Cornwall Partnership NHS Foundation Trust

Quality Report

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Core services inspected	CQC registered location	CQC location ID
Community health services for adults	Newquay Community Hospital	RJ807
Community health services for adults	Camborne and Redruth Community Hospital	RJ817
Community health services for adults	Launceston Community Hospital	RJ870
Community health services for adults	Stratton Community Hospital	RJ867
Community health services for adults	St Austell Community Hospital	RJ8X2
Community health services for adults	Falmouth Community Hospital	RJ842
Community health services for children, young people and families	Trust Headquarters	RJ8H5
Community health inpatient services	Newquay Community Hospital	RJ807
Community health inpatient services	Liskeard Community Hospital	RJ8A3

Summary of findings

Community health inpatient services	Stratton Hospital	RJ867
Community health inpatient services	Launceston Community Hospital	RJ870
Community health inpatient services	Helston Community Hospital	RJ805
Community health inpatient services	Falmouth Hospital	RJ842
Community health inpatient services	Camborne and Redruth Community Hospital	RJ817
Community health inpatient services	St Mary's Hospital	RJ8Y4
Community health inpatient services	Bodmin Hospital	RJ866
Community health inpatient services	St Austell Community Hospital	RJ8Y2
End of life care	Bodmin Hospital	RJ866
End of life care	Falmouth Hospital	RJ842
End of life care	Newquay Hospital	RJ807
End of life care	Liskeard Hospital	RJ8A3
End of life care	Helston Hospital	RJ805
End of life care	Truro Health Park	
MIU Urgent Care	Bodmin Hospital	RJ866
MIU Urgent Care	Camborne Redruth Community Hospital	RJ817
MIU Urgent Care	Falmouth Hospital	RJ842
MIU Urgent Care	Helston Hospital	RJ805
MIU Urgent Care	Launceston Hospital	RJ870
MIU Urgent Care	Liskeard Community Hospital	RJ8A3
MIU Urgent Care	Newquay Hospital	RJ807
MIU Urgent Care	St Austell Community Hospital	RJ8Y2
MIU Urgent Care	St Marys Hospital	RJ8Y4
MIU Urgent Care	Stratton Hospital	RJ8Y7

Summary of findings

Acute wards for adults of working age and psychiatric intensive care units (PICU's)	Longreach House	RJ863
Acute wards for adults of working age and psychiatric intensive care units (PICU's)	Bodmin Hospital	RJ866
Community-based mental health services for adults of working age	Trust Headquarters	RJ8H5
Mental health crisis services and health based places of safety	Accident and Emergency Department	RJ8Y5
Specialist community mental health services for children and young people	Trust Headquarters	RJ8H5
Community-based mental health services for older people	Bodmin hospital	RJ866
Long stay/rehabilitation mental health wards for working age adults	Bodmin hospital	RJ866
Forensic inpatient / secure wards	Bodmin hospital	RJ866
Wards for older people with mental health problems	Bodmin hospital	RJ866
Community mental health services for people with a learning disability or autism	Trust Headquarters	RJ8H5

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

Summary of findings

Ratings

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

Overall rating for services at this Provider	Requires improvement 
Are services safe?	**Requires improvement** 
Are services effective?	**Requires improvement** 
Are services caring?	**Outstanding** 
Are services responsive?	**Good** 
Are services well-led?	**Requires improvement** 

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

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

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

Summary of findings

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Overall summary

Following the inspection in September 2017, we have rated Cornwall Partnership NHS Foundation Trust as requires improvement because:

- At the time of our inspection, three of the trust's 13 hospitals were subject to an organisation review under Section 42 of the Health and Social Care Act 2014. This related to a number of safeguarding concerns initially raised under organisation abuse by CFT in April 2016 following the transfer of services from PCH on 1 April 2016. The trust had implemented an action plan to address these concerns; this was ongoing.
- Not all premises were suitable for patient assessment, treatment and maintaining confidentiality. Falmouth, Newquay, Bodmin and Liskeard hospitals stored hazardous substances in unlocked sluices, including bleach tablets, cleaning solutions and nail varnish remover. The physical environments at Bolitho House, Truro Health Park and St Austell required improvements; including some basic maintenance and ensuring safe and age appropriate environment for children and young people. Truro integrated community mental health team had not carried out a health and safety audit since 2013. Staff based at Caradon did not know how to activate the emergency alarms. Within some community health services, 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.
- Some community-based services did not have a sufficient number of staff. Five out of the six integrated community mental health teams that we inspected had vacancies. At the time of the inspection there were approximately 114 patients unallocated for treatment and the trust did not have a clear process in place to monitor these patients. In the minor injuries unit's reception staff did not work out of core hours or at weekends and there was no observation of patients in the waiting room at these times; there was a risk that patients with serious or life-threatening conditions may not be identified promptly. In the specialist community mental health services for children and young people there was not enough provision of service to provide a safe service for the numbers of children and young people need care.
- Medicines management systems were not robust in all trust clinical settings; not all clinic rooms contained the expected equipment and in some cases where there was medical equipment it was not calibrated or tested in line with the trust policy. None of the six integrated community mental health teams had a robust system in place for the management of medicines. We found out of date medicines and medicines not being stored at the correct temperatures. A fridge in the Bodmin clinic had not had the temperature recorded since November 2016.The cards used to record patient's depot medicine had essential information missing from a number of cards. In Kerrier, a paliperidone injection box (an anti-psychotic individually prescribed medication), had its patient label removed. Cover provided by pharmacists and pharmacy technicians across the community inpatient service was inconsistent.
- Compliance with mandatory training was low; data provided by the trust up to May 2017 showed that the training compliance for trust-wide services was 54% against the trust targets of either 85%, or 95%.

However, we found the following areas of good practice:

- Staff were positive about working for the trust as an employer and said it encouraged individual services to improve and had a 'no-blame' culture. Staff knew who senior managers were and generally felt they were visible. Senior managers and executive board members had visited all locations, though staff on the Isles of Scilly felt distant and at times forgotten by the organisation following several cancelled visits. Non-executive directors had a good understanding of the trust's strategy and presented appropriate challenge to the executive team.
- There was good assessment and management of risk throughout most services. For example, ligature risk assessments were in place and well managed either by rectifying the issues identified or by actively managing the areas where risk was identified to reduce the risk to patients.
- Generally, the wards and community environments were clean, bright and well furnished. The trust was

committed to refurbishing environments that required it. However, at the Bodmin hospital site there were difficulties with refurbishment and maintenance programmes. The site was managed as part of a private finance initiative and the provider struggled to get the landlord to make changes and improvements as required in a timely manner. The trust had taken legal action against the landlord to get improvements made.

- The trust had robust infection control policies and procedures and staff adhered to these across almost all environments.
- Staff delivered care and treatment to patients in a kind, caring manner that respected their dignity. Where concerns had been expressed by patients and carers this had been addressed appropriately and in line with the expectations of duty of candour. Staff described an awareness of the need to be open and apologise to patients when necessary.
- There was a strong commitment to patient safety, the community team for learning disabilities and autism would routinely follow up service users discharged from their service to identify any changes to their epilepsy. This aimed to reduce cases of sudden death in epilepsy.
- The majority of the patients that we spoke with on the wards were positive and complimentary about the support they received from staff. Staff interacted with patients positively and respectfully. They demonstrated that they knew the patients well in their interactions with patients and in their responses to them. This was particularly apparent on Fettle ward where there were many opportunities for patients to have their voice heard and staff helped them realise their potential. Staff truly valued patients emotional and social needs and were committed to helping them recover in a meaningful way.
- Care plans mostly documented patients' wishes and feelings about their treatment with the exception of the community mental health teams where there was a lack of recording to show that the patient had been involved in developing their care plan. Where it was appropriate carers and family members were involved in the care planning process. Staff referred carers for assessments and advocacy support when needed.
- The trust had processes in place to identify and report serious incidents. Risks were generally well managed across most services with locally held risk registers that fed into the trust wide risk register. There were robust processes in place to review risks at both local and trust level and plans were agreed at board level to reduce significant risk across the organisation.

Summary of findings

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

We always ask the following five questions of the services.

Are services safe?

We rated safe as requires improvement because:

- The specialist community mental health services for children and young people service (CAMHS) received more referrals than it could safely work with. The thresholds for accessing the service had been raised by the trust following discussion with commissioners and so children and young people had to be seriously ill before receiving a service. Out of hours support was limited for children and young people and those using the service did not have access to specialist psychiatric support outside of core service hours. The service was not meeting its waiting time targets, with one young person waiting five months for treatment.
- Staffing levels across the community health services were of concern. In the community inpatient service staffing levels were inconsistent. There were high numbers of vacancies, which, despite high agency and bank staff use, resulted in unfilled shifts. In the minor injury units the trust could not be assured that patients were safe at all times; because reception staff were not scheduled to work out of hours and at weekends, there was no observation of patients in the waiting rooms during these times. This presented a risk that patients with serious or life-threatening conditions may not be identified promptly. Two community hospitals shared registered nursing staff between wards and minor injury units at night, which left wards with unsafe staffing levels when those staff were called to attend the minor injuries unit.
- Clinic rooms and items of physical health monitoring equipment were not maintained, or not available in some of the community mental health teams and CAMHS teams. Storage of medicines was not always safe in both community health services and community mental health teams. Processes for checking resuscitation trollies were not always followed in the community inpatient services.
- Cover provided by pharmacists and pharmacy technicians across the community inpatient service was inconsistent; this was recorded on the trust risk register.
- The community mental health services for people with a learning disability or autism teams had a higher than trust average sickness rate and could not cover this with bank staff.

Requires improvement

Summary of findings

- Information supplied by the trust showed that staff did not always attend mandatory training. As of 31 May 2017, the training compliance for trust-wide services was 54% against the trust targets of either 85%, or 95%. Eighty out of the 96 training courses for the most recent year had not met the trusts targets for staff attendance.
- The community nursing teams were not consistently completing risk assessments, risk management plans and reviews. Therefore, assessments were not used to respond positively to patient risk and did not ensure the safety of the patient. Staff did not always comply with infection prevention and control best practice or policy within the community health services. Lone working systems and processes in the community services did not ensure the safety of staff. This left staff working on call vulnerable and posed a risk to their safety.
- The trust were not following national guidance in a number of areas. For example, the sepsis-screening tool was not fit for purpose. Nursing staff did not have the equipment identified on the chart to monitor patients for sepsis. The community nursing service were 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.
- Learning from incidents was not always shared between the teams. Investigations into serious incidents did not always demonstrate learning had been fully understood. Actions did not demonstrate how learning was to be implemented and embedded into practice.
- Risks were not always accounted for or managed appropriately when planning and delivering services. There was a lack of challenge from senior staff in the community adult services about anticipated patient risk during handovers.
- Staff in the minor injury units did not record and monitor how quickly patients were assessed by triage or were seen by a nurse practitioner. The recording of the time the triage started did not include the time patients waited to be booked in and so did not recognise the risk that a serious or life threatening condition may not have been identified promptly.

However;

- Policies and procedures were in place to support the safeguarding of vulnerable adults and children. The trust had a robust training programme for safeguarding.

Summary of findings

- In most services, there were systems in place to report, investigate and learn from incidents. Managers could use the electronic incidents reporting system to monitor trends and give feedback to staff. Managers fed back learning from incidents in team meetings and supervision.
- The older person's mental health team kept and monitored a top-ten list of patients most at risk of being admitted to hospital. Staff increased support to these patients to try to prevent hospital admissions where possible.
- Across the inpatient wards, the trust assessed staff and patient safety on wards and would increase staffing numbers or decrease bed numbers to ensure that services could be provided safely if the needs of patients increased. Inpatient staff practiced relational security to a high standard and staff actively promoted de-escalation techniques to avoid restraints and seclusion where possible. On the acute and psychiatric intensive care unit staff carried out a daily 'safety huddle' which is a nationally recognised good practice initiative to reduce patient harm and improve the safety culture on the wards.
- The majority of services were staffed to safely meet the needs of the patients.
- The majority of buildings were safe and well maintained; the facilities were suitable to meet the needs of the patients. Environmental risk assessments were undertaken, risks such as ligature points were documented, and any risks were managed through observations of patients
- Staff used nationally recognised risk assessment tools. For example, the HCR-20 (a risk of violence tool) and STORM (a self-harm mitigation tool). Staff regularly reviewed these risk assessments and updated them appropriately.
- There was an embedded multidisciplinary approach to patient care. Assessments and care plans were comprehensive and patients were involved in discussions about risk. There was a recovery-focussed approach to care and staff considered and responded to carer's needs and concerns.
- There were safety procedures and protocols in place in relation to personal safety, this included; an effective lone working procedure, which staff in the community teams followed. Infection control policies were followed in ward areas; staff carried hand-sanitizing gels and there were posters on display to remind staff and visitors to the wards to wash their hands to reduce the risk of spreading infections.

Are services effective?
We rated effective as requires improvement because:

Requires improvement

Summary of findings

- Staff working in the community health services did not always meet the basic care needs of patients. The management of pain was inconsistent across the community adults service 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. Some patients, who required help with eating, were left without assistance during mealtimes in community hospitals.
- In the end of life service, the role of the specialist palliative care teams was not clearly defined. Since the merger of the two organisations, there had been changes in the management arrangements. Liaison and communication between community, hospital staff and specialist palliative care teams, both formal and informal varied between localities.
- The trust did not ensure that all staff had the training or support they needed to fulfil their roles. In the end of life service, clinical supervision was not formalised or embedded across all services and managerial supervision was inconsistent.
- Confidential patient matters were not always kept private in the community inpatient services. Telephone conversations could be heard when taking place at nurses' stations.
- Not all staff on the wards understood the gold standards framework system being used to monitor and deliver end of life care. Staff did not record personalised information in the care plans for patients receiving end of life care. There was little detail completed about any personal preferences or wishes, which may have been identified through discussion with a patient or their family. There were inconsistencies in the completing of the patient treatment escalation plans, which could mean that patients were at risk of not receiving care and treatment in line with their preferences. It was not always clear if consent had been obtained in relation to do not resuscitate orders.
- Staff in the community mental health teams did not always undertake physical health checks for patients who needed them. The trust reported, prior to the inspection, that it had identified an inconsistency in practice about the recording of physical health care. However, we did not see an action plan to establish what the trust had planned to do about it.

However:

Summary of findings

- Patients nutritional and hydration needs were regularly assessed and reviewed within community hospitals and appropriate referrals were made to specialists when required.
- Discharge planning was commenced upon admission to community hospitals and all staff were dedicated to ensuring patients achieved good outcomes.
- There was an effective telehealth service that empowered patients to manage their care and treatment in their own homes. The service was valued by many patients and other community adult services.
- There were effective systems in place for staff to be able to access up to date patient records. Care records were mostly person centred and recorded in a timely manner. With the exception of the community mental health teams care planning, was holistic and person centred.
- There was a policy on the Mental Capacity Act including Deprivation of Liberty Safeguards, which staff were aware of and were able to refer to. Staff completed mental capacity assessments when required and these were decision specific and of a good standard.
- Staff completed Mental Health Act documentation appropriately. Staff reviewed the documentation on a regular basis as part of an audit. If staff had any questions or concerns, they could seek advice from the trust Mental Health Act office.
- There was effective multi-disciplinary working across most services, with evidence of positive engagement with external stakeholders to improve outcomes for patients. The exception to this was the specialist children and young persons' service, which had limited access to psychiatrists and clinical psychologists particularly in the east locality teams. There were no occupational therapists in the west or mid children's services.
- Staff used a range of recognised tools to ensure that treatments were delivered in line with National Institute for Health and Care Excellence guidance. The trust used a range of audits across services, the results of these helped to develop service improvement plans.
- Most staff received appraisals annually.

Are services caring?

We rated caring as outstanding because:

Outstanding ☆

Summary of findings

- Staff across the trust, in all services treated patients with kindness, dignity, compassion and respect; they interacted with patients in a respectful and considerate manner.
- Patients were consistently positive and complimentary about the care they received. Staff worked hard to empower patients to manage their own health and wellbeing. Patients were supported to identify who they wanted to be involved in their care.
- Emotional support and information was provided to those close to people who use services, including carers and dependants.
- On the mental health inpatient wards staff sought feedback through patient surveys and the community meetings. There were regular visits from the chaplaincy and advocate services who fed back patient views. Community meetings were happening regularly.
- The community mental health team for older people had demonstrated a willingness to go the extra mile in the provision of services; they had established memory cafes and a gardening group to provide stimulation and support for people experiencing memory loss. The gardening project had been created following feedback from male patients that the memory cafes were not meeting their needs.
- When staff spoke to us about patients, they showed understanding of their needs and circumstances. We observed multidisciplinary meetings where staff showed consideration, and sought consent from the patient. These meetings reflected the wishes and views of the patients they were discussing, and patients confirmed this when we spoke with them.
- We saw examples of patient involvement in service delivery and planning. The learning disability and autism service had included patients on staff interview panels and patients were represented on a health-based place of safety working group, which enabled the trust to incorporate patients' views into decision-making. The teams continued to provide support for safe place (local business that advertised that people with a learning disability could go to if they were worried or feeling threatened).
- The long stay rehabilitation ward invited prospective patients to visit the ward prior to admission to help them to become familiar with the ward. Staff on the ward typed up care plans with patients to ensure that the patient voice was embedded in the care plan. They had also involved patients in the decoration of the ward and supported patients to contribute to the day-to-

Summary of findings

day running of the ward. This included displaying patient comments and suggestions on the notice board so that staff and patients could see suggestions made and action taken to meet the suggestions.

Are services responsive to people's needs?

Good

We rated responsive as good because:

- 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.
- Access to the majority of community adult teams overall was timely, and where possible, services prioritised care and treatment for patients with urgent needs.
- Where complaints were raised, they were generally investigated and responded to in a timely manner.
- Staff were flexible with regard to patient appointments, they tried to see patients at times and venues that were suitable to the patients' needs. This included out of hours appointments were it was required.
- The trust was consistently above the 95% national target for following up patients within seven days of discharge from mental health inpatient care as part of the care programme approach.

However:

- There was variable provision for supporting patients in their own homes at the end stages of life. The continuing care at home team, were very responsive but this was only commissioned for one locality.
- The specialist community mental health service for children and young people was not able to respond to the needs of all children and young people who might benefit, because the criteria for access were so high that children and young people had to be seriously ill before they were accepted. There had been a significant increase in the number of referrals over the previous two years but no increase in funding.

Are services well-led?

Requires improvement

We rated well-led as requires improvement because:

- There was a corporate vision and strategy in place for the trust but not all community health services had their own strategy.

Summary of findings

There was no specific minor injury unit or end of life vision or strategy in place. The vision, strategy and specific values of the community inpatient service were not widely known to the staff in the service or across the community health services.

- The local senior management teams did not always communicate important information coming from the trust board/executive team regarding significant changes to services at community hospitals, to ward staff. Staff told us there was limited engagement with ward staff regarding significant decisions regarding the hospitals they worked in.
- Reporting of incidents through the national reporting and learning system was not done in a timely manner.
- The trust could not provide us with accurate trust wide information on the percentage of staff that had received clinical supervision in line with their policy.
- The trust did not have a bespoke risk register for end of life care. There was no assurance that any potential risks to the effective delivery of end of life care were being identified and recorded.
- The trust was not able to provide accurate trust wide data to show current compliance with mandatory training requirements.
- The trust did not follow national guidance consistently across all areas of the community health services.

However:

- The trust had a clear vision and values that were communicated across all services; staff understood these and worked to achieve them. Staff knew who the executive team were. Senior leaders, including executive and non-executive board members) were visible across most services and staff told us that they could approach senior leaders with any concerns. Staff told us they felt supported and heard, and there was a collective culture of openness to drive quality and improvement.
- The governance processes were overseen by a non-executive board member through the monthly Mental Health Act committee and quality and governance committee. There were systems in place to provide oversight and scrutiny of audits and service development plans. The board provided challenge and oversight to the executive team as required.
- Staff knew what their responsibilities were and they followed trust policies and procedures to adhere to the requirements of the Mental Health Act.

Summary of findings

- The trust had a system of audits in place to ensure that services were generally safe and effective.
- The trust had developed numerous strategies to support the health of staff. This included a staff well-being day for staff to explore ways to maintain their health in the workplace and a fund to provide resources to assist the development of team wellbeing.
- There were systems in place to share learning from incidents. Learning was shared across different services to ensure lessons learned could become embedded into working practices.

Summary of findings

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 included two CQC inspection managers, 24 CQC inspectors, a CQC assistant inspector, two Mental Health Act reviewers, one report writing coach, 39 specialist advisors including allied health professionals, doctors and nurses and two experts by experience. An expert by experience is a person that has experience of using services or caring for someone using services.

Why we carried out this inspection

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

The trust took over the provision of community health services previously provided by Peninsula Community Health Community Interest Company in April 2016.

This was the first inspection of the trust following that change.

We last inspected Cornwall Partnership NHS Foundation Trust in April 2015 and rated the trust as good overall.

We last inspected Peninsula Community Health Community Interest Company in January 2015 and rated the organisation as good overall.

The transfer of services from Peninsula Community Health Community Interest Company to Cornwall Partnership NHS Foundation Trust took place in a shorter than usual timeframe.

In 2015 Peninsula Community Health Community Interest Company was offered a one year extension to its contract to deliver community health services. Peninsula Community Health Community Interest Company requested an extension of two years and an increase in funding to ensure it could meet the requirements of the contract. However, Kernow Clinical Commissioning Group made the decision to enter into a procurement process and invited providers to 'Propose a solution (to deliver) Adult Community Health Services in Cornwall and the Isles of Scilly. Although Peninsula Community Health Community Interest Company put forward a proposal Kernow Clinical Commissioning Group decided to take up the proposal led by Cornwall Partnership NHS Foundation Trust.

The trust told us that it did not have access to all of the information required to determine the functioning and performance of Peninsula Community Health Community Interest Company prior to the takeover of service provision in April 2016, although this was disputed by Peninsula Community Health Interest Company. The trust told us it felt it was unable to make any assessment of the quality of the services or the resources required to ensure the services delivered within the community health care services were of the standard expected within national guidance as it did not have all the core information until three months after the community services had transferred to the trust. Following the transfer of the services the trust identified a number of issues related to patients receiving poor services and so embarked on a programme of change management to embed the culture and ethos of the trust. To support this it introduced a programme of recruitment and retraining for staff; this process is ongoing.

How we carried out this inspection

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?

Summary of findings

Before the visit, the inspection team:

- reviewed a range of information that we held about the trust
- asked other organisations to share what they knew about Cornwall Partnership NHS Foundation Trust (these included the local clinical commissioning group, NHS Improvement, Healthwatch, the local council, partner organisations, the General Medical Council, the Nursing and Midwifery Council and the royal colleges)
- reviewed what people using services said (collected from emails, telephone conversations and our website)
- held focus groups and drop-in sessions with a range of staff including nurses, therapists, administrative and clerical staff, governors and union representatives. We also spoke with staff individually as requested.

During the announced inspection visit on 25 to 29 September and 4 October 2017, the inspection team:

- observed 46 episodes of care and interactions between staff and patients in wards, clinics and visit's to people's homes
- spoke with 257 people who used the services, carers or their family members
- reviewed 193 comment cards collected from patient areas across the trust
- spoke with 464 staff who worked within the trust
- spoke with senior members of the trust's leadership team including the chair, chief executive officer and other non-executive and executive board members
- reviewed 300 care and treatment records of people who use services

Information about the provider

Cornwall Partnership NHS Foundation Trust provides services across the area of Cornwall and the Isles of Scilly to a population of 534,400. It has 17 registered locations serving community health services, mental health and learning disability needs, including 13 hospitals, four of which were temporarily closed at the time of our inspection. Edward Hain Hospital was closed by the previous provider (PCH) in February 2016. Following transfer to CFT in April 2016 subsequent health and safety concerns were identified regarding the evacuation of patients in the event of a fire emergency and therefore the in-patient facilities remain temporarily closed.

In February 2017, due to safe staffing and recruitment challenges, the Trust decided to consolidate its South East Cornwall in-patient hospital staff into the larger, modern facilities at Liskeard Hospital to maintain patient safety. St Barnabus in-patient facilities remain temporarily closed.

There are 122 mental health and 264 general health beds. The trust employs 3698 staff and has a turnover of £166 million. The trust took over the provision of community health services previously provided by Peninsula Community Health Community Interest Company in April 2016.

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

- Personal care
- Transport services, triage and medical advice provided remotely
- Treatment of disease, disorder or injury
- Surgical procedures
- Assessment or medical treatment for persons detained under the 1983 Mental Health Act
- Diagnostic and screening procedures

Cornwall Partnership NHS Foundation Trust has been inspected ten times since registration and was last inspected in April 2015.

Following the April 2015 inspection we told the trust it must take the following actions to improve :

Acute wards for adults of working age and psychiatric intensive care units:

- The provider must ensure all staff working in the acute wards and psychiatric intensive care units are clear about the steps they need to take to reduce the risks of ligature points to patients.
- The provider must take action to reduce the blind spots in the seclusion rooms so that staff can observe patients at all times when secluded.
- The provider must ensure the repair of the intercom in the seclusion room to ensure staff and patients can communicate when patients are in seclusion.

Summary of findings

- The cleaning and maintenance of the wards at Bodmin hospital must be improved to reduce the risk of infection to patients and staff.

Community mental health services for children and young people:

- The provider must ensure that there are sufficient competent staff to meet the needs of the population safely.
- The provider must engage with local commissioners to review staffing provision, in particular the out of hours crisis provision for young people.

Mental health crisis services and health based places of safety:

- The provider must ensure that physical health assessments, crisis plans and care plans reflect patients' needs and contain specific plans to manage or mitigate any risks. Care plans must ensure they meet the patient's individual needs and ensure their welfare and safety.

Following this inspection, we found that the provider had met the majority of these requirements. There are still some issues to address in community mental health services for children which have been highlighted in this report.

Peninsula Community Health Community Interest Company was last inspected in January 2015. Following this inspection in January 2015 we told the provider it must take the following actions to improve:

MIU Urgent Care

- Develop an effective governance framework for urgent care and minor injuries services, including a comprehensive assurance system to monitor and report on activity, performance, quality, safety and effectiveness. The service must maintain a service level risk register and escalate serious risks to a corporate risk register.

End of life care

- Ensure that all allow a natural death orders were completed accurately to ensure the patients preferences, choices and best interests are accurately recorded.

However, as these services have now transferred to Cornwall Partnership NHS Foundation Trust the requirements cannot now be attributed to it and so become obsolete.

This CQC inspection covered nine mental health and five community core services:

- Acute wards for adults of working age and psychiatric intensive care units
- Community-based mental health services for adults of working age
- Mental health crisis services and health based places of safety
- Specialist community mental health services for children and young people
- Community-based mental health services for older people
- Long stay/rehabilitation mental health wards for working age adults
- Forensic inpatient / secure wards
- Wards for older people with mental health problems
- Community mental health services for people with a learning disability or autism

And:

- Community health services for adults
- Community health services for children, young people and families
- Community health inpatient services
- End of life care
- MIU Urgent Care

What people who use the provider's services say

Patients were consistently positive about the care they had received and felt that the trust was a good place to receive care. Patients and carers said that they were treated with dignity and respect by staff. Patients told us that they were able to contribute to their care plans and participate in meetings about themselves. Patients felt able to ask questions about their care and staff responded with clear and understandable answers to their queries.

Summary of findings

Good practice

- The trust had implemented new ways of recruiting new staff. It had started to hold recruitment days on weekends to encourage more applicants. As part of the process, group interviews and practical based tasks were used to identify the most suitable and competent candidates.
- Nursing staff in schools for children with complex care had adapted their paperwork to make it easier for school staff to understand the care plans and needs of the children.
- The trust had won a number of national awards. The bowel and bladder service had been recognised for its innovation in designing products to support patients. The tissue viability service had won a bid from the Health Foundation to spread learning across the county around pressure ulcers. The team had also 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 long stay and rehabilitation ward staff had continued to use the procedure for patients to self-administer their medicines safely. This allowed for greater autonomy and helped to prepare patients for living more independently in the community.

Areas for improvement

Action the provider MUST take to improve

Community health inpatient services

- The provider must ensure that staffing levels across all community hospitals are safe and account for the acuity of patients on the wards.
- The provider must ensure that all relevant staff receive consistent and structured clinical and managerial supervision.
- The provider must ensure that all documentation related to a patient's mental capacity and consent is complete and accurately and appropriately recorded on all occasions where applicable.
- The provider must ensure that all appropriate staff are updated and consulted before decisions are made to withdraw or modify services, which will adversely affect their roles and responsibilities.

Community adult services

- The provider must take action to ensure that risk assessments are completed to ensure the health and safety of patients.
- The provider must ensure that 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.
- The provider must ensure compliance with mandatory training and safeguarding training to ensure staff have the knowledge and skill to carry out their role safely.
- The provider must ensure that the sepsis tool is fit for purpose and staff have access to a national early warning score, to establish an effective 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).
- The provider must ensure that all patients have their nutritional and hydration needs assessed.
- The provider must take action to ensure that 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.
- The provider must take action to ensure that community nurses are working in line with trust policies to complete consent documentation.

Urgent care services

- The provider must accurately record the time triage started at all times, including the time patients waited to be clerked in to ensure the risks of patients deteriorating unseen in a waiting room are understood.

- The provider must ensure that the triage start time is correct and so informs the trust accurately.
- The provider must ensure that appropriate action is taken to address patient transfer delays.
- The provider must ensure that governance at department level within minor injuries units is effective to monitor and improve patient safety.

End of life care

- The provider must ensure that all staff complete patient capacity assessments correctly and that consent to treatment is correctly recorded.
- The provider must ensure that risks within the end of life service are fully identified and mitigated.

Community-based mental health services for older people.

- The provider must ensure that appropriate psychological therapies are available to patients with an organic mental health problem.

Community mental health teams for working age adults.

- The provider must ensure that a sufficient number of suitably qualified, competent, skilled and experienced staff are available to meet the needs of the people using the service at all times.
- The provider must ensure that managers facilitate regular staff supervision.
- The provider must ensure that all staff has access to, and the time, to undertake mandatory training.
- The provider must ensure that patients are involved in their care planning. Including making any reasonable adjustments and providing support to help them understand and make informed decisions about their care and treatment options.
- The provider must ensure that risk assessments are in place, monitored and updated regularly.
- The provider must ensure that proper and safe management of medicines. Including auditing of stock and safe disposal of medicines no longer required.
- The provider must ensure that patients receive physical health checks in line with national guidance, especially for patients on anti-psychotic medicines. This includes providing sufficient quantities of appropriate equipment to ensure the safety of patients and to meet their needs.
- The provider must ensure that there are robust working relationships in place with GPs to support health monitoring of high risk patients, including prescribing of medicines.

Specialist community mental health services for children and young people

- The provider must engage with local commissioners to review the CAMHS provision across Cornwall, including the threshold for access to CAMHS, the out of hours crisis provision for children and young people and the service offered to young people aged 16 and 17 who were not known to CAMHS and required admission to an inpatient tier 4 inpatient facility.
- The provider must ensure that all areas accessible by staff and children and young people at the locations inspected are safe, well- maintained and age appropriate. Equipment such as weighing scales and blood pressure monitors must also be maintained.

Action the provider SHOULD take to improve

Wards for older people with mental health problems.

- The provider should continue to address the staffing shortages on the Garner ward team actively.
- The provider should ensure that the female lounge has clear signs to comply with guidance on same-sex accommodation.
- The provider should review the reduction in psychology input to the ward so that there is adequate cover to provide psychology therapies for older people in patient services.
- The provider should record one to one supervision so that this can be monitored.
- The provider should ensure that do not resuscitate records are fully completed within the trusts agreed timescales.
- The provider should improve the environment to Garner ward together with the wider community hospital to ensure it is providing a dementia-friendly environment.

Acute wards for adults of working age and psychiatric intensive care units. (Acute Wards or PICU)

- The trust should ensure that staff complete care records to reflect discussions on decision specific ‘best

interests' assessments when they have taken place. There was no detailed account of the discussions we were told had taken place about capacity and consent, recorded in the documentation.

- The trust should ensure that there is no blind spot impairing staff observation, in the garden area of Harvest ward.
- The trust should investigate and implement a solution, to reduce the risk of patients gaining access onto the low roofs, accessible to patients in all of the four ward gardens, across both hospital sites.
- The trust should ensure, in all cases, that staff carry out physical observations, post rapid tranquilisation or following intramuscular injections, administered for agitation, to reduce the risk of adverse effects and record these accurately .
- The trust should ensure that its mandatory training target of 85% is reached across the acute and PICU wards.
- The trust should consider, highlighting high dose antipsychotic medicine on medication administration charts, to ensure there is a method to alert any nurse administering medicines.
- The trust should ensure that the privacy windows in the bedroom doors on Harvest ward afford patients privacy and dignity. Patients were not able to close the blinds, when they were in their bedrooms.
- The trust should review the arrangements for which psychiatrist looks after which patient on the acute wards.
- The trust should review arrangements for the length of time patients are on arranged leave, as the occupancy figures and length of stay figures were significantly inflated due to a number of patients who were on extended leave arrangements under Section 17 of the Mental Health Act.

Community-based mental health services for older people.

- The provider should review the out of hours service provision to patients with an organic illness to consider whether there is the need to provide a specialised out of hours service to these patients.
- The provider should ensure that the community environments are well maintained

Community mental health services for people with learning disabilities or autism

- The provider should ensure that staff could work flexibly over the county to ensure consistent care.
- The provider should work with staff to ensure the moving of the psychiatrist clinics address staff's concerns relating to service user access.
- The provider should review multidisciplinary team arrangements for the mid team.

Forensic inpatient/secure wards.

- The provider should ensure that it continues with its ligature reduction programme to ensure it meets national good practice for a low secure environment.
- The provider should ensure that patients have adequate access to outside space on the ward and that the patient garden is secure and well maintained.
- The provider should ensure that all staff who work with patients detained under the Mental Health Act (MHA) have access to MHA training.

Specialist community mental health services for children and young people

- The trust should take steps to ensure consistency in the quality of care records across the services so that all care plans are holistic and sufficiently recovery focused. They should contain clear evidence of how staff respond to children and young people's physical health care needs, how children and young people have been involved in developing their care plan and that they have received a copy as appropriate.
- The trust should ensure that there was a range of relevant information provided at each location for children, young people and their families.

Community mental health teams for working age adults.

- The provider should ensure staff that have been transferred to the low intensity pathway receive appropriate training.
- The provider should ensure that all staff have access to specialist training and are given time to attend.
- The provider should ensure that patients are informed about any CCTV recording equipment fitted in services.

Summary of findings

- The provider should ensure that patients have access to psychology services.

Crisis teams and health based place of safety

- The provider should ensure that their monthly monitoring reports for section 136 accurately collect the information on total length of stay, time to assessment and reasons for any delay in assessment or discharge/transfer from the health-based place of safety.
- The provider should ensure that staff are recording the presentation of people detained in the health-based place of safety a minimum of hourly as per the trust's guidance.

Community health services for children, young people and families.

- The service should consider options to ensure that dispersed teams have a greater knowledge of breast feeding rates in their areas, in order to be able to measure improvement or decline. The children's service should consider formalising an approach to the reassessment of competencies for its staff.
- Provide assurance that staff consistently cleanse their hands and equipment used, between patient visits if there has been any contact with patients or their belongings.
- Provide assurance through the use of audit, that all staff who store, transport or administer medicines do so according to trust policy.
- Provide assurance that patient records completed on paper and transferred to the electronic patient record system are checked as being accurate.

Community health inpatient services

- The provider should ensure that all staff have completed relevant safeguarding training.
- The provider should ensure that all medicine fridges are locked and are not used to store blood specimens.
- The provider should ensure that the temperatures of storerooms, containing medicines, do not exceed 25 degrees.
- The provider should ensure that all infection prevention and control practices are adhered to at all times.
- The provider should ensure that all asset registers at each community hospital are up to date and contain all relevant information.
- The provider should ensure that all staff treating patients using the detoxification service have completed the necessary training to do so.
- The provider should ensure that all appropriate staff are aware of when records audits should be completed.
- The provider should ensure that all staff are afforded opportunities to develop.
- The provider should ensure telephone conversations regarding patient care are kept confidential.
- The provider should ensure that all patients requiring assistance, when eating, are provided with the support they need.
- The provider should ensure that information on how to make a complaint is easily accessible and visible to patients and relatives across all community hospitals.
- The provider should ensure that dementia awareness training is delivered to all relevant staff and measures introduced to aid dementia patients are implemented across all community hospitals where appropriate.
- The provider should ensure that staff have the required training and skills to care for patients living with learning disabilities.
- The provider should ensure that all risks identified at all community hospitals are appropriately risk assessed and recorded on the risk register as appropriate.

Community Health services for Children, Young People and Families

- The provider should consider options to ensure that dispersed teams have a greater knowledge of breast feeding rates in their areas, in order to be able to measure improvement or decline.
- The provider should consider formalising an approach to the reassessment of competencies for its staff.
- The provider should ensure that staff consistently cleanse their hands and equipment used, between patient visits if there has been any contact with patients or their belongings.
- The provider should have assurance that all staff who store, transport or administer medicines do so according to trust policy.
- The provider should have assurance that patient records completed on paper and transferred to the electronic patient record system are checked as being accurate.

Summary of findings

Community end of life services

- The provider should ensure that all staff are up to date with their mandatory training and that there is an effective system in place to monitor this.
- The provider should ensure that staff are competent in the completion of Treatment Escalation Plans.
- The provider should ensure that staff are competent in the use of the GSF (Gold Standards Framework) and the coding in relation to assessments of patients.
- The provider should ensure that individualised care plans contain sufficient detail to reflect the personal choices and preferences of patients.
- The provider should ensure that there is clarity around the training provided by the specialist palliative care teams and that records of the training completed are kept. The provider should provide staff with clearer information about how this training is requested or organised and about the role of the palliative care teams to ward staff.
- The provider should consider the need for a trust wide strategy group that focuses on the implementing of trust policies and initiatives in relation to end of life care. Consideration should also be given as to how such a group could involve representatives from services involved in end of life care.
- The provider should have a strategy and vision for end of life care across the service.
- The provider should ensure that all risks to the provision of quality end of life care are identified and recorded on the risk register.
- The provider should replace or repair the bed, and cover, used to transport the deceased patients to the mortuary at Cambourne and Redruth hospital.

Community adult services

- The provider should ensure a sustainable system for managing the setup of syringe drivers out of hours.
- The provider should make sure that there is a system to ensure stock rotation and cleaning of storage rooms.
- The provider should ensure that systems provide assurance that infection control risk assessments have been completed for patients who require these.
- The provider should make sure that team leaders are actively engaged with the day to day caseload of the nurses and actively challenge risks associated with patients.
- The provider should establish a system to ensure effective pain management for patients.
- The provider should establish a system to provide regular supervision sessions for community nurses.
- The provider should establish a clear and consistent method of referral into the community nursing teams.
- The provider should make sure that all staff are informed and confidently understand their role and responsibility around the mental capacity act and best interest decisions.
- The provider should make sure that staff adhere to the trust policy with regards to the timeframe for closing complaints and make sure patients have access to information, which explains how to make a complaint.
- The provider should make sure that 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.
- The provider should make sure that all risks to the community adult services are identified and recorded on the risk register.
- The provider should establish a system to ensure lone working systems and processes ensures the safety of the community nurses, particularly when working on call.
- The provider should inform all staff and provide a clear message about the implementation of the new electronic recording system.

Urgent care services

- The provider should ensure that mandatory training compliance meets the trust's target and all staff received mandatory training in line with trust policy.
- The provider should ensure that staff have access to clear instruction to run the service to within the planned opening hours.
- The provider should ensure that the trust website has a system, which would reflect when primary service GPs are not available at Camborne Redruth MIU.
- The provider should ensure that the remote e-rostering system recognises the geographical challenges of the region.
- The provider should ensure that each minor injury unit premises are suitable for use. Some premises were not suitable for assessment treatment and confidentiality.

Cornwall Partnership NHS Foundation Trust

Detailed findings

Mental Health Act responsibilities

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

The trust had a robust process to ensure it met its Mental Health Act responsibilities. A non-executive board member who chaired the monthly Mental Health Act committee and quality and governance committee oversaw this. The non-executive director (NED), who had an extensive knowledge of the Mental Health Act (MHA) and Code of Practice, was also integral in a number of other governance groups where MHA data was presented. The mental health manager and legal manager worked well together to support wards and teams through a range of regular audits, training and ward visits.

There was a working group was in place that regularly reviewed learning from data, external reports and feedback from clinical leads. A register of blanket restrictions was kept to help ensure least restrictive practice. Wards and teams followed a policy that any blanket restriction must be pre-approved. The trust had just recently changed its template care plan for Section17 leave following a Mental Health Act reviewer visit. The trust had implemented the improved process across the trust.

Joint working between the trust, police, social service and acute hospital was robust. This was enabling positive communication and allowed issues to be addressed in a timely manner. For example, the criminal justice group, with partners such as the police, worked together to reduce the timeframe for places of safety from 72 to 24 hours.

The trust provided MHA training, which included mandatory online training and face-to-face training for everyone at the trust. As of May 2017, 80% of staff had received training in the Mental Health Act, against the trust target of 85%. Individual wards had examples of bespoke training such as Fettle ward's reducing restrictive intervention training. The NED was clear that mental health was a priority for the trust.

Mental Capacity Act and Deprivation of Liberty Safeguards

The trust had a policy covering the Mental Capacity Act and Deprivation of Liberty Safeguards. The majority of staff could accurately describe the principles of the Mental Capacity Act. The care we saw followed these principles, offered patients the least restrictive care possible, and supported them to make decisions around their care. In the majority of records, staff assumed that a patient had capacity to consent to treatment unless there was evidence otherwise. This was more prevalent in the mental health services, in the community health services staff awareness of and compliance with the Mental Capacity Act and consent to treatment policy was limited.

Requires improvement

Are services safe?

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

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

Summary of findings

Our findings

Safe and clean care environments

- The mental health inpatient wards were visibly clean and well maintained. The corridors were clear and clutter free. Bedrooms we inspected were all clean. Patients told us that wards were invariably clean and tidy. We saw cleaning schedules and these were fully completed and dated, showing that the provider had a commitment to maintaining a clean and safe environment.
- Liskeard Community Hospital and Bodmin hospital, corridors were cluttered with equipment and trollies. Staff had said storage at the hospitals was limited and therefore equipment needed to be stored on the ward. On one occasion, a two-door emergency exit was blocked with cleaning equipment.
- Between 1 September 2016 and 20 January 2017, Cornwall Partnership NHS Foundation trust completed seven ligature risk assessments across seven mental health inpatient wards. A ligature point is anything that could be used to attach a cord, rope or other material for the purpose of hanging or strangulation. Where there are ligature points on the wards, these are documented in ligature audits and managed through risk assessments based on the needs of the patients on the wards.
- The trust was compliant with same sex accommodation guidance and reported no breaches of this guidance between 1 June 2016 and 31 May 2017. On the wards we inspected same sex accommodation was well manged within guidance apart from a lack of a sign on the female only lounge on Garner ward.
- Environmental risk audits had been completed and action plans were in place. Some of the actions related to work that needed to be completed by the private finance initiative landlord and the trust did not have any control over these. For example, at the Bodmin hospital site the trust had experienced difficulties in getting the landlord to meet their responsibilities in making required changes and alterations. Changes were required in the layout of the garden areas on the forensic and acute mental health wards as these contained hazards, which could pose a risk to patient safety. The trust had resorted to taking legal action to ensure that work was progressed.
- Prior to our inspection the trust had identified that the physical layout and low staffing numbers at Falmouth hospital meant that care could not be delivered in a safe way. As a result, there had been a reduction in the numbers of patients on the wards to ensure that care and treatment could be delivered safely. Staff told us that they felt the senior management team had responded positively to their concerns, the ward felt safer, and they were better able to care for the patients as result of the changes.
- The trust had identified that some of the hospital premises such as Edward Hain hospital in St Ives were not compliant with fire regulations and had placed these on the risk register as matters of concern. The concerns regarding the ability to evacuate patients safely in the community hospitals has led to the temporary closure of inpatient beds at Edward Hain hospital in St Ives and St Barnabus hospital. The trust was working with the League of Friends, the landlord and NHS estates to raise the funds to finance the remedial works required.
- Overall, the trust scored worse than the England average for every environmental aspect of care in the patient led assessment of the care environment (PLACE) assessments in 2016. Cleanliness had the highest score of 97.3%, which is close to the England average of 97.8%. For the other aspects; condition, appearance and maintenance, dementia friendly and disability all locations scored below the England average. It was also not always clear whether equipment was clean and ready for use. Stickers were attached to some equipment to show it was clean and ready for use,

though this did not happen routinely across the organisation concerns regarding the PLACE assessments were on the risk register recorded with actions to mitigate concerns listed.

Track record on safety

- In the 12 months prior to the inspection, there had been three prevention of future death reports sent to the trust. One was within the crisis teams, one was within the community adults core service and one was related to both the crisis teams and community-based mental health services for adults of working age. The trust had responded to these reports and changes had been made to service delivery, staff training had also been provided where required.
- Between 1 June 2016 and 31 May 2017, the trust reported 7618 incidents to the National Reporting and Learning System (NRLS). The majority of these incident resulted in no harm to patients; 1% (48) resulted in death and 0.2% (14) resulted in severe harm.
- In the latest benchmarking performance report 1 April 2016 to 30 September 2016, the trust appeared to have a higher than average rate of incidents for implementation of care and ongoing monitoring, patient accidents and infrastructure (including staffing, facilities, environment) and a lower than average rate of incidents relating to self-harming behaviour and disruptive, aggressive behaviour. The trust had increased in size during this time period with the acquisition of the Peninsula Community Health Services and this would reflect the increase in incident reporting.

Learning from incidents

- There was a positive incident reporting culture across all services, although the timeliness of incident reporting was slower than other comparable trusts. Staff were encouraged to report incidents, they had a good understanding of incidents and what to report, processes were in place and they felt confident to do so. There was scrutiny of incidents at local and organisational level and mechanisms were in place for feedback to staff. Where incidents were reported, investigations were undertaken and learning was shared widely. However, there were some examples where learning from incidents was not always shared between the teams. Investigations into serious incidents did not always demonstrate learning had been fully understood. Actions did not demonstrate how learning was to be implemented and embedded into practice. Not all reporting was done in a timely manner. The most recent Patient Safety Incident Report (April 2016 to September 2016) identified that 50% of incidents reported by the trust were submitted more than 42 days after the incident occurred.
- In the latest patient safety incident report the trust was third in terms of most incidents reported per 1000 bed days, out of 55 trusts. Organisations that report more incidents usually have a better and more effective safety culture, therefore this is considered to be positive. Within the report, the trust had a higher than average proportion of low harm incidents and a lower than average proportion of no harm incidents. The proportions of moderate and severe harm incidents and deaths were broadly similar to the national average.
- The community adult and inpatient services 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 and involves a monthly snapshot audit over the course of one day.

Safeguarding

- There were arrangements in place to safeguard adults and children from abuse. Staff understood their responsibilities and adhered to safeguarding policies and procedures. The trust had a safeguarding team that supported and investigated safeguarding incidents in accordance with the local authority safeguarding processes. At the time of our inspection, the trust was subject to an organisational review under Section 42 of the Health and Social Care Act 2014. This related to a number of safeguarding concerns raised in the community hospitals since transfer into the trust in April 2016. The trust had implemented an action plan to address the concerns. This had included refresher training in safeguarding and care standards training delivered by the director of nursing. However, data provided by the trust showed the number of staff who had completed safeguarding training was, in places, significantly below their target. For example within the community inpatient services only 47% of relevant staff had completed safeguarding children level two training, only 31% of relevant staff had completed safeguarding adults level two training (human rights) and only 35% of

relevant staff had completed 'prevent' training. 'Prevent' training is part of the Government's counter-terrorism strategy and aims to stop people becoming terrorists or supporting terrorism.

Assessing and monitoring safety and risk

- There were good examples of risk assessment and risk management across most core services. In particular, the long stay rehabilitation ward was continuing to enable patients to self-administer their medicines that we noted on our last inspection. This process was facilitated through individual medicine drawers, risk assessments and facilities in patient rooms to allow them to store some medicines there. The trust used nationally recognised risk assessment and risk monitoring tools to ensure that patient care was delivered in a safe way for patients and staff across most core services. However, countywide, within the community adult service, risk assessments, risk management plans and reviews were not being consistently completed by the community nursing teams. Risk assessments were not being used to respond positively to patient risk or to minimise harm to patients and anticipated risks were, at times, not challenged or managed.
- There was no consistent approach to the early recognition and management of sepsis in the community health services. The community adult service had a sepsis screening tool but this was not fit for purpose, because the nursing staff did not have the equipment identified on the sepsis screening chart to monitor patients for sepsis.
- In the community adult service, lone working systems and processes did not ensure the safety of staff. This left staff that were working on call vulnerable and posed a risk to their safety.
- Within the minor injuries units, time to triage recording did not include the time patients had waited to be booked in. Systems were not always in place to manage this risk and potentially patients could have arrived and be deteriorating in the waiting area, unknown to staff.
- Patients who required emergency transfer by ambulance to an acute hospital were placed at risk due to delays in ambulance service response. The service was delivered by South West Ambulance Trust. While this affected the minor injury units, it was not caused by Cornwall Partnership NHS Foundation Trust. Staff in all locations told us they had, at times experienced delays. The trust told us that they had raised this as a concern with South West Ambulance Trust.

Safe staffing

- The trust had recognised that staffing levels and recruitment were a risk and this featured on both service level and organisational risk registers. The trust was addressing this through its people and development strategy, a three-year strategic plan that included recruitment, training and staff wellbeing approaches. A non- executive director chaired a monthly workforce management group that maintained an immediate oversight of the challenges faced by the recruitment and retention issues.
- For the period 1 June 2016 to 31 May 2017 the average monthly vacancy rate across the trust was 5.1%. During these 12 months, long stay/rehabilitation mental health wards for working age adults had the lowest average monthly vacancy rate. Mental health acute wards for adults of working age and psychiatric intensive care units had the highest average monthly vacancy rate of 7.9%. The vacancies were well managed with overtime and bank staff; there was minimal use of agency staff to cover shifts. This included staff such as speech and language therapists and pharmacists, the trust had identified deficiencies in pharmacy and speech and language therapists on the trust risk register.
- The staffing levels in the minor injury units had potential to lead to harm to patients. The lack of reception staff cover out of hours and the sharing of staff between wards and minor injury units could lead to delays in patients being seen in a timely manner and meant that patients would not be observed in waiting rooms out of hours. If a patient's condition deteriorated whilst waiting to be treated this may not be seen by staff if they were treating another patient. Staff shifts were arranged via a remote e-rostering system. Whilst this appeared to work well in most areas, we saw it did not always recognise the geographical challenges of the region. For example, the rostering of staff on the Isles of Scilly. The shortage of permanent staff at St. Mary's hospital meant this was an ongoing problem and impacted on staff leave, training and senior nurse on call cover.
- Most community hospitals had vacancies for both registered nurses and healthcare assistant, and a number of registered nursing shifts were filled by bank

and agency staff or left unfilled. Between the period of 1 June 2016 and 31 May 2017, 4.3% of registered nursing shifts were left unfilled across all community hospitals. Stratton Community Hospital had the most unfilled registered nursing shifts with 8.7%.

- The trust submitted its sickness data for the period 1 June 2016 to 31 May 2017 and had an average sickness rate of just over 5%. This was worse than the England average of 4.95%, February 2017. Mental health wards for older people with mental health problems had the highest sickness rate over the 12 months of 7.7%, in community health services; end of life care had the lowest with 2.1%.

- Across most core service the trust managed sickness and vacancies well, there were exceptions in the community mental health teams for adults of working age and the community learning disability or autism team. The community mental health teams had high caseloads due to staff vacancies and, at the time of our inspection, they had 114 unallocated patients. These patients had received an initial assessment but were not considered high risk requiring immediate allocation to a caseworker. However, there were no clear processes for proactively monitoring the well-being of these unallocated patients. The community learning disability or autism team had an increasing number of vacancies. Because there were a high number of speech and language therapy vacancies the manager had included them in the team risk register as this was impacting on the delivery of the service.

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 data for mandatory training for the two years prior to the inspection on training compliance for all core services. As at 31 May 2017, the training compliance for trust-wide services was 54% against the trust targets of either 85%, or 95%. This is a noticeable decrease from compliance rates of the previous years of 88% and 86%. The trust had implemented a new tool to capture training data in June 2017 and it is possible that not all of the data had been incorporated into the data provided to CQC. Staff told us they struggled to access places on the mandatory training sessions.

Potential risks

- The trust had a comprehensive governance structure to manage risks both actual and potential. There were robust risk reporting systems in place, with reporting at operational level, the trust wide risk register and the board assurance framework.

Duty of Candour

- Staff demonstrated an understanding of their responsibilities about the duty of candour. The organisation had a duty of candour policy and process available on the intranet, for staff to follow when applying it. The policy explained the duty of candour and the principles of being open. The policy also contained the roles and responsibilities of the staff about 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 trust understood and applied the duty of candour appropriately. Over the past 12 months, the trust had applied duty of candour 234 times. Adult community services applied it the most with 91, which was followed by community inpatient services with 64. The trust undertook an audit of compliance with the policy; the positive results were reported to the board in March 2017.

- Staff received training in duty of candour and the trust provided regular listen, learn act sessions, which were open sessions available to all staff to update their knowledge of the requirements of the legislation.

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 of findings

Our findings

Assessment and delivery of care and treatment

- Across the majority of the inpatient and community services staff worked with patients and their families to deliver individualised care. Most care plans were holistic, documented detailed assessments of both the emotional and physical needs of patients, were patient centred and most had a strong recovery focus; an exception to this was the community mental health teams. Care planning in the community mental health teams was an exception. Here many of the care plans were limited, not person centred and staff had not checked whether GPs were monitoring physical health care as agreed.

Best practice in treatment and care

- The trust had a range of audit tools and oversight measures to ensure that services were provided in line with best practice and guidance. The trust provided details of 71 national and local audits (including clinical audits) that had been completed over the last 12 months and information as to how they had changed practice. The types of audit undertaken were clinical, clinical practice, national audit, policy compliance audits and service evaluations.
- Community hospital inpatient wards gathered Patient Reported Outcome Measures and these show good clinical improvement. This data set includes Dignity in Care Assessments; Patient Led Assessments of the Care Environment, safety thermometer and Gold Standard Framework after death analysis. The findings of the audits were reported to the operational assurance group and the trust board and outcomes were fed back to staff teams to make improvements in service delivery. However, 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.
- The trust had produced an organisation-wide document for sharing, implementation and monitoring of National Institute for Health and Care Excellence (NICE) guidance and related quality standards, this provides a framework to help guide clinicians on how to implement and follow NICE guidance.
- The 'effective working group' had developed a process to receive and review new NICE guidance and quality standards; these were reviewed by the relevant operational assurance group for information and action.
- A monthly 'effective report' was shared with operational assurance groups and committees that included a list of new published and updated NICE guidance. A yearly clinical audit programme reviewed the compliance with NICE guidelines. This was an ongoing process and was updated to reflect and include new guidance.
- Treatment pathways were mapped against NICE guidance for example, memory assessment, mental health cluster pathways, and learning disability pathways.
- All mental health inpatient services were using Modified Early Warning Scoring to monitor the physical health of patients.
- In the community mental health services for older people, staff used recognised rating scales such as the Addenbrookes Cognitive Examination to aid in their assessment of needs. The service had introduced a memory screening tool to ensure that referrals were appropriate to the specification of the service
- The trust's proportion of admissions to acute wards gate kept by the crisis resolution home treatment (CRHT) team exceeded both the trust target and the England average across all recorded quarters. The trust's CRHT gate kept 100% of admissions to acute wards across the period with just one exception in quarter four of 2014/15 whereby 99% of admissions were gate kept. This meant that patients could be supported in their own homes and not admitted to an inpatient mental health ward.

Requires improvement

Are services effective?

Outcomes for people using services

- The children's speech and language team introduced a helpline for families and professionals to contact with queries relating to their care or to make a referral. Following the introduction of this, the service reviewed the available evidence and designed alternative intervention packages to support a triage process as well as producing resource and information packs for families and referrers. They also developed a training package for professionals on selective mutism and toddler talk. The children's speech and language team developed an inreach service into the acute trust to ensure early intervention for children with eating and drinking difficulties to improve outcomes.
- The child and adolescent mental health service had developed a robust model of care incorporating the Maudsley model through the four phases of treatment. This was evidence based and measures were taken at every session to track patient progression and satisfaction with the service. An integrated service had been developed that included physical monitoring delivered by specialist physical monitoring nurses to ensure physical health needs were not neglected, which improved outcomes.

Skilled staff to deliver care

- Despite mandatory training completion rates being low, generally, staff had the skills, knowledge and experience to deliver effective care and treatment. However, whilst the health care assistants in the continuing care at home team were very motivated, and a largely experienced team, they had little or no formal training in end of life care. They often provided personal care to patients in the final weeks or days of life.
- The trust was unable to provide a full data analysis of clinical and management supervision rates across all core services. It told us that the service restructure had an impact on the data available. This meant that the trust could not be confident that staff were being supported to fulfil their roles or that performance management issues were being appropriately dealt with.
- Supervision rates were not routinely reported and monitored in the community health services. In the community inpatient service clinical supervision was not formalised or embedded across the service and managerial supervision was inconsistent. Not all community nurses received formal supervision sessions. However, in the end of life care team, staff spoke positively about the supervision and support they received from managers. All staff had an annual appraisal, and those requiring clinical supervision could access it. The mental health services reported higher rates of supervision, on the mental health inpatient ward for older people staff were up to date with appraisals and felt well supported with regular team meetings, supervision and training.
- Trust wide appraisal rates were 83% against a trust target of 85%; this was an improvement on the previous year of an appraisal rate of 62%.

Multidisciplinary working

- We saw numerous examples of positive interagency working. For example, the long stay rehabilitation ward had a strong relationship between the staff and local services. This meant that patients benefitted from courses at the local college and were enabled to integrate with the local community in a meaningful way as part of their recovery. There was good interagency working within home treatment teams and the health based place of safety. Home treatments teams had psychiatry and psychology input. Approved mental health act professionals were integrated into the teams which allowed for continuity of care for patients accessing the service.
- In the child and adolescent mental health service multidisciplinary working occurred routinely and across specialisms, organisational and geographical boundaries. We saw how this led to a more effective service for children and families. There were clear and effective pathways in place for referral, transfer and discharge of children and families. We saw how this ensured work was targeted and effective. Multidisciplinary community 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.
- The community mental health teams for adults of working age had struggled to build up positive joint working arrangements with local GP's. This meant that the physical health observations required for the patients on anti-psychotic medication was not monitored in line with NICE guidance and could place patients' physical health at risk.

Requires improvement

Are services effective?

Technology and telemedicine

- The community adults service had an efficient, valued telehealth service that 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. Though due to be decommissioned from November 2017, 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. 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. 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. Whilst the trust had raised concerns that the service was no longer to be commissioned, it was not clear at the time of inspection what alternative provision was being planned to deal with the additional face to face patient contact likely to occur once the service had ceased.

Information and Records Systems

- All staff had access to online electronic record systems, though not all staff accessed the same systems meaning information was not always available to all staff. The organisation was due to introduce a new electronic system in November 2017 to ensure all teams had access to the same information. The migration to a new electronic system was postponed based on feedback from staff and this was communicated to all staff.

Consent to care and treatment

- In the community inpatient service, not all staff understood their role and responsibilities around the mental capacity act and best interest decisions.
- On the acute and psychiatric intensive care units staff did not always complete care records to reflect discussions on decision specific 'best interests' assessments when they had taken place. There was no detailed record of the discussions that we were told had taken place about capacity and consent. The majority of mental health teams demonstrated a good understanding of capacity and consent to treatment.
- There was a lack of compliance countywide with the community nursing teams and community inpatient services completing the consent to share information with other relevant health care professionals.
- The treatment escalation plan contained the do not attempt coronary resuscitation decision, and also information about whether a patient had capacity or not. Whilst we saw all patients had a treatment escalation plan in place, there was some inconsistency in the detail that was recorded. Not all forms we looked at had the detail recorded of whether a patient had capacity or not, or how a decision had been reached. If it was suspected that a patient lacked capacity, the relevant parts of the form were not always completed.

Assessment and treatment in line with Mental Health Act

- The trust was not achieving its target for Mental Health Act training. As at 31 May 2017 80% of staff had received training the Mental Health Act against the trust target of 85%. This course is mandatory for all relevant clinical staff. The renewal timeframe for this training course is every three years.
- Staff completed legal documentation in line with the Mental Health Act appropriately and the trust's Mental Health Act office audited this. The acute and psychiatric inpatient wards maintained an updated patient board that detailed when rights should be repeated for each patient. This information was audited every week.

Good practice in applying the Mental Capacity Act

- The trust made 140 Deprivation of Liberty Safeguard (DoLS) applications to the Local Authority between 1 June 2016 and 31 May 2017. Twenty-four of which were approved. Community inpatient services made the most DoLS applications with 96, which accounted for 69% of all DoLS made by the trust. The trust indicated that 'all

Requires improvement

Are services effective?

DoLS applications were notified to CQC as of February 2017'. According to CQC data, we received 137 DoLS notifications between the same date range (1 June 2016 to 31 May 2017).

- Mental Capacity Act training formed part of the trusts essential online training. As at 31 May 2017, the overall compliance rate for this was 93% against the trust target of 95%.

Outstanding ☆

Are services caring?

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

Summary of findings

Our findings

Dignity, respect and compassion

- Staff showed patience and gave encouragement when supporting patients. Patients told us that they were the priority for staff and that their safety was always considered. Community mental health patients living on the Isles of Scilly were provided with funding to travel to the mainland for appointments if they did not want their care co-ordinator to visit them at home. Patients on the Isles of Scilly felt that there confidentiality may be compromised if staff visited them at home as they lived in such a small community.
- Comment cards completed by patients in both the community health services and mental health services were consistent in praising the care and support the trust staff had provided to them.
- In the Friends and Family test November 2016 to April 2017 for mental health, the trust scored better than the England average for four of the six months between January and June 2017 for recommending the trust as a place to receive care. The trust consistently scored better than the England average in terms of the percentage of patients who would not recommend the trust as a place to receive care in all six months.
- For community health services the trust scored better than the England average for all six months between January and June 2017 for recommending the trust as a place to receive care. The trust scored similar to the England average in terms of the percentage of patients who would not recommend the trust as a place to receive care across all six months.
- The percentage of staff who would recommend the trust as a place to receive care was better than the England average - 82% compared to the England average of 79%. The percentage of staff who would not recommend the trust as a place to receive care was also better than the England average at 5% compared to the England average of 7%.
- In relation to privacy, dignity and wellbeing, the 2016 PLACE score for Cornwall Partnership NHS Foundation Trust was 70.2%, which was worse than the England average of 89%. All 12 sites at the trust scored worse than the England average, with St Barnabas hospital at the lowest with 56.4%. (Although at the time of our inspection St Barnabas hospital was temporarily closed.)

Involvement of people using services

- There was evidence of patient involvement in the majority of the care records we looked at in all core services and all patients had either signed a copy of their care plans or said they did not want to sign the plans. The approach of the staff to patients was person centred, individualised and recovery orientated. The long stay rehabilitation ward was proactive in including patients in the writing of their care plans.
- On the mental health acute wards and psychiatric intensive support unit, staff encouraged feedback from patients and satisfaction surveys were available for patients to complete on every ward. On each ward a 'you said we did' initiative was advertised on patient information boards and gave examples of staff making changes on the wards in response to patient requests.
- In the end of life service staff ensured that patients and families were involved in their care and understood their treatment and prognosis.
- The community learning disability or autism service involved service users in service development. Service users interviewed new staff. An advisory group reviewed new working practices and service information leaflets to ensure they were suitable for the patient group. Staff encouraged patients to give feedback to the service via questionnaires.
- In the forensic inpatient service patients had been involved in their care through regular community meetings, patient surveys and discussions.

Outstanding ☆

Are services caring?

Emotional support for people

- Emotional support was offered to patients and their families in a way patients would be able to accept. Staff ensured patients understood their options. Staff understood the impact patients' care, treatment and condition had on their wellbeing.
- Patients were empowered and supported to manage their own health, care and wellbeing to maximise their independence. Patients were asked for their thoughts and feelings regarding treatment plans and had direct input into setting their individual goals and objectives.

Good

Are services responsive to people's needs?

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

Summary of findings

Our findings

Planning and delivery of services

Diversity of needs

- Services were planned to take account of the needs of different people, including those living with dementia. Access to the community hospitals was good, with disabled parking available at all sites.
- Staff had equality and diversity training during induction, which then had to be updated every three years. Equality and diversity training was part of the trust's mandatory training programme and was included in their two essential learning packages. Compliance with these training packages varied across services but was generally near the trust target of 95%.
- Arrangements were in place to access translation services. However, staff were unaware if leaflets could be printed in other languages or braille.
- A chaplaincy service provided spiritual and pastoral care to staff and patients. The chaplain had plans to redesign the service to make better use of limited resources.

Right care at the right time

- Access to care and treatment for the majority of teams was timely though some services such as the bladder and bowel service had some delays. The specialist community mental health services for children and young people (CAMHS) had raised the threshold for accessing the service. All clinicians in the CAMHS team spoken with stated the threshold for access had been raised in recent years so children and young people were now more acutely ill before they were seen which often made care and treatment harder and more lengthy.
- Senior staff within the community adults service 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. However, this service had not received any increased investment since 1998.
- Bed occupancy levels for each community hospital, between April 2016 and March 2017, was consistently over 85%. There were four occasions when bed occupancy reached 100% at Fowey Community hospital (August 2016), Lamorna Ward (July 2016), Lanyon ward (November 2016) and the Woodfield Stroke Unit (February 2017). Delayed discharges from the community hospitals were high. Between 1 June 2016 and 31 May 2017, there were 1,325 delayed discharges across the all the community hospitals service, which amounted to 31% of all discharges. The ward with the highest proportion of delayed discharges was Edward Hain, which reported 79% of all discharges being delayed. Between April 2016 and March 2017, there were a total of 871 delayed patients and 24,740 delayed days at the trust. Lack of resources in social care accounted for the largest proportion of patients delayed (55%) which correlated with also having the most delayed days (54.4%). The most prominent reasons for a patient being delayed during the period were awaiting care package in own homes (37.6% of patients).

Learning from concerns and complaints

- There were systems and process for monitoring and managing complaints but patients did not always know how to make a complaint. There were not many posters or leaflets advising patients or relatives how to complain in the areas we visited although information on how to make a complaint was available on the trust's website. The process for making a complaint was clear and simple.
- The trust received 109 complaints between June 2016 and May 2017. There is a target of three days for responding to a complaint, which the trust met for all complaints. The trust target for completing a complaint

Good

Are services responsive to people's needs?

was 25-60 days. The trust was meeting this target 44% of the time. Two complaints had been referred to the Parliamentary health Service Ombudsman (PHSO), both are ongoing and no outcome has been reported yet.

- Complaints were handled effectively and confidentially, with complainants updated regularly.

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 of findings

Our findings

Vision, values and strategy

The trusts vision of "Delivering high quality care" was underpinned by five strategic objectives:

- To deliver high quality, safe and accessible services
- To maximise the potential of our workforce to deliver high quality patient care
- To achieve the best value and ensure the Trust is sustainable and financially sound into the future
- To diversify and develop services that meet commissioner and patient needs and expectations
- To improve health and wellbeing by working in partnership to create life opportunities for our patients
- Staff in all core services could tell us what the trust vision and values were
- There was a detailed strategic plan which set out the vision for the organisation from 2014 to 2019, this was underpinned by numerous work streams including the workforce and development strategy.

Good governance

- The trust had a governance framework that set out responsibilities for managing quality, performance and risks. The board assurance framework set out the means by which the organisation tracked its progress as well as setting out controls to mitigate potential risks to the delivery of annual objectives. There was a strong emphasis on governance that was reinforced with policies and processes to ensure consistency across services. Executive Director level accountability was in place reporting to the full trust board.
- However, the governance framework needed further development to ensure quality and risks were fully understood and managed across all services and all core services had their own risk registers.
- The trust was unable to provide clear data for the completion of mandatory training across the whole of the trust; it had recently adopted a new system of recording training across the mental health and community core services. Without clear data, the trust could not assure itself that the staff teams were skilled and competent to deliver their roles.
- There were arrangements for identifying, recording and managing risks, and mitigating actions. However, identified risks were not always contained on the risk register, for example, the closures of St. Barnabus Community Hospital or Edward Hain Community Hospital, or the poor compliance with mandatory training, and not all risks were regularly updated.
- There were systems in place for executive directors to report to the full trust board as part of the board assurance process.
- There was an information governance framework and strategy. The information governance and records management lead reported annually to the board.
- The trust completed the Information Governance Toolkit every year and achieved a satisfactory compliance score with 81% in the year 2016 to 2017. The trust was successfully managing increases in freedom of information requests and subject access requests. The trust demonstrated learning and improvement in response to information governance breaches.

Leadership and culture

- The majority of staff felt leadership within the trust was good and the executive team was accessible. Staff told us they felt supported and heard, and there was a collective culture of openness to drive quality and improvement. The executive team were known by staff in all core services, with the executive team attending some team meetings and training events. Staff could approach executive directors directly if they wanted to raise concerns. The executive team had recently undertaken a series of meetings with community hospital staff as there had been safeguarding concerns on the wards. One outcome of the meetings was a reduction in beds at Falmouth hospital as staff were

able to show that the staffing levels were insufficient to meet the needs of the patients. Staff told us that they felt supported by this outcome and that their concerns were both listened to, and valid.

- The chief executive and chair of the board were confident that the skills required were present in the current executive team and if required additional skills could be sourced.
- Staff were aware how to raise a concern and understood the whistleblowing policy.
- The trust had recently had a day focussed on breaking the rules. This was an opportunity for staff to feedback to the senior team rules they thought were unnecessary or restricted positive patient care. The quality improvement lead was still reviewing the findings from this at the time of inspection.
- The trust had set up a 'care awards' and 'excellence report' schemes when staff were nominated for going above and beyond what was expected of them at work, this further increased staff morale and well-being.

Fit and Proper Person Requirement

- The trust was meeting its obligations under the fit and proper person's requirements. There was an up to date Fit and Proper Persons requirement (FPPR) policy, which the board had ratified. We reviewed the personnel files for the executive team and all files were in good order with up to date annual self-certification forms in place.

Engaging with the public and with people who use services

- The organisation engaged with the public in a variety of ways. For example, the use of the friends and family test to gather feedback about the various services. A new interview assessment process to recruit community nurses in the north and east locality included patients on the interview panel, and the neurological care advice coordinator had set up a peer support group for patients where they were supported to provide feedback and suggest changes to ways of working to make services more effective and stream lined.
- The trust's patient experience team had oversight of the implementation of the trust's patient experience strategy and patient and carer involvement strategy. There was a monthly carers' forum, which provided insight regarding services from the perspective of carers.

Quality improvement, innovation and sustainability

- There were areas of innovation in many services across the trust. For example, in September 2017, the tissue viability nursing team won the Quality Care award from the European Pressure Ulcer Advisory Panel. The bowel and bladder service had won Continence team of the Year 2015 and the consultant lead had also won the Royal College of Nursing Advanced Nursing Practitioner award in 2016.
- The trust had been part of a multi-agency accessible communication group for a number of years. This group was established to improve all forms of communication between public sector organisations and patients, and the wider population of Cornwall and the Isles of Scilly. National funding to make a promotional video had been received and the group ran a conference to raise awareness of the standards prior to implementation. They were currently developing a self-accreditation framework to support organisations with their implementation.
- The trust had implemented new ways of recruiting new staff. It had started to hold recruitment days on weekends to encourage more applicants. As part of the process group interviews and practical based tasks were used to identify the most suitable and competent candidates.
- The acute and psychiatric intensive care wards had developed regular safety huddles, which is a nationally recognised good practice initiative to reduce patient harm and improve the safety culture on the wards. There had been a significant reduction in the use of restraint and seclusion in the year before the inspection.
- There was a research department within the trust that had conducted specific dementia targeted research. The aim was to embed research into everyday practice. Staff showed us examples of research into lesbian, gay, bisexual and transgender needs in dementia and in auditing antipsychotic use across the complex care and dementia team.
- The community learning disability and autism service had been accredited as being autism friendly by the national autistic society.

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
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care In the integrated community mental health teams for working age adults the provider did not always work collaboratively with patients to ensure their preferences were taken account of when creating care plans.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent 11.—(1) Care and treatment of service users must only be provided with the consent of the relevant person. The provider must ensure that staff are fully aware of the requirements of the Mental Capacity Act and that patients with mental capacity are involved in decisions about their care and treatment

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The records did not accurately record the time triage started to include the time patients waited to be booked in, to ensure the risks of patients deteriorating unseen in a waiting room were understood and managed safely. The triage start time was not correct and so did not inform the trust accurately. It was unclear in some minor injury unit's when the 'clock started' in order to meet the 15 minute triage target.

This section is primarily information for the provider

Requirement notices

In some minor injury units patient records showed that the triage time started and stopped with the receptionist taking the initial booking information, despite the triage being undertaken by the appropriate staff.

In the integrated community mental health teams for working adults of working age the provider did not always assess the risks to the health and safety of patients of receiving the care or treatment.

In the integrated community mental health teams for working adults of working age the provider did not always ensure that the equipment used for patient care was safe for such use.

In the integrated community mental health teams for working adults of working age the provider did not ensure robust procedures were in place to monitor the physical health of high risk patients.

The provider did not provider proper and safe management of medicines.

The threshold for accepting children and young people into CAMHS had been raised – meaning that some children and young people did not get a service (or got a service that did not meet their safety and care needs) until they were seriously ill. There was limited out of hour's crisis provision for children and young people and there was no CAMHS available for young people aged 16 and 17 who were not known to CAMHS and presented in crisis at the emergency department.

In the community nursing teams service 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.

This section is primarily information for the provider

Requirement notices

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.

Arrangements for managing medicines were not always safe and staff were not working in accordance with standard two of the Nursing and Midwifery Council: 'standards of proficiency for nurse and midwife prescribers' (NMC, 2015).

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.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures 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
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment The locations that a number of CAMHS services were delivered were unsafe, were not well-maintained or age appropriate. Equipment like weighing scales and blood pressure monitors were not always maintained.

Regulated activity	Regulation

This section is primarily information for the provider

Requirement notices

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

Diagnostic and screening procedures

Treatment of disease, disorder or injury

Regulation 17 HSCA (RA) Regulations 2014 Good governance

Regulation 17 HSCA (RA) Regulations 2014 Good Governance 17(2)(b) (c) assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity.

In the minor injury units patients were placed at risk due to delays in emergency ambulance transfer. Once the patient had been identified as needing a transfer to the acute trust staff in all locations had experienced unacceptable delays in the patient being emergency transferred.

In the minor injury units there was no formal plan in place to support staff with decisions to close the units on time. Should a minor injury unit be full and closing time of the minor injury unit be approaching, there was no plan in place to inform or support staff to close the unit to prevent patients being seen out of minor injury unit opening hours.

There were no risk assessments and reviews of the minor injury units which presented specific geographical challenges and how they should be managed.

In the integrated community mental health teams for adults of working age the provider did not have robust management oversight to ensure they were operating a safe service.

In the community health inpatient services the provider's system for recording risk did not always identify current risks and measures were not always taken to reduce or remove risks within a timescale that reflects the level of risk and impact. The provider had failed to implement measures to reduce the risk of prescribing errors and infection prevention and control risks to patient safety.

This section is primarily information for the provider

Requirement notices

In the community health inpatient service the provider did not always actively seek the views of staff about their experience of, and the quality of care and treatment delivered by the service.

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. 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
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing There were insufficient, competent staff to safely meet the increased needs of the children and young people requiring CAMHS in population it serves. In the community health inpatient services, the provider was unable to deploy sufficient numbers of suitably qualified, competent, skilled and experienced persons across the whole service. The staffing numbers within the community hospitals were inconsistent and there were hospitals, which could not always provide safe staffing levels. There was no embedded system of clinical supervision for relevant staff. Supervision, both managerial and clinical, was inconsistent across the community inpatient service. Not all staff had been provided with specialist training to treat patients admitted to the community health alcohol detoxification service. There was poor compliance with mandatory training in the community health adult service with only 36% of

This section is primarily information for the provider

Requirement notices

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.