in place to check that medicines were stored within safe temperature ranges. In particular we looked at the storage of medicines in clinical treatment rooms on wards. Medicines should be stored at 25 degrees C or below for safe storage. We found that the medicine storage rooms felt very warm. However, there were no thermometers or records available in order to check and record the room temperatures. Medicines requiring refrigeration were stored safely in locked refrigerators with refrigerator temperatures recorded daily. All the refrigerators checked were within the safe recommended range for medicine storage.

Suitable arrangements were not in place to allow sufficient space for additional medicine instructions to be clearly recorded on people's medicine administration records. We

Good

Are services safe?

found it was sometimes difficult to read the extra instructions written by the pharmacists because the space allowed was too small. This was raised with the chief pharmacist who agreed and explained that electronic records were being investigated however there was no agreed date for implementing this.

The trust had good lone working policies and arrangements which were embedded across all the teams.

Overall, the trust had adhered to national guidance on same sex accommodation (SSA) with the exception of Garner ward were the ward was at risk of not fully complying with guidance on same-sex accommodation.

There was only one bath which was located at the centre of the ward and one shower was out of use. If several patients required the facilities at the same time then female patients might need to walk through a male only area.

Duty of Candour

Throughout the inspection we saw evidence of an open culture and a willingness to learn from when things go wrong. We saw in the core services that staff were open and transparent when things went wrong.

The trust could demonstrate that following a serious incident in 2010 they had actively promoted openness and transparency within their services. This was driven from the chief executive who promoted this approach across all service lines.

Good

Are services effective?

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

Summary of findings

Please refer to the summary at the beginning of the report.

Our findings

Assessment and delivery of care and treatment

From the data we received over the last two years the trust had been performing above the national average for the proportion of admissions to acute wards gate kept by the community home treatment and recovery team.

Core services could demonstrate that they used evidence based practice and followed national guidance. Physical health checks were carried out across most core services. However, in the home treatment team there was an inconsistency in approach.

Across the core services, we found that care plans varied in consistency and quality but overall care plans were regularly updated to take account of changes to care needs. On Fettle ward care records were written in plain English without jargon. They were clear, succinct and information was up-to-date. They included goals for occupation, physical health, social and psychological needs. The recovery star tool was being used with some patients for collaborative recovery-focussed care planning. In the community learning disabilities teams a number of recognised multi-disciplinary assessment tools were used to plan and monitor care needs. However, within the home treatment team, the majority of care plans did not include sufficient details to ensure the safety of patients, for example in relation to crisis/relapse plans. The trust had identified areas for improvement in relation to quality of care records and we saw that the trust had developed an audit tool and training to support staff and improve the quality of records. We saw evidence in supervision records that this was implemented.

On Garner ward, we reviewed four care records and saw evidence of comprehensive and timely assessment completed after admission and thereafter. However, not all of these records demonstrated that they were following the 12-week assessment model. We were told that staff were half way through updating the patient records to follow the Newcastle model in full.

Across the child health teams, we saw there was guidance in care plans about pain management for children where it was appropriate.

Staff in these teams were developing the use of social media such as Facebook and twitter as a way of communicating with young people harnessing the use of technology in healthcare. Funding received in March 2014 had accelerated the trust IT strategy across the service with touch screen tablets or laptops available to staff.

Outcomes for people using services

Our data shows the trust were performing above target for all "key national priorities" in 2013/14.

The trust is flagging as a risk within the intelligent monitoring system for the indicator "percentage re-admissions of less than 7 days out of total admissions". There were 44 readmissions after less than 7 days of discharge from 587 total admissions to the trust's acute ward between April 2013 and March 2014. This is a rate of 7.5% against an expected rate of 3.6%. Fletcher ward had the highest number of readmissions within 90 days (18).

Garner ward was the only location with any reported delayed discharges in the past 6 months (1 patient, 6 bed days)

The trust engaged in a range of national audits and local audit programme were seen in most core services. The audit committee is chaired, by a non – executive director, whose role is to oversee and report to the board through the quality and governance committee on a quarterly basis. The audit committee oversees both clinical and non-clinical audit.

We saw a summary of audit outcomes being presented by one of the psychiatrists to his colleagues in one of the

clinical team meetings within the child and mental health service. Other core services described how they disseminated and learnt for audits carried out in their service.

The trust were within national averages for all reported outcome measures relating to child health.

Health of the Nation Outcome Scales (HoNOS) was the most used clinical measure in core services and the finding used to inform changes.

Staff skills

Data showed that in the 2014 staff survey the trust performed better than average for the number of staff having appraisals and the number of staff receiving health and safety training in the last 12 months. As at 11th Feb 2015; the trust had achieved and maintained their training compliance rate of 95%. The exception to this was across medical service line that were not on target with training compliance and Cornwall healthcare estates and support services that were within 5% of their.

The trust compared unfavourably in staff survey 2014 results for good communication between senior management and staff as well as the number of staff receiving job relevant training, learning or development in the last 12 months. However, within the children's health team we found that staff had specialist knowledge and skills to treat children with their presenting conditions. Across the core services most staff confirmed that, if they were up to date with all the mandatory training, they were able to access additional and external training where appropriate. The trust required that all staff have up to date mandatory training before any additional training was agreed. Some nursing staff we spoke with felt less supported than other disciplines, in accessing external training and conferences.

Managers showed us the comprehensive induction programme in place for new staff. There were systems in place to monitor the performance within each team which managers used for reporting. We saw evidence in supervision records of action being taken to address performance issues.

Supervision records were reviewed at all sites visited by the inspection teams and most nursing staff we spoke with were positive about the quality and the frequency of supervision they received. The community based services for learning disabilities had not received an appropriate level of support through the current change programme.

Multi-disciplinary working

The inspection teams attended a number of multi-disciplinary team meetings (MDT), handovers, business meeting and patient contacts. We saw evidence that staff worked professionally and cooperatively across different disciplines and organisations. There were regular interface meetings with the commissioners and local authority, which trust team managers attended and felt were useful to contribute to effective, collaborative working. Staff reported that the relationships with GP surgeries across the teams were generally good.

In the child and adolescent service families told us that at times liaison with other services could be better, this included communication between the service and the local GP, however we did see evidence of good multiagency working with schools and other agencies.

MDT meetings were attended by a broad spread of professionals, including nurses, doctors, occupational therapist, pharmacist, and patients themselves or their representatives as required. However, in the home treatment teams there was no direct input from occupational therapists, psychologists, and medical staff. The lack of access to a psychologist for advice regarding formulation of plans for people who received treatment in some teams and wards meant that there was a risk that the expertise of a psychologist was missing from the multi-disciplinary environment.

Staff reported that the trust intranet was a good forum for communication and links between groups and services.

In the older person's community team we found good joint working and regular meetings between staff and local authority teams at practitioner and first level manager level. We were told that due to various reconfigurations at the local authority this had become more difficult and has impacted on the quality of care and that people did not receive a seamless service. For example, when carers' needs were identified and the local authority was responsible for carrying out carers' assessments the information was not proactively shared between the organisations.

Good

Are services effective?

Information and Records Systems

Case records were stored on a secure trust wide computer system with the teams operating a "paper light" approach. In services were some paper records were held, which included letters or non-urgent clinical information, these were stored in locked cabinets within staff only areas. Staff told us that system had historic care plans and information, which they found helpful.

In the children team when the new electronic records system had been introduced staff we spoke with told us they had received training and support to learn how to use this. It was recognised by staff and managers that some aspects of the system needed to be adjusted to make it more user friendly. Staff we spoke with explained how they had feedback the issues that concerned them, particularly about the complexity of some of the recording documentation. Parts of the system were being redesigned to address the issues identified. It was intended that information would be easy to enter and therefore save staff time.

Consent to care and treatment

The trust informed us that between April 2014 and 9 February 2015 there had been 131 incidents of use of seclusion; 124 of them occurred in Harvest ward. All incidents of seclusion were reported to the director on call with a justification outlined and the decision ratified.

23 DoLS applications had been made since April 2014, 17 of them from the Garner ward.

Overall, there was a mixed picture in relation to the use of the MCA and DoLS across the trust.

We saw evidence in some services to show mental capacity had been considered, assessed and reviewed periodically and routinely. This was generally done on a decision-specific basis. We also observed that capacity was routinely discussed in clinics, assessments, MDT meetings and complex case reviews.

In some services we saw patient's case records which showed recent mental capacity assessments regarding treatment. However in other services, consent to treatment and information sharing was not consistently recorded. In the community services for older people we checked records relating to mental capacity and found mixed recording. Most records contained completed assessments; in one team two out of the seven records reviewed did not contain evidence of understanding of the MCA.

We reviewed how best interest's decisions were made on Garner ward and saw that the records were detailed and that decisions had taken account of the person's wishes, feelings and history. We saw that less restrictive options were considered before decisions on more restrictive care were made in the patients' best interests. However, do not attempt resuscitation (DNAR) status records were not always individual and did not clearly set out how the decision-making process regarding the person's capacity was made. Five patients who had DNAR status did not have a capacity assessment recorded.

In the majority of services staff had received training and there was a good understanding of the aims and principles of the Act. However there were variations in the recording of assessments and reviews. In some instances staff did not appear to understand the decision-specific nature of assessments of mental capacity.

Assessment and treatment in line with Mental Health Act

During the week of the inspection four MHA reviewers carried out MHA monitoring visits to Bowman, Garner, Harvest and Fettle wards. The reviewers spoke to patients and family members and scrutinised MHA documentation. These visits were reported separately. The use of the MHA was mostly good across the teams. However, there were a number of MHA themes.

- The independent mental health advocate (IMHA) covering the Bodmin site spoke positively about her experience of working with the staff and said the staff had become much more supportive of her role. However the IMHA service on Garner ward had only commenced a few days before the inspection, despite the fact that it had been identified as a gap on a previous MHA reviewer visit in 2013. This service had only recently been commissioned.
- IMHAs' access to patients' notes could take up to 21 days. We were told this was in order to remove any third party information however this represents a delay for the patient who has requested the service of the IMHA.

Good

Are services effective?

- The policy for the use of the seclusion room on Harvest ward was not in full accordance with the Code of Practice.
- Most patients said that they understood their rights and this was confirmed in their records. There was also evidence of planned revisiting of patients' rights and one patient said that he had been reminded after six weeks.
- On most wards there were leaflets and posters about the IMHA service. However the service was not always mentioned at the time of explaining patients' rights. Patients could refer themselves to the IMHA service or staff would refer someone who lacked capacity.
- Section 17 leave of absence forms were on most units clearly linked to care plans. However copies were not always given to patients or relatives.
- The MHA office worked proactively in relation to renewals and consent to treatment issues.
- Capacity to consent to treatment at the point of admission was not always recorded on the files scrutinised.
- Were we saw evidence of restrictive practice on the wards, when restrictions were applied the rationale was communicated to patients and alternative arrangements sought in some instance

One of the inspection teams visited the health-based place of safety at Longreach House in Redruth. This two-bed unit re-opened recently and now takes people of all ages brought in by the police on section 136 of the MHA. The unit also takes those on section 135 and an admission was planned on one of the visit days.

There had been an increase in staffing and the development of joint working arrangements with social services and the police in order to meet the needs of people in times of crisis in accordance with the requirements of the mental health crisis care concordat. The numbers of people being brought into the place of safety rather than into a police station had gone up considerably over the past months and it appeared to be the case that there were good working relationships between the police, health and the approved mental health professionals (AMHP) team, with the development of a joint strategy, regular dialogue and shared training.

We were informed by the trust that training for the MHA Code of Practice will take place for all staff to ensure compliance by October 2015 and we saw the training pack produced for roll out across the trust.

During our inspection we carried out a consent to treatment audit for patient detained under the MHA who did not consent to treatment.

The audit undertaken by a second opinion appointed doctor and pharmacy inspector who reviewed the treatment forms of patient subject to consent to treatment rules.

The audit showed:

There were 103 patients detained, 35 of whom were subject to the consent to treatment rules. Eighteen required a certificate of consent to treatment signed by the approved clinician or SOAD (T2) and eighteen required a certificate of consent to treatment signed by SOAD (T3). One patient both T2 and T3 in place.

Seventeen of the T2 forms had an error, including the following:

- Failure by the approved clinician to delete a non-applicable statement
- No route stated for drug
- No dose limit given for drug
- Wrong British national formulary category given
- Medication for physical health stated on T2
- No address given for either approved clinician or patient

Some of these errors did not impact upon patient safety or rights, but some were of greater significance, since they could result in a patient receiving a drug at a higher dose than that which they have consented to, or by a route not consented to. It was clear that the systems and processes for scrutiny of consent to treatment forms were inconsistent and flawed.

Good

Are services caring?

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

Summary of findings

Please refer to the summary at the beginning of the report.

Our findings

Dignity, respect and compassion

From data reviewed we found that the trust had the following scores for Patient Environment Action Team inspections (PLACE). The trust's overall score for dignity, privacy and respect was 94.6%, which was almost 6% above the England average. However, there was only PLACE information available for Bodmin Hospital. PLACE information was not available for Longreach as the hospital was closed for remediation work on the mandated PLACE assessment date.

Friends and Family Test showed that 56% of respondents said that they would be either extremely likely or likely to recommend the trust to friends and family as a place to work. 71% of respondents said they would be either extremely likely or likely to recommend the trust as a place to receive care.

80% of patients were not asked about their religious belief. This was the first year the RIO system across the trust has had the facility to capture data regarding sexual orientation. This shows 98.8% registered cases were not asked about their sexual orientation and only 1% of clients were asked if they had a disability.

During the inspection the teams witnessed numerous interactions between patients and staff and in some wards undertook the short observational tool for inspection. The interactions that we observed were respectful and kind in nature.

On the acute wards for adults of working age, we observed meal times and saw that staff and patients interacted throughout. At the rehabilitation ward, we observed lunchtime and saw lots of friendly chatter and laughter with staff being proactive in talking to quieter patients so that they felt involved. We observed staff being flexible and adapting scheduled activities when a patient requested this.

The feedback from people who use services and their carers was positive with patients praising staff highly.

The inspection teams reported that staff actively addressed the issue of diversity and respected people's personal, cultural and social needs. On Harvest ward when the team had been unsuccessful at obtaining halal foods for a patient because of catering difficulties staff took it upon them to resolve the issue.

All inpatient rooms were single and in most cases ensuite rooms that in the main afforded good privacy when patients required physical or intimate care.

Involvement of people using services

On Fettle ward and across the learning disabilities community teams we saw outstanding practice in engaging and ensuring full involvement of patients.

In most core services we saw patient involvement in care planning. However in some circumstances this was not always clearly documented although patients recognised this having been a collaborative action. Also, in some care settings, patients did not routinely have access to their care plans. Care plans in the older person community services did not consistently record people's voice and preferences in them and people were not routinely given copies of their care plans.

Advocacy services were visible on the wards and promoted widely. All patients who spoke with us told us that they either accessed the advocacy service or knew they were able to access an advocate if they wished for that support. However, it was reported that there was often a delay of up to 21 days for advocates to gain access to patients' records.

Emotional support for people

Across the children's services we found evidence that staff supported parents, young people and their families

Good

Are services caring?

emotionally. During clinics and home visits we saw positive engagement and support. Parents told us they felt supported emotionally by staff. Staff were always available on the phone for advice and support between visits.

In the adult services we were told by patients that, where appropriate, families and carers were involved in care planning.

All wards had access to telephone facilities for patients to remain in touch with family members.

We saw that there were good supplies of patient information leaflets that covered a wide range of relevant topics available for patients and their relatives.

On Garner ward people were able to get involved in decisions about the service they received. For example, carers were involved in recent staff interviews. In addition, the older people's service held a drop-in session, 'our say' and 'tea and talk sessions' for patients and their relatives to encourage involvement in the service, although the trust reported that this was not well attended.

Good

Are services responsive to people's needs?

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

Summary of findings

Please refer to the summary at the beginning of the report.

Our findings

Planning and delivery of services

We heard from Kernow Clinical Commissioning Group that there have been instances where the redesign of services had occurred without consultation or involvement with commissioners this included redesign of learning disability community services, integrated community mental health teams and single point of access. All service line associate directors told us that ongoing discussions and review of service quality is undertake with commissioners, local authority and third sector stakeholders. The associate directors told us that, in the main, were cost improvements are to be made they felt they had some influence and impact on the final decisions, however, some felt this was a top down decision.

The senior team report, overall, good relationships with Kernow commissioning group. The clinical commissioning group reported the trust had been consistently good in the provision of the required quality report which had generally been comprehensive.

Staff told us there was significant impact on patient care them of changes made by other care providers. This was particularly noted in child and adolescent mental health services with an increase of referrals attributed to reduction in services for children by other agencies. Learning disability community teams had limited access to respite beds or appropriate facilities for short assessment admissions. On Garner ward discharge was sometimes delayed for non-clinical reasons as suitable alternative accommodation could not be found.

In the home treatment teams, as a result of the absence of medical input, outpatient appointments could be difficult to arrange. We were told that the night duty home treatment team were often under pressure with three staff on duty for the whole county. One member of staff would be an approved mental health practitioner (AMHP) and would co-ordinate and attend any MHA assessments leaving two staff to field varied phone calls and other requests for urgent assessments.

Some patients we spoke with did express concerns about getting to community based locations, especially if they had to rely on public transport. Which we understand was very limited. Some teams had taken steps to address this and we heard of flexible and innovative approached developed locally.

The inspection teams found, with the exception of some day resource centres and one learning disabilities community resource the buildings were of an acceptable standard. However, the inspection team found the Bodmin hospital site private finance initiative contracts did not respond flexibly to meet any changing needs. This was of particular note on Harvest ward when staff required Halal foods and when requesting that repairs are carried out.

However, the poor quality of buildings and facilities had an impact on accessibility and availability of services in some learning disabilities teams when, in winter, the building basement was prone to flooding and access was unsafe.

Diversity of needs

The trust recognises that, with a white population of 98.2% across Cornwall, this is an area that requires consideration to ensure they meet the needs effectively of non-white service users. The staff we spoke with told us that as the requirement to meet the diverse needs on non-white population are less frequent and they believe they were extra vigilant and responsive when needed. During the course of the inspection we saw a range of information leaflets and posters around the wards and team building, including information about local services and activities.

The multi faith rooms at the Longreach site provided facilities for all faith groups and there was access to a range of materials and personnel to meet the needs of most. However, one patient told us he was not able to access an Imam or his mosque because of staffing shortages.

Good

Are services responsive to people's needs?

We were told and we saw in action that interpreter services were available for patients and their families whose first language was not English and Staff told us that they were able to access information in a range of languages if needed.

Bodmin Hospital scored 74% for 'food' in the 2014 PLACE survey and steps were being taken to address the shortfalls. We saw that in one case staff had difficulty accessing appropriate meals for a patient with specific dietary requirements. Bowman ward had an ongoing issue with the quality of the food provided. We heard that staff had on Harvest ward had addressed a shortfall in providing halal foods for one patient when there was a delay from the catering department by shopping themselves. Both wards form part of the Bodmin hospital site.

Right care at the right time

Where referral pathways and targets of 28 days from referral to initial treatment are set these were being met in most core services. Child and adolescent mental health services has the longest referral to initial treatment time with 47 days wait reported and 70% of referral were seen in the 28 day timeframe.

Reported delayed transfer of care; the trust were below the England national average for number of patients delayed (2014). 'awaiting nursing home placement or availability' and 'public funding' were the top two reasons in terms of number of patients being delayed and number of delayed days during 2014.

On Garner ward the trust had reported one delayed discharge in the past six months. However, we were informed that the ward was unable to discharge five patients because there were not enough suitable safe places for them to go and we saw that one patient had been on the ward for almost three years. Staff confirmed that patients frequently stayed longer than needed due to the very complex physical needs and challenging behaviour.

Percentage of patients on care programme approach followed up within 7 days after discharge from inpatient care: the trust was consistently above the England average between July 2013 and September 2014. In the latest reported quarter (Oct-Dec 2014) the trust has fallen just below the England average. In addition CQC intelligent monitoring raised as concern the proportion of discharges from hospital followed up within 7 days. During our inspection we saw recording systems in each integrated community mental health team which showed that all patients received a follow up within seven days of being discharged from psychiatric inpatient care.

In child and adolescent mental health services we heard that the volumes of referrals to screen has increased to 15-20 referrals a day. One family told us that they had waited for a year to get in to the service as their daughter was considered low risk. We were also told by another family of a 6 month wait for an autism assessment.

The wide geography of the trust meant that all staff were travelling considerable distances to deliver services and this had an impact on what was able to be achieved. This was of particular concern when the traffic increased during the summer months. For services who deliver care to people of Isle of Scilly weather conditions could also affect travel and access. The trust explored the use of a range of technologies to improve communications but we heard this could also be problematic in some areas due to poor communications infrastructure.

The home treatment teams told us that there was often a shortage of beds for acute admissions. On the day of our visit the bed co-ordinator reported that there were six or seven people needing admission, with no placement yet identified, but that this was unusually high. Normally there would two or three. Patients in acute admission beds were informed that when they went on leave their bed could not be kept open. However, though there was evidence that patients were not discharged until they were ready to leave the ward we were not sufficiently confident to provide a rating across the acute core service. We did not see evidence of a system to record what action is taken when patients requiring re-admission that cannot return to an inpatient bed in their local area. There were fourteen patients out of area for the acute inpatient service line at the time of inspection.

The inspection teams saw evidence of systems in place to monitor and manage delays in treatment in some core services. However, we saw that 4.2% of child and adolescent mental health services appointments were cancelled this was attributed to the consultants having to carry out emergency follow up from out of hours emergencies. We saw that the trust had engaged with Kernow CCG previously to attempt to review this.

Learning from concerns and complaints

Good

Are services responsive to people's needs?

Our data collection showed that complaints received came from nursing, midwifery and health visiting in relation to all aspects of clinical treatment. Locations with more than 10 complaints in previous 12 months included integrated community health team bases in Kerrier, Penwith, Carrick, and Caradon and Fletcher ward in the inpatient estate.

35% of the 111 complaints that were received in 2013-2014 were upheld.

During our site visit and in our conversations with patients we found there was a clear understanding of how to make a complaint or raise a concern. In the main, we saw evidence that the team had learnt from the issues raised at a local level and across services.

The inspection teams saw opportunities for patients to feedback and make suggestion about services through comment boxes, community meeting and patients told us they felt able to raise issues with the staff teams.

Patient advice and liaison services were actively promoted across the services and easy read complaints information had been developed where required.

Good

Are services well-led?

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

Summary of findings

Please refer to the summary at the beginning of the report.

Our findings

Vision, values and strategy

The trust described clear vision and values and staff we spoke with were clear about these. Some staff told us they had been involved in the developments and felt they could identify with the content.

The trust appointed an organisational development manager who visited each team to hear their views and ensure that values were built from the bottom up. This process included representatives from all disciplines and grades including executive and non-executive staff.

The trust had five strategic objectives which are:

- to deliver high quality, safe and accessible services
- to maximise the potential of our workforce to deliver high quality patient care
- to achieve best value and ensure the trust is sustainable and financially sound in the future
- to diversify and develop services that meet commissioner and patient needs and expectations
- to improve the mental health and wellbeing by working in partnership to create life opportunities for our patients

The senior team had a series of strategic away days to review strategy and targets. It was of note that the whole board had a shared awareness of the challenges they faced and an agreement toward the solution to move forward.

The financial situation of the trust is healthy with a good history of identifying and delivering cost improvement programmes the cash releasing efficiency savings.

The non-executive directors interviewed demonstrated clarity about their role and their contribution to the trust performance.

Good governance

The trust business information reports were generated for each team to monitor overall performance. This enabled managers to have a good understanding of their areas. Data was collected at a team level about caseloads per member of staff, referral rates, discharges, work completed and referrals into the service and waiting times. In addition staff training records, supervision and appraisal rates and sickness and vacancy rates provided mangers with useful management information. We saw that this information was circulated throughout the services and used effectively.

The trust collected information from electronic patient records, staff records and incident reports a range of data that they used to inform performance and gain assurance. The chief executive met with all service line leads to review this information and challenge and support findings. To triangulate these finding the trust executive team, including non-executive directors, carried out patient safety walk round, shadowing visits and a range of announced and unannounced visits. The medical director remained a practising clinician holding a regular clinic and rostered on call.

The trust had recently launched a governance processes to manage quality and safety. The operational assurance group had a number of groups looking at various issues of quality and development who reported to it. These groups were structured around the CQC five domains and focussed on different aspects of their services.

Across the core services most team managers felt they had sufficient authority and administrative support. Staff had the ability to submit items to the service line's risk register.

We saw a range of local service led audits which had guided development, improvement and evaluation of service provision. The audit committee was open for

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attendance by governors who had a clearly described role with processes in place to support this activity. The chair of the audit committee gave a clear and comprehensive account of the success and areas for improvement.

All teams held staff meetings and produced minutes for cascade to those not present. Most agendas included performance, incidents, and learning. Team managers told us they felt their line manager knew the local issues within each team through a combination of information sharing, managerial supervision, weekly conference calls and being accessible to staff.

Most staff were receiving supervision and receiving annual appraisals and we saw records which confirmed this.

We saw good evidence of learning from complaints and incidents across the core services visited.

Leadership and culture

Our data and the feedback we received showed:

- The General Medical Council: A national training scheme survey 2014 highlighted one result which was 'worse than expected' – study leave in general psychiatry.
- NHS staff survey: the trust performed better than the national average for staff experiencing physical violence or harassment/bullying/abuse from patients/the public, staff experiencing physical violence from other members of staff, effective team working and support from immediate managers.
- NHS staff survey: the trust performed worse than the national average for staff experiencing harassment/bullying/abuse from others members of staff and work pressure/stress felt by staff.

The executive team had remained stable. However, there have been some challenges in attracting staff to associate level leadership roles. There were clear lines of accountability throughout the services. However, some new staff and temporary or interim roles require further consideration.

The executive team had invested in setting clear expectations and challenging cultures across the service areas. This included responding to poor practice quickly and taking necessary steps to change longstanding poor practice. The trust carried out training sessions with a range of staff at all levels looking at maintaining professional boundaries. This followed a series of disciplinary and poor practice concerns being raised and addressed. The programme ran for 6 weeks covered all service areas and included a range of staff.

During the staff focus groups we invited staff to talk with us about the culture in the trust. They raised no concerns and we sought additional assurance from the staff survey results. The focus groups were attended by 110 staff from a range of disciplines and grades. We were informed that themes from staff grievances are reported to the chief executive.

During our inspection we heard that most staff felt supported by their immediate team manager. In two core service areas staff expressed concern they would not feel able to raise an issue above their immediate line manager. One team provided an example of how they felt a colleague had been treated unfairly as a result of raising an issue of concern.

Staff in the community mental health team for people with learning disabilities told us that a service redesign was underway, and this had been a very difficult process that had a significant impact on staff morale. We asked for information around the plans to support staff and monitor the impact of this process on staff health and wellbeing. We were informed that this was largely the responsibility of the team managers to oversee. However, the team managers were new in post, which could make it potentially difficult for them managing the degree of impact from the redesign. We reviewed a sample of managers' supervision files (including allied health managers and team managers). We found that there was little evidence of individual regular, structured supervision from the senior management team, or additional leadership training, to effectively support them in managing this change. However, the team managers did have a weekly meeting with the service manager to review a range of service issues.

Counselling support was also available for staff as required. There was a health and well-being strategy in place and the organisational development lead was engaging with teams with a programme of work based on the outcomes from the staff survey.

The chair and non-executives aim to be a visible presence across the service lines through a series of planned and

unplanned shadowing visits. Each non-executive has a specific service line lead and they were represented on committees and working groups. There were some challenges in attending the remote sites.

The staff reported that the executive and senior team's presence on the wards and the teams was variable. Staff told us that the chief executive was responsive offering front line staff the opportunity to have 1:1 sessions. Some staff told us they had been visited by some executive team members. However, the presence and visibility of other executive leads on the wards or in the teams was limited and there was confusion about the executive lead nurse role. The current director of nursing held serval key roles in the trust and juggled competing demands as the executive lead nurse, the director of quality governance and had an additional lead role for human resources. Staff were not always able to answer who was in the executive nurse post and we were told by nurses they did not feel they had a strong voice or representation. Some staff told us there was less priority given to training for nursing staff than other disciplines.

During the interviews undertaken with the senior staff, governors and executive team we were informed of and saw systems that allowed for assurance to be sought, challenges to be made and were achieved success to be demonstrated.

The lead for human resources outlined a range of opportunities for staff to support and develop leadership across the workforce. This included a level 5 leadership course delivered by Cornwall College. The trust recognised that they could do better in talent management and had plans underway to address this. All senior leaders were able to describe how they updated and maintained connection to the wider NHS.

Fit and Proper Person Requirement

We saw the trust fit and proper person requirement register was complete and all necessary checks carried out. We saw paperwork created which demonstrates that all executive board members met the requirements.

Engaging with the public, with people who use services and staff

The data analysed prior to the site visits showed that the trust performed better than the national average for staff receiving equality and diversity training and staff experiencing discrimination.

The trust performed worse than the national average for staff recommending the trust as a place to work or receive treatment and for staff motivation at work.

There was an active board of governors who reported they felt well catered for by the trust. They participated in training and learning to equip them to better understand their roles.

All locations displayed posters and had leaflets explaining how to access Patient Advice and Liaison Service if patients or their relatives wanted support in raising concerns. The trust website gave details on how to make a complaint and the actions that the trust had taken as a result of complaints. We saw a range of local initiatives about engaging with service users for feedback. On Fettle ward and across the learning disabilities community teams we saw outstanding practice in engaging and ensuing full involvement of patients.

A trust-wide monthly newsletter called Cascade was sent to all practitioners electronically. Staff we spoke with said they felt the trust communicated most information to them in a timely and effective manner. The newsletters provided information about trust wide consultation meetings which staff could attend and other actions being taken by the trust.

Quality improvement, innovation and sustainability

The trust were involved in a re-tender process for children's services at the time of the inspection. Financial forecasting had been undertaken and the trust would remain financially viable in the event of this loss.

Cost improvement proposals were discussed with the executive team who would, in some cases, reject proposals if they felt the impact on patient quality was not mitigated. In some core services staff did not always feel involved in service development and told us this could affect their level of satisfaction with their job. The cost improvement programmes were frequently described as a top down implementation. However, some teams felt they had an input into the development of business plans across some service lines.

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Cost improvement initiatives were monitored through the performance monitoring frameworks and impacts discussed on a regular basis with the chief executive, chief operating officer and associate directors for each service line. This includes further analysis of unplanned cost improvement achievements as a result of vacancies.

We saw examples of participation in national accreditation schemes and engagement in a range of quality improvement approaches. We found:

- National Autistic Society accreditation has been achieved
- Tamar memory service has been accredited as 'excellent' through the Royal College of Psychiatrists' memory service national accreditation programme.
- 93% of standards met on Fettle ward through the Royal College of Psychiatrists' Accreditation for Inpatient Mental Health Scheme (REHAB)
- Bowman ward staff were active members of forensic quality network initiative for low secure services and helped develop the benchmark standards used in the accreditation scheme.
- Bodmin Hospital ECT clinic has been rated as excellent by Royal College of Psychiatrists' ECT Accreditation Service.

We saw innovative projects aimed at improving the services for patients. One example was the development of a new approach to dealing with psychosis called "open dialogue". There was a research service within the trust and some research work has been undertaken specifically within dementia services. The physiotherapy team in the learning disability community services had been recognised by the trust for their innovative work in rebound therapy.

During our inspection we visited the community forensic service. This is not a service that we rate as part of the comprehensive inspection process however we visited the services at the request of the trust who felt this was an outstanding service. The staff were friendly and hospitable and keen to share the good work they had achieved with us. The team gave an overview of the work and shared some outcome measures with the inspection team. Of particular note was the joint work with the police and courts and community psychiatric nurses across all service lines including training supervision and support for staff. In addition the team provided support for patients making the transition from inpatient care to the community.