Good

Cornwall Partnership NHS Foundation Trust

Community-based mental health services for adults of working age

Quality Report

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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 HQ	ICMHT Caradon	PL14 4EN
RJ8X7	Trust HQ	ICMHT Kerrier	TR15 25P
RJ8X7	Trust HQ	ICMHT Penwith	TR18 2AB
RJ8X7	Trust HQ	ICMHT Restormal	PL25 4QN
RJ8X7	Trust HQ	ICMHT N Cornwall	PL31 2QT
RJ8X7	Trust HQ	Roswyth day resource centre (DRC)	TR7 1BA
RJ8X7	Trust HQ	Fountain House DRC	PL25 4SZ

Summary of findings

RJ8X7	Trust HQ	Trelil Court DRC	PL31 2JW
RJ8X7	Trust HQ	Elfordleigh DRC	PL15 8HW
RJ8X7	Trust HQ	Boundervean DRC	TR14 7QE
RJ8X7	Trust HQ	Richmond House DRC	TR18 2AB

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	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive?	Good
Are 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

Contents

Summary of findings

Overall summary

We rated community based mental health services for adults **good** because;

- We found staff understood the local safeguarding procedures, what their responsibilities were and how they could raise concerns.
- ICMHTs had well established and clear referral routes to the mental health wellbeing services (BeMe team), for patients requiring short term interventions and who would not be referred onto the ICMHT caseload.
- Staff we observed demonstrated compassion and genuine feeling about the patients who they supported. We saw examples of staff being respectful, empathic and providing emotional support in the ICMHTs and the DRCs at every location we went to.
- We saw specific projects aimed at improving the services for patients. 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 the 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.

However:

- Staff within the teams told us their case loads 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
- We did not see and the manager was unable to provide any evidence of patient involvement in the evaluation of the DRCs core programme.
- In the DRCs we noted there was limited room for any disabled patients, no accessible toilets and wheelchair access was very limited throughout. Space was limited in each building with sessions often being run in upstairs rooms with no lift access. Staff told us they would make adjustments to accommodate individual patient's needs, and we saw a copy of the environmental risk assessments, but we did not see any specific evidence of how the centres were assessed to comply with the Equalities Act 2010

Summary of findings

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

Are services safe?

Good

We rated safe as **good** because;

- We found the risk assessments were comprehensive and holistic in each ICMHT. The risk records completed at the initial triage stage included the persons' risks to themselves and others. It also indicated if they were vulnerable due to their mental health needs.
- We found staff understood the local safeguarding procedures, what their responsibilities were and how they could raise concerns.
- The ICMHTs had suitable arrangements in place for the management of medicines (none were stored in the DRCs). This included the receipt, storage, administration and recording of medicines.

However:

- In all the ICMHTs we visited staffing levels were below the establishment set by the trust. This gap ranged from between two to four qualified staff in each team. This was through a combination of unfilled vacancies and/or a mix of short and long term sickness absence. All of the team managers we met were working to address the situations through short term cover. They showed us how longer term recruitment plans were in the process of being addressed in collaboration with the HR department.
- The DRCs we visited all varied in terms of cleanliness and the standard of furniture and fittings. At Penzance, the toilets were unclean with much of the furniture and carpets in need of replacement. We were told by the manager there was a planned programme of improvements, but no date had been set for its implementation.
- Staff within the teams told us their case loads 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

Are services effective?

Good

We rated effective as **good** because;

Summary of findings

- The Trust had introduced 5 day training on psychological therapies, as part of its mandatory training for community nursing staff.
- At the Trelil court DRC 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.
- ICMHTs had well established and clear referral routes to the mental health wellbeing services (BeMe team), which was for patients requiring short term interventions and who would not be referred onto the ICMHT caseload.
- Care plans were developed with the patient to meet their identified needs under the framework of the care programme approach.

However:

- In the DRCs 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. This meant staff had to rely on their knowledge of the patient rather than up to date information, to inform the type of care they were given.

Are services caring?

Good

We rated caring as **good** because;

- Staff we observed demonstrated compassion and genuine feeling about the patients they supported. We saw examples of staff being respectful, empathic and providing emotional support in the ICMHTs and the DRCs at every location we went to.
- Each team undertook surveys to seek the views of all patients who used the service. They used an electronic system, and we were able to review a sample which showed a majority of patients felt they received a good service.
- At the Caradon ICMHT we met a lead practitioner who had undertaken some specific county wide work on carers involvement. This had resulted in each ICMHT having a designated carers lead.

However:

- We did not see and the manager was unable to provide any evidence of patient involvement in the evaluation of the DRCs core programme.

Summary of findings

Are services responsive to people's needs?

Good

We rated responsive as **good** because;

- Each ICMHT had a system in place which ensured all new referrals were placed via a single point of access. The teams triaged each new referral based upon the information they received and assessed if further support was required.
- Reception areas in ICMHTs had clear and concise notice boards giving a range of information such as local self-help groups, advocacy services, treatment and advice, patients' rights and how to complain
- Team managers told us they encouraged staff to be proactive when dealing with patients raising issues. An example of this was in ICMHT Kerrier, where a music system had been placed in the waiting area by the administrator, following patient feedback to her.

However:

- The trust had introduced a new model for the DRCs in 2014 along with an operational policy which was ratified on 8 January 2014. This indicated that all patients would be in receipt of CPA. We found in each DRC they were operating a limited group programme for these patients, with an open access facility for all others not on the CPA. Whilst the group programme had clear timescales for completion, there was no care pathway for patients attending open access.
- In the DRCs we noted there was little room for any disabled patients, no specific toilets and wheelchair access was very limited throughout. Space was limited in each building with sessions often being run in upstairs rooms with no lift access. Although staff told us they would make adjustments to accommodate individual patient's needs, we did not see evidence of how the centres complied with The Equalities Act 2010.

Are services well-led?

Good

We rated well led as **good** because;

- Team managers told us they felt their line manager knew the local issues within each team which was through a combination of information sharing, managerial supervision, weekly conference calls and being accessible to staff. They also attended monthly community managers meeting which looked in detail at governance issues and performance feedback from the trust.

Summary of findings

- The trust had an electronic reporting system which enabled team and senior managers to monitor quality and assurance at a local level.
- Patients using the service were given the opportunity to participate in a satisfaction survey in addition to informally feeding back their experiences at care planning meetings. In ICMHT Penwith, we saw how the team used a volunteer to help patients complete the survey with access to an IPad.

However:

- Staff we spoke with in the DRCs told us they felt supported by their manager, but her large geographical area of cover made it difficult to provide regular face to face support. They also reported feeling uncertain about the longer term vision for the DRCs.
- There were local risk registers but managers we spoke with were unable to tell us how these had influenced the trust wide risk register.

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 with no upper age limit.

The 6 integrated community mental health teams (ICMHTs) provide multi-disciplinary assessment and if appropriate treatment, throughout Cornwall. They are made up of consultant psychiatrists, psychiatric nurses, social workers, approved mental health professionals (AMHP), support workers, occupational therapists and psychologists. Each team provide a range of treatments, interventions, advice and assistance to patients. The ICMHTs are divided into three parts –

• support and recovery - provide longer term care and support to people with a psychotic disorder and people who previously would have been supported by the assertive outreach team.

• brief treatment - provide care and treatment for up to 12 months.

• clinical support – staff who are band 3 and 4 and will support patients across both teams as required.

The service is for patients who have severe and persistent mental health problems and come under the framework of the care programme approach. Any patients who are assessed as not meeting these criteria are referred onto the "Be Me" team. Be Me is a mental wellbeing service for people with emotional or psychological difficulties, providing short term.

There are 10 adult community day resource centres (DRC) which support ICMHT's by providing care to patients within specific geographical locations. Each resource centre works closely with its relevant ICMHT and receives all new referrals via the weekly ICMHT allocation meeting.

An assessment is completed following referral to determine the level of need and subsequent interventions. Consultant psychiatrists retain medical responsibility for patients across the care pathway in the ICMHT, in-patient facilities and the crisis teams.

The teams were inspected by the care quality commission in 2013.

Our inspection team

Our inspection team was led by:

Chair: Mike Hutt, Independent Consultant

Head of Inspection: Pauline Carpenter, Head of Hospital Inspection, CQC.

Team Leader: Serena Allen, Inspection Manager, CQC.

The team which inspected adult community services included CQC inspectors, mental health social worker, registered mental health nurses, consultant psychiatrist, occupational therapist and an expert by experience

Why we carried out this inspection

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

Summary of findings

How we carried out this inspection

To get to the heart of patients experience of care, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to patients' 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. We carried out an announced visit on 13 – 17 April 2015.

During this inspection we visited five ICMHT's (integrated community mental health teams), six DRC's (day resource centres), spoke with 32 patients who used the service. We spoke with 30

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. We looked at 28 care records.

We attended three care programme approach meetings, two assessments of new patients, three multi-disciplinary planning meetings, two team meetings, observed two groups and three home visits.

We looked at a range of policies, procedures and other documents relating to the running of the services.

What people who use the provider's services say

We spoke with 32 patients who used the service. They told us staff were respectful towards them, kept them informed and involved in planning care, and staff had provided good care and had responded quickly to changing need.

Some patients said getting inpatient care close to home was not always possible, and sometimes they had to go out of the immediate area. They told us it was difficult when they were out of the area as they had limited access to family and friends.

We saw staff interacted well with patients and used an empathic approach.

Good practice

- All the ICHMT staff we spoke with told us how they had appreciated the 5 day training on psychological therapies, which the trust had introduced as part of its mandatory training for community nursing staff.
- At the Trelil Court DRC 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. 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 the 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.

Summary of findings

Areas for improvement

Action the provider SHOULD take to improve

- The trust should ensure caseloads of all ICMHTs are managed to ensure they maintain effective services.
- The trust should develop a long term recruitment strategy for ICMHTs.
- Privacy and security should be reviewed in the interview rooms.
- There should be an evaluation of the current model of the day resource centres to assess how it meets the needs of all patients.

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
ICMHT Caradon	Trust HQ
ICMHT Kerrier	
ICMHT Penwith	
ICMHT Restormal	
ICMHT N Cornwall	
Roswyth day resource centre (DRC)	
Fountain House DRC	
Trelil Court DRC	
Elfordleigh DRC	
Boundervean DRC	
Richmond House DRC	

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.

- We reviewed a sample of 6 care plans in relation to patients subject to community treatment orders (CTO). These were found 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.
- We were unable to speak to anyone subject to a CTO but attempts to facilitate this were made by care coordinators.
- When someone required a Mental Health Act assessment, it was arranged through the duty team. We spoke to a care coordinator, who was an AMHP. They told us that, although the service was under pressure, they were not aware of any assessments being missed. They did report there were often delays in completing an assessment due to problems accessing a local bed, because of high occupancy levels across the trust.
- Staff we met had a good understanding of the MHA, but managers acknowledged they were still in the process of learning about the recent changes to the Code of Practice, in order to pass this onto their staff.

Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff we spoke with in the ICMHTs said they were familiar with obtaining a person's consent. If required they would seek clarification from relatives and/or their representatives to support decision making. This was evidenced by the records we saw. However, in the DRCs staff we spoke with were less clear, and told us they thought this would have been dealt with prior to attendance, as part of the assessment process. Patients had access to an independent mental capacity advocate as part of the CPA process.
- Training in the Mental Capacity Act 2005 (MCA) was not mandatory in the trust. Some staff told us they had received training in the use of the MCA. Although it was not clear whether agency staff had received MCA training as records for completion of this training were not available. The one agency nurse we spoke with told us he had received his training in this subject from another provider.

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 see summary at beginning of report.

Our findings

Safe and clean environment

- Access into the integrated community mental health team (ICMHT) bases for appointments and clinics was through a staffed reception with identified waiting areas.
- We saw the ICMHT environments were generally well maintained. Call alarms were in place in all interview rooms with a direct line to the local police station. CCTV coverage was in place in some interview rooms and all public areas. We noted ligature risks and inward opening doors in each interview room we saw. Managers showed us how they had risk assessed these and no patient would be left alone in these rooms.
- The DRCs we visited all varied in terms of cleanliness and the standard of furniture and fittings. At Penzance, the toilets were unclean with much of the furniture and carpets in need of replacement. We were told by the manager there was a planned programme of improvements, but no date had been set for its implementation.
- We saw each ICMHT base was equipped with clinic rooms where there was the necessary equipment to carry out physical examinations, and these were regularly maintained.

Safe staffing

- In all the ICMHTs we visited staffing levels were below the establishment set by the trust. This gap ranged from between two to four qualified staff in each team. This was through a combination of unfilled vacancies and/or a mix of short and long term sickness absence. All of the team managers we met were working to address the situations through short term cover. They showed us how longer term recruitment plans were in the process of being addressed in collaboration with the HR department.
- Bank and agency staff were being used to cover qualified posts. In the North Cornwall ICMHT the manager showed us how she had successfully used the trust escalation policy to bring in extra staff to address the shortfall.
- Staff within the teams told us their case loads over the last twelve months were between 45-55 and had been in excess of this in some cases. Staff attributed this to a wide range of demands on the teams, such as increasing referral rates and the direct impact of low staffing levels. Team managers showed us the systems they had developed to monitor and manage caseloads, which verified these figures.
- Each ICMHT had access to consultant psychiatrists and each team had its own approved mental health professionals (AMHP).
- The day resource centres (DRC) were staffed by two unregistered staff per day. There was one part time band 6 vacancy across the service that covered two DRC. The band 7 RMN manages the whole DRC service, but local management is with the local band 6's.
- Managers told us mandatory training required by the trust was usually undertaken during the autumn period. We saw the training records kept by the managers which showed us this was correct. Attendance at mandatory and other training opportunities was monitored through the trust's training department and managers and staff would be informed by email. Compliance with e-statutory training was 100% and e-essential was 99% for the whole team.

Assessing and managing risk to patients and staff

- We reviewed a sample of at least four records in each ICMHT, and saw needs and risks were assessed and clearly documented. Care plans were up to date and

Good

Are services safe?

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

reflected current individual risks and relevant historical information. However, in the DRC's we visited, we noted not all patients attending the "open access" sessions had an up to date risk management plan.

- Overall, we found the risk assessments were comprehensive and holistic. The risk records completed at the initial triage stage included the persons' risks to themselves and others. It also indicated if they were vulnerable due to their mental health needs. Where a risk had been identified, we found good evidence that management plans, including relapse prevention plans, had been developed. We saw evidence of the person and their family being involved in the development of these plans.
- We saw some evidence of crisis plans being used, but these were mainly used for patients being treated under the support and recovery function of the ICMHT.
- Staff told us about their regular caseload management supervision, where they could discuss in more detail strategies for managing risk. However, anyone on the waiting list other than for an urgent 5 day appointment was not routinely monitored for changes in risk. We were told this was undertaken by their GP.
- Staff were aware of the trust's lone worker policy. In each ICMHT staff told us they followed this and were confident in getting a swift response. Each base had a record of staff whereabouts and a message system was available via the switchboard to call for support.
- We saw there was a protocol for joint visits to be undertaken by staff when risks were identified, and these were supported by clear risk assessments.
- We saw training records which showed 65% of staff had received up to date training on safeguarding adults and children. Managers explained to us the gaps in training were brought about through staff missing annual sessions through either absence or service need. These were being addressed through supervision with extra training dates arranged for May 2015. Staff confirmed that they had attended training but told us the programme was in the process of being changed to become more streamlined. In each ICMHT there were designated leads for safeguarding and we saw clear communication systems and flow charts.
- All staff we spoke with demonstrated a good knowledge on how and where to report safeguarding issues. We saw evidence of how safeguarding concerns were discussed during team meetings. There were a variety of current safeguarding issues at the time of inspection, and these were being managed appropriately.
- The ICMHTs had suitable arrangements in place for the management of medicines (none were stored in the DRCs). This included the receipt, storage, administration and recording of medicines. In the base of North Cornwall ICMHT, we saw how the fridge had been labelled as out of action due to high temperature by the pharmacist. The team manager showed us the alternative arrangements they had negotiated with other areas for the safe storage of their medicines.

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 they were not always told of historical incidents.
- Safety incidents which had occurred resulted in an investigation taking place including sharing of lessons learnt. These were undertaken by another team manager and were reported to the monthly managers meeting. We saw the minutes and associated reports for these meetings, along with how they had been communicated back to the ICMHT business meetings. An example had been making improvements to communications between ICMHT's and the home treatment team when working out of normal hours.

Reporting incidents and learning from when things go wrong

- All the staff we spoke with knew how to report incidents on the trust wide system. We were told this information was given to them by team managers during monthly team business meetings and were shown minutes of these meetings which confirmed this.

Good

Are services safe?

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- The ICMHT team managers showed us how they used the trust's management information system and local risk registers to identify and monitor risks. This included systems to report and record concerns and near misses.
- We saw the local monthly incident reports which were reviewed and discussed during the area monthly management team meeting. These meetings outlined the impact to the local service, any underlying causes as well as the local managers' comments.
- An example of a change which had been implemented following an incident had been to establish clear access protocols for patients moving between teams along the acute care pathway.
- Staff we spoke with told us they felt supported by their line managers following any incidents. They told us how debriefing was well organised and they could access psychological support from within each team.

Are services effective?

Good

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

Summary of findings

Please see summary at beginning of report.

Our findings

Assessment of needs and planning of care

- We looked at 28 care records across the five ICMHTs. We found each patient had a comprehensive assessment completed as part of the initial assessment process which included social, occupational, cultural, and physical needs.
- The care records contained comprehensive information, and showed us patients physical healthcare needs were assessed and addressed in partnership with the person's GP.
- Care plans were developed with the patient to meet their identified needs under the framework of the care programme approach. Patients were offered a copy of their care plan and this was confirmed by the patients we spoke with. They also told us they had access to emergency numbers to enable them to access advice and support when required.
- In the DRCs 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. This meant staff had to rely on their knowledge of the patient rather than up to date information, to inform the type of care they were given.
- Care records were held on a secure trust wide computer system with the teams operating a "paper light" approach. There were some paper records held but these only contained letters or non-urgent clinical information. These were stored in locked cabinets within staff only areas.

Best practice in treatment and care

- We found evidence which demonstrated the teams had implemented best practice guidance within their clinical practice.An example of this was psychological therapies programme which had been developed by the Psychological Therapy Lead for use in both the DRC and the whole community service.
- All the teams we visited provided a range of therapeutic interventions to support patient's recovery. These included both group and individual interventions. We also saw support specifically for clients over 65 in response to the service not having any upper age limit.
- All the ICHMT staff we spoke with told us how they had appreciated the five day training on psychological therapies, which the trust had introduced as part of its mandatory training for all staff.
- At the Trelil Court DRC 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 found teams ensured the physical health care needs of long term patients were assessed and this was confirmed by staff and patients we spoke with. We found the team's consultants retained responsibility for patients prescribed high dose anti-psychotic medication, in line with best practice, rather than care being transferred to the GP.
- Staff assessed patients using the Health of the Nation Outcome Scales. These covered 12 health and social domains and enabled the clinicians to build up a picture over time of their patients' responses to interventions. Team managers told us this was mainly used to inform that the right clustering of patients were coming into the team, to ensure they could deliver the commissioners contract specification.
- Teams participated in limited clinical audits and fed this information back through the team meetings, as well as through the trust performance reporting system. An example we saw was from the ICMHTs who were reviewing care records to look at the quality of record keeping.

Skilled staff to deliver care

- The ICMHTs were made up of staff which included; community mental health nurses, support workers, social workers and approved mental health professionals (AMHPs), psychologists, occupational therapists, administrative support, consultant psychiatrists and more junior doctors. Staff told us that they had good working relationships with pharmacists who attended on a weekly basis, and could access

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specialist help such as physiotherapy or speech and language therapy if required. The ICMHTs were an integrated health and social care model, but the AMHPs were seconded from Cornwall county council.

- Managers showed us the comprehensive induction programme in place for new staff. However, we were unable to speak to any new permanent staff to ask if they felt this had been effective. We were able to speak to an agency nurse in one ICMHT who told us they had received a very effective local induction which enabled them to carry a small caseload of patients.
- We saw supervision records and systems which showed us staff had received regular supervision with the exception of North Cornwall ICMHT. This had been caused by the absence of a manager but was now being addressed by the new one. Staff we spoke with told us that supervision sessions did sometimes get cancelled due to work pressures and having to cover sudden absence. Staff confirmed they had received an appraisal in the last year, and these were used to identify individual training needs.
- Staff told us they were supported by their managers and had access to a range of training to help meet the needs of patients they worked with. In ICMHT Kerrier we saw how each lunchtime a 10 minute "mindfulness" session was run by the team psychologist for staff, to assist them with their own mental wellbeing.
- There were systems in place to monitor the performance within each team which managers used for reporting. They showed us evidence of how they disseminated this information at their monthly team meetings. The team managers told us they also monitored performance and quality through individual supervision, and felt supported by the HR department when they had to address staff performance issues.

Multi-disciplinary and inter-agency team work

- We attended three care programme approach meetings, two assessments of new patients, and a team meeting. These were all well planned and organised. At daily team meetings patients receiving care where a higher risk was identified were discussed, along with new referrals for assessment. We saw staff worked well with other specialities and therapy services to provide good multi-disciplinary care. We also saw from records that patients were able to access voluntary organisations to support their needs in the community.
- We observed appropriate sharing of information to ensure continuity and safety of care across teams, including involvement of external agencies such as the local safeguarding team.
- In each team we were told by staff how much they appreciated having a range of disciplines. In particular we were told about the contribution of the psychologists. They were able to provide staff with a range of support and learning, plus they provided specific interventions for patients using the service, such as cognitive and dialectical behavioural therapy
- Staff reported that the relationships with GP surgeries across the teams were generally good. Each consultant psychiatrist met a cluster of GPs from within their catchment area every three months, to resolve issues. Staff felt there were, at times, inappropriate referrals to the teams, but said they thought this was caused by a lack of understanding about the role of ICMHTs.
- Each team allocated duty staff to work each day on a rota basis. This role was to support care coordinators in their roles, contribute to urgent assessments and enable patients to be treated in a timely manner to cover any unresolved absence. We also saw draft guidance and protocols for accessing and working with home treatment teams, who could provide support out of normal working hours.
- ICMHTs had well established and clear referral routes to the mental health wellbeing services (BeMe team), which was for patients requiring short term interventions and who would not be referred onto the ICMHT caseload.

Adherence to the Mental Health Act and the Mental Health Act Code of Practice

- We reviewed a sample of 6 care plans in relation to patients subject to community treatment orders (CTO). These were found 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.
- We were unable to speak to anyone subject to a CTO but attempts to facilitate this were made by care coordinators.
- When someone required a Mental Health Act assessment, it was arranged through the duty team. We spoke to a care coordinator, who was an AMHP. They told us that, although the service was under pressure,

Are services effective?

Good

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

they were not aware of any assessments being missed. They did report there were often delays in completing an assessment due to problems accessing a local bed, because of high occupancy levels across the trust.

- Staff we met had a good understanding of the MHA, but managers acknowledged they were still in the process of learning about the recent changes to the Code of Practice, in order to pass this onto their staff.

Good practice in applying the Mental Capacity Act

- Staff we spoke with in the ICMHTs said they were familiar with obtaining a person's consent. If required they would seek clarification from relatives and/or their representatives to support decision making. This was evidenced by the records we saw. However, in the DRCs staff we spoke with were less clear, and told us they thought this would have been dealt with prior to attendance, as part of the assessment process. Patients had access to an independent mental capacity advocate as part of the CPA process.
- Training in the Mental Capacity Act 2005 (MCA) was not mandatory in the trust. Some staff told us they had received training in the use of the MCA. Although it was not clear whether agency staff had received MCA training as records for completion of this training were not available. The one agency nurse we spoke with told us he had received his training in this subject from another provider.

Good

Are services caring?

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

Summary of findings

Please see summary at beginning of report

Our findings

Kindness, dignity, respect and support

- Staff we observed demonstrated compassion and genuine feeling about the patients who they supported. We saw examples of staff being respectful, empathic and providing emotional support in the ICMHTs and the DRCs at every location we went to.
- Patients we spoke with told us they found staff helpful and caring.
- When staff spoke to us about patients, they showed understanding of their needs and circumstances. We observed MDT meetings and at one found the staff anonymised the patients name to preserve confidentiality. These meetings reflected the wishes and views of the patients they were discussing and this was supported from feedback we received.

The involvement of people in the care that they receive

- The care plans we reviewed were comprehensive, individualised and incorporated patients views with regard to their care and treatment.
- We did not see and the manager was unable to provide any evidence of patient involvement in the evaluation of the DRCs core programme.
- We saw how each team undertook carers assessments of their needs and support. At the Caradon ICMHT we met a lead practitioner who had undertaken some specific county wide work on carers involvement. This had resulted in each ICMHT having a designated carers lead. They had also provided training in carrying out carers assessments for staff. In the DRCs carers workshops regularly take place to give advice and support. We noted a carer's section of the trust website with lots of additional information.
- Records we saw showed patients had received a review of their care under the care programme approach. In all of these cases the patient had been invited to attend.
- Advocacy information was available in each of the team bases we visited. Not all staff we spoke with knew how to access the service but said they would always check with the team manager first. Some of the patients we spoke with were also unaware of how to access the advocacy service.
- Each team undertook surveys to seek the views of all patients who used the service. They used an electronic system, and we were able to review a sample which showed a majority of patients felt they received a good service. This also showed in the ICMHTs they felt supported in being involved in decisions about their care.

Are services responsive to people's needs?

Good

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

Summary of findings

Please see summary at beginning of report.

Our findings

Access and discharge

- Each ICMHT had a system in place which ensured all new referrals were placed via a single point of access (SPoA). The teams triaged each new referral based upon the information they received and assessed if further support was required. The duty worker would liaise with the SPoA staff to confirm the priority of the referral and to ensure there were sufficient appointment times available. We saw evidence to show how urgent referrals were allocated an assessment within 5 days and a standard referral was seen within 28 days. We were told by managers there was some limited scope to see high priority patients the same day, but generally these would be assessed by the home treatment team.
- Staff we spoke with in each ICMHT told us the referral rates had increased significantly since last year. They said this along with the various staff absences, had resulted in significant pressure on all teams to maintain the target times for assessments. Managers we met showed us the performance monitoring reports which they submitted to the trust to keep up to date with the situation. They told us there were plans to review and change the number of available assessment slots later this year.
- We saw recording systems in each ICMHT which showed that all patients received a follow up within seven days of being discharged from psychiatric inpatient care.
- In the DRCs the referral process for all new patients was via the ICMHT. We were told by staff how a member of the relevant DRC would attend referral meetings and saw this occur in two meetings we attended. Staff in the various DRCs we visited told us referral rates were relatively low each month and as a consequence they felt the group programme was poorly attended. ICMHT managers confirmed the low referral rates but felt this reflected the needs of the patients, as not everyone was suited to attend a DRC. We visited six DRCs during three days and found attendance fluctuated, with some not having any patients in attendance.
- The trust had introduced a new model for the DRCs in 2014 along with an operational policy which was ratified on 8 January 2014. This indicated that all patients would be in receipt of CPA. We found in each DRC they were operating a limited group programme for these patients, with an open access facility for all others not on the CPA. Whilst the group programme had clear timescales for completion there was no pathway for patients attending open access.
- In the ICMHTs staff told us of the procedure for following up patients who did not attend appointments. These ranged from telephone contact, conducting a follow up home visit and/or sending repeat letters. They showed us how they recorded this, and the information sent to the person's GP to keep them informed.
- Patients we spoke with did express concerns about getting to community based locations, especially if they had to rely on public transport. This had recently been exacerbated by the demise of a local bus company and there was uncertainty about replacement times and routes.

The facilities promote recovery, comfort, dignity and confidentiality

- In all four ICMHT team bases we visited there was a range of rooms at each base designed to be used for individual or group work, along with a locked clinic area. The interview rooms we saw were mainly adequately sound proofed to give patients a good degree of privacy. However, in Redruth ICMHT interview room 4 had a large two way mirror, which did not provide adequate sound proofing when the adjacent room was in use.
- Reception areas in ICMHTs had clear and concise notice boards giving a range of information such as local self-help groups, advocacy services, treatment and advice, patient's rights and how to complain.

Meeting the needs of all people who use the service

- The trust covers a wide geographical area but does not have a diverse population range. There are pockets of high deprivation, drug and alcohol problems, and homelessness. In Penzance, we were told by the manager there appeared to be an increasing number of new patients with existing mental health problems re-locating to the town. Managers from each ICMHT were aware of the local demographics, and showed us how they had developed the team models in response to the

Are services responsive to people's needs?

Good

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

developing needs. For example, the Penwith ICMHT covered the population of the Isles of Scilly, and a community psychiatric nurse attended a fortnightly clinic on the islands. A consultant psychiatrist also attended as required.

- Within the DRCs care was dependent on the ability of a patient being able to travel to the base. We did not see any evidence which evaluated the needs of the population which each DRC served. On the Wednesday when we visited three sites there were no patients being seen and staff told us they closed to allow administrative tasks.
- In the DRCs we noted there was limited room for any disabled patients who required a wheelchair. There were no specific toilets available and access to rooms was very limited throughout. Space was limited in each building with sessions often being run in upstairs rooms with no lift access. Staff told us they would try to make adjustments to accommodate an individual patient's needs, such as by ensuring groups were held on the ground floor. Although we saw a copy of the environmental risk assessments, we did not see any specific evidence of how the centres were assessed to comply with the Equalities Act 2010.
- Staff we spoke with told us how they could access interpreting services and patient information in a variety of languages from the trust.

Listening to and learning from concerns and complaints

- Information on the patient advice and liaison service (PALS) and independent mental health advocacy services were available in each ICMHT reception area.
- Team managers told us they tried to address concerns informally as they arose and provided examples of changes made to care as a result. For example, a person wanted to discuss their medication effects and an appointment with a pharmacist was arranged for them.
- Information detailing how to make a complaint was not always displayed in waiting areas. Patients we spoke with told us they felt able to raise concerns or complaints about their care with their care coordinator. Staff we spoke to said they were aware of the complaints process and would re-direct patients to the local PALS service if they felt they were unable to deal with their query.
- We saw copies of team meeting minutes which showed complaint issues were discussed and any actions taken to ensure any lessons were learnt. This included feedback from the trust on complaints from other areas. Team managers told us they encouraged staff to be proactive when dealing with patients raising issues. An example of this was in ICMHT Kerrier, where a music system had been placed in the waiting area by the administrator, following patient feedback to her.

Are services well-led?

Good

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

Summary of findings

Please see summary at beginning of report.

Our findings

Vision and values

- The majority of ICMHT staff we spoke with were aware of the chief executive and senior managers within the directorate. However, nursing staff told us they were unsure of the impact the director of nursing had within the organisation and in particular on nurses.
- Staff said they understood the vision of the trust and copies of the trust values were on display in two team bases.
- Each ICMHT team manager we spoke with told us they now felt supported by their line manager, and were clear about the overall direction teams were taking.
- Staff we spoke with in the DRCs told us they felt supported by their manager, but her large geographical area of cover made it difficult to provide regular face to face support. They also reported feeling uncertain about the longer term vision for the DRCs.

Good governance

- There were monthly team meetings held for each team, where staff discussed issues such as 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. They also attended monthly community managers meeting which looked in detail at governance issues and performance feedback from the trust.
- The trust had an electronic reporting system which enabled team and senior managers to monitor 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.
- ICMHT managers told us they felt they had sufficient authority within their teams and were well supported by the senior medical leadership. There were senior administrative staff available to support them and all spoke very highly of these working relationships.
- There were local risk registers for the teams but we did not see any evidence of how these would influence the trust wide risk register.

Leadership, morale and staff engagement

- Staff we spoke with felt that at a local team level the service was well–led and there was a clear managerial and clinical structure in place. They told us they were aware of the whistleblowing policy and felt they could raise any issues either through supervision or directly with the team managers.
- 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 impacting on them, but felt confident in the approaches the managers were taking. An example of this was recruitment of a social worker into a band 5 post rather than a nurse.
- Staff told us there were opportunities for leadership development but these were mainly focussed on band 6 and above posts.
- We spoke with the full range of staff based within both ICMHTs and the DRCs during our inspection and they felt confident about delivering good care within their own teams. They told us about the different changes which had occurred over the last two years, and how morale was beginning to improve. They told us the local arrangements to review practice and suggest changes worked well.

Commitment to quality improvement and innovation

- Patients using the service were given the opportunity to participate in an electronic satisfaction survey in addition to informally feeding back their experiences at care planning meetings. In ICMHT Penwith, we saw how the team used a volunteer to help patients complete the survey with access to an iPad.

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- The teams had monthly meetings which discussed issues such as medical cover, lessons learned from serious untoward incidents, supervision arrangements, team risk register. The minutes showed there was a commitment to maintain quality.
- 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". A small team from Finland had provided training in the 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.