Cornwall Partnership NHS Foundation Trust

RJ8

Community health services for adults

Quality Report

Cornwall Partnership NHS Foundation Trust, Head Office, Carew House, Beacon Technology Park, Dunmere Road, Bodmin, PL31 2QN
Tel: 01208 834600

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Summary of findings

Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RJ807	Newquay Hospital	Newquay Community Hospital	TR7 1RQ
RJ817	Camborne and Redruth Community Hospital	Camborne and Redruth Community Hospital	TR15 3ER
RJ870	Launceston Community Hospital	Launceston Community Hospital	PL15 9JD
RJ867	Stratton Hospital	Stratton Community Hospital	EX23 9BR
RJ842	Falmouth Hospital	Falmouth Community Hospital	TR11 2JA
RJ8Y2	St Austell Community Hospital	St Austell Community Hospital	PL26 6AA

This report describes our judgement of the quality of care provided within this core service by Cornwall Partnership 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 Foundation Trust and these are brought together to inform our overall judgement of Cornwall Partnership Foundation Trust

Summary of findings

Ratings

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

Summary of findings

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Overall summary

Overall, we found the community adult service required improvement because:

- Risk assessments, risk management plans and reviews were not being consistently completed by the community nursing teams. Therefore, assessments were not used to respond positively to patient risk or to minimise harm to patients. We saw examples of serious incidents investigations where risk assessments had not been completed for patients.
- Monthly audits for the Titration of Diabetes Medicines by Diabetes Specialist Nurses were not being carried out according to trust policy.
- Learning from incidents was not always shared between the teams. Investigations into serious incidents were insufficient and did not always demonstrate learning had been fully understood. Actions did not demonstrate how learning was to be implemented and embedded into practice. There was little evidence to demonstrate how learning or action was taken to improve safety.
- Compliance with mandatory training was poor and not meeting the trusts target. Compliance with mandatory training was just 36% for the community adult service.
- The sepsis screening tool was not fit for purpose, as the nursing staff did not have the tools identified on the chart to monitor patients for sepsis. The community nursing service was not using a national early warning score to identify deteriorating patients and the trusts sepsis policy was not based on the most recent National Institute for Health and Care Excellence guidelines for sepsis (NG51).
- Staff at the leg clinic were not working in line with the Nursing and Midwifery Council Code Of Conduct: Professional standards of practice and behaviour for nurses and midwives standard 10.4 (2015).
- Risks were not always accounted for or managed appropriately when planning and delivering services. There was a lack of challenge from senior staff with regards to anticipated patient risk during handovers.
- The management of pain was inconsistent and did not always include an appropriate assessment and management plan for patients who were, or could be, experiencing pain.
- There was poor compliance countywide with completion of initial nutrition and hydration assessment for patients.
- Not all community nurses received any formal supervision sessions.
- The process of receiving referrals into the service was not clearly defined.
- Staff were not always compliant with the trust's consent policy and completion of the consent to sharing information documentation.
- Not all staff provided us with assurance they understood their role and responsibility around the Mental Capacity Act and best interest decisions.
- There were mixed feelings about the senior management team and their understanding about caring for patients with physical problems. However, teams spoke highly of the support from their local managers.
- The governance system needed to be reviewed to ensure processes were standardised and aspects of quality and safety were fully understood.
- Meeting minutes did not demonstrate any depth or quality as to the content of the meeting. Minutes did not demonstrate how incidents were scrutinised for trends to ensure learning was identified, to improve performance and safety for future patients.
- Not all risks to the community adult service had been identified and recorded on the risk register.
- Lone working systems and processes did not ensure the safety of staff. This left staff working on call vulnerable and posed a risk to their safety.
- There was confusion between the community adult service teams with regards to the introduction of a new electronic records system being introduced in November 2017. At the time of our inspection, staff still had not received any training on the new system being implemented.
- Specialist nursing teams were concerned about the future sustainability for their services and the need for financial investment.

However

- Staff understood their role and responsibility to report safeguarding concerns and knew the process to carry this out.

Summary of findings

- Patient group directions used by the community nursing teams and the musculoskeletal service were complete, signed and in date.
- Infection, prevention and control practice was adhered to by the majority of the staff.
- Staffing levels, skill mix and caseloads accounted for patient risk and acuity when they were planned and reviewed
- Care and treatment was based on relevant evidence based practice, national guidance and legislation. Staff were able to demonstrate how they were underpinning national guidance to support their practice.
- Audit programmes captured positive information about patient outcomes.
- Teams provided comprehensive training for staff to upskill them in their roles. Staff were competent to carry out their roles effectively.
- Staff received yearly appraisals to determine their development for the following year.
- We saw good examples of multidisciplinary working both internally and also with external partners.
- Patients were consistently positive and complimentary about the care they received. Staff worked hard to empower patients to manage their own health and wellbeing.
- Staff treated patients with kindness, dignity, compassion and respect, and interacted with patients in a respectful and considerate manner.
- Staff ensured patients understood the care and treatment they were receiving and understood the importance of involving family members or carers as partners in their care.
- Patients were given timely support and information to cope emotionally with their condition.
- Where possible, services were planned to meet the needs of the local population. Staff used information about the local population to support the planning for future service delivery.
- Team leads in specialist nursing teams demonstrated knowledge about what their services were commissioned to deliver.
- Services were planned to take into account the needs of individual patients, and staff were non-judgemental in the way they cared for patients.
- Teams delivered services which took into account the needs of patients with complex needs such as learning difficulties and dementia.
- Access to the majority of community adult teams on the whole was timely, and where possible, services prioritised care and treatment for patients with urgent needs.
- Leaders at local level understood the challenges faced by the community adult services and staff felt supported by their leaders at local level.
- A clear vision and strategy had been set out for the service which staff were on board with and able to discuss.
- There was a programme of internal and external audit to monitor quality and performance.
- There was a strong culture of patient centred care.
- Innovative work was being carried out by the specialist nursing teams.

Summary of findings

Background to the service

Cornwall Partnership Foundation Trust took over the provision of community adult services (within the organisation, this service is known as the adult community service) in April 2016, from a local community interest company. The trust provides community adult services across Cornwall and the Isles of Scilly, for a population of around 553,000 people. Community adult service delivers care and treatment to patients across three localities, west, mid and north and east Cornwall, with staff covering different geographical areas. Within the organisation, this service is known as the adult community service.

The community adult teams provide care and support in patients own homes, care homes and local health centres, clinics and community hospitals. Community nursing teams provided a seven day service with a seven day on call service between 5pm and 10pm.

During our inspection we visited staff and patients in relation to the provision of community services in the following areas;

- Perranporth
- Newquay
- Camborne and Redruth
- Truro
- Falmouth
- Callington
- St Austell
- Launceston
- Wadebridge
- Penzance
- St Ives
- Stratton

We reviewed the following services and spoke with a variety of staff members. These included;

- Community nursing teams
- Podiatry
- Speech and language therapist
- Rehabilitation teams including physiotherapists and occupational therapists
- Respiratory team
- Home First
- Acute Care at Home team
- Community matrons
- Bladder and bowel service
- Tissue viability service
- Parkinson's disease nurse specialists
- Telehealth
- Leg club
- Cardiac rehabilitation team
- Neuro rehabilitation team
- Musculoskeletal outpatient physiotherapy teams

During our inspection, we spoke with 104 staff, 64 patients and 19 relatives and carers. Patients and their relatives made very positive comments regarding the care and treatment provided by staff.

We observed how adults across the county were cared for, held focus groups for staff and looked at 51 care and treatment records.

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 who inspected this core service included a variety of specialists: community nurses, a community physiotherapist and a community occupational therapist. We also used experts by experience who have experience of using healthcare services to talk to patients who had used or were currently using the service.

Summary of findings

Why we carried out this inspection

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

The trust merged with Peninsula Community Healthcare NHS Trust in April 2016 and as such we always undertake a comprehensive inspection at an appropriate time following a merger.

How we carried out this inspection

During our inspection we reviewed services provided by Cornwall Partnership Foundation Trust across Cornwall and the Isles of Scilly. We visited the community nursing teams and the early intervention team accompanied them on visits to people in their homes whilst they were receiving treatment. We also attended clinic run by healthcare professionals in the community and spent time with allied health professionals providing rehabilitation to patients who were also receiving treatment in their own home.

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

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

Before visiting, we reviewed a range of information we hold about the core service and asked other organisations to share what they knew. We carried out an announced visit on 25 to 29 September 2017. During the visit we held focus groups with a range of staff who worked within the service, such as nurses, and therapists. We talked with people who use services. We observed how people were being cared for and talked with carers and/or family members and reviewed care or treatment records of people who use services. We met with people who use services and carers, who shared their views and experiences of the core service.

What people who use the provider say

Patients we spoke with during the inspection were highly complementary of the care and treatment they received from various teams. Quotes from patients we spoke with included;

"nothing but total satisfaction,"

"I couldn't wish for better care,"

"staff really listen to me"

"I felt my care was personalised, like they knew how I felt"

and, "the nurses make me feel comfortable because they talk to me like I am a friend."

Good practice

- The initiative set up by the neurology care advisor facilitating a meeting between patients and key healthcare professional to listen to the concerns of people suffering from spinal cord injuries was outstanding. The group held healthcare professionals to account and facilitated service improvement to the care they and others received in the county.

Summary of findings

Areas for improvement

Action the provider MUST or SHOULD take to improve

Action the service MUST take to improve

- Take action to ensure risk assessments are completed to ensure the health and safety of patients.
- Ensure monthly audits for the Titration of Diabetes Medicines by Diabetes Specialist Nurses are carried out according to trust policy.
- Make sure learning from incidents is shared consistently between the teams and ensure investigations into serious incidents capture all learning and thoroughly identify how learning will be implemented an embedded into practice.
- Ensure compliance with mandatory training and safeguarding training to ensure staff have the knowledge and skill to safely carry out their role.
- Make sure the sepsis tool is fit for purpose and staff have access to a national early warning score, to effectively establish a process to ensure the early identification and management of sepsis. Ensure the sepsis policy is based on the most recent National Institute for Health and Care Excellence guidelines for sepsis (NG51).
- Ensure all patients have their nutritional and hydration needs assessed.
- Take action to ensure staff at the leg clinic are working in line with the Nursing and Midwifery Council Code Of Conduct: Professional standards of practice and behaviour for nurses and midwives standard 10.4 (2015) and not completing patient records when logged into the system under someone else's name.
- Take action to ensue community nurses are working in line with trust policies to complete consent documentation.

Action the service SHOULD take to improve

- Ensure compliance with mandatory training and safeguarding training to ensure staff have the knowledge and skill to safely carry out their role.
- Ensure a sustainable system for managing the setup of syringe drivers out of hours.
- Make sure there is a system to ensure stock rotation and cleaning of storage rooms.
- Ensure systems provide assurance that infection control risk assessments have been completed for patients who require these.
- Make sure team leaders are actively engaged with the day to day caseload of the nurses and actively challenge risks associated with patients.
- Establish a system to ensure effective pain management for patients.
- Establish a system to provide regular supervision sessions for community nurses.
- Establish a clear and consistent method of referral into the community nursing teams.
- Make sure all staff are informed and confidently understand their role and responsibility around the mental capacity act and best interest decisions.
- Take action to ensue community nurses are working in line with trust policies to complete consent documentation.
- Make sure staff adhere to the trust policy with regards to the timeframe for closing complaints and make sure patient have access to information which explains how to make a complaint.
- Make sure the governance system standardises discussion agendas at meetings and ensure aspects of quality and safety were fully understood and scrutinised for learning and trends, to improve performance and safety for future patients.
- Make sure all risks to the community adult services are identified and recorded on the risk register.
- Establish a system to ensure lone working systems and processes ensures the safety of the community nurses, particularly when working on call.
- Inform all staff and provide a clear message about the implementation of the new electronic recording system.
- Specialist nursing teams were concerned about the future sustainability for their services and the need for financial investment.

Cornwall Partnership NHS Foundation Trust

Community health services for adults

Detailed findings from this inspection

Inadequate

Are services safe?

By safe, we mean that people are protected from abuse

Summary

We rated the safety of community adult service as requires improvement because:

- Risk assessments, risk management plans and reviews were not being consistently completed by the community nursing teams. The lack of risk assessments did not ensure the safety of the individual patient. There missed opportunities to minimise harm to patients. We saw examples of serious incidents investigations where risk assessments had not been completed for patients.
- Monthly audits for the Titration of Diabetes Medicines by Diabetes Specialist Nurses were not being carried out according to trust policy.
- Learning from incidents was not always shared between the teams. Investigations into serious incidents were insufficient and did not always demonstrate learning had been fully understood. Actions did not demonstrate how learning was to be implemented and embedded into practice. There was little evidence to demonstrate how learning or action was taken to improve safety.
- Compliance with mandatory training was poor and not meeting the trusts targets. Compliance with mandatory training was just 36% for the community adult service.
- Compliance with safeguarding training was poor and not meeting the trusts target.
- The lone working policy did not ensure the safety of the community nurses when working on call during an evening.
- Nursing staff did not have access to the tools identified on the sepsis screening chart to monitor patients for sepsis. The community nursing service was not using a national early warning score to identify deteriorating patients. Despite being recently updated, the trusts sepsis policy was not based on the most recent National Institute for Health and Care Excellence guidelines for sepsis (NG51).
- Staff at the leg clinic were not working in line with the Nursing and Midwifery Council Code Of Conduct: Professional standards of practice and behaviour for nurses and midwives standard 10.4 (2015).

- Risks were not always accounted for or managed appropriately when planning and delivering services. There was a lack of challenge from senior staff with regards to anticipated patient risk during handovers.

However

- Staff understood their role and responsibility to report safeguarding concerns and gave us examples of safeguarding concerns they had reported.
- Patient group directions used by the community nursing teams and the musculoskeletal service were complete, signed and in date.
- Infection, prevention and control practice was adhered to by the majority of the staff.
- Staffing levels, skill mix and caseloads accounted for patient risk and acuity when they were planned and reviewed

Detailed findings

Safety performance

- Staff monitored safety performance and harm free care using the patient safety thermometer. The safety thermometer is a local improvement tool for measuring, monitoring and analysing patient harm and harm free care. The safety thermometer involves a monthly snapshot audit over the course of one day. The audit includes information on pressure ulcers, falls, urinary tract infections, catheters and venous thromboembolism (a condition in which blood clots form in the deep veins of the leg). We reviewed data for the community adult service. August 2017 data identified 94.5% of harm free care had been provided across the community adult service.
- The community nursing teams had seen a significant reduction in recorded new pressure injuries in August 2017. Pressure injuries had reduced from 3.1% to 0.72%. This demonstrated an overall decrease in all pressure injuries from 6.9% to 4.7% in the service. The service was performing better than the trust's 6% target.
- The tissue viability specialist nurse team had set up a monthly pressure ulcer prevention group. The group aimed to share learning about pressure ulcers and prevention across the organisation, to reduce pressure damage to patients. The group also included external organisations such as local care homes and hospices. Learning was shared following incidents and investigations, in order to develop people's knowledge, understanding and skills to manage pressure ulcers. The group aimed to empower staff to develop practice within their own areas to improve patient safety and reduce the risk of patients developing pressure ulcers.
- A wound awareness group had been developed by the tissue viability team. The aim of this group was to upskill staff to enable earlier recognition and better management of wound care and leg ulcers. The basis for the group was the 'TIME' acronym, (tissue breakdown, infection, moisture and edges). The service used a 'wound formulary' to help nurses select appropriate dressings to promote wound healing.

Incident reporting, learning and improvement

- Staff within the community adult service were encouraged to report incidents, however, learning from incidents was not always shared with all teams so that improvements could be made. There was little evidence to demonstrate how learning or action was taken to improve safety. There were inconsistences between the teams in receiving feedback about reported incidents and only s small number of staff could give us examples feedback and learning following incidents. Learning following serious incidents was not always fully understood, because not all learning was identified and action plans lacked depth as to how learning was to be implemented and embedded into practice.
- Staff understood their responsibilities to raise concerns, record safety incidents and near misses and report them internally. There was a policy and system in place to report incidents, which was available to staff on the trust intranet and staff knew how to access this. The policy outlined the procedure for reporting incidents. Staff told us the incident reporting system was straightforward to use.
- There had been 11,892 incidents reported by the trust between April 2016 and March 2017, with 7,351 incidents being reported by the community adult services. Of these, the two most common reported incidents were pressure ulcers which accounted for 1,958 (27%) and 1,257 (17%) were slips, trips and falls.
- A limited number of staff from a few teams were able to give us examples of feedback from incidents they received during handovers, team meetings and the cascade newsletter. For example, changes to practice and outcomes following incidents relating to insulin. We saw evidence of discussions of incidents in some team meeting minutes, however some of these lacked quality

and depth as to the discussions which had taken place. We also saw minutes of meetings where there was no set agenda item to discuss feedback and share learning from incidents. We saw two sets of meeting minutes from the July and August 2017 district nursing forum. This meeting was attended by the nursing team leads. The agendas were not standardised and there had been no discussion around incidents, safety performance or risk between the teams. Therefore, we were not assured team leads had full oversight of safety performance and risk, and we were not assured of the quality of information being fed back to the staff.

- There had been 31 serious incidents reported by the community adult service between June 2016 and May 2017. Serious incidents are incidents where one or more patients or staff members experience serious injury or harm, alleged abuse, or the service provision is threatened. The majority of serious incidents, 24 out of 31 (84%) were due to grade three or four pressure ulcers. Serious incidents had been reported mainly by the community nursing teams and one serious incident had been reported by the early intervention service (now named Home First service). The serious incidents had been identified under five specific categories. There had been one incident concerning a confidential information leak/information governance breach, two serious incidents relating to apparent/actual/suspected self-inflicted harm and one infection control incident, which met the serious incident criteria, one treatment delay meeting serious incident criteria and 26 serious incidents related to pressure ulcers.
- All serious incidents were subject to a thorough investigation however, the approach to reviewing and investigating these was insufficient. We were not assured all learning had been fully understood, taken forward and actioned following incidents. We saw examples of serious incident investigations which identified learning and had accompanying action plans. We saw one investigation following a grade four pressure ulcer. The report had a detailed timeline of events, however, it identified at 12 out of the 15 visits, no risk assessments had been completed for this patient. The investigation also identified the staff involved had not received any pressure training and stated an e-refresher mandatory training course should have been carried out. However, despite the mandatory requirement for this training, information also stated the training was not yet available for staff. Despite these findings, the action plan did not include any reference to the need to ensure staff were completing risk assessments and reviewing these regularly to ensure patient safety. The action plan did not demonstrate how the actions and learning were going to be achieved, implemented and embedded into practice and cascaded to staff, to improve safety for future patients.
- We saw two further serious incident investigations following grade three and four pressure ulcers. Although there was a clear timeline of events, a lack of checking pressure areas had been identified. It was unclear with one of the investigations we reviewed whether care had been provided in line with the care plan. The actions plans again lacked depth and detail as to how actions were going to be implemented and learning cascaded. An investigation following an unexpected patient death identified a lack of completed baseline observations and further physical observation checks. The action identified nurses needed to take patient observations at each visit, however, the action plan provided no detail as to how this was to be implemented and embedded into practice.
- The trust had received one Regulation 28 report (where a coroner is under a duty to make areportto prevent other deaths) to prevent future deaths in December 2016 related to the community adult service. The death of the patient occurred prior to community adult service being taken over by Cornwall Partnership Foundation Trust in April 2016. However, as current providers of the service, the Regulation 28 report to prevent future deaths was served to the trust. The trust had investigated the incident and had taken several actions to improve practice and prevent future deaths. Actions included, reviewing the community falls risk assessments, development of a falls policy and appointment of a falls lead. Learning following this incident had been shared trust wide and staff were able to tell us about the incident and learning and actions following the incident.

Duty of Candour

- Staff demonstrated an understanding of their responsibilities with regards to the duty of candour. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety

incidents' and provide reasonable support to that person. This regulation requires staff to be open, transparent and candid with patients and relatives when things go wrong.

- The organisation had a duty of candour policy and process available on the intranet, for staff to follow when applying duty of candour. The policy explained the duty of candour and the principals of being open. The policy also contained the roles and responsibilities of the staff with regards to the duty of candour and provided a flow chart identifying actions which needed taken at service manager level when the duty of candour was applied. The duty of candour had been applied 91 times by the community adult service between June 2016 and May 2017.
- All four serious incidents we reviewed demonstrated the duty of candour had been met. In one serious incident report, information demonstrated the patient had been spoken with and an initial letter had been sent. In another, the patient's next of kin had been contacted and a letter, together with the investigation had been sent out to the patient's family. Letters we saw offered the patient the opportunity to be involved with the investigation and to attend either a meeting or have a telephone call to discuss the outcomes of the investigation.

Safeguarding

- There were systems and processes reflecting relevant safeguarding legislation to safeguard adults and children from abuse. The majority of staff we spoke with understood their responsibility to report safeguarding incidents and were able to tell us what they would do. Staff could give us examples of safeguarding concerns they had reported. We saw information in offices for various teams providing information and a telephone number for staff to use when raising safeguarding concerns. Between May 2016 and April 2017, the community adult service had reported 99 adult safeguarding referrals.
- The organisation had a policy for safeguarding adults, which reflected current legislation and guidance. The policy was easily accessible and included the details for the relevant local authorities. The policy outlined what safeguarding was, its importance and provided definitions of the different types of abuse. The policy also covered staff responsibilities with regards to raising safeguarding concerns and the procedure by which to report these. Female genital mutilation and PREVENT training were also covered in the policy. 'PREVENT' is training for the government counter terrorist strategy so people have due regard to the need to prevent people from being drawn into terrorism, identifying people who may be vulnerable to radicalisation and referring and reporting these individuals.
- There was poor compliance with safeguarding training for the community adult service, which was not in line with the organisations policy. Only 445 staff out of 849 (52%) had completed their three yearly update of safeguarding adults 'Prevent' training, whilst only 187 staff out of 901 (21%) had completed the required three yearly update for the safeguarding adults face to face course. Only 387 staff out of 901 (43%) had completed safeguarding children level 2. This meant not all staff had up to date knowledge and skills to safeguard adults and children.
- We listened in on a discussion at a community nursing handover. A patient in a residential home had a moisture lesion/grade 2 pressure damage. The nurse discussed concerns about the patient being in a wet bed, which had dried up and was then soiled. This could be a contributing factor to the moisture lesion/ pressure ulcer developing. However, there was no discussion about if this was a safeguarding issue. We discussed this with the nurse afterwards and they were unsure whether this was a safeguarding issue. The nurse told us they were going to discuss this with their team leader.

Medicines

- Arrangements for managing medicines did not always ensure the safety of patients. Staff did not always follow trust policies and could not provide assurance they were following national guidance with regards to the management of medicines. Despite this, medicines policies and procedures were available on the intranet for staff to refer to. Staff told us they were aware of the guidance available to them and how to access it.
- The trust informed us that diabetes specialist nurses were working in accordance with National Institute for Health and Care Excellence guidance (NICE) for the Management of Type 1 and Type 2 Diabetes and NICE clinical knowledge summaries. NICE guidance states nurses can titrate (make small adjustments) to dosages by 10-20% increments for medicines prescribed by the GP or a non-medical prescriber without the need for a prescriber qualification. However, the lead nurse told us

the prescriptions did not specifically identify the initial dose of medicine and just stated 'as instructed'. Without this specific dose identified the nurses were not titrating doses, they were effectively prescribing. This meant they did not comply with the national guidance and legislation.

- We sought further clarification from the trust following the inspection about this issue. The trust informed us that all prescriptions were written by the following clinicians, members of the diabetes team who were Nurse Prescribers, endocrinologists or GP's. Where patients had "as instructed" on their prescription, these prescriptions were written by the patients GP. Patients could self-adjust insulin doses as these were not static. The trust told us patients were aware what dose they were self- administrating. At the patients review with the diabetes nurse, the nurse would review and record the dose the patients were self-administering and any changes to self-administration after review within the 10-20% parameter.
- The trust's guidelines for the Titration of Diabetes Medications by Diabetes Specialist Nurses stated monthly audits should be carried out. This was to enable the process to be monitored to ensure nurses were working in accordance with guidance. Following the inspection, we asked the trust for audits undertaken by the diabetic specialist nurses. The trust responded to inform us no audits had been undertaken in the last six months. Therefore, the trust's policy on monitoring and reviewing this practice was not being adhered to. The trust could not provide us with assurance the non-medical nurse prescribers were working in line with national guidance. Following the inspection the trust told us they would implement a six monthly records review for this. This however, was still not in line with their policy the Titration of Diabetes Medications by Diabetes Specialist Nurses of monthly audits.
- The community nurses did not routinely carry medicines. The community nursing teams carried adrenaline for emergencies, to ensure patient safety if they were to experience an allergic response. Nurses carried adrenaline which came in pre-packed envelopes from the pharmacy at the local acute NHS trust. The envelopes were clearly labelled with the dose and the expiry date of the medicine. We checked some of the adrenaline carried by the community nurses and found this to be in date. Medicines were prescribed by patients' GPs and stored in their' own homes. The prescription charts were kept in patients' homes so in the event of a medical emergency, there was a record available for other healthcare providers to see.
- Nurses carried medicines in exceptional circumstances. Nurses told us of two occasions when they would carry medicines for patients. One situation involved taking end of life medicine to patients to ensure their needs were met. The other involved taking intravenous medicines to patients who lived in very rural, isolated when patients would be unable to collect medicines themselves. Staff told us when these situations occurred; they would take the medicines to patients, storing them in the locked box in the boot of their car. This was in line with section 7.4.7 of the trusts medicine management policy.
- Community nurses used syringe drivers for some patients receiving end of life care, however managing the setup of this during out of hours was unsustainable long term. Syringe drivers are a device used to deliver medicines just beneath the skin and are used for pain relief and/or symptom control. The trust's policy required two nurses to check medicines for syringe drivers prior to administering to patients. This was challenging if a syringe driver needed to be set up out of hours by the on call nurse or at weekends, as only one nurse was on duty. In this instance, nurses would have to call neighbouring teams for support. Nurses told us this was challenging if the nurse in the neighbouring team was busy as co-ordinating a joint visit could be a difficult. Nurses gave us examples of instances where they had called on another nurse living locally in the area, but not on duty to act as the second person checking the medicines. At the time of our inspection, work was ongoing to look at the on call nursing service. Nurses told us where possible, they tried to ensure syringe drivers were not set up during an on call shift.
- Some community nursing teams used patient group directions (PGD's) to be able to administer specific medicines to patients, for example flu vaccinations. PGD's provide a legal framework, which allows some registered healthcare professionals to supply and/or administer specified medicines to a pre-defined group of patients without them having to see a prescriber (such as a nurse prescriber or a doctor). We saw the national Public Health PGD for flu vaccinations, which was in date and there was current and up-to-date training available for nurses who would be

administering flu vaccinations. This training included anaphylaxis training (anaphylaxis is a severe and potentially life threatening allergic reaction). Some nursing teams also had PGD's for example, for saline peripherally inserted central catheter (PICC) flushes (when saline is injected to flush out a peripherally inserted central catheter).

- The musculoskeletal service used PGD's to administer steroid injections to patients. Steroid injectionsprovide an effective anti-inflammatory and pain relieving treatment directly to the joint or soft tissues causing pain. We saw the PGD, which was signed by the prescriber, all staff and was in date. We also saw the paperwork maintained in patient's files which was also completed, signed and dated by both the members of staff and the patient. In November 2016, the musculoskeletal department had audited compliance with the PGD's. The results of the audit demonstrated, all 13 clinicians audited adhered to all of the sections.
- Staff had discussions with patients about their medications, checking any side effects, whether their medicines had been changed and whether they had the appropriate medicine. We observed one of the Parkinson's disease nurses routinely asking each patient she saw about their medicine. In particular, the nurse spent time going through in detail about patient's medicine for the new patients visited. The nurse was very thorough in checking patients were managing their medicine safely and effectively to ensure treatment optimisation.

Environment and equipment

- In most cases, equipment was fit for purpose and well maintained. However, the design and maintenance of the facilities varied across the county. Specialist community nurses held clinics and used facilities in community hospitals and GP surgeries to carry out consultations with patients. There was a difference between community hospitals with some being new, modern and well-designed and others being older. However all were clean, well maintained and free from clutter. Some of the older hospitals where clinics were held were undergoing renovation work at the time of our inspection.
- The majority of equipment was maintained and fit for use. We reviewed equipment held by the different services we visited. The majority of equipment was maintained and in date, however we did find some gloves in the podiatry service which expired in 2013 and observations machine which had last been serviced in 2012 at the leg clinic.
- The office and storage arrangements for some community nursing teams were poorly maintained. We looked at the storage facilities for consumables at Launceston Community Hospital, which was small and not fit for purpose. There were no audits carried out to demonstrate when the storeroom had last been cleaned and staff did not know when it was last cleaned. There was ineffective stock rotation and we found two boxes of syringes which were out of date, one of which expired in February 2016.
- There were no policies or guidance about what equipment community nurses should carry or how to ensure the cleanliness and maintenance of the consumables and equipment. Community nurses carried some consumables and monitoring equipment in their cars. The community nurse manager at Launceston Community Hospital carried out spot checks of how community nurses ensured the safe storage of consumables and equipment in nurse's cars. This was not audited and the practice was not consistent across the county.
- Telehealth maintained an up to date asset register of equipment held by patients in their home. We reviewed the register to ensure all monitoring equipment in people's homes was maintained and safe to use. The asset register demonstrated all equipment had been serviced in a timely manner to ensure safe practice. The telehealth service had a designated member of staff who was responsible for the installation of equipment in patient's homes, teaching patients how to use the equipment and to troubleshoot if patients or staff reported equipment malfunction. Staff managed waste and transporting of clinical specimens effectively to keep people safe. Minimal clinical waste was carried in cars and this was limited to sharps bins. Staff told us they took special care to ensure the lid was closed and that it was secured during transport. When nurses were required to transport clinical specimens such as blood tests, these were stored in a secure plastic container in their boot, which ensured there could be no accidental contamination or infection risk.
- The podiatry clinic at Callington had access to two first aid boxes in the department in case of an emergency.

The boxes were well stocked and equipment and consumables in them were in date. The clinics were clean, tidy and free from clutter. Equipment was organised and stored neatly on trolleys.

- Community nurses worked with an assessment proforma of different wound dressings to manage patients in the community. The proforma had been developed by the tissue viability nurses in conjunction with the community nurses. Nurses kept a stock of wound dressings at their bases. Nurses recorded what they took from the store to ensure the correct stock level was re-ordered and maintained at each base. If patients required a specific wound dressing, this would be prescribed via the patients GP and either collected from the pharmacy by the patient, their family or delivered to the patient's home.

Quality of records

- Individual care records were not always written and managed in a way which kept people safe. We reviewed 51 sets of patient records, 45 electronic records and six paper records.
- The organisation used an electronic patient records system; however, not all teams used the same system. For example, the cardiac service and the Parkinson's disease service did not use the same system. However staff could view patient records on other systems and see what current care and treatment the patient was receiving from other teams if required. This allowed for a more holistic and joined up approach to patient care when staff made these additional checks.
- The trust was due to introduce a new electronic reporting system in November 2017 so all services were working from the same system. At the time of our inspection, there was confusion across the county between staff as to what system was being introduced. At the time of our inspection, none of the staff had received any training on how to use the new system.
- Electronic patient records were kept securely and patient confidentiality was maintained. The system could only be accessed via individual staff passwords and we observed staff logging on and logging out of the system during their shifts.
- Electronic records were not always completed by the community nursing teams, which did not ensure the safety of the patient. For the majority of records we reviewed, risk assessments, for example malnutrition universal screening tools and skin assessments were not completed and had not been reviewed. We saw examples of patient records, where patients had wounds and pressure ulcers, but we saw no evidence of wound assessments or wound care plans individualised for the patient. This meant there was no formal review or evaluation of care and treatment provided. For example, an active patient on a community nursing caseload had received no review of their wound since May 2017. Care plans we reviewed were very task orientated and lacked a personalised and holistic approach to individual patient care.
- Staff at the leg clinic were not working in line with the Nursing and Midwifery Council Code Of Conduct: Professional standards of practice and behaviour for nurses and midwives standard 10.4 (2015). Staff at the clinic were writing patient notes in the electronic record when logged onto the system by another member of staff. Therefore electronic patient notes were then signed off by a different member of staff. This made the member of staff whose name was attributed to the notes accountable for anything that's should happen to that patient. Staff told us they only had three computers available during the clinic and keeping three computers logged on for the duration of the clinic saved time. The NMC code of practice states 'attribute any entries you make in any paper or electronic records to yourself' (10.4).
- The electronic records system could be used offline by the community nursing team; however, many staff did not speak highly of this feature. The nurses could download their daily case load from their base in the morning and write up their notes when out on visits, working offline. Once they returned to base, they were then able to upload their notes onto the live system. Nurses told us the system was slow and the process was time consuming. The majority of nurses we spoke with did not use this feature when on visits in the community. Nurses preferred to make their own notes and record them directly onto the live system on their return to the office.
- Individual teams carried out annual records audits to identify compliance with record keeping. For example, the musculoskeletal service (MSK) identified some areas for improvement, including entering a time in the patient's records in accordance with national guidance and recording of patient consent to treatment. We saw a

copy of the action plan following the audit and minutes from the MSK leads meeting where the audit was discussed and a local team meeting where the audit results and actions were discussed with staff.

Cleanliness, infection control and hygiene

- Infection control practice was adhered to by the majority of staff. We saw staff were bare below the elbow and washed their hands before and after patient contact. Staff also had access to personal protective equipment which was used appropriately. However, we were not assured risk assessments with regards to infection control were carried out for patients when there was a risk.
- We observed staff demonstrating good infection control and prevention practice when visiting patients in their home. In many of the clinics we visited, staff washed their hands at appropriate times and wiped down equipment following its use, ready for the next patient. Staff were 'bare below elbows' when carrying out patient interventions such as wound dressing. We saw that staff applied an aseptic non-touch technique when carrying on care interventions where this was required. However, as of May 2017, only 26% of staff were compliant with aseptic non-touch technique training.
- Personal protective equipment was available to staff and staff wore personal protective equipment such as aprons and gloves when carrying out care interventions which could pose an infection control risk. We observed the majority of staff using the five points of hand hygiene, including washing their hands before carrying out care activities. However, we saw one nurse who did not wash their hands after removing their gloves, on completion of a wound dressing change.
- We were not assured infection control risk assessments were always carried out for appropriate patients. We visited one patient who had been admitted onto the community nursing caseload when discharged from hospital following an operation. The patient had not been screened for methicillin-resistant Staphylococcus aureus (MRSA), which should have been risk assessed on the first visit. There was a section in the electronic patient record that required staff to assess a number of prompts about infection. If more than four prompts were answered positively, an MRSA screen should be carried out on the first visit. Staff explained that the assessments and subsequent documentation was very time consuming. They also explained the assessment was not relevant for all patients, and there was no option to indicate when this was not applicable. However, we were not assured efficient screening was carried out to ensure prevention of the spread of infection. If patients were not screened, staff would be unaware of any potential risks which would not be built into and accounted for when planning daily visits.
- Clinical waste was managed safely and appropriately. We visited clinics where clinical waste was separated from regular waste into the correct colour coded bags in separate bins. This prevented the spread of cross infection. Clinic rooms in a variety of locations we visited were equipped with hand washing sinks, paper towels, liquid soap and pedal bins were also available. We saw clinics which used disposable instrument packs and these were disposed of correctly.
- The acute care at home team carried out monthly hand hygiene audits. The results of the most recent audit demonstrated a lack of compliance with being bare below the elbow and having short tidy nails. We saw the acute care at home monthly team meeting minutes. These demonstrated that the results of the audit, learning and actions had been fed back to the team. The team would re-audit hand hygiene on a monthly basis.
- Medical wipes were used to clean equipment and plinths between patients at the musculoskeletal clinics.

Mandatory training

- There was poor compliance with mandatory training, which meant not all staff were trained in the delivery of safety systems, processes and practices to ensure the safety of patients. The trust provided two months of data prior to our inspection, to demonstrate mandatory training compliance for the community adult service. Data provided demonstrated training compliance with mandatory training on 31 May 2017 being 36% against the trusts target of 85% for the majority of courses. There were eight mandatory training courses where the compliance target was 95%, however not all of these were applicable for the community adult service. These courses included E-essential update, E-stat update, fire safety face to face (non-inpatient) information governance and moving and handling practical.
- Mandatory training compliance with e-Essential was 95%, which met the trusts compliance target of 95% along with information governance training where 97% of staff were complaint. However, staff were just under compliance with e-stat training at 94%. E-Essential and

e-Stat training included training for display screen compliance, fire safety awareness, health and safety awareness, moving and handling theory, equality and diversity awareness, harassment and bullying, infection, prevention and control, and information governance to name a few. Compliance with moving and handling practical training was 43% against a target compliance of 95%, whilst basic life support training saw 64% of staff compliant against a target of 85%.

- The trust had introduced a new system to capture mandatory training compliance in June 2017. Staff received emails when their mandatory training required updating. However, staff told us that accessing face-to-face training was challenging due to insufficient courses available. Staff also told us that the nearest training could involve significant travel time due to the geography of the county. Some community nurses told us of times where they had been required to cancel mandatory training due to sickness or staff shortages within the teams.
- Mandatory training included community assessment of the sick patient' (CASP) training which included information about sepsis. Sepsis is a serious infection and timely treatment is critical. There seemed to be confusion between the nurses we spoke with as to whether this training was mandatory or not. Despite this, training data demonstrated by May 2017, only 78 members of staff out of 406 staff eligible for the training (19%) had completed CASP training. Also, we did not see any posters displayed in staff areas to help increase the awareness of sepsis, despite a national sepsis campaign in September 2017.

Assessing and responding to patient risk

- Countywide, risk assessments, risk management plans and reviews were not being consistently completed by the community nursing teams. Therefore, risk assessments were not being used to respond positively to patient risk or to minimise harm to patients. Risk assessments were available for staff on the patient electronic care record, which had been developed in line with national guidance, however, these were not utilised appropriately by community nurses to respond to patient risks. We reviewed 36 sets of community nursing electronic patient records. We saw evidence where risk assessments had not been carried out for patients who had experienced falls and wound assessments and pressure ulcer risk scores not completed for patients with pressure ulcers. We also saw patients at risk of further skin breakdown did not have care plans to mitigate these risks. We also saw examples of serious incidents investigations where risk assessments had not been completed for patients.
- We reviewed the records of vulnerable patients where risk assessments and care plans had not been completed. For example, we looked at the records of a patient who had a pressure sore on their hip and sacrum. We found no evidence in the patient's records to demonstrate any assessment of the patient's skin had been carried out. We saw evidence of patient records where patients had open wounds. No pressure ulcer risk assessments had been completed for them and there was no evidence to demonstrate pressure areas were assessed during each visit. We saw another patient's records who had recently been referred into the service. The patient had three necrotic toes (where there is no blood supply and the tissue is dying). No wound care plans had been completed for this patient and no photographs had been taken to enable the nurses to monitor the patient's condition.
- The community nursing service was not using national tools such as the national early warning score (NEWS). This tool is used to aid the recognition of the deteriorating patient, based on scored observations including temperature, pulse, oxygen saturations, blood pressure and respiratory rate. A specific scoring system identified the need for escalation of a deteriorating patient. Evidence demonstrates that use of the NEWS enables a standardised assessment approach to identifying acute illness severity and a more timely response for the deteriorating patient.
- The community adult service had a sepsis screening tool however; this was not fit for purpose as the nursing staff did not have the tools identified on the sepsis screening chart to monitor patients for sepsis. Therefore there was no consistent approach to the early recognition and management of sepsis in the community. The trust had a sepsis policy: sepsis screening in community and home environment, however, despite being recently updated this did not include any reference that the policy was based on the most recent National Institute for Health and Care Excellence guidelines for sepsis (NG51).
- Nurses carried a sepsis screening tool; however the tool recommended escalation of the patient if their NEWS

score was above three. The community adult nursing teams were not using a NEWS. Baseline observations such as pulse, temperature, respiratory rate were not routinely recorded for patients under the community nursing team. This did not provide nurses with a comparable set of observations for the patient if they suspected the patient may be deteriorating. The National Institute for Health and Care Excellence (NICE) quality statement QS161 recommends a structured set of observations are taken if sepsis is suspected, including temperature, heart rate, respiratory rate, level of consciousness and oxygen saturation. Not all nurses had access to a pulse oximeter to monitor oxygen saturations whilst out on visits, and only 16% of relevant staff had completed training in clinical observations based on data provided by the trust for April to May 2017.

- The cardiac rehabilitation service risk stratified patients to identify how many staff were required for the cardiac rehabilitation session. Prior to patients starting at cardiac rehabilitation, a thorough pre-assessment was carried out, this included a set of baseline observations. This assessment identified the patient's individual level of need which contributed to the number of staff required to safely run the group.

Staffing levels and caseload

- Staffing levels, skill mix and caseloads accounted for patient risk and acuity when they were planned and reviewed. Staffing levels were adequate to meet the needs of the local population to ensure people received safe care. At the time of inspection, staffing levels were planned, and despite some gaps in staffing accounting for vacancies and sickness, the teams we visited were managing their caseloads.
- The organisation was aware of the demand, capacity and workload pressures facing staff, and the teams where this had greater implications. This was evident on the corporate risk register where we saw mitigation in place for risks.
- The trust was aware of their staffing levels and vacancy rates. In May 2017, the community adult service had a 3.2% vacancy rate for staff within this service. This was lower than the trusts average of 4.8%.
- Staff turnover rates for the community adult service was lower than the trusts average. Between June 2016 and May 2017, the service had an annual turnover rate of 11.8% against the trust average of 12.5%.
- The community adult service had a lower average sickness rate than the trust's average. Between June 2016 and May 2017, the service had an average sickness rate of 4.5% against the trust's average of 5%.
- Bank and agency staff were used across the community adult team to bring staffing to planned levels where there were gaps due to vacancies or sickness. Prior to the inspection, we requested data with regards to the use of bank and agency staff for the community adult team. The trust was unable to supply any data for this request. This was because a new system to manage staffing levels was being introduced to the service, and information at the time of our request was not yet live on the system.
- Community nursing teams were commissioned to provide an evening service, however, the evening service was not standardised throughout the community nursing teams. The nursing teams in the mid and east localities provided one registered nurse to be on call at home between 5pm and 10pm, whilst nursing teams in the west provided a full evening service where nurses provided cover and remained in the office between 5pm and 10pm. Nurses in the mid and east localities worked a full day shift and would then cover the on call service. There were concerns as staff could have a busy day, followed by a busy night shift and still be expected to come in for work the following morning.
- Staff had raised concerns about this and a risk had been raised and reported by a band 7 nursing team lead. We saw the risk and the controls in place to mitigate the risk to staff; however work was ongoing to manage the risk effectively long term. The community nursing teams had audited in March 2017 and August 2017 the number of referrals which came in over the course of a month for each on call shift. This work had been taken to the integrated care managers to escalate to see whether there was funding available for a proper evening service in the mid and east localities, with dedicated evening staff, like in the west locality. A workshop had been held for nurses to attend to discuss their concerns and ideas about how to move forward with the evening service. We saw an overview document summing up themes from the meeting. At the time of our inspection, work was ongoing to move forward the issues with the on call services. In the Camborne district nursing team, there were different shift patterns to accommodate the evening cover.

Inadequate

Are services safe?

- A capacity and dependency tool has been trialled by the Bodmin and Liskeard community nursing teams where caseloads were allocated daily and reviewed in line with team capacity and patient risk. The tool was now being rolled out in west Cornwall. Work had been done to identify the different tasks carried out by nurses on a daily basis, which showed, after all of the administration tasks, the nurses had four hours to visit patients. The teams were using a unit based system, where one unit was equal to 15 minutes of nursing care time. Nurses could be allocated a maximum of 16 units daily for clinical contact time. Nurses could be allocated a maximum of 16 units daily for clinical contact time. Patients on the team caseload are allocated a dependency score (units) based on their clinical needs and this would be used to achieve the maximum caseload of 16 units for each nurse. The tool used was a live tool and caseloads could change at any point during the day. Team leads would contact the nurses to inform them of any changes. Patients were triaged to ensure urgent patients were seen as soon as possible and allocated to the most appropriate nurse's caseload.
- The trust had developed new recruitment strategies to ensure the right staff were employed by the trust and were committed to providing safe, high quality patient care. Recruitment days were based on the trust values and had been set up to secure recruitment and retention of staff. The locality manager told us recruitment and retention at the time of our inspection was positive.
- The trust had introduced a rotational physiotherapy post, to attract physiotherapists to the area and provider greater opportunity for therapists to gain greater experience. The post was designed to increase the flexibility of staff and improved their opportunities.
- The acute care at home team had concerns about funding withdrawal for three full time nursing posts. It was unclear why the funding for these posts had been withdrawn. The service had seen an increasing demand over the last year. In August 2017, the service had carried out 212 new visits, and 1,082 follow up visits. This was significantly above target set by the trust at just 123 new visits and 671 follow up visits. The team lead was very concerned about the sustainability of the team with the funding withdrawal for three members of staff. At the time of our inspection, the team consisted of 19 nurses based in different localities working across the county. There were also an additional seven nurses working from St Barnabus Community Hospital who supporting the team.
- The home first team had exceeded their target for care delivery in July 2017. The generic support workers were seeing 4.9 patients daily, which exceeded their target of 3.1 patients. Despite this, the team had the capacity to take on all referrals. Care and treatment was provided for two weeks for patients under this service, however, 14 patients received care for over the two week period. This was due to capacity challenges within the adult social care team, patients needing further rehabilitation following fractures and family delays which included waiting for private packages of care.
- The Centipede leg ulcer club had the capacity to see 40 patients during each clinic session. Clinics were held in Penzance twice weekly between 9am and 3pm.

Managing anticipated risks

- Risks were not always accounted for when planning and delivering services. On occasions, risks were not challenged by senior staff, including team leads. The community nursing teams held a daily handover, which included discussion of caseloads, patient's acuity and treatments required. We observed a handover session at Launceston Community Hospital where community nurses discussed each patient they had seen during the morning. This enabled discussion amongst the whole team to ensure continuity of care, positive challenges of treatment provided or suggestions of alternative solutions to problems. Nurses used a handover book to enable quick access to issues and solutions discussed. However, we also observed a handover session in Camborne. Here, there was little support for community nurses and risks were not challenged and some were overlooked. For example, one nurse had been unable to obtain some blood from a patient to send of for a review. There was no challenge as to the urgency of these. No questions were asked as to what the bloods were for. Some blood tests can be critical to safely manage patient medicine. A nurse also informed the team that a local care home had become confused due to several different patients all being treated with different creams. The home had become confused as to which patient needed which cream and had requested a teaching session on the different creams. No plan was

made to provide support to the home to safely manage patients. The handover did not provide us with assurance that the community nurse team lead was engaged in the day to day running of the service.

- The lone working policy did not ensure the safety of the community nurses when working on call during an evening and did not ensure their safety at all times. The policy stated, 'If you are visiting a patient or area that you have concerns about, contact the person on call for the neighbouring area, discuss concerns and consider a joint visit or use the Switchboard following the staff safety communications/mobile phone monitoring and call out procedure.' The system did not ensure staff were safe following their last visit and whether they had made it home safely and only guided staff to use the system if they felt they could be at risk. When working out of hours, unless staff activated the lone worker policy by calling switchboard, there was no one to ensure their safety. Staff told us when working on call, they would not routinely call the switchboard to inform them they had completed a visit, or finished their shift and were safe. Neither did the switchboard team call the nurses to ensure their safety at the end of a shift. Staff told us they were concerned about their safety when working on call. There was a code word which staff could use in an emergency if assistance was required immediately. However, despite the policy clearly outlining a specific code staff we spoke with were not aware of the code word.
- Mobile phone connectivity was both a challenge and a concern between the community nursing teams and a risk to lone working. In rural parts of the county, this was a concern particularly if a nurse was on call in the evening attending visits alone. There was a lone working policy which provided guidance for staff and risk assessment templates. However, during the inspection, we did not see any of these, nor were we made aware by the staff about them. We were not assured that there was consistent use of the risk assessment templates as outlined in the lone worker policy. Staff safety could be compromised if they were unable to request help or assistance in an emergency. This risk had not been identified on the risk register.
- There was an acute care at home team and a Home First team to relieve pressure on local hospitals in times of increased demand. The aim of the service was to help prevent patient admission into the community hospitals and the local acute trust. The Home First team were also able to support earlier discharge for some patients from the community hospitals. The service was able to take patients who, within two weeks following discharge were able to regain their confidence and independence and live independently in their own home.
- Community nursing teams were using a RAG rated escalation tool to determine the status of their team in terms of capacity and availability. The escalation flow chart identified four levels; green, amber, red and black. Each colour represented a different level of pressure, which a team could be working at. The flow chart also identified a de-escalation plan for the teams depending on the level of pressure they were working at. Teams identified their status on a weekly basis and discussed this on a weekly call with team leads from other community adults' services and the locality integrated care manager. If a team was under pressure, the call enabled staff to look to teams under less pressure to provide support where possible. This ensured effective management of team caseloads and the delivery of safe care to patients.

Major incident awareness and training

- The organisation had a business continuity plan which would be followed in the event of an emergency or major incident. We saw the plan which was held in a file in the community nurses office at Stratton Community Hospital. The plan included information and guidance for staff on severe weather conditions, senior staff contact details, advice on prioritising caseloads and what to do in the event of failure of the electronic records system. Staff we spoke with were aware of the plan and how to access it.
- There was a business contingency plan specifically for the acute care at home team in case of adverse weather conditions. This plan identified the team's access to a 4x4 vehicle to be able to carry out visits to patents in rural areas in bad weather conditions. Appropriate patients would be referred to the community nursing team, and the acute care at home staff where possible would try to pick up patients in their local area.

Requires improvement

Are services effective?

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

Summary

We rated the effectiveness of community adult service as requires improvement because:

- The management of pain was inconsistent and did not always include an appropriate assessment and management plan for patients who were, or could be experiencing pain.
- There was poor compliance with the completion of an initial nutrition and hydration assessment for patients under the care of the community nursing teams. There was no documented evidence to identify when an assessment was not required.
- Not all community nurses received formal supervision sessions.
- The process of receiving referrals into the service was not clearly defined.
- Staff were not always compliant with the trust's consent policy with regards to the completion of consent to sharing information documentation.
- Not all staff provided us with assurance they understood their role and responsibilities around the mental capacity act and best interest decisions.

However

- Care and treatment was based on relevant evidence based practice, national guidance and legislation. Staff demonstrated how they underpinned national guidance to support their practice and the care and treatment of patients.
- There was an effective telehealth service empowering patients to manage their care and treatment in their own homes. The service was valued by many patients and other community adult services.
- Audit programmes captured positive information about patient outcomes.
- Staff demonstrated competence to be able to carry out their roles effectively.
- The service had just exceeded the trusts target for completion of staff appraisals.
- We saw good examples of joined up working between teams internally and external partners.

Detailed findings

Evidence based care and treatment

- Care and treatment was based on relevant evidence based practice, national guidance and legislation. Care plans, risk assessments, policies and assessment templates were also based on current evidence based national guidance.
- The electronic patient record system included risk assessments based on current national guidance such as the Bradon score for identifying pressure ulcer risk, and the malnutrition universal screening tool (MUST), which assessed the risk of malnutrition.
- Community specialist services were based on current and evidence-based practice. We saw many examples of this and staff were aware of the underpinning national guidance to support practice. For example, staff the telehealth service followed 29 different clinical pathways based on guidance from the National Institute for Health and Care Excellence (NICE) when responding to abnormal monitor readings from patient. For example, national guidance for patients with chronic obstructive pulmonary disease (a lung condition which causes breathing difficulties). These pathways were reviewed every year and records were kept to ensure all pathways were regularly updated to reflect new national guidance.
- The respiratory service followed the British Thoracic Society (BTS) guidelines to ensure care and treatment provide to patients was current and evidence based. The service had recently achieved an accreditation from the BTS for its pulmonary rehabilitation groups. The accreditation process was based on meeting a set of accreditation standards, which was assessed by a combination of a visit to the pulmonary rehabilitation group and a pre-visit submission of written evidence. The standards used are based onBTS Quality Standards for Pulmonary Rehabilitation. The service lead was very proud of the team for being awarded the accreditation. The team also contributed to a national audit programme run by the BTS. Data had been submitted and the results were about to be published but were not

available at the time of our inspection. The service lead discussed what they had heard was one of the outcomes from the audit. This was the standardisation of education provided to patients nationally.

- Patients attending the podiatry department had their needs and risks assessed in line with national guidance. The podiatry service carried out care and treatment in line with the National Institute for Health and Care Excellence (NICE) guidelines, diabetic foot problems: prevention and management (NG19). The service also used a nationally recommended scoring system to classify the severity of diabetic foot ulcers.
- The speech and language therapists used clinical guidance from the Royal College of Speech and Language Therapists (RCSLT) on which to base their care and treatment. The guidelines informed and optimised care and treatment for patients as this was based on evidence based practice. The teams waiting times for incoming referrals was also standardised by the RCSLT clinical guidelines.
- The service ran a Centipede club for patients with leg ulcer problems. Care and treatment at the club was based on NICE guidelines and evidence based guidance for wound management. The clinic had started in March 2017 for patients in Penzance and the surrounding areas. The club aimed to relieve the community nursing caseload, reduce the clinical time used for these patients being seen by the community nursing team and reduce costs. Evidence collected, during one week in October 2017, demonstrated the number of clinical hours saved treating patients at the club rather than by the community nursing team. Evidence also demonstrated the time saved in travelling and cost saving implications.
- The cardiac rehabilitation service was based on national guidelines from the British Association for cardiac Prevention and Rehabilitation.
- The acute care at home team managed a variety of patients with different presenting conditions. The team used care pathways based on NICE guidelines, for example, urinary tract infections in adults (QS90) and pneumonia in adults: diagnosis and management (CG191).
- The trust had a sepsis screening in the community and at home policy, however, despite the policy being recently updated, the policy did not include any reference to the latest NICE guidelines, Sepsis: recognition, diagnosis and early management 2016 (NG51).

Pain relief

- The management of pain was inconsistent between the different community adult services. Care plans for patients under the community nursing team did not always include an appropriate assessment and management plan for patients who were or could be experiencing pain.
- During visits we heard nurses discussing pain with patients. However, we saw limited evidence of discussion and pain management plans recorded in patient records. For example, one patient was receiving visits from the community nurses for wound management following an operation. Whilst the nurse asked about pain management during the visit, this was not documented on previous visits to demonstrate pain had been addressed. Staff were not aware of a trust wide assessment tool to use to document the severity of pain reported by patients.
- Patients told us community nurses always asked about their pain and gave relevant advice regarding painkillers as per the patient's prescription. If nurses thought patients' medicines were not sufficient to keep patients pain free, they advised patients to contact their GP or would discuss pain management with the GP on their behalf, with patients' consent.
- We observed a patient attend a podiatry clinic appointment. Three times during the consultation the patient directly brought up the subject of the pain they were experiencing from their leg ulcer. On one occasion the patient directly said "I'm in so much pain, I don't know if you can do anything about it." There were two clinicians tending to the patient during the appointment and neither of them addressed the patient's pain or suggested a management plan to help the patient manage their pain.
- The musculoskeletal clinic routinely asked patients whether they were experiencing pain. A numerical pain scale between one and 10 was used to identify a patient's pain. We heard discussion during consultation we observed and saw documented evidence of pain in the patients' records and a review of the pain during follow up appointments.

Requires improvement

Are services effective?

Nutrition and hydration

- Countywide, compliance with completion of the malnutrition universal screening tool (MUST) as a standard initial nutritional risk assessment for patients under the community nursing teams was poor. Research has shown that malnutrition is common in some community settings and a routine assessment of height and weight in high risk patients in the community has been recommended. Community nursing teams were not consistently assessing and developing care plans to ensure patient's nutrition and hydration needs were met. We looked at 36 sets of community nursing records. Out of these, 30 records (83%) did not have an initial MUST risk assessment completed for patients. This did not provide us with assurance that patients nutritional and hydration needs were being identified and managed where appropriate. Nurses told us some patients did not require a MUST assessment to be completed; however, there was no documented evidence to identify when this was not required for a patient. Therefor it was unclear whether patient's nutrition and hydration needs were being met.

Technology and telemedicine

- The service had an efficient telehealth service, valued by many of the community adult services. The service supported patients to manage their health in their own homes however, at the time of our inspection, it was undergoing a consultation to be decommissioned by the local clinical commissioning group. Data received prior to the inspection stated the decommissioning was due to be effective from November 2017, although we were told by the locality manager this had been delayed, and there was currently no set end date. Despite this, the service was discharging patients and staff numbers had been reduced as staff had sought employment elsewhere.
- We met with the telehealth team who were all concerned for the wellbeing of the patients using the service, when the service was no longer delivered. The service could monitor up to 1,000 patients in their home, although at the time of the inspection the number was approximately 450 patients as they were no longer admitting new patients to the service and were in the process of discharging current patients. The service would normally run at 90% capacity, which meant that approximately 900 patients were monitored remotely daily. Patients monitored their own health such as heart rate, blood pressure, oxygen saturation, weight and blood glucose levels using designated equipment provided by the trust. Information from these measurements was sent electronically to staff in the telehealth service for review. If measurements fell outside of patient specific parameters, staff would contact the patient by telephone to discuss their reading and enable the patients to make decisions regarding actions to take such as contacting their GP. Staff made regular contact with all patients, even if measurements did not fall outside of their specific parameters, once or twice a week.

Patient outcomes

- Information about people's care and outcomes were collected and monitored by the trust. Teams carried out internal audits, whilst some specialist teams also collected data for national audits.
- Some specialist services took part in national audits. The Parkinson's disease specialist nurses took part in the Parkinson's UK National Audit. The service was in the process of collating the relevant data for submission by end of October 2017. We asked how the service used the data and compared it to other similar services to develop their service. Following the 2015 audit, staff told us they had reviewed and adjusted the assessment of activities of daily living to also include information about quality of life.
- We spoke with the lead Parkinson's' specialist nurses and asked how the effectiveness of their service was assessed in term of patient's outcomes. These were reviewed partly in relation to key performance indicators (KPI's) as set out in the commissioning framework. However, staff did not feel these KPIs were fit for purpose. This was because national guidance and performance ideals had changed, and the KPI's set had not been updated to reflect different targets in relation to care and treatment. The service level agreement review was due for a review in 2015, however, at the time of our inspection, this had not yet happened. Following the inspection, we were informed by the trust that action had been taken to ensure the service was reviewed. This was to take place in March 2019.
- Some services had outcome specific audits and key performance indicators by which they could evaluate the effectiveness of their service. For example, the telehealth service produced a yearly outcome report

against set objectives in patients' management plans. The 2016/17 outcome report included a review of 244 patients' management plan. The audit demonstrated early detection of patient deterioration in 81% of cases, 76% of patients had increased awareness of their illness and how to manage this effectively, 26% of patients had received 'step down' service in preparation to be discharged from the telehealth service and 8% had received support to facilitate early discharge from hospital. The telehealth service also collected information about the monetary savings of funds for patients receiving their services. For example, for patients who were referred to the service for respiratory monitoring had demonstrated savings of £1.9M for 795 patients, during a 12-month period of support provided for 305 patients there was a saving of £746,000 and in the 12 months after discharge the savings were £164,000 based on 67 patients who were reviewed. These savings were achieved through support to discharge patients early from hospital, hospital admission avoidance and increased patient knowledge and empowerment to enable patients to manage their own conditions.

- The centipede leg club audited patient outcomes and leg healing rates in August and September 2017. Results demonstrated the leg club was achieving healing rates of 25% in August and 26% in September 2017. Healing rates greatly exceeded the national average healing rates of 6-9%. Results also demonstrated the club was exceeding the national average with regards to reoccurrence of leg ulcers. Between March and September 2017, the leg club had seen a leg ulcer reoccurrence rate of just 3% compared to the national average of 46%.
- The podiatry service used a nationally recognised tool to measure the severity of a patient's diabetic foot ulcer and their likely outcome. The SINBAD scoring index (site, ischaemia, neuropathy, bacterial infection, area and depth) was used to classify a patient's foot ulcer. The data collected was submitted to the national diabetic foot ulcer audit, in order to be nationally recognised and benchmark outcomes for patients with diabetic foot ulcers.
- Performance targets for the community adults teams were set by the trust. In July 2017, 93% of patients were seen within zero to five working days this exceeded the target of 90%, whilst 92% of patients who were referred into the community stroke service were contacted within seven working days, which exceeded the target of 85%. Both the physiotherapy and occupational therapy rehabilitation team exceeded their target of 90%, with 95% of patients being offered an appointment within five working days. However, 87% of patients received an assessment within two weeks of referral to cardiac rehabilitation, heart failure and primary prevention work for patients with atrial fibrillation which fell just under the target of 90%.
- The speech and language therapy team used set measurable goals with patients to identify whether the patient had achieved good outcomes from their care and treatment under the service. Goals were set in conjunction with the patient and what they wanted to achieve. We observed patient records which included patient's goals and regular reviews thereof.
- A new augmentative and alternative communication pathway for patients had been developed by the speech and language service. This pathway was for patients who were unable to speak and used electronic aids to communicate. Previously, the supply of equipment for these patients had not been effective. Now the service had new equipment and was planning to carry out an audit to identify the effectiveness of this pathway on patient outcomes.
- The cardiac rehabilitation service used outcome measures to monitor the progress of the patients attending the sessions. The BORG scale was used at each session to monitor individual patient outcomes on a session by session basis. The BORG scale is an outcome measure used to capture perceived exertion for an individual patient both at rest and during activity. The service also had a choice of three tools to monitor patient's outcomes to determine their aerobic fitness on an individual basis. One appropriate outcome measures was used for the individual patient when they started cardiac rehabilitation sessions. Once their course of treatment was complete, the outcome measured would then be reviewed to identify improvements in the patient's performance. The service used either the Chester step test, incremental shuttle walk test or the six minute walk test.
- A recent wound care audit had been carried out in June 2017 by the tissue viability team. At the time of our inspection, the results of the audit were still being reviewed and the outcome determined and reported on. The audit was carried out countywide. The aim was to identify both good and poor practice of would care, and

monitor care and treatment of wounds against the National Institute for Health and Care Excellence guidelines. A further re-audit was due to take place in January 2018.

Competent staff

- Staff had the skills, knowledge and experience to deliver effective care and treatment apart from a handful of diabetic specialist nurses who were prescribing medication without the relevant competence to do so. Despite this, across the teams, staff received in-service training and some teams required staff to complete competency frameworks to support their role. This ensured staff were competent and knowledgeable in providing the most effective care and treatment for patients under the care of their service.
- The podiatry service had recently attended a staff training day to develop their knowledge and skills in the management of diabetic foot ulcers. The team received presentations from the diabetic specialist nurse, vascular consultant and orthopaedic consultant and had the opportunity to ask questions and discuss current complex cases. The training was designed to upskill the staff to optimise care and treatment for patients.
- Peer sessions were held within the speech and language service to discuss and learn from complex cases. This provided an opportunity for staff to learn from current and previous cases in order to be able to optimise treatment with future patients with similar conditions. Any member of staff could bring a current patient or a successful case to the group to discuss. The team also held quarterly continuous professional development days where members of the team who had recently attended training would present and feedback to the team their learning to benefit all of the team.
- Newly qualified members of staff in the speech and language department were required to complete a competency framework on starting their role in the service. This was to ensure staff had an in-depth knowledge and were competent to carry out their role.
- Healthcare assistants working at the Centipede club attended a Doppler course (a Doppler measures the blood pressure in the arteries at the ankles and compares itto the pressure in the arms to rule out any circulation conditions). The healthcare assistants attended this course to ensure they were competent to carry out a Doppler assessment on patients attending the clinic.
- The acute care at home team was proactive in attending courses to develop their knowledge and skills in their field, and routinely fed learning back to benefit the whole team. Two members of staff completed a venous therapy access course and an intravenous therapy course and a member of staff had attended a diabetes masterclass. Information from the training courses was cascaded at team meetings and via email. We saw the email providing the team with information from the member of staff who attended the diabetes masterclass. The service was also keen to develop the band 5 nurses within the team. These nurses attend long term conditions training run by consultants from the local acute trust. Training helped to upskill the nurses, and ensured their competence when managing patients with long-term conditions.
- The musculoskeletal teams held twice weekly case study meetings. Here, staff got the opportunity to discuss complex cases and the management of these patients to enhance their learning and ability to learn from their peers and provide more effective treatment for patients. Staff also had daily access to more experienced musculoskeletal therapists where they could discuss specific cases on a one to one basis if they needed support with care and treatment plans. The service also held in service training sessions where all the staff from the department attended. Training sessions were carried out by the therapists themselves or by external speakers. Recent examples of the training included vertigo training, tendinopathies, and feedback from the spinal interest group.
- The musculoskeletal service provided an intensive joint assessment learning programme for new starters to ensure competence in their role. A band 5 physiotherapist had recently rotated into the Falmouth musculoskeletal service. On starting the role, a teaching programme for different joint assessments was started. This programme gave the band 5 member of staff the opportunity to spend two weeks with a senior clinician looking in depth at one joint a day whilst also observing assessments of particular joints. The band 5 member of staff told us they felt well supported by the team.
- The Telehealth service required staff joining the team to complete a competency framework. This was to ensure

staff were competent to carry out their role. The competency framework included the various assessment process required to manage the variety of patients monitored by the Telehealth team. We saw two staff files where all of the competencies had been completed and signed off.

- The Parkinson's disease nurses used a competency framework to ensure the competency of the nurses managing patients with Parkinson's disease. The framework set out specific competencies for nurses with specific skill levels. For example, for competent nurse (band 5), for an experienced specialist nurse (band 6) and for an expert specialist nurse (band 7/8). New nurses would undertake the competency framework and progress through the different frameworks in line with the posts available in the service for career progression. There were three band 7 nurses who all held the nurse prescribing qualifications. This was included in the expert specialist nurse competence assessment (specialist competency 6: medicines management). Staff could not progress onto this unless they had completed all other aspects of the framework.
- Nurses in the bladder and bowel service demonstrated advance qualifications and competence in their role. All staff had advanced qualifications in bowel and bladder management, for example, effective promotion of continence and management of incontinence at degree level.
- All diabetic specialist nurses held a certificate in a post registration course in diabetes management. These nurses had attended regional and national diabetes conferences and had participated in the regional forum for benchmarking and sharing of best practice.
- There were inconsistencies between the arrangements for one to one supervision for staff. During the inspection we found evidence the specialist teams, rehab teams and musculoskeletal teams provided regular six to eight weekly supervision sessions for staff. We saw evidence of one to one sessions, which included various discussions about performance, caseloads and concerns and actions to address these. We saw evidence that actions were reviewed at the following meeting to ensure they had been completed. However, we found the community nursing teams were not receiving regular one to one supervision. Some of the teams we visited held a group supervision session. However, this was not always regular due to work pressures. This did not give the nurses the opportunity to discuss any concerns they may have or have discussion relevant to their caseload of their performance at that particular time.
- There were arrangements for staff to have yearly appraisals. Appraisals are important to ensure each member of staff had a performance review which can identify areas which require improvement, and enabled clinicians to develop a plan to support their career progressing over the coming year. The trust provided us with data demonstrating compliance with staff appraisals between April and June 2017. This demonstrated 86% of the community adult service had received their yearly appraisal. This was just above the trusts target of 85%.

Multi-disciplinary working and coordinated care pathways

- All necessary staff, including those in different teams and services were involved in assessing, planning and delivering care and treatment to meet the holistic needs of the patients. Teams worked together to optimise care and treatment for patients and in some cases minimise the number of appointments they needed to attend to see various healthcare professionals. Staff we spoke with across the different teams told us they felt they worked well together to deliver co-ordinated patient care. Staff gave us numerous examples of how they had worked together within the community adult's service to effectively meet the needs of the patients. We were also privileged to see some excellent integrated working between the teams from the community adult service and the local acute NHS trust.
- The tissue viability clinic had access to support from the consultant from the local NHS acute trust. Care had been co-ordinated to enable the tissue viability clinic and the vascular consultant from the local NHS acute trust to run in parallel on the same day at the same location. We attended this clinic and saw numerous examples of joined up working to benefit the patient and provide a more efficient and effective service. We saw examples where the tissue viability nurse requested the support and advice from the consultant and vice versa, and examples of both clinicians supporting each other for part of the patient's appointment. This enabled the tissue viability nurse and consultant, in

conjunction with the patient plan further care and treatment. This way of working provided an optimised, integrated approach to care and treatment for the patient.

- The speech and language team told us how they worked closely with the motor neurone disease nurse-co-ordinator at the local acute NHS trust to better manage care and treatment for patients under the care of both services. This enabled the teams to be fully aware of the intervention being provided for the patient, and provided a platform to raise any concerns about the patient which could be followed up by either team. This provided a joined up approach to working and optimising treatment in the best interest of the patient.
- Services had treatment optimisation for patients at the forefront of what they were trying to achieve. The Centipede leg club treated patients with leg ulcers. If a patient attending the club was not healing as expected by the nurses, they would liaise with the tissue viability nurses for support and advice on other options to ensure optimal management for the patient.
- The bladder and bowel service met monthly with the lead specialist physiotherapist for continence services in the trust and also with urology and gynaecologists from the local acute trust to discuss complex patient cases. The aim of the meeting was to identify how best to care and treat the patient, referring into other specialist service if required. This ensured patients were receiving timely optimised treatments to manage their condition.
- Two members of staff felt supported by the mental health teams, for their complex patients since merging with the trust in April 2016. Nurses from the respiratory service and the Parkinson's disease service told us how the mental health team had started to attend meetings which had improved links with the team and made for better joint working. The respiratory nurse also told us about a complex patient who was under the care of the mental health team. The nurse frequently spoke with this patients mental health nurse to discuss how best to manage their needs.

Referral, transfer, discharge and transition

- Referral into the community nursing teams was not consistent between the different teams, and with multiple referral methods there was a risk referrals may be overlooked or not dealt with in a timely manner. Referral processes were determined locally and there was a standard operating procedure to support the process. Referrals came in to the community nursing teams by telephone, email, on a rare occasion by fax, and some teams had to go directly to local GP surgeries to pick up new referrals. The process of receiving referrals into the service was not clearly defined.
- A single point of referral form was being trialled in the East and North localities of Cornwall. This method of referral aimed to ensure all relevant information about patients, their condition and the reason for referral was collected in one place and passed to the appropriate team. However, some nurses we spoke with in the North locality had never heard or seen the form. It was unclear how effectively this form had been rolled out to the different teams to trial or how the form was going to be evaluated for its effectiveness.
- The musculoskeletal service had set up and urgent referral system for local GP's. If a local GP felt the patient required an urgent physiotherapy review, they had the option to directly allocate the patient into one of 20 appointments held for urgent GP appointments each month. A referral letter would then be emailed to the musculoskeletal department ready for the patient's appointment.
- The speech and language service had specific criteria for referrals to manage swallowing problems and referrals to manage communication problems. Patients with swallowing problems triaged as urgent were seen within two days as these patients had a higher risk of developing complications if they were to aspirate (when foreign material for example food which enters the lower respiratory tract could cause an infection). Patients with urgent communication problems were seen within 10 days. Communication problems, if left untreated for any length of time, could have implications upon a patient's quality of life.
- The acute care at home team and the local GP surgeries had a telephone number to enable direct communication for referral and discharge of patients into and out of the service. The aim of the service was to prevent hospital admission. GP surgeries referred patients to the team to provide intensive care and treatment to meet the needs of the patient. The team would liaise with the GP surgeries when the patient was coming to the end of their treatment and nearing discharge or if the patient was recovering quicker and

was not going to need the service for the full two weeks. Staff felt it was helpful being able to feedback and discuss things with the GP directly, and felt this made for better patient care.

- Telehealth used clinical pathways which identified clear referral pathways depending on the outcome of a patients monitoring. Referral pathways included referral to the GP or for emergencies, 999 was called to arrange for urgent assistance for patients.
- Community adult services received referrals from a variety of sources. For example, the local acute NHS trust, local GPs, other healthcare professionals, relatives/carers or patient self-referral. The neuro rehabilitation team also spoke of receiving repatriation referrals from services in other parts of the country. Some patients received intensive treatment in specialist units around the country, and on discharge they were referred to their local community teams to continue their rehabilitation in their own home. We asked team leads in the different services we visited about capacity to take on new referrals. Although team leaders were concerned about the ever increasing demand for their services, they all said they would never turn a patient referral away.
- Specialist services supported patients when transitioning between children's and adult services. Both the bladder and bowel service and the diabetes service both provided children's services as well as adult services. This meant they were able to support children and provide a smooth transition for them into adult services.
- Most specialist services did not discharge patients from their care and they remained inactive on their caseload. These patients had long term complex conditions, and it was inevitable they would need to be seen again by their specialist service in the future. The telehealth service had a 'step down' process for patients admitted to the service for a limited period of time. These patients could have recently been discharged from hospital, where a short period of monitoring was beneficial. For example, during the step down process, monitoring would go from being daily, to three times weekly and a step down approach continued until the patient was weaned complete from the support of the service. Once staff and the patient were confident that the patient no longer needed the service they were discharged. The telehealth service saw an approximate 6% turnover of patients each month.

Access to information

- Information needed to deliver care and treatment was available to some staff, however, at the time of the inspection, not all teams were using the same electronic system and therefore information was not always available to all staff. This meant certain services were unaware of other care and treatment being provided for patients, which made it challenging at times to provide a holistic, more joined up, integrated approach to care. The organisation was due to introduce a new electronic system in November 2017 to ensure all teams had access to the same information.
- The tissue viability nurses had access to the same electronic recording systems to support nurses at the centipede leg club with leg ulcer healing. Nurses could request the support of the tissue viability team if they had concerns about patients' leg ulcers.
- There were inconsistencies between the community nursing teams and their ability to share patient records with the local GP surgeries. Some community nursing teams were using the same electronic patient record as their local GP surgeries. This made it possible for both the nurses and the GP to be able to access patient information to determine the outcome of visits and to enable more effective co-ordinated care for the patient. Not all of the community nursing teams had the ability to access this information.
- The musculoskeletal service had access to letters from consultant clinics which patients had attended. The service used an electronic system to access this information.
- The Parkinson's disease specialist nurses and stroke service did not have access to the same electronic recording system used by other services, and therefore were unable to access information about other care and treatment being provided for their patients. These services used paper based notes and a standalone electronic database. This database was used to log audits and outcome measures so they could be benchmarked nationally against other similar services. Staff told us they could request any information they required about their patients which was not a problem.
- Policies and procedures were available for staff on the trusts intranet system. Staff we spoke with knew how to access them to deliver effective care and treatment.
- Information was displayed and easily accessible in the offices at the various clinic and community nurse bases

we attended. Important information was displayed on noticeboards which included information about link nurse roles and key information of how to escalate concerns, for example about safeguarding.

Consent, Mental Capacity act and Deprivation of Liberty Safeguards

- Staff understood the importance of obtaining consent before providing care or treatment interventions,. We observed staff obtain consent prior to care and treatment interventions. Consent was obtained verbally or by implied consent in most cases in community health. Some nurses documented this within the progress records on the electronic patient record system. This was in line with the trust's consent policy (2017).
- Some staff below team leader level did not provide us with assurance they understood their role and responsibilities around the Mental Capacity Act 2005 and best interest decisions. Some staff were unable to tell us about the two stage capacity assessment. However, senior staff we spoke with had a more in depth knowledge and knew the processes to assess a patient's mental capacity if this was required. Staff told us this would be carried out in a joint visit with other health care professionals.
- Staff were not compliant with part of the trusts consent policy. There was a lack of compliance countywide with the community nursing teams completing the consent to share information with other relevant health care professionals as required form. This form was supposed to be completed and signed by the patient at their first encounter with the nurses, and then scanned into the patient's electronic record. However, we saw countywide evidence this for was not being completed consistently. The trusts consent policy (for adults over the age of 18) states 'staff should comply with statutory requirements regarding the seeking of consent, and its documentation, using the necessary clinical record entries, and/or statutory forms.'
- Staff we spoke with had varying understanding and experience with Deprivation Of Liberty Safeguards applications. They explained this was not something there were often required to deal with.
- Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards was included in the e-Stat and e-Essential mandatory learning packages. Compliance rates in May 2017 idents 94% and 95% compliance with these courses. This was against the trusts target of 95%.
- A band 5 community nurse fed back during handover about a patient who had refused to consent to treatment. There was no challenge from other team members or the team lead as to whether this patient had the capacity to understand the implications of not receiving treatment and was making an informed decision.
- One band 7 nurse we spoke with gave us an example of a complex patient, who had the capacity to make basic choices; however, this patient did not have the capacity to make an informed decision about the management of their condition and was putting themselves at risk. A best interests meeting was held and was attended by the community matron, GP, community nurses, diabetes specialist nurse and the patient's family. A best interest's decision was made to ensure the community nursing service visited the patient twice daily to monitor the patients' blood glucose and to administer the medicine required.
- Staff in the telehealth service used a specific consent to share information forms for all their patients.
- The consent to take and use photographs form was not routinely being used by community nursing teams. The trust had a 'consent to treatment' policy, which sign posted staff to a specific policy for 'clinical photography and video recording' on the trust's intranet. Staff were aware of the obligation to gain consent but there was an inconsistent approach and knowledge regarding the type of consent required. The policy stated 'Informed consent should be obtained in writing and be recorded in the health record, using the Recordings Form, detailing the specific use(s) of the recording i.e. as a part of treatment, for teaching or for further specified uses e.g. publication. Staff used their work mobile phones to take relevant photographs of patients wounds, which were uploaded to the patients electronic record upon which, staff delete the image from their phones. Staff spoke of the many benefits of being able to share these photographs with for example the tissue viability services when asking for their advice. Staff also spoke of how these photos were used in handover sessions to discuss and evaluate the effectiveness of current treatment plans. When asked about obtaining consent

prior to taking photographic evidence, for example, of wounds, staff told us the 'consent to take and use photographs' form which required patients to give written consent was not consistently completed. Staff told us instead, they always obtained verbal consent before taking any photographs.

Good

Are services caring?

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

Summary

We have rated caring for the community adult service as good because:

- Patients were consistently positive and complimentary about the care they received.
- Staff treated patients with kindness, dignity, compassion and respect.
- Staff interacted with patients in a respectful and considerate manner.
- Staff ensured patients understood the care and treatment they were receiving.
- Staff understood the importance of involving family members or carers as partners in their care.
- Patients were given timely support and information to cope emotionally with their condition.
- Patients were empowered by the community adult teams.

Detailed findings

Compassionate care

- Staff interacted with patients in a respectful and considerate manner. We observed positive interactions between staff and the patients., with staff being courteous and polite at all times.
- Staff treated patients with kindness, dignity, compassion and respect. Patients we spoke with during the inspection were highly complementary of the care and treatment they received from various teams. Quotes from patients we spoke with included, “nothing but total satisfaction,” “I couldn’t wish for better care,” “I felt my care was personalised, like they knew how I felt” and “the nurses make me feel comfortable because they talk to me like I am a friend.”
- Nurses and therapists introduced themselves to patients who they saw for the first time.
- Staff took time to interact with patients in a respectful and considerate manner. We observed staff carrying out treatments with patients. Staff gave patients time and worked at the pace of the patients and did not hurry them.
- Staff were caring, sensitive and supportive to patients’ needs in their own home, in clinics and in group settings.
- The respiratory nurse took time to listen and support a vulnerable patient attending a clinic appointment. The nurse provided reassurance and support. After the consultation, the patient thanked the nurse for her encouragement and support.
- Staff respected the privacy and dignity of the patients under their care. For patients whose needs were of a more personal nature, staff were sensitive and delicate in the terminology they used.
- Community nurses built positive relationships with patients they were treating. All the interactions we saw between the nurses and patients were positive. Patients told us it was an excellent service with ‘nothing to change’.
- Staff demonstrated an understanding of the need to respect people’s personal needs and take these into account when delivering care. A complex patient was under the care of the community nursing team in Launceston, the patient had capacity to make their own decisions. However, despite having the impact and risks of certain activities on their health and wellbeing, explained by the nurses and understanding these, the patient chose to continue with the risky activity. Nurses respected the patient’s decision and continued to do their best to manage the patient’s condition.

Understanding and involvement of patients and those close to them

- Staff communicated with patients to ensure they understood their care and treatment. Patients at the leg clinic told us the nurses would always explain what was happening with their care and treatment and nurses used language they understood.
- Staff clearly communicated with patients about their condition. We observed clinics taking place within the podiatry and musculoskeletal service. Staff took the time to explain to patients what they felt the problem was, how it should be managed and what treatment was required.
- Staff at the musculoskeletal clinic encouraged and gave patients lots of opportunities to ask questions to

understand their condition, care and treatment. We observed a physiotherapist clearly and simply explain the anatomy of the shoulder to a patient so they could understand their injury.

- Nursing staff understood the importance of involving carers in the care and treatment of patients. We visited a residential home with the community nursing team. The nurse took the time to discuss the patient's revised care and treatment needs with the manager. This enabled good continuity of care for the patient.
- Staff worked to empower patients. We observed numerous examples of staff empowering patients at clinics and during visits from the community nursing staff. Staff encouraged patients to ask questions about their care and treatment and signposted to other services to enable them to access support or advice
- Staff at the various clinics we visited and in the musculoskeletal service kept patients informed and engaged during their treatment sessions. We observed staff providing information to patients about their observations through the session. This kept the patient engaged and involved with their care and treatment.
- Patients were routinely involved in planning and making decisions about their care and treatment. Patients and their relatives were involved as partners in their care. On all visits, we observed, staff included patients in discussions about their care and treatment, where applicable relatives and carers were also involved. Patients felt they were always empowered to make decisions about their care. They felt fully included and staff respected their opinions.
- We observed a daily handover in the community nursing team in Launceston, where nurses discussed concerns relating to patients they had seen that day. There was a holistic approach in the discussions to consider all aspects of the patient's care and welfare, including how to ensure the patient and those close to them were involved in decisions about the care received.
- We spoke with patients receiving support from the telehealth service. Patients were complementary about the service and explained they had benefitted in many ways. Patients told us how the service had supported them to access their GP and community matron. However, the need to see GPs had been greatly reduced due to the daily monitoring of patients and discussions about actions to take to manage their condition. One patient said they would normally be admitted 5-6 times a year but this year only had one admission to hospital in March 2017 because of the daily monitoring. Another patient told us the service had saved his life on more than one occasion, by the early detection of deterioration in their condition. Patients felt involved in their care, and empowered to make decisions about how to best manage their health.
- Patients' relatives told us they felt informed and were able to contribute to decisions made about care of their loved ones. Staff encouraged patients and their relatives to telephone the service if they had any concerns in the time between visits.
- Staff worked hard to empower patients. During home visits and clinics, we observed staff empower and support patients to continue to live within their ability and manage their condition as independently as possible in their own home. Staff considered the emotional needs of the patient alongside their physical needs.

Emotional support

- Staff considered the emotional needs of the patient alongside their physical needs. Patients told us they felt supported emotionally. Comments from two patients were "staff really listen to me" and "I've felt really listened to today."
- A member of staff in the respiratory service understood, how a patient's personal problems were impacting upon the patient's condition. The member of staff took the time to listen to the patient and provide support, and reassurance and signposted the patient to where they could receive further support.
- Patients were given timely support and information to cope emotionally with their condition. Patients using the telehealth service praised the team for making contact regularly even if their observations were stable. This meant patients felt staff cared about them and offered them an opportunity to voice concerns or discuss any problems, including feeling low in mood.
- We observed a nursing handover where a member of staff updated colleagues on a patient nearing the end of their life. The nurse stated she would return for a second visit that day, which was not usually scheduled; to ensure all patient and family needs were met. Staff spoke of their commitment to end of life care including the support of patients and their relative's emotional needs. Staff told us they had stayed with families for extended periods of time to support them during this difficult time.

Good

Are services responsive to people's needs?

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

Summary

We rated the responsiveness of the community adult service as good because:

- Where possible, services were planned to meet the needs of the local population and staff used information about the local population in the planning of future service delivery.
- Team leads in specialist nursing teams demonstrated knowledge about what their services were commissioned to deliver.
- Services were planned to take into account the needs of individual patients and were non-judgemental in the way they cared for patients.
- Teams delivered services which took into account the needs of patients with complex needs, such as learning difficulties and dementia.
- Access to the majority of community adult teams on the whole was timely, and where possible, services prioritised care and treatment for patients with urgent needs.

However;

- The bladder and bowel service had a backlog of over 600 patients awaiting follow up, however, the team had recognised this and had put an action plan in place to reduce the waiting list numbers.
- Complaints and concerns were listened to and used to improve the quality of care. However, patients using the service were unable to tell us how to make a complaint and complaints were not always handed within the set timeframes outlined in the trust's complaints policy.

Detailed findings

Planning and delivering services which meet people's needs

- Services were planned and delivered to reflect and meet the needs of local people and provide flexibility, choice and where possible, continuity of care. There was a wide range of community adult services to meet the needs of the local population across a wide geographical area. For example, the respiratory service was available countywide. There were some challenges with standardisation of services across each of the three localities with regards to a small number of specialist services at the time of our inspection. For example, the leg club was only available for patients in Penzance and the surrounding areas. Following the inspection, we were provided with information from the trust that there was a programme for planned expansion of the service and work was underway across the county to provide this service for patients in other areas.
- Senior staff used information about the local population in the planning of future service delivery. Service leads were aware of the rising demand on their services, due to the demographics of the local population and national trends associated with age and living style, which had an adverse effect on people's health. Many services spoke of the increasing referrals year on year. For example, the diabetic specialist nursing team had seen an increase of 1,000 extra patients per year but there had not been any investment in the service since 1998. When we spoke with team leads within the services this was consistently raised as a concern, in terms of sustainability for services in the future.
- Senior leaders in specialist nursing teams demonstrated knowledge about what their services were commissioned to deliver. However, some services had not had recent reviews of their service level agreements, or realistic up to date targets set in line with updated national recommendations and guidance. For example, the commissioning agreements for Parkinson's disease' specialist nursing and for the neuro rehab team had not been reviewed since 2015 and 2016 respectively. Leaders of these services had highlighted this to locality managers and the operational managers for the trust.
- We spoke with some specialist nursing team leaders about cost improvement programmes and how this affected their services. The most prominent cost saving activity for services was to reduce travelling costs for staff. However, this was often a dilemma for leaders as they were also aware of patients' ability to travel and wishes about accessing services in localities close to their homes.
- Staff had an awareness of the local population and the challenges in the specific localities. For example, certain areas were very rural. Staff were conscious of patients travel times to and from clinic appointments. The

podiatry service had set an internal standard that no patient should travel more than 30 minutes for their clinic appointment. To make this a reality, the podiatry service held smaller clinics, less frequently over the county to ensure patients all over the county could access the service in a timely way. The team lead told us, depending upon the clinic being held, they would ensure the skill mix and number of staff required to meet the needs of the patients attending the clinic was correct.

- The centipede leg club developed a combined clinical and social model by which to deliver the service to the local population. It was felt this model of care would best meet the needs of the local population, some of which were socially isolated. Development of the leg ulcer club was born from different elements of current, successful working models of leg ulcer clubs around the country. The team lead visited these clubs to see them in action to see how they could be developed and tailored for the population of Cornwall.
- The respiratory team had identified a lack of understanding of their service between other teams and external colleagues. For example local GP's were unaware of what service was delivered to patients by the team. The team had carried out a recent audit looking at patients journeys into the service. An audit had identified a large number of inappropriate referrals to the service and identified a lack of understanding and education in the community about what the service could provide to meet the needs of the local population. To rectify this, the team was planning to deliver a respiratory masterclass inviting local clinical commission group, local GP's, local acute trusts and other services under the trust to provide education about what the team could provide. At the time of our inspection, this was in its early planning stages.

Equality and diversity

- Services were planned to take into account the needs of individual patients and were non-judgemental in the way they care for patients. Equality and diversity awareness training was part of the e-Stat and e-Essential learning package mandatory for all staff. There was also an equality and diversity policy available for staff on the trusts intranet.
- The Equality Act 2010 places a legal duty on all service providers to take steps or 'make reasonable adjustments' in order to avoid putting a disabled person at a substantial disadvantage when compared to a person who is not disabled. The Accessible Information Standards (2015) directs and defines a specific and consistent approach to identifying, recording, flagging, sharing and meeting information and communication needs of patients, where those are related to a disability, impairment or sensory loss. We saw evidence that patients communication needs were assessed when they were referred into community adult services.
- Language translation services were provided by the organisation and available to all teams and services.
- Access for patients with disabilities had been considered at all of the clinics and the outpatient departments we visited. Although limited in some places, venues had disabled parking and access available for patients.
- Community nursing teams regularly visited patients in their own homes. This meant people with disabilities were able to access the service on an equal basis to others.
- Reasonable adjustments were made to support people with disabilities, to ensure their care and treatment needs were met. For example, we spoke with a patient attending cardiac rehabilitation who was blind. We were told the staff at the clinic had taken the time to modify some of the exercises for this patient so he could receive the treatment he needs but in way which was safe and responsive to his needs.

Meeting the needs of people in vulnerable circumstances

- The community adult service planned, co-ordinated and delivered services to take into account people with complex needs. Staff were able to discuss how they had accommodated patients in vulnerable or challenging circumstances to meet the diverse needs of the local population.
- The podiatry service had worked with other services to co-ordinate care for a patient with a learning disability. Providing a joined up approach to working and coordinating care helped relieve stress and anxiety for this patient. The patient required a general anaesthetic for three different procedures under three different services which included the podiatry service. The teams worked together along with the patient's carer to arrange all appointments for the same day at the same time so treatment could be carried out together to meet the needs of the patient.

Good

Are services responsive to people's needs?

- The cardiac rehabilitation service ensured patients with learning difficulties got the most out of their sessions. Exercises were not only explained to the patient but also to the patient's carers. This enabled patients to be supported both in the group and at home by their carer, and to continue their rehabilitation to make improvements to their condition and quality of life.
- The speech and language team worked with local residential and nursing homes to empower staff to manage the needs of potentially vulnerable patients. The team provided information packs to the homes. These packs provided detailed information and a flow chart on how to manage specific issues. The pack provided support to staff at the home to recognise when a patient may be deteriorating and need a referral or re-referral into the service to ensure a timely response to meet their needs.
- The speech and language team were flexible to meet the needs of patients in vulnerable circumstances. If an urgent swallowing referral was to come in, staff had a degree of flexibility in their diary to see the patient the same day. This provided a more timely response for the patient and ensured they remained safe and were able to maintain their independence and stay in their own home.
- Staff understood the importance of meeting the needs of patients living with dementia. Staff understood that routine and stability was key for patients living with dementia. A patient living with dementia regularly attended the Centipede leg club. The team lead told us they tried as far as possible to allocate the same nurse to see this patient. The team lead also told us this patient liked a specific biscuit and the club tried to provide these particular biscuits for this patient for the social element of the club.
- Staff at the Centipede club understood the impact of social isolation on the patients who attended the club. A volunteer from Age UK attended the club to provide support and advice for patients attending the club. The group provided refreshments for patients to get them talking to other patients in a similar situation to develop camaraderie between patients attending the club. Due to its success, the Centipede leg club was hoping to expand and open another club for patients to capture more patients from the Hayle and surrounding areas of Cornwall.
- The cardiac rehabilitation service demonstrated an understanding how a patient's cardiac condition could impact on the mood and quality of life and took measures to support patients. There was a risk if patients were low in mood their rehabilitation would suffer, which would ultimately impact on their quality of life. The service monitored patients for depression and anxiety using a nationally recognised tool and had links with a local service which provided emotional support to patients through group working.
- The respiratory team recognised a need to maintain patient's motivation and enthusiasm to maintain their health and wellbeing once they had completed their course of pulmonary rehabilitation. The respiratory team had worked to engage and upskill qualified exercise professionals in the community. This meant when a patient finished a course of pulmonary rehabilitation, they could be signposted to qualified exercise groups to maintain their exercise regime in order to maintain their new way of life. The respiratory team used an accredited service to develop the qualifications of exercise professionals in the community to enable them to continue working with these patients. The team also recognised that transport was an issue for patients travelling to and from the community groups. The team worked to secure funding from the national lottery for a local bus company to provide a free service for patient attending the community groups to make sure patients could access the community service being provided.
- The respiratory team also understood the importance of group camaraderie and support to meet the needs of vulnerable and some socially isolated patients. The team had set up self-help support groups for patients who were currently under the service or for patients who had been discharged from the service. Groups included breathers groups, gaspers groups, singing for breathing and breathe easy groups in affiliation with the British Lung Foundation. The groups were an opportunity for patients with similar problems to get together and to provide support for each other. The team continued to visit these groups when possible to demonstrate their continuing support for the groups and the patients attending them.
- The respiratory service was proactive in ensuring clinic appointments did not conflict with other personal arrangements patients had. One patient worked full time. In order to ensure the patient could keep working

and not miss work to attend clinic appointments, the respiratory lead would start clinic at 7.30 when this patient needed to be seen, so their condition did not impact upon their life and work commitments.

- The acute care at home team worked extended hours to meet the needs of vulnerable patients. The team worked extended hours from 8am until 8pm daily to prevent the most vulnerable patients in each locality requiring a hospital admission. GP's were able to refer directly into the service and patients would be seen urgently on the same day. The team gave us an example where they had extended their hours to accommodate a patient attending a hospital appointment the same day. The patients had asked to be seen at 8am prior to the hospital appointment. A member of staff started work earlier to accommodate this request.

Access to the right care at the right time

- Access to care and treatment for the majority of teams was timely. However, data demonstrated that access to the bladder and bowel service, respiratory service and the diabetes service was slightly more challenging. Where possible, services prioritised care and treatment for people with urgent needs.
- All but three teams under the community adult service were meeting their referral to treatment targets. Services worked to meet an 18 week from referral to treatment target, with the target for achieving this being 95%. Between June 2016 and May 2017, 100% of patients met the target in the musculoskeletal service and the musculoskeletal interface service. The cardiac service saw 99% of patients meet the target along with the tissue viability service, specialist falls service, the rehab physiotherapy and the adult speech and language therapy service. Rehab occupational therapy saw 98% of patients meeting the 95% target, whilst 97% of podiatry patients met the target. However, 90% of patients for both the bladder and bowel service and the diabetes service were seen within 18 weeks whilst only 87% of patients were seen within the 18 week target by the respiratory service.
- Some services had experienced an increase in demand over the past few years and were finding it challenging to meet referral to treatment targets. These services were the diabetes service, Parkinson's disease service and the bladder and bowel service. The clinical service leads had identified this challenge and taken steps to make efficiency changes within the services. For example, trialling new smarter more efficient ways of working. Service leads told us they had exhausted all options to work smarter to improve waiting times, and felt their service was in need of a review of their provision and funding, to ensure sustainability for the future. The diabetes service had not seen any financial investment since 1998 whilst the Bowel and Bladder and Parkinson's disease service was due a review in 2016 and 2015 respectively. However, at the time of the inspection, these reviews had not happened.
- The bowel and bladder service had a backlog of more than 600 patients awaiting follow up appointments with the team at the time of our inspection. We spoke with the service lead about the reasons for this and of the actions taken to reduce the waiting list. They explained there had been some unplanned sickness in the team and pressures to meet referral to treatment time (first consultation) often meant these took priority. The service had raised an incident report about this but it was not entered as a risk on the trust risk register. The service was now fully staffed again. Other work which had been carried out was to review the scattered locations were services were delivered and how these may be re-organised to reduce staff travelling time between appointments.
- The bladder and bowel service monitored 'did not attend appointment' (DNA) rates at the clinic. The DNA rate for the bladder and bowel service was around 20%. When patients did not attend their appointment, the clinician's time was wasted. Patients who did not attend would then have to be booked in again, further increasing patient numbers on the follow up appointment waiting list. To reduce the number of DNA appointments, the service had trialled clinics out of hours, but the uptake had not been sufficient to implement these on a permanent basis. The service was hoping to introduce a texting service so that reminders were automatically sent out to patients. When patients did not attend clinics, the service contacted them to rearrange another appointment.

Learning from complaints and concerns

- People's complaints and concerns were listened to and used to improve the quality of care. However, some patients using the service were unable to tell us how to make a complaint. We saw limited information available for patients about how to make a complaint.

Good

Are services responsive to people's needs?

- The trust had a complaints policy. The policy covered the procedure for managing complaints, roles and responsibilities of the staff and the length of time taken to complete the investigation, which was agreed in conjunction with the patient. This was usually anything between 25 to 60 working days. The average time it took the trust to close the complaint for this service was 88 days. Time frames ranged from 43 to 216 days. This meant the trust was not always managing complaints in accordance with its policy. We reviewed a complaint made against the podiatry service. The final response to the patient was set out clearly and each item had been investigated with the learning and outcome explained to the patient.
- The trust had received 109 complaints between June 2016 and May 2017, however only nine of these complaints (8%) had been for the community adult service. Complaints were split into four categories. Four complaints were due to all aspects of clinical treatment, three were due to the staff attitude, one complaint was due to a delay or cancellation of an appointment and one was a complaint about a patient's privacy and dignity.

Requires improvement

Are services well-led?

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

Summary

We rated well led for the community adult service as requires improvement because:

- There were mixed feelings about the senior management team and their understanding about caring for patients with physical problems. However, teams spoke highly of the support from their local managers.
- The governance system needed to be reviewed to ensure processes were standardised and aspects of quality and safety were fully understood.
- Meeting minutes did not demonstrate any depth or quality into scrutinising incidents for trends to ensure all learning was identified to improve performance and safety for future patients.
- Not all risks to the community adult service had been identified and recorded on the risk register.
- The lone working policy did not ensure the safety of staff at all times, only when staff felt they were at risk. Staff working on call were vulnerable and there was a risk to their safety.
- There was confusion between the community adult service teams with regards to the plans for the introduction of a new electronic records system being introduced in November 2017. At the time of our inspection, staff still had not received any training on the new system being implemented.
- Specialist nursing teams were concerned about the future sustainability for their services and the need for financial investment.

However

- Leaders at local level understood the challenges faced by the community adult services and staff felt supported by their leaders at local level.
- A clear vision and strategy had been set out for the service which staff were on board with and able to discuss.
- There was a programme of internal and external audit to monitor quality and performance.
- There was a strong culture of patient centred care.
- Innovative work being carried out by the specialist nursing teams.

Detailed findings

Leadership of this service

- Staff felt supported by leaders at a local level. However, there were inconsistencies between staff in different teams as to how supported they felt by the senior management team. There was mixed thoughts between staff in the community adult service as to the senior management teams understanding of patients with physical conditions and challenges faced by teams under the community adult umbrella. Some staff felt the team and trust was very mental health orientated, whilst others spoke highly of the senior management team and the support they had received.
- Leaders at local level were visible and approachable, with some leaders demonstrating a high level of skills, experience and qualifications to lead their teams. Staff told us leaders at a local level were supportive and accessible. Staff felt listened to and recognised their manager's efforts to try and make improvements.
- Leaders at local level understood the challenges faced by the community adult services. Local leaders discussed some of the challenges faced such as recruitment, caseload capacity, the nursing capacity tool, retention, succession planning and career development for staff. We found from speaking with staff there was an inequality for the district nursing teams to attend university courses for career development. The specialist nursing teams had access to external courses and were supported with research opportunities whereas community nurses told us they found it hard to access continuing professional development courses.
- There was an inconsistent picture of the leadership provided by the senior management team and their understanding of community services for patients with physical problems. The community adult services had been taken over by Cornwall Partnership Foundation Trust, a mental health trust, in April 2016. Some staff we spoke with during the inspection, told us they did not feel the senior management team had an

understanding of the challenges faced by community adult team providing services for patients with physical health needs. For example, the withdrawal of the funding for three nurses in the Acute Care at Home team, despite them exceeding predicted targets for referrals into the team, with demand for the service continually rising. However, some staff we spoke with, for example, the Home First team praised the senior management team for their support and efforts to set up and launch the service.

- The chief executive had been out to visit some community teams. Some staff we spoke with told us they had met the chief executive when he had visited some community teams. They told us he took the time to listen to them and gave them the opportunity to ask questions which made them feel valued. However, nursing teams in other locations had never met or seen the chief executive or any other members of the senior management team. They told us there were 'open door' events, where they could meet with the senior management team however, they often had a long way to travel and it meant they would have either to do this on their days off or be away from the service for half a day. Staff did not feel this was realistic due to the demand of their caseloads.
- Some staff in management roles had attended or were in the process of completing leadership courses, which provided them with the skills required to lead their team effectively. Staff said it was a good course and applicable to their role.
- Due to a change in management structures, there were concerns amongst staff about professional leadership within the organisation. Concerns were raised particularly by staff working for the therapy teams about professional supervision. Staff told us they received regular operational supervision; however this was often by another professional. For example, an occupational therapist could receive supervision from a nurse. Whilst staff were receiving supervision, not receiving this by a professional from the same profession did not provide assurance that staff were being supervised against their own professional standards required for their registration. Following the inspection, the trust told us there had been changes in management arrangements implemented in January 2016 prior to the transfer of services to the trust. Also, following the trust's Therapy Review, professional lead capacity was increased in July 2017. Despite the changes made, we were unable to identify improvements which had been made to clinical supervision as a result of these changes.

Service vision and strategy

- There was a clear vision for the community adults' service, which was in line with the "Shaping our Future" sustainability and transformation plans (STP) for Cornwall and the Isles of Scilly. Clear priorities of safety and quality had been identified along with ensuring service delivery was maintained within the parameters of the resources available, to ensure spending control. The vision was to build on work already underway to integrate services, to bring care closer to home in the community and standardise working in line with the STP.
- There was an overall strategic set of objectives in line with the vision for the whole trust. These were to deliver high quality, safe and accessible services, to maximise the potential of the workforce to deliver high quality patient care, the ensure the financially sustainable services for the future, to develop and diversify services to meet the needs and expectations of the patient and to improve the health and wellbeing of the population living in Cornwall and the Isles of Scilly by working in partnership, to create life opportunities for patients. These objectives formed the foundations of the vision and strategy for the community adult service.
- A realistic strategy for delivering the vision and its priorities of safe, high quality care for the community adult service had been developed. The strategic aim was to create and embed Integrated Care Teams, which would provide shorter term, effective care when people need it, closer to home. Person-centred care planning for patients with complex needs was ongoing, as well as providing support for their carers. The trust was also focusing on older people living with frailty, and adults with multiple long term conditions regardless of age. The promotion of independence and rehabilitation as part of a coordinated and integrated health and care community service was key to meeting the increasing demand on the service. Countywide, staff told us about the future vision for the service.
- The service was in the process of developing a frailty pathway for patients, due to Cornwall and the Isles of Scilly having a population older than the national average, and a longer life expectancy. The organisation

had set out a two year implementation plan for development of this pathway. This included a time framed action plan which included information about how actions were to be implemented, and how success was going to be monitored.

- Staff were familiar with the trusts four values. These included providing compassionate services, achieving a high standard and providing the best service to patients, respecting all individuals and empowering people to be the best they can be. We saw posters in many of the staff bases we visited displaying the trusts values to patients and the staff.
- Some individual specialist service leads discussed their vision for their services. For example, the lead for the neuro rehabilitation service explained how they had a plan to expand their team. The aim was to include all relevant allied health professionals, including psychologists and social services to ensure all needs of patients receiving care from the service, were met.

Governance, risk management and quality measurement

- The governance framework needed further development to ensure systems and processes provided clear lines of responsibility, and to ensure quality and risks were fully understood and managed. Meeting minutes lacked depth and detail and there was a lack of an audit trail to demonstrate how issues such as safety, risk and performance was scrutinised for trends and learning. Information was cascaded up to locality managers at local level, onto the board, and back down to front line staff.
- There was a local structure within service for holding various meetings to cascade information up to the local managers and back to front line staff. These included various local team meetings for services, district nurse forums, community matrons meetings. Management level meetings, such as clinical business service meetings took place, which looked at developing new ways of working and learning. The service also had a fortnightly operational assurance group meeting, which the integrated care managers, locality managers and patient flow managers attended. These reviewed service performance and included discussions around, safeguarding alerts, coroner's reports, incidents and learning.
- Minutes from the August 2017 operational assurance group meetings were inconsistent between the localities with regards to the quality and depth of discussions around safety quality and performance. The meetings looked at information such as quality and safety, risk, audit, learning and development and complaints. Minutes from the East locality demonstrated the most scrutiny for safety and performance issues. The minutes contained details of discussions held, and provided a good level of scrutiny of the issues raised. However, meeting minutes from the Mid and West locality did not provide any detail around the quality of discussions held during the meeting. Therefore, there was a lack of an audit trail to demonstrate how issues raised were scrutinised for trends and learning to make improvements to the service.
- Monthly integrated care manager meetings did not have a standardised set agenda. We saw minutes of August 2017 and September 2017 meetings. The minutes did not contain any discussions around safety, quality or risk within the service. This did not provide us with assurance that the locality managers had their own perspective of safety performance and risk within the community adult service.
- There was a programme of clinical and internal audit to monitor quality and systems were in place to identify where actions needed to be taken. Audit data was fed into monthly quality assurance reports and we saw evidence in board reports, which demonstrated audit outcomes and actions were presented to the board.
- The trust had a system to identify record and manage risks; however, not all risks associated with the community adult service were on the risk register. The trust held a corporate risk register, which contained some risks relating to the service. These included long standing vacancies and staff shortages, short and long term sickness in telehealth services, inaccuracies of paperwork to support glucose monitoring in the diabetes service and the potential failure of equipment in the bladder and bowel service due to age. The risk register recorded a description of the risk, identified mitigating actions, provided a named responsible person and comments were recorded against regular progress reviews. However, during our inspection, we identified risks to services, which were not on the risk register. These included, poor compliance with

mandatory training, lone working and the risks associated to other services provided under the community adults service, in relation to the decommissioning of the Telehealth service.

- Despite being on hold at the time of our inspection, staff felt the decommissioning of the Telehealth service was already impacting the district nursing teams and other services under the community adult service umbrella had concerns about the service closing. Due to this, patients who were under the Telehealth service for observations such as their weight, had been referred to the district nursing service to pick up this monitoring of patients who were housebound or unable to get out to local services themselves. Nurses felt this was starting to impact on their already increasing caseloads. Other services such as the diabetes service, cardiac service and Parkinson's disease service also raised concerns during the inspection about the closure of this service and the impact to their patients in terms of deterioration of their health and increased hospital admissions. The senior management team had responded to the local clinical commission group with their concerns regarding the lack of engagement with the trust, Telehealth service and patients receiving the service. The trust had tried to mitigate the risk of the closure of the service to patients. There were 38 community matrons to manage patients with long term conditions and the trust was training 18 district nurses in long term condition management. However, it was unclear how these staff were going to absorb 1,000 patients under the care of the telehealth service, once the service was decommissioned. Following the inspection, we were provided with an update from the trust about a further consultation regarding the telehealth service which had taken place with patients and staff. Following this, delivery of the telehealth service had been revised and the new caseload size for the service was for 200 patients. Work was still ongoing to determine further detail about the telehealth service provision.
- The podiatry service had identified risks to patients not attending the service due to changes to the eligibility criteria for patients using the local transport service. Due to this change some patients were not long able to use the transport service and were refusing to attend their clinic appointments. The podiatry service had produced a document identifying nine vulnerable patients who were not attending podiatry clinic due to the changes to the transport service. These patients were vulnerable and at high risk of an adverse incident occurring and their condition deteriorating. The service had mitigated the risk to these patients by referring them to the district nursing team. However, there were implications of these referrals to the district nursing teams and increasing pressure of their already demanding caseload. Although this was ultimately a commissioning issue, we had no assurance the board had an understanding of the risks to the vulnerable patients under the podiatry service.
- Senior leaders of specialist services spoke of challenges to their services. Most of these challenges were centred around capacity to meet demand and staffing. The lead for the bowel and bladder service discussed planned absence of staff members and the potential impact this may have on their service. This was not entered on the trust risk register at the time of our inspection although incident reports had been completed to ensure senior managers were aware.
- Leads for specialist teams had a good understanding and knowledge of the role of the risk register. We discussed examples of mitigating actions taken by services to reduce risks long term. For example, in June 2016 the diabetes specialist service identified and entered on the risk register that the documentation used to support glucose monitoring was not fit for purpose. Work had been carried out involving some input from pharmacy services, to improve the documentation template and it was ready to be rolled out in two areas for a trial.
- There was countywide confusion with regards to which new records system was being implemented across the community services in November 2017. The aim of the introduction of the new electronic records system was to ensure the organisation was working from one system to enable a joined up, more integrated approach to working. During the inspection, different staff members had conflicting information about which system was being implemented. Staff told us everyone was going on the same system, however, inspectors heard of three different systems and it was unclear as to which system may be implemented. Due to the level of confusion between different teams and staff members, we were not provided with assurance that one clear

message had been cascaded to staff about the system change. At the time of our inspection, none of the staff had received any training on the new system which was due to be implemented in November 2017.

- Some specialist services had concerns for the future sustainability of their service. For example, service level agreements/commissioning agreements and targets were not always reviewed in a timely manner and there had been no financial investment in the diabetes specialist services since 1998. There was clear data, as mentioned previously, about the impact of losing the telehealth service would have in meeting the needs of the population and the increased financial burden this would place on other community adults teams to manage these patients. Also, there was an increasing demand, significantly above the trusts target, for the acute care at home team and the impact the withdrawal of funds for three nurses would have on the ability of the team to take on new patients. This was also likely to have a significant impact on the wider healthcare system, meaning there was a risk of more patients being admitted to hospital rather than being maintained and treated in their own home.

Culture within this service

- There was a positive culture centred around the needs of the people who used the services. Staff were proud of their teams and the care and support they provided to patients.
- Staff spoke of empowering patients to optimise their potential to remain living independently in the community. This reflected what we saw during the inspection.
- Staff told us the culture in the organisation was to learn from both incidents, when things had gone wrong, and also to learn from positive incidents being reported to highlight good patient care. Reporting positive incidents had recently been introduced within the organisation. However, we saw inconsistencies between teams in terms of how much feedback they received following incidents and their ability to learn from this.
- Lone working systems and processes left staff working on call vulnerable and there was a risk to their safety. Trust guidance for operational staff did not ensure their safety at all times, but only at times when they felt there could be a risk. Risk assessments for lone working were out of date in 2015. This meant, risks had not been reviewed, to identify new risks and mitigating actions to ensure the safety of the nurses when covering the on call shift. We were not assured the locality managers or the senior management team had a full understanding of what was happening around lone working for the nursing teams providing the on call service. Also, staff we spoke with were not aware of any code words they could use in an emergency if assistance was required immediately, despite the policy clearly outlining a specific code. This risk was not on the corporate risk register.

Public engagement

- The service gathered the views and experiences from patients using their services. The organisation used the friends and family test to gather feedback about the service. The friends and family test enabled patients and those close to them rate whether they would recommend the service or not. In August 2017, data demonstrated between 96.4% and 97.7% of people using the community adult service would recommend it to friends and family. The Acute Care at Home East team received the best result. The service received 26 completed questionnaires. Although the team only had a small number of responses, all patients who answered the questionnaire would recommend the service to friends and family.
- A new interview assessment process to recruit community nurses in the North and East locality included patients on the interview panel. Nurses completed a variety of exercise such as a team building exercise and were interviewed by the panel. Patients who sat on the panel were then included in discussions about the suitability of the member of staff for the post. Staff felt having patients on the panel provided more of a well-rounded view of the nurses being employed by the trust. We were told that candidates attending this interview process had provided positive feedback.
- The neurological care advice coordinator had set up a peer support group for patients. As part of this group, arrangements had been made for different people from different agencies to come in and meet with patients to enable patients to provide feedback and suggest changes to ways of working to make services more effective and stream lined for patients. The external agencies included NHS England, and ambulance services. NHS England had pledged to return to meet the group in November 2017 to present improvement plans in response to the shared concerns. One of the

improvements following the meeting was for a change to the curriculum in the paramedic course with regards to transferring patients with long-term spinal injuries on stretchers.

Staff engagement

- Staff received by email, Cascade, a monthly newsletter produced by the trust providing information about the organisation to the staff. The newsletter included learning from incidents, information about the organisations performance, development opportunities and health and wellbeing for staff. Staff told us the newsletter provide them with useful information and also signposted them to other areas of interest.
- The chief executive, director of nursing and the medical director held quarterly staff engagement events, to provide a forum for staff to ask questions and raise concerns about the organisation. Team leads told us these were very engaging; however frontline staff we spoke with did not tell us about these events. Team leads told us very few frontline staff attended these meetings due to caseload requirements and the lack of capacity. Staff who did attend told us the senior management team “were listening,” and they felt they could ask questions.

Innovation, improvement and sustainability

- The tissue viability lead had won a bid from the Health Foundation to spread learning across the county around pressure ulcers. The funding was initially received following an investigation into a non-concordant patient who developed a pressure ulcer in the community. Research was carried out to look at pressure monitoring devices. The most recent funding will support this learning to be cascaded countywide. At the time of the inspection the tissue viability nurse had arranged an event to engage the local clinical commissioning group and a study event for community nurses consisting of 12 sessions to share the research and good practice. This study event was also being offered to local domiciliary care teams and care homes across the county.
- In September 2017, the tissue viability nursing team won the Quality Care award from the European Pressure Ulcer Advisory Panel.
- The Tissue Viability Service had received a Wounds UK Award for Excellence for continuous pressure monitoring of patients in the community in order to reduce and prevent pressure ulcers.
- The adult speech and language therapy lead received a "Giving Voice" award from The Royal College of Speech and Language Therapists in September 2016. This was for outstanding work and leadership in promoting the service especially during the "Focus on Adult speech and language therapy" month in Cornwall in October 2015 which captured the attention of several MPs and the Media.
- The nurse consultant for older people and long term conditions had been awarded a National Institute of Health Research Clinical Academic Doctoral Research Fellowship in April 2017. The research undertaken by the nurse was to enable the completion of the development of a nurse-led intervention to support frail older people in primary care in line with the trusts future priorities for quality improvement 2017/18.
- The consultant nurse for bowel and bladder service was actively involved with a research project. They had also invented a specific device used by women with certain bowel complaints. This device was marketed both in the UK and in Europe. The bowel and bladder service hadwon Continence team of the Year 2015 and the consultant lead had also won the Royal College of Nursing Advanced Nursing Practitioner award in 2016.
- In the Parkinson’s team, a member of staff was nominated for the trust’s golden award for hard work, commitment and for going the extra mile.

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
Nursing care Personal care Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment 12 (2) (a) Assessing the risks to the health and safety of service users of receiving care and treatment. 12 (2) (b) Doing all that is reasonable practical to mitigate any such risks 12 (2) (c) Ensuring that persons providing care or treatment to service users have the qualifications, competence, skills and experience to do so safely 12 (2) (g) Care and treatment must be provided in a safe way for service users. The registered person must ensure the proper and safe management of medicines. 12 (2) (a) Risk assessments, risk management plans and reviews were not being consistently completed by the community nursing teams; therefore assessments were not used to respond positively to patient risk. 12 (2) (b) Learning from incidents was not always shared with all teams so that improvements could be made. There was little evidence to demonstrate how learning or action was taken to improve safety. 12 (2) (g) Staff did not have access to an early warning score as recommended by the sepsis tool they carried to ensure the early identification and management of sepsis. The sepsis policy did not make reference to the most recent national guidance.

This section is primarily information for the provider

Requirement notices

Monthly audits for the Titration of Diabetes Medicines by Diabetes Specialist Nurses were not being carried out according to trust policy.

Regulated activity	Regulation
Nursing care Personal care Treatment of disease, disorder or injury	Regulation 14 HSCA 2008 (Regulated Activities) Regulations 2010 Meeting nutritional needs 14 (1) The nutritional and hydration needs of service users must be met 14 (1) Compliance with completion of the malnutrition universal screening tool (MUST) as a standard initial nutritional risk assessment for patients under the community nursing teams was poor.

Regulated activity	Regulation
Nursing care Personal care Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance 17 (2) (d) Maintain securely such other records as are necessary to be kept in relation to- (i) Persons employed in the carrying on of regulated activity, and (ii) The management of regulated activity 17 (2) (d) Staff at the leg clinic were not working in line with the Nursing and Midwifery Council Code Of Conduct: Professional standards of practice and behaviour for nurses and midwives standard 10.4 (2015). Staff at the clinic were writing patient notes in the electronic record

This section is primarily information for the provider

Requirement notices

when logged onto the system by another member of staff. This made the member of staff whose name is attributed to the notes accountable for anything that's should happen to that patient.

Regulated activity	Regulation
Nursing care Personal care Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing 18 (2) (a) Receive such appropriate support, training professional development, supervision and appraisal as it is necessary to enable them to carry out the duties they are employed to perform. 18 (2) (a) There was poor compliance with mandatory training in the adult community service with only 36% of staff being compliant with training, compared to the trusts target of 85%. This meant not all staff were trained in the delivery of safety systems, process and practices to ensure the safety of patients. There was poor compliance with safeguarding training for the adult community service.