Requires improvement

Cornwall Partnership NHS Foundation Trust

Community-based mental health services for adults of working age

Quality Report

Cornwall Partnership NHS Foundation Trust, Head Office, Carew House, Beacon Technology Park, Dunmere Road, Bodmin, PL31 2QN
Tel: 01726291000
Website: www.cornwallpartnershiptrust.nhs.uk

Date of inspection visit: 26 – 28 September 2017
Date of publication: 02/02/2018

Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RJ8X7	Trust Headquarters	Trevillis House CMHT N.Cornwall	PL31 2QN
RJ827	Trengweath	Trengweath CMHT Penryn Street Redruth	TR15 2SP
RJ857	Alexander House	Restormel Alex House CMHT 52 Alexandra Road St Austell	PL25 4QN
RJ862	Banham House	Banham House CMHT Boundary Road Bodmin	PL31 2QT
RJ815	Bolitho	Bolitho House CMHT Laragan Hill Penzance	TR18 2NY

Summary of findings

RJ858	Pydar Street	Pydar Street CMHT Carrick Team 57 Pydar Street Truro	TR1 2SS
	Location name	Day Resource Centre The coach House Lodge Hill Liskeard	PL14 4EN

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

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

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

Summary of findings

Ratings

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

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

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

Contents

Summary of findings

Overall summary

We rated community based mental health services for adults as **requires improvement** because;

- Staffing levels were not safe. Five out of the six integrated community mental health teams that we inspected had vacancies. The vacancies had affected all five integrated community mental health teams as at the time of inspection, there were approximately 114 patients unallocated for treatment and the trust did not have a clear process in place to monitor these patients.
- The trust had not taken all of the actions to keep staff safe. Truro integrated community mental health team had not carried out a health and safety audit since 2013. Staff based at Caradon did not know how to activate the emergency alarms. The trust did not have an effective process in place to manage risk when staff met with patients that staff had assessed as high risk.
- The provider did not ensure patients receive physical health checks in line with national guidance. The emergency equipment available in each clinic room varied and some of it was out of date. We found four integrated community mental health teams did not have resuscitation masks. Eight of the masks found were out of date. In three integrated community mental health teams the dates recorded on physical health, monitoring equipment had expired. For example, two tympanic electronic thermometers dates expired in March 2015 and December 2015. However, there was no risk to patients, as staff did not carry out physical health checks.
- Staff did not work together with GPs to ensure patients had robust health monitoring in place. None of the six integrated community mental health teams had a robust system in place for the management of medicines. We found out of date medicine. Medicines were not being stored at the correct temperatures. One fridge in the Bodmin clinic had not recorded the temperature since November 2016. The cards used to record patient's depot medicine had essential information missing from a number of cards. In Kerrier, a paliperidone injection box (an anti-psychotic individually prescribed medication), had its patient label remove.
- Staff recognised that they did not always report incidents. This was because staff had high workloads and did not get the chance to complete the paperwork. In two of the three sites visited, the managers told us they were behind and had outstanding incidents awaiting manager sign off. The September 2017 team brief highlighted there were 203 outstanding incidents.
- The quality and detail of patient risk assessments was inconsistent. We found risk assessments that were out of date. Staff had not updated risk assessments following significant change/incidents involving patients and in particular, five of the 12 records reviewed had no risk assessment.
- Care plans varied in quality, style, and content. There was little evidence that patients had been involved in their care planning. At Carrick, integrated community mental health team seven of the 12 care records reviewed did not contain a care plan, and a further three were out of date.
- Mandatory training attendance was low. Rates across the six locations ranged from 58%-87%, core essential training 66%-77% and other 52%-73%. This included safeguarding training where 52% of staff had attended level two safeguarding training

However;

- The trust responded to the time it took to carry out an assessment by creating a dedicated assessment team. There were six core members of the team with a further six members of staff rotating from their roles within the integrated community mental health team.
- Patients found staff to be kind, polite, respectful, supportive, caring, and encouraging.
- Patients described staff as excellent despite so many organisational changes.

Summary of findings

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

Are services safe?

Requires improvement

We rated safe as requires improvement because:

- In five of the integrated community mental health team we visited staffing levels were below the establishment set by the trust. This was due to unfilled vacancies. All of the team managers we met were working to address the situation through short-term cover.
- The integrated community mental health team did not have suitable arrangements in place for the management of medicines (none were stored in the day resource centres. This included the receipt, storage, administration, and recording of medicines.
- Staff within the teams told us their caseloads over the last twelve months were between 45-55 and had been in excess of this in some teams. Team managers we met with confirmed this was correct.
- At the time of the inspection, there were 114 patients unallocated for treatment and the trust did not have a process in place to manage this safely.

However;

- Independent contractors routinely carried out fire safety checks, drills, and risk assessments across all sites
- Staff explained how to raise safeguarding concerns and how to report incidents.

Are services effective?

Requires improvement

We rated effective as requires improvement because:

- Care plans were not consistent across all six services. In one of the integrated community mental health teams, seven out or 12 care plans were absent.
- There was little evidence that staff had produced care plans in conjunction with patients.
- Physical health checks were not consistently undertaken. The trust reported prior to the inspection, that they had identified an inconsistency in practice about the recording of physical health care. However, we did not see an action plan to establish what the trust had planned to do about it.
- We found no evidence that staff carried out local audits.

Summary of findings

However;

- The trust had introduced a new clinical pathway, low intensity (LI) with the aim to manage caseloads.

Are services caring?

Good

We rated caring as good because:

- We observed psychologists, consultants, and care coordinators interaction with patients, which was supportive and kind. We saw examples of other staff based at the day resource centres, providing emotional support in a respectful and empathic way.
- We reviewed 17 patient comment cards. Patients told us they felt staff listened to them, and supported them when they need it. Some patients said they did not know what they would do if they did not have this service.
- Staff enabled patients to get the best out of the care and treatment. For example, a patient had been struggling with their essential skills group homework so staff booked a homework session before the group started to help the patient prepare.
- The trust arranged for patients that lived on the Isle of Scilly to have a £5 ferry ticket to enable them to come to the main land for their appointments. These meant patients that did not want staff to come to their home could maintain privacy as the Isle of Scilly was such a small community.

However;

- Patients and carers found electronic versions of care plans complicated.
- We did not see and the managers were unable to provide any evidence of patient involvement in the evaluation of service delivery.

Are services responsive to people's needs?

Good

We rated responsive as good because:

- The trust changed the admission criteria and team structure to ensure patient referrals were appropriate, and responded to quickly. For example, the trust had introduced a dedicated assessment team to help reduce patient waiting times.
- The trust introduced a green card that enabled discharged patients, to access the service quickly. These meant patients did not have to go back through their GP.
- All waiting areas seen had a good variety of information about the service, complaints, PALS, groups, and a variety of information signposting access to other services

Summary of findings

- The trust introduced a low intensity pathway to reduce staff caseloads. This meant staff could transfer patients that required low-level support from a community psychiatric nurses caseload to a support workers caseload.
- The trust recognised the impact of psychology vacancies across the service and provided training for staff in cognitive behaviour therapy and essential life skills to support patients waiting for psychological therapy.

However;

- The trust reported prior to the inspection that patients had to wait 31 days before they could access psychology. On inspection, we found that this was not the case. For example, Truro integrated community mental health team had a waiting list of up to 18 months to access psychology.
- Staff transferred to the low intensity pathway told us the trust had not provided training for them to deliver the low intensity pathway and they did not feel confident to do so.

Are services well-led?

Requires improvement

We rated well led as requires improvement because:

- Regular changes in management structure had affected the quality of service delivery and staff morale.
- Staff attendance at mandatory training was low across all locations. Staff did not have the correct skills to deliver the low intensity pathway
- Staff felt disconnected form the trust reporting that senior managers rarely visited the service
- The trust was unable to provide any data on staff supervision and appraisals. Some staff had received clinical supervisions but managers could not advise why other staff had not received managerial supervision..

However;

- Staff confirmed there had been no incidents of bullying or harassment and that managers were supportive.

Summary of findings

Information about the service

Cornwall Partnership NHS Foundation Trust adult community based mental health services, offer patients with mental health problems a range of community based treatments, psychological support, medication and advice in Cornwall. Patients can access the services from the age of 18 to 75, the trust recently introduced an upper age limit.

There are six integrated community mental health teams that provide multi-disciplinary assessment and if appropriate, treatment throughout Cornwall. The team includes consultant psychiatrists, psychiatric nurses, social workers, approved mental health professionals (AMHP), support workers, occupational therapists, and psychologists. Each team provides a range of treatments, interventions, advice, and assistance to patients. The integrated community mental health team includes Caradon, North Cornwall, Restormel, Carrick, Kerrier, and Penwith. Integrated community mental health teams are open Monday to Friday between 8.45am and 5.15pm.

The integrated community mental health teams are for patients who have severe and persistent mental health problems and come under the framework of the care programme approach. The Care Programme Approach (CPA) is the national framework for mental health services assessment, care planning, review, care co-ordination, and patient and carer involvement focused on recovery.

There are also 10, day resource centres, which support integrated community mental health teams by providing care to patients within specific geographical locations. Each day resource centre works closely with its relevant integrated community mental health team and receives all new referrals via the weekly allocation meetings.

The management structures and care pathways for delivering the integrated community mental health teams have been through considerable change over the last few months. For example, the trust introduced a separate assessment team to complete assessments following referral to determine the level of need and subsequent interventions. The service had also introduced a new pathway, called low intensity, for stable patients. The management structure had been in a state of change over the last six months, the service was in the process of temporarily employing three additional managers to change the structure back to one manager per integrated community mental health team. The structure and service will be subject to a further review within six months.

Consultant psychiatrists retain medical responsibility for patients across the care pathway, 'locality model' in the integrated community mental health team's in-patient facilities, and the crisis teams.

Cornwall Partnership NHS Foundation Trust is registered in respect of Regulated Activity: Assessment or medical treatment for persons detained under the Mental Health Act 1983, diagnostic and screening procedures, nursing care, and personal care, treatment of disease, disorder, or injury.

The Care Quality Commission last inspected Cornwall Partnership NHS Foundation Trust adult community based mental health services on 9 September 2015. At that, inspection we rated community based mental health services for adults as good.

Our inspection team

The inspection of Cornwall Partnership NHS Foundation trust was led by:

Karen Bennett-Wilson, head of hospitals inspection, supported by Michelle McLeavy, inspection manager, mental health and Mandy Williams inspection manager, community health.

The team that inspected adult community mental health services included a Care Quality Commission (CQC) lead inspector, Sharon Dyke, two other CQC inspectors, and six specialist advisors, including mental health social workers, registered mental health nurses, and a psychiatrist.

Summary of findings

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

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

'Before the inspection visit, we reviewed information that we held about these services, and sought feedback from patients at two focus groups.

During the inspection visit, the inspection team:

- visited six integrated community mental health teams
- visited two DRC's (day resource centres)
- interviewed three locality managers
- interviewed three service managers
- interviewed five clinical team leaders
- spoke with 12 patients who used the service
- spoke with one carer of a patient who used the service
- spoke with 61 members of staff from a range of disciplines, which included: psychiatrists, psychologists, occupational therapists, registered mental nurses, social workers, approved mental health professionals, support workers
- spoke with one pharmacist and one medical director
- attended one multi-disciplinary meeting
- attended one serious incident meeting
- attended one business meeting
- observed seven patient review meetings
- observed one patient assessment.

We also:

- collected feedback from 17 patients using comment cards
- looked at 73 care records of patients
- looked at 26 staff personnel files
- carried out a specific check of the medication management within each Integrated community mental health team
- looked at a range of policies, procedures, and other documents relating to the running of the service.

What people who use the provider's services say

We spoke with 12 patients, and one carer of a patient, who used the integrated community mental health teams. We also reviewed 17 comment cards.

Overall, patients across all six integrated community mental health teams were satisfied with the care and service provision and gave very positive feedback about the staff that cared for them.

Patients found staff to be kind, polite, respectful, supportive, caring, and encouraging. Patients described staff as excellent despite so many organisational changes. Patients told us how much they valued the staff talking and listening to them. Patients we spoke with knew they could contact the crisis team when the integrated community mental health team was closed.

Carers said that they felt staff cared and were committed to working with their relatives. However, they felt staff were also stretched which resulted in community staff cutting visits short.

The inspection team observed staff interacting well with patients and using an empathic approach.

Summary of findings

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure sufficient numbers of suitably qualified, competent, skilled and experienced staff are available to meet the needs of the people using the service at all times.
- The provider must ensure managers facilitate regular staff supervision.
- The provider must ensure all staff has access to, and the time, to undertake mandatory training.
- The provider must ensure risk assessments are in place, monitored and updated regularly
- The provider must ensure proper and safe management of medicines. Including auditing of stock and safe disposal of medicines no longer required.
- The provider must ensure patients receive physical health checks in line with national guidance, especially for patients on anti-psychotic medicines.This includes providing sufficient quantities of appropriate equipment to ensure the safety of patients and to meet their needs.
- The provider must ensure there are robust working relationships in place with GPs to support health monitoring of high risk patients, including prescribing of medicines.
- The provider must ensure the waiting list is managed safely.

Action the provider SHOULD take to improve

- The provider should ensure staff that have been transferred to the low intensity pathway receive appropriate training.
- The provider should ensure all staff have access to specialist training and are given time to attend.
- The provider should ensure patients are involved in their care planning. Including making any reasonable adjustments and providing support to help them understand and make informed decisions about their care and treatment options.
- The provider should ensure patients are informed about any CCTV recording equipment fitted in services.
- The provider should ensure patients have access to psychology.

Cornwall Partnership NHS Foundation Trust

Community-based mental health services for adults of working age

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Trevillis House CMHT N.Cornwall	Trevillis House CMHT N.Cornwall Cornwall Partnership NHS Foundation Trust Head Office Carew House, Beacon Tecnology Park, Dunmere Road, Bodmin
Trengweath CMHT Penryn Street Redruth	
Restormel Alex House CMHT 52 Alexandra Road St Austell	
Banham House CMHT Boundary Road Bodmin	
Bolitho House CMHT Laragan Hill Penzance	
Pydar Street CMHT Carrick Team 57 Pydar Street Truro	

Detailed findings

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.

Staff told us they were confident in their understanding of their responsibilities under the Mental Health Act (MHA). There were also approved mental health practitioners within the community mental health teams.

Patients had their rights under the Mental Health Act/ Community Treatment Order explained to them at the start of their care pathway and routinely thereafter in all six locations visited. Administrative support and legal advice on implementation of the MHA and its code of Practice was available from a central team.

We reviewed care plans across all six locations in relation to patients subject to community treatment orders (CTO). We found these to be in order and up to date. Staff we spoke with providing care and treatment to patients subject to a CTO were aware of the conditions stipulated within the order. However, we were unable to speak to any patients subject to a CTO.

Mental Capacity Act and Deprivation of Liberty Safeguards

- The service had made no Deprivation of Liberty Safeguard (DoLS) applications to the Local Authority between 1 June 2016 and 31 May 2017.

Requires improvement

Are services safe?

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

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

Our findings

Safe and clean environment

- Patients accessed the integrated community mental health team bases for appointments and clinics through a staffed reception with identified waiting areas. The environment was clean at all six integrated community mental health teams. The trust provided a central team that carried out infection control duties. However, managers across all six locations were not aware if the central team carried out any infection control audits. Managers across all six locations did not monitor infection control within the buildings.
- Four of the six integrated community mental health teams and the two day resource centre buildings were tired and in need of refurbishment. In Bolitho House, integrated community mental health teams the walls were wet with damp and paint was peeling off the wall in patient areas. Staff had highlighted some of the environmental concerns on the team's risk register and senior managers within the service were aware of them. However, the risk register did not reflect the damp in the clinical rooms. Restormel, Carrick and Kerrier integrated community mental health teams had plans to relocate their services to buildings that are more appropriate in the future, as part of the Trust's Estate Strategy.
- The locality administration managers were responsible for the health, safety, and environments of the team bases. Two administration managers were unable to locate the previous audits. The third location, Truro, had not carried out a health and safety audit since 2013. They were of aware of this and said it was because they had plans to move to a different location before the end of this calendar year.
- Independent contractors routinely carried out fire safety checks, drills, and risk assessments across all sites.
- All sites had different emergency alarm systems in place. Carrick, Kerrier and Penwith integrated community mental health teams had a mixture of CCTV, wall mounted alarms or personal alarms. Staff used rooms with CCTV to see high-risk patients and we saw evidence that staff tested the alarms. Caradon integrated community mental health teams had alarms in each interview room situated by the exit doors. North Cornwall integrated community mental health teams had alarms situated by windows, Restormal integrated community mental health teams had one alarm on the top floor, and each room on the ground floor was alarmed.
- Staff based at Caradon did not know how to activate the emergency alarms. We raised this with the managers who told us there was process in the security protocol. We checked the security protocol dated February 2017; staff signed this at induction confirming they understood the process.
- There was a lone working process across all six integrated community mental health teams. These included signing in and out, end of shift safety calls by the administrative team and an emergency process called the pink diary. When we reviewed the care records we found staff met patients at a third party providers premises if they had been assessed as high risk. However, staff had not recorded an alert on the electronic record system for these patients or completed risk assessments or management plans to ensure staff safety, we raised this during the inspection.
- We reviewed all six-clinic rooms used by the community teams. Carrick, Kerrier and Penwith integrated community mental health team clinic rooms were clean. Community psychiatric nurses (CPN) in each area had responsibility for overseeing the clinic rooms. There were inconsistencies in equipment provided in each room reviewed. For example, the emergency equipment available in each clinic room varied and was out of date.
- All managers stated that the procedure in an emergency was to call 999 and they were therefore not required to hold any emergency equipment. Staff told us they would call 999 and begin to resuscitate if necessary. The trust policy, 'Cardiopulmonary Resuscitation' states community staff should have access to oropharyngeal airways sizes 2 & 3 (plus sizes 0 & 1 in units with paediatric patients) and pocket masks. We found four integrated community mental health teams did not

have resuscitation masks, two team's stocked masks. Several of the masks found were out of date. One clinical lead told us they had ordered a 'resus bag' and defibrillator for their clinic room.

- The physical health equipment for patient's wellbeing checks or checks associated with administering anti-psychotic medicine in each clinical room also varied. For example, three clinic rooms had blood pressure, scales, and other necessary equipment, while three clinics did not have this equipment. In three integrated community mental health teams the physical health monitoring equipment seen was out of date. For example, we found no date or calibration on three sphygmomanometers, no date, or calibration on two ophthalmoscopes, first aid box expiry date February 2006, and a blood glucose machine/kit that had expired in 2006. Boxes of expired latex gloves and syringes expiry date April 2017.
- The integrated community mental health team had 'depot bags' available at each location. Staff took the 'depot bags 'to patient's homes to enable patients to receive their medicine by injection. The equipment provided in the bags varied. Staff said that no emergency equipment or medicine should be kept in bags in North Cornwall; however, in three other integrated community mental health team the bags contained adrenaline.
- We reviewed 12 staff files. All DBS records reviewed were up to date references were in place and staff eligibility to work in the UK was available.

Safe staffing

- The registered nurse vacancy levels varied across the integrated community mental health teams. Five out of the six locations visited had vacancies. Overall, the trust reported the annual vacancy rate for this core service was 6.7% against the trust average of 5.1%. For May 2017, the vacancy rate was 11.4% against the trust average of 4.8%. The trust reported several risks in their risk register relating to staffing. These included the inability to allocate patients and caseload volumes. The trust had taken steps to fill the vacancies where possible. For example, they had recently appointed seven care co-ordinators from an external recruitment programme. The trust used long-term agency and bank staff when available. Four out of the six ICMTs still had unfilled or uncovered vacancies for registered nurses. The impact was across the integrated community mental health teams as there were approximately 114 patients unallocated for treatment. We discussed this with the managers of each integrated community mental health teams and were told patients assessed as high risk were immediately allocated a care co-ordinator.
- Following a meeting in June 2017 to resolve staff vacancies and unallocated patients the integrated community mental health teams introduced, and fast tracked, a number of initiatives to reduce these risks. For example, the trust created a new method of caseload supervision and a new low intensity pathway as well as adjusting their admission criteria. This had reduced the numbers of patients per integrated community mental health team.
- Despite the positive impact of these changes in some areas, we still found pockets of high caseloads. We found staff carried caseloads of 45, 46, 47, and 48. Kerrier integrated community mental health teams average caseload was 40 per full time clinician. All six integrated community mental health team had recently changed the way they monitored caseloads. The data used to monitor caseloads did not give an accurate picture as it the trust recorded them in groups and did not take account of working hours. For example one part time member of staff had a caseload of 24, this equated to a caseload of 48 when converted to a whole time equivalent post. Managers were keeping their own data based on the allocation on the computer system. Staff told us that caseloads had reduced over the last few months. This was because managers, clinical leads and the B5 support staff managers now had caseloads.
- The practice for allocating and managing unallocated (post assessment) patients differed. Staff allocated high-risk patients immediately. However, staff sent all other patients a letter by post with a telephone number for patients to call if they felt worse. Trengweath and Restomal teams told us they rang patients every two weeks to ensure risks had not changed, while other patients waited to be allocated before contacted. Senior clinicians told us they had raised serious concerns regarding the risks with unallocated patients and that the trust had not addressed this.
- The trust submitted their turnover data for the period 1 June 2016 to 31 May 2017. This core service had an average annual turnover rate of 10.7% against the trust average of 12.5%. The day resource centres had the

highest turnover of substantive staff leavers during the period, with 63.2%. Five teams had the lowest with 0%. Managers told us that the majority of turnover was due to retirement. There were several cases seen of retired staff returning as bank staff working set hours every week.

- The trust reported attendance of mandatory training as of 31 May 2017 was 83% against the trust target of 85%. Mandatory training data provided on site for June 2017 was far lower. The trust recorded the training data in three categories; statutory, core essential and other. Statutory training attendance rates across the six locations ranged from 58%-87%, core essential training 66%-77% and other 52%-73%. The trust classed 13 of 18 categories as 'red' across all integrated community mental health teams. Managers told us their mandatory training performance levels had recently fallen; in particular, attendance was low for basic life supportand managing aggression and violence training (MAV). This was because staff could not get onto waiting lists for mandatory training due to work pressures.
- The integrated community mental health teams had introduced a 'KitKat' week. This comprised of one week each month where staff would specifically diary activities that include protected admin time, training, supervision and CPD sessions. Teams continued to see patients where it was indicated by the level of clinical need and assessment of risk. In North Cornwall, they had delivered their own cluster training instead of the mandatory course and were inviting external trainers to deliver workshops during this "KitKat" week.
- None of the six integrated community mental health teams had a robust system in place for the management of medicines. For example, we found out of date medicine at Trevellis House that included adrenaline and chloiphenamine, these expired in August 2017.
- Medicines were not being stored at the correct temperatures. Medicine cupboards at Restormal integrated community mental health team recorded the temperature between 18C and 26C. Maximum temperature for storing some depots is 25C - Modecate, Fluphenazine and Haldol, Haloperidol, should not be stored above 26c. There was no way of checking how long the temperature had been at this level, as staff had not recorded the temperature of the cupboard.
- Staff did not use fridges that stored medicines regularly. One fridge in the Bodmin clinic had not recorded the temperature since Nov 16. On the day of the inspection, the fridge was empty. One fridge was new on the morning of the inspection and staff had turned the third fridge off, as the thermometer did not work on the fridge. Receptionists in the Bodmin clinic held the keys to the fridges and medicines cupboards, clinicians had to sign keys in and out to access the medicines.
- Staff across all integrated community mental health teams kept the cards used to record patient's depot medicine in a locked cupboard in the offices, separate from the clinical areas. There was essential information missing from a number of cards. For example, GP details and the allergen boxes were not completed.
- In Kerrier, a paliperidone injection box (an anti-psychotic individually prescribed medication), had its patient label remove. A member of staff told us the team kept this for students to practice drawing up medicines. However, there was nothing written down to confirm this process which meant anyone who did not know could administer the medicine to the wrong patient.
- There was a lack of assurance and oversight of the administering of depot medicine. One area had a list of patients on depot and another had recently introduced a depot list. However, individual community psychiatric nurses managed the majority of depot medicines. One member of staff gave us an example of a patient being out of 'sink' with their medicine due to confusion with the GP regarding blood tests. Also, staff at Trevellis house had raised concerns at their multi-disciplinary meeting on 19 September 2017, care co-ordinators and support worker identified a problem with administering depots due to shortage of nurses, the corresponding action for staff, was to ensure depot cover arrangements were to made by individual co-ordinators if on leave or off sick. Staff, including a pharmacist, told us they used to audit depots, however this had stopped.

Assessing and managing risk to patients and staff

- All six integrated community mental health teams had introduced an assessment team, made up of six dedicated community psychiatric nurses and an additional six community psychiatric nurses allocated from each integrated community mental health team. The team carried out assessments and provided a duty rota. We saw evidence in North Cornwall that all urgent patients had been risk assessed within five days and

Requires improvement

Are services safe?

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

that was within the trusts target of 28 days for non-urgent patients. Other managers were unaware of their progress in meeting assessment targets. Feedback from staff including consultants was that the new system was successful and the quality of assessment was good.

- The trust used STORM, (skills-based training onriskmanagement for suicide prevention) risk assessments for patients who are at risk of self-harm. However, we saw very limited use of risk assessments in care records. Staff told us that they did not use STORM risk assessments regularly.
- The detail and quality of risk assessments across all six teams varied. We saw an excellent example of a risk assessment for a very complex patient in Bothilo integrated community mental health team. However, In Carrick integrated community mental health team we found six risk assessments that were out of date, one that staff had not updated following a significant incident and five of the 12 records reviewed had no risk assessment.
- The trust had an in house safeguarding team. Staff described how to report safeguarding to the internal team. Two of the managers held a list of all ongoing safeguards and kept oversight. They felt supported by safeguarding team for example they were holding a monthly drop in clinic to help staff with ongoing safeguard issues. Managers also met monthly with local safeguarding leads to review their safeguarding. We saw safeguarding discussed in team meetings and multi-disciplinary team meetings. We found one unreported financial safeguarding incident while tracking records; we raised this with the local manager who was not aware of the concern. Staff told us managers did not always feedback outcomes of safeguarding alerts and they did not know if the trust reported safeguarding to the local authority.

Track record on safety

- There were 12 serious incidents involving a death of a community patient in receipt of community mental health services in the 12 months leading up to our inspection. Managers and permanent staff we spoke with had a good understanding of serious incidents, which had occurred within their service. The temporary staff we spoke with told us managers did not always tell them about historical incidents.
- Incidents, which had occurred, resulted in an investigation carried out by a team of independent investigators. This included sharing of lessons learnt. Managers discussed outcomes at the monthly managers meeting. We saw the minutes and associated reports for these meetings, along with how the managers communicated this information back to the team business meetings. An example had been making improvements to communications between integrated community mental health teams and the home treatment teams when working out of normal hours.

Reporting incidents and learning from when things go wrong

- Staff across all six teams told us they knew how to report incidents. The local manager told us they reviewed and signed off all incidents. However, we found incidents that staff had not reported at Carrick, managers said this was because workloads were too high.
- Staff told us they did not receive feedback from individually reported incidents. However, we did see evidence, in particular in North Cornwall, where staff had reported incidents and discussed them in business meetings. Staff had not documented business meetings well in other locations, which meant staff not attending would not receive feedback on any learning.
- Two of the six sites inspected, Trevillis House and Trengweath, had outstanding incidents awaiting manager sign off. The September 2017 team brief highlighted there were 203 outstanding incidents. This was in part due to the trust removing clinical leads permissions' to sign off the incidents. Despite clinical leads running team meetings and multi-disciplinary meetings where staff would use this data. We requested, but staff could not provide, any information on any thematic learning from incidents.
- Integrated community mental health teams had 31 serious incidents between 1 June 2016 and 31 May 2017. The category with the highest number of incidents was apparent/actual/suspected self-inflicted harm, 93%.

Are services effective?

Requires improvement

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

Our findings

Assessment of needs and planning of care

- Care plans varied in quality, style, and content. There was little evidence that patients were involved in care planning, staff wrote the majority as instructions for patients. Care plans were not holistic and we found numerous examples of care plans constituting or containing a set form of words. At Carrick, seven of the 12 care records reviewed did not contain any care plans and a further three were out of date. The trust produced reports regarding care plans; staff displayed these in some of the offices highlighting large gaps in care planning.
- Clinical practice across all six integrated community mental health teams was inconsistent. For example, progress notes for patients receiving depots for anti-psychotic medicine had no associated health checks documented. Integrated community mental health team staff prescribed the anti-psychotic medicine, carried out the majority of depots injections, and carried out associated blood test such as for clozapine.
- We saw evidence that staff sent blood tests to GPs for processing, but found no evidence of staff carrying out physical health checks. We saw National Early Warning Score (NEWS) assessments in a small minority of patient care records; staff had completed some of these during the patient's admission onto a ward. The trust had identified prior to the inspection that all six integrated community health teams had a different approach to monitoring physical health care. However, we did not see evidence of how the trust planned to address these inconsistencies.

Best practice in treatment and care

- The trust saw psychological therapies as a priority as they had introduced a new enabling and rehabilitation ethos across the integrated community mental health teams. However, there were vacancies in psychology staff across the teams. The trust told us the waiting list average for psychology was 31 days. However, the individual lists for psychology varied by integrated community mental health teams, with Bolitho stating up to 18 months and Trengweath stating waiting times of 6-12 months.
- Community psychiatric nurses had received training in different therapeutic interventions. For example, essential life skills, cognitive analytic therapy, and EMDR (eye movement desensitization and reprocessing). This helped support patients with immediate emotional needs.
- Communication between GP's and all six integrated community mental health teams was not robust. For example, staff requested feedback of patient physical health checks and when they reviewed the shared database GPs had not entered the information. We also saw examples of concerned staff making GP appointments and taking patients to their appointments.
- Prior to the inspection the trust provided details of four national and local audits (including clinical audits) undertaken by integrated community mental health teams over the past 12 months. These included safer sharps audit, service evaluation, and Health of the Nation Outcome Scales (HoNOS), psychological therapies within the early intervention in psychosis team and triage pathway.
- Staff across all six teams told us pharmacy completed a medicine management audit and they believed there was an infection control audit, but staff did not know who completed this or where the information was kept. We did not see any care planning and risk assessment audits and staff did not receive any feedback from managers regarding the outcomes of any audits carried out.

Skilled staff to deliver care

- The teams included registered nurses, psychiatrists, social workers, occupational therapists, support workers, and administrative staff. Staff vacancies affected the effective running of the service. For example, there were large caseloads, unallocated patients, increasing psychology, and doctor waiting lists.
- The trust had introduced a new clinical pathway, called a low intensity pathway (LI) with the aim to manage caseloads. There was clear criteria for patients to access this pathway; it included patients who were stable on their medication and on a care programme approach. The pathway included access to groups and a social skills course. Support workers managed the pathway. The trust had transferred patients onto the pathway

Are services effective?

Requires improvement

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

away from community psychiatric nurse caseloads. However, support workers felt the trust had not provided appropriate training for them to deliver the new pathway with confidence. We reviewed the low intensity policy which did not outline how the trust was going to support or train staff to deliver the pathway, it also did not inform staff how or when to escalate risks.

- The trust provided appraisal data from 1 April 2017 to 30 June 2017. The integrated community mental health teams had achieved was 71% against the trust target of 85%. All appraisals reviewed were thorough. Managers were using pre-appraisal checklists, which included issues such as current DBS and professional registration.
- The trust was unable to provide supervision data due to inconsistencies with the data available. The integrated community mental health teams Bolithio had recently introduced a new clinical supervision process in response to caseload and staffing concerns. This involved monthly clinical supervision with a B7 clinical lead or manager. We saw documented example within personnel files of staff reviewing each patient and a 'case load performance grid' highlighting patients for discharge or actions to be taken. However, the trust had not introduced this approach in any of the other integrated community mental health teams. We reviewed 14 files across the other teams and six staff had not received supervision at all in 2017.

Multi-disciplinary (MDT) and inter-agency team work

- All teams had weekly multi-disciplinary meetings. The multi-disciplinary meetings assessed all admissions into the service and all complex discharges. Several staff in Truro integrated community mental health team said that the multi-disciplinary meeting process needed greater consultant psychiatrist input.
- Partnership working between the integrated community mental health teams and GPs was not robust. We saw documented evidence that several of the integrated community mental health teams and GPs were not engaging in a positive shared care partnership even though the trust had a shared care agreement in place. For example, the agreement for the use of lithium had no written process to ensure that the shared care was being carried out effectively. We also saw no communication from GPs regarding physical health checks on patient's records.

Adherence to the MHA and the MHA Code of Practice

- As at 31 May 2017, 86% of staff was up to date with their Mental Health Act - legislation & policy training. The trust target for this mandatory training course is 85%. All doctors over ST4 were Section 12 trained and approved within the integrated community mental health teams.

Good practice in applying the MCA

- Mental Capacity Act training is encompassed within the e-stat and the e-essential e-learning packages delivered by the trust. The majority of staff told us they felt they understood MCA. However, not all staff felt confident in applying it practice; this was raised across several integrated community mental health teams.

Good

Are services caring?

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

Our findings

Kindness, dignity, respect and support

- During our inspection, we observed one assessment visit, several community psychiatric nurse, and patient contacts, some of which were held in the day resource centres, a Doctor, patient consultation. At all time's staff treated patients with dignity, respect, and courtesy.
- We spoke with 12 patients across all six integrated community mental health teams who told us the care and treatment they received from staff was consistently positive. Patients described community staff as caring, compassionate, kind, respectful, understanding, supportive, helpful, and encouraging. Patients also said staff listened to them and they felt safe when they had regular contact and care.
- When staff spoke to us about patients, they showed understanding of their needs and circumstances. We observed multi-disciplinary meetings where staff showed consideration, and sought consent from the patient. These meetings reflected the wishes and views of the patients they were discussing, and patients confirmed this when we spoke with them.
- We reviewed 17 patient comment cards. Patients gave examples of staff listening to them and supporting them. This included when patients found one of the 'essential life skills' course challenging and a staff member planned support sessions prior to the meetings to help the patient's recovery and progress. Another patient gave a similar example where they raised their concerns about attending group sessions; they told us staff supported them to attend without judgement.
- Staff described the importance of confidentiality. For example, the trust gave patients living on the Isle of Scilly's a subsidised £5 return airline ticket to travel to the mainland rather than have a home visit. This was because confidentiality was difficult to maintain in an established small community.

The involvement of people in the care they receive

- Patients we spoke with knew what a care plan was and believed they had one. The patients' knowledge of their care plans varied across all six teams, one felt they needed to know more about them, two other patients told us their care co-ordinator knew about their care plan and one patient told us they had a copy and were involved in the decision making process.
- Staff used a printed copy of the electronic care plan. This was not user friendly, the trust were aware that the printed version was not helpful or usable for patients. However, there was no evidence that the trust was addressing this at the time of the inspection.
- Patients gave us examples of when the trust had asked them to complete feedback forms on the service. Staff across all six teams had also carried out 360-degree reviews seeking patient feedback. Patients also take part in the friends and family test. The trust kept any action plans from the results centrally and shared them locally. However, patients told us they did not see any outcome from the feedback and they had not been involved in any of the service development that was taking place.

Are services responsive to people's needs?

Good

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

Our findings

Access and discharge

- Integrated community mental health teams are accessible through a recently created assessment team. They accept referrals from GPs between 9.00am - 5pm, Monday to Friday. The service received 2590 referrals from April 2017 to August 2017.
- The trust told us there 'were no targets for referral to treatment within this core service'. However, two managers were able to demonstrate that the service had targets of five days to assessment (urgent) and 28 days (non-urgent). In North Cornwall since the introduction of the new assessment team all their urgent assessments were being done in five days and they were carrying out all non-urgent assessments within 14 day and in St Austell all assessment were completed in 17 days. Other managers and clinical leads were unaware that data was available on time to assessment.
- The new assessment team manage all referrals into the service. There was a new 'assessment team operating procedure' in place. Part of the assessment teams role was to carry out, mental state exam on the core assessment, risk assessment, cluster assessment, immediate risk plan. Staff reviewed all assessments in the multi-disciplinary team meetings. However, due to staff vacancies there was a waiting list of 191 unallocated patients across the six teams. One team had to use the escalation policy and rated them self 'red', one-step under major incident.
- The teams approach to managing contact with the patients that were unallocated varied. All patients received a letter with details of how to contact the service in an emergency. North Cornwall staff also telephoned patients on the unallocated list every two weeks. In other areas, patients would have to wait until allocated to receive any further contact from the service.
- Managers had discussed referrals with GPs via 'hub' meetings. A recent review of referrals indicated that 3% of referrals staff triaged were not appropriate for the service and a further 40% were signposted to other services post assessments.
- The trust was in the process of ratifying a new operational policy. However, due to operational pressures, steps staff had already implemented the recommended changes about access and delivery of the service. For example, introducing an upper age limit of 75 and negotiating further reduction to 70. However, patients and staff had not been involved in this development.
- Several staff and doctors told us consultant psychiatrists had increasing waiting lists for appointments; for example, North Cornwall had a waiting list of 57 patients.
- The recent focus on clinical supervision aimed to improve discharge rates across the service. 'Green Cards' had been introduced, a system where patients that had been discharged could access the service directly for three months post discharge. The service had also been reviewing every 'complex' discharge during multi-disciplinary meetings. Managers told us patients were finding this process difficult and one area had set up PALS 'drop-ins' for patients.
- The service had introduced a new pathway to support discharge into the community. The low intensity pathway was to support stable patients and those with lower risks to transition to discharge. This pathway was new, some the integrated community mental health teams were still adjusting to the new protocol.
- The service had introduced a text alert system to help patients remember to access the system and attend appointments.
- The trust told us that waiting times for psychotherapy was 31 days. However, we identified that there were several unfilled vacancies across the six teams. For example, Truro had a B7 vacancy and their B8 was leaving the service. North Cornwall did not have any vacancies. Truro integrated community mental health team had a waiting list of up to 18 months to access psychology. In response, the trust planned to; discharge them to the low intensity caseload. In addition, to address the shortfall the trust had trained five full time community psychiatric nurses to deliver cognitive behaviour therapy. This meant care co-ordinators were able to offer some therapeutic interventions. The trust also trained several care co- in different therapy techniques, these included cognitive analytic therapy, and EMDR (eye movement desensitization and reprocessing).

Are services responsive to people's needs?

Good

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

Provision of accessible information on treatments, local services, patients' rights, how to complain etc.

- All clinical areas were on the lower floors. They were wheelchair accessible, and had adapted disabled toilets. The service had access to translators; we reviewed one example where staff had asked a patient to support a patient who was struggling with English.
- All waiting areas seen had a good variety of information about the service, complaints, PALS, groups, and a variety of information signposting access to other services.
- Two of the integrated community mental health teams, Truro, and Bolitho used CCTV in their interview and clinical rooms. The trust had CCTV stations fitted in the main reception areas where visitors could not access. Staff and contractors could see the CCTV. However, we saw no signs alerting patients to the presence of CCTV recording. Staff recorded the CCTV routinely and not based on risk.

Listening to and learning from concerns and complaints

- The trust reported 41 complaints across the integrated community mental health teams in the last 12 months, June 2016 to May 2017. This accounted for 38% of the total number of complaints across the whole trust. The trust upheld fully, two of the complaints, 11 were partially upheld, 16 were not upheld, and 12 are still under investigation. Managers told us they were receiving an increased number of concerns due to the new access criteria, the new low intensity pathway, and increased levels of discharge.
- The trust kept comprehensive spreadsheets of complaints and concerns to track contact and progress. All six teams were proactive in recording concerns as well as complaints. Managers felt the PALS service supported them well in tracking and investigating complaints. The trust had trained all managers in dealing with complaints. We saw evidence of a PALS drop-in session in response to increased concerns in the Bolitho integrated community mental health team. We saw evidence of learning from a complaint regarding staff sharing confidentiality across the teams.
- We also saw a complaint against the Trengweath integrated community mental health team involving carers, the patient had not given consent to share information with them. Because of this complaint, the team changed their approach to listening to carers and family. For example, the policy had changed to ensure that, even if staff could not provide any information, they could listen and record the families feeling on the patients' presentation and risk.
- There were 52 compliments for the integrated community mental health team in the last 12 months, June 2016 – May 2017. Reception staff at Bolitho House had also received an excellence award under the internal compliment scheme for being helpful and friendly.

Are services well-led?

Requires improvement

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

Our findings

Leadership, morale and staff engagement

- Leadership was not robust. The constant change of management structure across all six integrated community mental health teams by its senior management team was affecting the quality of the service and staff morale. Initially the service had reduced the number of B7 managers from six to three. The rationale was to align the management structure with the acute community adult service following the April 2017 merger. Staff, including a senior clinician, told us they had raised the potential impact of these changes up to CEO level.
- Following serious concerns with the new model and B7 managers being unable to support the delivery of the service, the trust appointed six temporary B7 clinical leads. However, at the time of the inspection the trust was in the process of appointing three temporary B7 managers that will replace the six B7 clinical leads. The three new appointments are temporary and the service is subject to another management review within the next six months.
- Managers told us they found it difficult to spread themselves over the two teams. In some areas, the clinical leads were acting as managers. During the inspection, some clinical leads could not answer questions relating to the management of the service this had an impact on how the service monitored quality and assurance at a local level. This included a range of indicators such as; the monitoring of follow up appointments for patients who had been discharged from an acute in-patient unit within the last seven days, staff training, appraisals, supervision and incidents. Clinical leads, also, could not evidence what clinical audits staff had completed across all six integrated community mental health team.
- Staff morale was low across all six integrated community mental health teams. For example, high vacancy levels meant that staff had to pick up the additional caseload. Managers carried an awareness of the stress on the team and the shortages. The trust reported that nurse posts are not easy to fill and that staff supported each other. Restormal integrated community mental health team reported Insufficient training, specifically specialist training such as cognitive behavioural therapy and cognitive analytical therapy. Staff told us this training was no longer available. However, the trust did provide emotional coping skills training but staff reported that they did not have time to attend.
- We spoke with the full range of staff involved in the new low intensity support programme. The trust had not provided training for staff to deliver this programme and staff felt they did not have the correct skills. For example, some patients were receiving regular depot injections and manager had told support workers they would be monitoring this. Staff felt unconfident about delivering good care within this programme.
- Changes had occurred over the last two years, and morale was low. However, the trust did make adjustments when new initiatives introduced did not work well. The trust did not report any instances of bullying or harassment and staff confirmed this was not an issue for them.

Vision and values

- Staff said they were aware of the trust's values. However, managers had not displayed them in any of the integrated community mental health teams we inspected. Staff told us they knew who the senior managers were in the trust, but they said they rarely visited the premises and felt disconnected from the wider trust. However, staff had regular contact with their immediate managers. They reported that immediate managers supported them to carry out their roles. All staff said they felt able to raise concerns with their managers.

Good governance

- Governance arrangements were not robust locally to support the quality, performance, and risk management of the services. There were three managers covering six services. Managers told us they could not maintain clear oversight of all six integrated community mental health teams.
- Attendance of mandatory training was low. In some subjects such as safeguarding, a very small number of staff had completed training. There were no robust

Are services well-led?

Requires improvement

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.

arrangements in place to monitor mandatory training amongst the teams we inspected and managers had not completed action plans to address the poor take up within the teams.

- The trust was unable to provide any data on staff supervision. Records across all integrated community mental health team demonstrated managers did not carry out supervision four to six weekly. There was a lack of consistency in the standard of supervision targets and notes taken during supervision. Some staff had never had supervision and managers could not advise why no supervision had occurred.
- Team managers held information about staff sickness and absence rates and were able to show us how they were tackling these with support from the HR department. Staff we spoke with told us how the various absences were affecting them. Between 01 June 2016 and 19 June 2017, there were six cases where staff were either suspended or placed under supervision within this core service. Records demonstrated managers managed poor performance appropriately.

Commitment to quality improvement and innovation

- The trust provided details on their participation in national service accreditation and peer-review schemes. However, there were no schemes specific to the integrated community mental health teams.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures Nursing care Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care The provider did not always work collaboratively with patients to ensure their preferences are taken account of when creating care plans.

Regulated activity	Regulation
Diagnostic and screening procedures Nursing care Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The provider did not always assess the risks to the health and safety of patients of receiving the care or treatment. The provider did not always ensure that the equipment used for patient care was safe for such use. The provider did not ensure robust procedures were in place to monitor the physical health of high risk patients. The provider did not provider proper and safe management of medicines.

Regulated activity	Regulation
Diagnostic and screening procedures Nursing care Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider did not have robust management oversight to ensure they were operating a safe service.

Regulated activity	Regulation

This section is primarily information for the provider

Requirement notices

Diagnostic and screening procedures

Nursing care

Treatment of disease, disorder or injury

Regulation 18 HSCA (RA) Regulations 2014 Staffing

The provider did not ensure sufficient numbers of suitably qualified, competent, skilled and experienced staff were available to meet the requirements of patients.

The provider did not ensure staff employed received appropriate training, professional development and supervision necessary to enable them to carry out the duties they are employed to perform.