Good

Cornwall Partnership NHS Foundation Trust

Community-based mental health services for older people

Quality Report

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Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RJ8X7	Bodmin Community Hospital	Camel	PL31 2QT
		Valency	Pl31 2QT
		Coombe	TR18 4NY
		Cober	TR15 2SP
		Gannel	TR15 2SP
		Fal	TR1 3SP
		Tamar and East	PL14 4EN
		Fowey	PL25 4QW

Summary of findings

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

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

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

Summary of findings

Ratings

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

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

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

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

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

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

Summary of findings

Contents

Summary of findings

Overall summary

We rated community-based services for older people as good because:

- Staffing was sufficient to meet the needs of the population safely. The provider had systems in place to ensure that caseload sizes were monitored and managed.
- Staff had a good understanding of safeguarding processes and reported incidents. When incidents did occur, there were mechanisms in place for learning.
- The service had embedded evidence-based practices into the operating models.
- Staff were well-supported with training and supervision and we saw that there were good systems in place to ensure multi-disciplinary working.
- People using services and carers were treated with kindness, dignity and respect. The service sought feedback in different ways which were devised to meet the needs of those using the service.
- Where targets for assessment and treatment were breached, the service developed plans to tackle this.
- Provision was tailored to meet the needs of a rural community by providing different hubs and they worked with local residential and nursing homes to provide additional support for people to reduce the need for a hospital admission which could be some distance away.
- The service was well-led as there were robust governance systems in place to ensure that information flowed from the management within the trust to staff at all levels.
- Staff were positive about working for the trust and generally found their managers supportive.
- The service was research friendly and some staff actively contributed to research evidence which they brought back into the service.

However:

- The lack of integration with the local authority had been a challenge in some situations.
- Some records were not comprehensively completed and did not evidence the work which was carried out by the team.
- There were no commissioned specialist crisis services for people living with dementia.

Summary of findings

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

Are services safe?

Good

We rated safe as **good** because:

- Teams were staffed to their complement and where there were vacancies, the trust had contingency plans to ensure that the needs of people who used the services were met.
- Caseloads were monitored centrally to ensure that they were maintained at a level which ensured the safety of people who used the service.
- Staff had a good understanding of safeguarding processes and were aware of reporting mechanisms.
- Staff had a good knowledge of the risk of people they worked with.
- Staff were aware of how to report incidents and displayed a good understanding of learning from incidents through the service and the trust.

However:

- Some of the crisis plans which were written for patients and carers did not clearly indicate the options available in a crisis.

Are services effective?

Good

We rated effective as **good** because:

- Services had established evidence-based models to deliver support for people with complex care needs and with dementia in the community.
- Some of the services around dementia care and management were particularly innovative and worked to established criteria such as NICE (National Institute for Health and Care Excellence) guidance.
- Staff were well supported within the team and had access to training opportunities, supervision and appraisals.
- There was strong multidisciplinary team working both within the trust and with agencies external to the trust such as community health services and primary health care services.
- Staff received training in the Mental Health Act and Mental Capacity Act and were generally aware of the impact this legislation had to the people who used the service.

However:

- Difficulties caused by a lack of integration and work with social services meant that people did not receive a seamless service.

Summary of findings

For example, when carers' needs were identified and the local authority was responsible for carrying out carers' assessments but the information was not proactively shared between the organisations.

- Some of the records we saw were not comprehensive and complete and did not reflect the clinical interventions that were being carried out. This meant that there was a risk that information available on the electronic database was not up to date and did not reflect the current situations of people which could have an impact in an emergency or if a regular member of staff was not available.
- At the time of the inspection, there was no clinical psychologist in the service and limited access to psychological therapies which could be delivered to people with cognitive impairments by those who specialised in this area. However, there was access to psychology based in the adult community teams and some clinical staff in the complex care and dementia services had undertaken training to deliver psychological interventions such as CBT (cognitive behavioural therapy).

Are services caring?

Good

We rated caring as **good** because:

- People who use services and carers reported to us that staff treated them with kindness and thoughtfulness. We observed positive interactions in the visits that we undertook with staff and observed that staff spoke with people in a respectful manner. Staff had a good understanding of the individual needs of people who use services.
- People who use services and carers had the opportunity to provide feedback to the service. This was used to develop the service. There had been positive intiatives to actively engage the service user groups, such as holding event days for stakeholders throughout the county which had been very positive for people.

However:

- Care plans did not consistency record people's voice and preferences and people were not routinely given copies of their care plans.
- Carers assessments and the support offered to carers was not clearly reported. Carers told us that they felt supported but the work being done was not reflected in the records we saw.

Are services responsive to people's needs?

Good

We rated responsive as **good** because:

Summary of findings

- Services were adapted to meet the needs of people living in the local area and provided on the basis of need rather than age and there had been work to develop models which ensured that people diagnosed with dementia across Cornwall had access to support when needed.
- People were provided with access to urgent care and treatment locally through the intermittent assessment pathway.
- Services tracked targets for timescales to assess and treat and where they were not met, had actions in place to work on this.
- The service tracked complaints and staff told people how they could make complaints. Learning from complaints was embedded in service wide governance systems.

However:

- Crisis services were not commissioned specifically for people living with dementia in Cornwall which meant that there was a gap in provision of care. Crisis teams for adults did cover immediate emergencies but people with cognitive impairments did not receive specialist support in crisis situations.

Are services well-led?

Good

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

- Staff were committed to the trust and its values and told us that they felt supported by the management.
- There were strong systems of governance in place which ensured that the senior management had an understanding of the strengths and weaknesses of the service and were able to ensure that information was shared and learnt.
- One of the teams had developed a memory service which was accredited as excellent through the Royal College of Psychiatrists' memory service national accreditation programme.
- There was a culture of research within the service and a commitment to share best practice.

However:

- Some staff told us that they did not have a strong link with the wider executive team within the trust.

Summary of findings

Information about the service

Community-based mental health services for older people in Cornwall are provided at different bases across the county and are part of the trust's complex care and dementia service line.

The service has five parts: we inspected the primary dementia care practitioner service, memory assessment services, complex care community services and the dementia liaison service. The service also provides specialist psychiatric liaison services in local acute hospitals. However, we did not inspect that part of the service.

Community-based services for older people had not been previously inspected in Cornwall.

Our inspection team

Our inspection team was led by:

Chair: Michael Hutt - Independent consultant

Head of Inspection: Pauline Carpenter - Head of Hospital Inspection CQC

Team Leader: Serena Allen - Inspection Manager CQC

The team that inspected the community-based services for older people consisted of two CQC inspectors, one expert by experience, one Mental Health Act reviewer, one consultant psychiatrist, two nurses, two clinical psychologists and one social worker.

Why we carried out this inspection

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

How we carried out this inspection

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

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

Before the inspection visit, we reviewed information that we held about these services.

During the inspection visit, the inspection team:

- Visited five team bases which included the complex care community teams, primary dementia care practitioners, dementia liaison nurses and memory assessment services.
- Spoke with 49 staff members; including the managers of each of the community teams, doctors, nurses and allied health professionals. We met the divisional director with responsibility for these services and met with staff from all the bases in the county.
- Spoke with fifteen carers of people who used the service and five service users.
- Observed three home visits taking place in the community.
- Observed one visit which took place in a local nursing home.
- Spoke with the manager of a local nursing home.
- Attended and observed two multi-disciplinary meetings.
- Attended one externally held multi-disciplinary meeting with primary care including GPs and community nurses.
- Looked at 41 treatment records of patients.

Summary of findings

- Looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the provider's services say

During the inspection visit we spoke with 15 carers of people who used services and five people who used services. This was from people who either used or cared for people who used the complex care and dementia services, primary dementia practitioner services and memory assessment clinic services. We observed three home visits and accompanied one dementia liaison nurse to a care home setting. We also spoke with one manager of a local nursing home. We looked at the feedback which the service had received from internal surveys and the feedback from recent engagement events which had taken place with people who used services, carers and other stakeholders across Cornwall in the year prior to the inspection.

The feedback we received was generally very positive and we were told that people found the staff caring and that they were given information about the service and were able to feedback.

Some of the direct feedback we received included the following comments: “can’t fault the care” (Camel Team), “staff always have time for us” (Fowey Team), “whenever I’ve had an issue with any aspect of care, I’ve been respected and supported” (Coombe Team), “amazing service, I just wish there were more of them” (Gannel Team) and “it’s nice to have someone at the end of the phone and to come and see you do you don’t feel alone in dealing with this” (Fal Team). This represented the views which were shared with us across the service.

Good practice

- The provision of dementia support with primary dementia care practitioners, memory assessment service, dementia liaison nurses and the complex care and dementia teams working together provided a coherent and supportive pathway for people with dementia and their carers in Cornwall. It ensured that people who used services and carers had contact with specialist services from the point of diagnosis through the course of the progression of their dementia. It provided a point of contact and information for community and acute health services where expertise around dementia care and management could be accessed.
- The intermittent assessment pathway ensured that people with short term urgent needs in an environment where 24 hour care can be delivered. This was through a pathway which was used by local clinicians using residential and nursing care placements and providing additional support as an alternative to a crisis situation. The service had adapted to meet the needs of a rural community as the distance to the inpatient services may be considerable from some parts of the county.
- The service has a strong and proactive approach to research in the care of people with dementia and have shared this research and interest through the publication of journal articles to ensure that learning and best practice is disseminated.
- A strong leadership within the service which has a vision of care for older people in the community which was consistent in all the sites which were visited. There were clear channels for information to be shared through the service and there was a commitment to learning from incidents and complaints both within the service and across the trust.
- The Tamar memory assessment service was accredited as excellent by the Royal College of Psychiatrists' memory services national accreditation programme.

Summary of findings

Areas for improvement

Action the provider SHOULD take to improve

- The provider should consider how access to crisis support can be delivered effectively for older people and that people who use services and carers have access to crisis support plans.
- The provider should consider access to support from a clinical psychologist and access to psychological therapies which is tailored for the needs of older people.
- The provider should ensure that clinical records are up to date, reflect the views of people who use services and carers (where appropriate) and ensure that decisions around capacity, where relevant, are documented in line with the Mental Capacity Act Code of Practice

Cornwall Partnership NHS Foundation Trust

Community-based mental health services for older people

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Camel Valency Coombe Cober Gannel Fal Tamar and East Fowey	Trust Headquarters

Mental Health Act responsibilities

All community staff had attended training related to understanding of the Mental Health Act.

Staff within the service were aware of how to access support and guidance within the trust if necessary. At the time of our visit, there were no patients who were subject to Community Treatment Orders (CTOs).

Detailed findings

Mental Capacity Act and Deprivation of Liberty Safeguards

All staff had received training related to the Mental Capacity Act and deprivation of liberty safeguards. This was part of the e-essential training package. Through the service line, in the community teams there was 100% compliance with this training.

We checked 41 records relating to mental capacity in the offices we visited. This included mental capacity assessments where they were documented, or references to capacity being assessed on a more informal basis in the notes we checked. We found mixed recording of mental capacity. For example, in the Bodmin team bases (Valency/ Camel), the six records we checked had completed assessments of their mental capacity. However, in the Fowey Team based in St Austell, two of the seven records we checked did not demonstrate an understanding of the Mental Capacity Act, as they had indicated that capacity should be assessed as part of a crisis plan without specifying what situation this would refer to. According to the Mental Capacity Act (2005), capacity should be assessed on specific decisions and the records were not clear what decision capacity would or should be assessed against.

Good

Are services safe?

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

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

Summary of findings

Please see summary at beginning of report.

Our findings

Safe staffing

- Staffing levels in the teams varied according to the needs of the local areas.
- Across all complex care and dementia community mental health teams for older people, there were 50.5 whole time equivalent (WTE) nursing posts with 1.8 WTE vacancies across the county.
- There were 8 WTE nursing assistant posts with no vacancies across the county.
- There were 4.7 WTE allied health professionals posts with 1.1 WTE vacancies across the county.
- There was one vacancy for a psychology post.
- We looked at the caseloads in each of the teams. The average caseload of a full time community psychiatric nurse (CPN) working in the complex care and dementia (CCD) community team was 29.
- Each of the teams had a consultant psychiatrist attached to them.
- Bank staff were generally staff who had experience working within this service and who were familiar with the role.
- The trust was looking to mitigate any potential gaps in the service caused by staff absences with plans to recruit bank staff specifically with skills in working with older people and to recruit two peripetic workers who could provide cover in sickness.
- In the three months up to 31/1/15, three teams had used bank staff. In Valency team 34 shifts had been covered by bank, in Coombe 39 shifts and in Cober it had been 3.8 shifts.
- Staff had received up to date mandatory training. All the teams including the management had 100% completion for e-essential and e-mandatory training which were the mandatory training records for the trust. This included training related to safeguarding adults and safeguarding children.

Assessing and managing risk to people who use services and staff

- Risk assessments were undertaken when necessary for people who were assessed in the service. We saw that risk was indicated on case records. Staff we spoke with had a good understanding of risk and the levels of risk attributed to people they worked with.
- Staff were aware of contingency and crisis plans. However, we looked at 37 records across the sites, we saw that some care plans had minimal crisis plans and some which were not comprehensive or written to inform people using the service or their families of support they could access in a crisis. We saw one record which had no crisis plan.
- We saw a record where a risk was identified which was not reflected in an associated care plan. This meant that there may be a risk that the issues which were noted by staff were not translated into documentation of how the risks were managed.
- The service had a specialist risk assessment tool called STORM (skills-based training on risk management for suicide prevention) which they used to assess and determine the risk of self harm and suicide. They had specific training on the use of STORM within the service. There was a trainer available within the service if necessary to provide additional support in the use of the tool.
- Risk within the service was managed by the use of 'top ten' lists of people who were at the higher level of risk within the team, either of deterioration in their mental state or physical health or due to external factors. These lists were shared within and between the teams and with the inpatient services so that potential crises could be averted and information could be passed on proactively between teams when people may need to access additional support. This ensured that the teams and the service could respond well to risk.
- The trust had a robust lone working policy for staff. Staff we spoke with were aware of this policy and how to ensure their own safety in a work environment.

Good

Are services safe?

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

- Systems were in place to ensure that where medicines were stored in community bases, they were stored and recorded appropriately and there were protocols in place which staff were aware of, relating to transport of medicines and disposal of sharps.
- Staff were aware of safeguarding procedures and how to raise safeguarding concerns. We saw some excellent examples in case records where concerns had been raised and agencies had worked together. However, we saw one record in the St Austell team where a safeguarding concern had been recognised, but there was no recording of outcomes and actions taken. When speaking with staff, they had an understanding of when action should be taken, however, there may be a risk that without recording those outcomes and actions, the evidence that action was taken may be lost.

Track record on safety

- There had been two serious incidents requiring investigation (SIRI) in the last 12 months in this service line. One was a death by hanging of a patient who had been admitted to a residential care home and the other was the potential suicide of a carer who had been providing support to a family member with dementia.

Reporting incidents and learning from when things go wrong

- Staff we spoke with were aware of the incident reporting process and were clear about incidents which needed to be reported.
- Staff met regularly in teams and learning from incidents was discussed as a part of business meetings.
- We saw the service had a newsletter called 'Insight' which was distributed to all members of staff quarterly by email. The most recent copy contained overviews of all the serious incidents in the service line and also in other service lines and the identified learning. We saw a previous copy had highlighted a new serious incident and learning from the same service line. This meant that there were a number of ways in which learning from serious incidents was disseminated.
- We saw that specific learning had taken place from incidents in the service. For example, one incident led to a recommendation about the use of STORM risk assessments. Staff had received additional training in the use of this tool following this incident which meant there was a clear impetus to develop services following incidents.

Are services effective?

Good

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

Summary of findings

Please see summary at beginning of report.

Our findings

Assessment of needs and planning of care

- We reviewed 41 care records across the service. Most care plans reflected the interventions and support which was provided to people. Assessments were holistic and reflected person-centred practice. However, we saw that few care plans explicitly recorded evidence of patients' views. We did not see evidence that care plans which were written in the CCD team were routinely given or sent to people.
- In the Cober team, we saw an example on the records, of a person who had been assessed by the team but the assessment was not documented on the care record system.
- Carer's needs and carer's assessments had been identified as a key focus in the Trust Quality Account 2013/4 where it stated that the service priority was to ensure that carers were offered an assessment of their emotional, psychological and social needs and, if accepted, receive tailored interventions identified by a care plan to address those needs.
- The Tamar team had adopted a pilot methodology to assess the needs of carers. However, staff in all the teams across the county told us that they had not found that the flow of information from the local authority, who had a duty to assess carers' needs, to be coherent. This meant that there was a risk that assessments of carers may be duplicated by the trust and the local authority. We saw some evidence of carers being involved in their family member's care. However, we saw some records where identified carers' needs were not addressed in the documentation, for example, we did not see that a referral for a carers' assessment had been made to the local authority. We saw one record where a member of staff had tried to make a referral to the local authority for a carers' assessment but this had not been accepted by the adult social care team as they did not have the date of birth for the carer but there was no evidence that this had been followed up with a later referral when the correct information had been acquired .

Best practice in treatment and care

- Staff in the service displayed a good understanding of relevant NICE guidelines. This included the use of cognitive enhancers when people were diagnosed with relevant types of dementias and guidance related to working with people with physical health needs. For example, working with specialist nurses such as Parkinson's nurses and Admiral Nurses who supported people with dementia and their carers, when it was appropriate.
- The service offered primary dementia care practitioners who provided support both to people with dementia and their carers and worked with GPs and community nursing staff to provide education and support around dementia. This model enabled a large number of people who had a dementia diagnosis to have contact with a specialist professional to provide advice and support.
- Dementia liaison nurses provided support to people in local nursing and residential homes. They worked with the Newcastle Model which provided an evidence-based framework to look at the way that behaviours which may challenge services were interpreted. They worked with people who used services and carers as well as professional staff within care settings.
- There was limited access to psychological therapies in the community. Two members of staff in one team in St Austell were cognitive behavioural therapy practitioners and one member of staff in Truro, Gannel Team was trained in cognitive analytical therapy. However, this was not a service which was offered across the county as the nurses who were trained in delivering some psychological work had caseloads to manage. There was no specialist psychologist available in the service and while some people would be appropriate to refer to the Improving Access to Psychological Therapies team, and people with functional mental health difficulties could access a referral to a psychologist based in the adult community service, this meant that there was a gap in access to the input of a clinical psychologist who specialised in working with people with cognitive impairments.

Are services effective?

Good

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

- The lack of access to a psychologist for advice regarding formulation of plans for people who received treatment in these teams meant that there was a risk that the expertise of a psychologist was missing from the multi-disciplinary environment.
- The service used health of the nation outcome scale 65+ as an outcome measure to determine the progress of treatment.
- Staff had access to individual scales related to depression and anxiety which they used in clinical settings to ascertain the progress of interventions.
- Staff recorded physical health checks and we saw from the records that information was shared with GPs and gathered from GPs to ensure that information was up to date.
- Medical staff had undertaken reviews of people on their caseloads who had dementia and were prescribed anti-psychotic medication to ensure that this was monitored and audited.
- Staff in the Tamar memory service had undertaken an audit of younger people who used services who were referred to a memory clinic and written a paper about the outcomes in an academic journal.

Skilled staff to deliver care

- We saw that staff from all disciplines in the multi-disciplinary teams received regular supervision and annual appraisals by looking at the records held centrally and locally and by speaking with staff who confirmed this.
- Staff new to the service received a comprehensive induction which included mandatory and specialist training. Most staff had completed additional training which was relevant to their work.
- Nurses in the memory assessment service, primary care dementia practitioners and dementia liaison nurses met monthly to discuss their work and to provide peer support. This was not yet happening in the complex care and dementia community mental health team services but this was planned for the future. This meant that practice was shared across the county by staff undertaking similar jobs.
- There was a regular 'West forum' which was a county-wide forum which focused on learning and sharing educational sessions including consultant led sessions.
- There was a clinical lead in the east locality who had worked on development of the memory services. They had been involved in sharing their knowledge with other services in the county, but also for publications in the UK and internationally. The Tamar memory assessment service had hosted overseas clinical attachments to share best practice internationally.
- Clinical information was shared between teams during weekly multi-disciplinary meetings which addressed the specific needs of patients and identified the highest risk patients thereby ensuring that information was shared between staff to ensure a consistency of care.

Multi-disciplinary and inter-agency team work

- The different teams have access to nursing staff, medical staff and therapy staff, including occupational therapist. They had regular multi-disciplinary team meetings.
- Primary care dementia practitioners were employed for the role and came from a variety of clinical backgrounds including nursing, occupational therapy and speech and language therapy.
- Staff in all the teams we visited, highlighted to us some of the practical difficulties with the lack of social work input in the multi-disciplinary team structure in the complex care and dementia service. There are some good pieces of individually led joint working but there are on regular meetings between the teams at a practitioner or first level manager level. We were told that various reconfigurations in the local authority had made access more difficult but this had had an impact on the team and the quality of care which could be provided as they were not integrated.
- Two members of staff told us that they had concerns that approved mental health professional did not have specific experience working with older people and that this could present a challenge.
- We observed a local 'hub' meeting which was a meeting which took place weekly between a primary care dementia practitioner and the local GP surgery, community nurses and other community allied health professionals. This showed that some of the different agencies, such as primary health care and community health care, worked well together and were able to join up to provide a cohesive service to people who received care in Cornwall.
- Family members we spoke with told us that they received support from the teams. However, two family members told us that some of the services, including physical health services such as community services and social services were not always linked up together

Are services effective?

Good

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

with mental health services and this could be confusing. Patients and their carers told us that they had been linked in to voluntary sector resources by staff in the mental health teams.

Adherence to the Mental Health Act (MHA) and the MHA Code of Practice

- All community staff had attended training related to understanding of the Mental Health Act.
- Staff within the service were aware of how to access specialist support and guidance within the trust if necessary.
- No one across the service at the time we visited was subject to a CTO (Community Treatment Order).

Good practice in applying the Mental Capacity Act (MCA)

- All staff had received training related to the Mental Capacity Act and deprivation of liberty safeguards. This was part of the e-essential training package. Through the service line, in the community teams there was 100% compliance with this training.
- We checked 41 records relating to mental capacity in the offices we visited. This included mental capacity assessments where they were documented, or references to capacity being assessed on a more informal basis in the notes we checked. We found mixed recording of mental capacity. For example, in the Bodmin team bases (Valency/Camel), the six records we checked had completed assessments of their mental capacity. However, in the Fowey Team based in St Austell, two of the seven records we checked did not demonstrate an understanding of the Mental Capacity Act, as they had indicated that capacity should be assessed as part of a crisis plan without specifying what situation this would refer to. According to the Mental Capacity Act (2005), capacity should be assessed on specific decisions and the records were not clear what decision capacity would or should be assessed against.

Good

Are services caring?

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

Summary of findings

Please see summary at beginning of report.

Our findings

Kindness, dignity, respect and compassion

- We spoke with fifteen carers of people who use services, including the memory assessment service, primary dementia care practitioners and complex care and dementia teams. We also spoke with five people who used the services. We observed and shadowed three home visits and one visit to a care home to observe the work carried out by the dementia liaison service in their direct work with someone who used the service. We also spoke with people during these visits and observed practice. We spent time in five bases and observed staff speaking with people who used the service and carers on the telephone.
- The feedback we received about the service was positive. Some of the feedback we received included "can't fault the care" (Camel Team), "staff always have time for us" (Fowey Team), "whenever I've had an issue with any aspect of care, I've been respected and supported" (Coombe Team), "amazing service, I just wish there were more of them" (Gannel Team) and "It's nice to have someone at the end of the phone and to come and see you do you don't feel alone in dealing with this" (Fal Team). This represented the views which were shared with us across the service.
- Through our visits we observed people being treated with care, dignity and respect. We saw that family members were involved when appropriate in people's care.
- We observed staff responding to people with dignity and respect when they answered the phone. This included non-clinical staff and was particularly notable in the Fowey team where we observed an administrative worker for the team who was particularly compassionate in dealing with callers.
- Staff spoke about people who used services with respect and showed a good understanding of the needs of the people they worked with.

The involvement of people in the care they receive

- While we did not see significant evidence of people's voice and preferences being noted in care plans, the people we spoke with had an understanding of the care that they were being provided with. Care plans were not sent or given to people routinely. However, they were discussed with people.
- The service had a target to improve carers' assessments and support. While some of the documentation around this was not clear in care records, families told us that they felt supported. There is a risk that the lack of comprehensive and consistent recording of carer support, for example, by carers not having separate assessments and records in the electronic record system, some of the work being done may not be captured comprehensively.
- Staff told us that people using the service had access to advocacy in the local area. Four people told us that they did not know or had not been told how to access advocacy services. Two people told us that they knew how to access advocacy services.
- Within the primary care dementia practitioner services, carers had been involved in recruitment decisions.
- There were regular opportunities for patients and carers to feedback information about the service. The trust used an electronic system to collate feedback surveys. We looked at the results of these surveys which were broken down into the type of service which was received. For example, we saw that between Sept 14 – March 15 in the complex care and dementia service, 72 surveys had been returned to the service with a 86% satisfaction rate and in the primary care dementia practitioner service, between April 2013 – March 2015, 459 surveys had been returned with a 96% satisfaction rate between April 2014 and March 2015. Free text comments were also logged as a part of this survey and this information was shared through the service to ensure that user and carer voice was captured.
- Between June and October 2014, the service had carried out six 'your say day' stakeholder events throughout Cornwall. This had been aimed at patients and carers, local voluntary groups, primary health care, adult social care, community health services, internal staff and the local CCG. 48 patients and carers had attended these events. This showed that the service was seeking different ways to ensure that patient and carer voice was

Good

Are services caring?

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

captured and fed into the service planning. There was a report written following these events to ensure that actions could be taken as a result and the feedback we saw was overwhelmingly positive.

Are services responsive to people's needs?

Good

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

Summary of findings

Please see summary at beginning of report.

Our findings

Access, discharge and transfer

- The trust operated a model which provided support through a coherent dementia pathway. This led from initial concerns being raised in primary care regarding possible mild cognitive impairment where there primary dementia care practitioners who were linked with GP surgeries. It continued through to referrals to the memory assessment service if a formal diagnosis were required. There was a key professional involved with patients through their diagnosis. Later through the progression of the dementia, patients and carers could access support from the complex care community team or dementia liaison nurses, if they were admitted to a residential or nursing home. This pathway model ensured that patients and families were well supported with access and information and was responsive to the needs of people with dementia in Cornwall and the Isles of Scilly.
- Within the complex care and dementia community service, there is a 28 day target from referral to assessment. Throughout the service, there were a total of 12 breaches since April 2014. This information has been centrally collated by the management within the service line and actions taken to address this to that there are systems in place to alert when referrals are within a seven day period of breaching the target (which is set at 100%).
- Between April 2014-January 2015, the Memory Assessment Service has a 99% average rate for patients being seen within 28 days. A pilot screening clinic is being held to look at potentially inappropriate referrals being made as a third of those assessed are diagnosed with dementia.
- The trust was not commissioned to provide out of hours specialist support to people living with dementia. The home treatment team provided services to adults of all ages with functional mental health difficulties and mental health act assessments out of hours for all adults including people living with dementia. This meant that there was a risk that people living with dementia who needed short term out of hours support or were in a crisis out of office hours may not have the same access to crisis support to meet their needs.There were managers who were on call who could assist in crisis situations. Two members of staff gave us examples of situations where two people may have been inappropriately admitted to hospital due to the lack of specialist crisis services which could meet the needs of people with complex care needs and particularly those with cognitive impairments.
- Each team operated a separate 'duty desk' system. This meant that someone is assigned on a rota basis to cover urgent work on a daily basis. Staff who cover the duty desk can be supported by their peers in other teams who are covering duty on the same day. This meant that patients and carers were supported during office hours in crisis situations.
- The service line had a clear operational policy. This operational policy stating the criteria for entry into the services and the process in which referrals are made. Some services, for example, the specialist psychiatric liaison service, also explained people who would be excluded and what services would be available to those people. For example, people who were dependent on alcohol or other substances would be seen by the specialist practitioner within the adult psychiatric liaison services.
- Services had different systems to see people who used the services. Some were seen in clinic settings, including local GP surgeries. Some people were seen at home or in the residential setting in which they lived and liaison services operated in the local acute hospitals.
- The intermittent assessment pathway worked by providing assessment over the short term in residential and nursing homes locally. Trust staff liaised with local clinicians and providers to ensure input and assessment could take place in a 24 hour care environment close to a patient's home and avoid a potential crisis situation.
- Staff across the service told us that sometimes access to quality nursing and residential beds to access the intermittent assessment pathway could be a concern. The provision of this service was dependent on the availability of beds in residential and nursing homes. This meant that when there were no local placements, due to a lack of provision across the health and social care economy locally, this could put the delivery of this

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Good

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service at risk. The lack of availability of high quality nursing and residential homes across Cornwall was a concern. Staff told us that sometimes this could lead to additional tensions between the health and social care sectors when there were shortages of supply in residential and nursing home beds.

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Meeting the needs of all people who use the service

- The intermittent assessment pathway meant that additional short term support and assessment could be provided in different geographic locations through Cornwall and was responsive to the needs of the rural community in Cornwall.
- The teams had developed some hub locations through the county. So, for example, some teams operated out of two or three different bases to ensure that they were closer to the local communities.
- Staff told us that they had access to interpreting and translation services as necessary.
- Staff demonstrated an awareness of meeting the needs of patients in relation to their gender, sexuality, ethnicity, disability and gender orientation. One member of staff in the memory assessment service had written an article about meeting the needs of transgender patients who had dementia and some staff spoke with us about the particular skills which were needed.
- Documentation about memory services was provided in clear language which was suitable for people with dementia and had been developed with carers and people who used services.

Listening to and learning from concerns and complaints

- Over the 12 months prior to the inspection visit, there had been 7 complaints across the complex care and dementia community services. One of these was partially upheld, three were not upheld, one was resolved locally, one was withdrawn and one is ongoing.
- Most people we spoke with told us that they knew how to make complaints to the service.
- Complaints were discussed in the team meetings, service assurance meetings and information relating to learning from complaints had been collated in a recent newsletter which had been provided through the service. This meant that information and learning from complaints was embedded in the governance structures for the service. For example, some of the issues raised at the 'Your say day' related to commmunication and simple language. This was addressed in the ideas which were presented for future events to include different communication strategies, for example, the local radio station, to publicise events.

Are services well-led?

Good

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

Summary of findings

Please see summary at beginning of report.

Our findings

Visions and values

- Information about the trust's vision and values was evident in the services we visited.
- Most staff told us that they were proud to work for the complex care and dementia service line.
- Staff were aware of the senior managers within the service and told us that they were visible throughout the service. Team managers had regular contact with the service management.
- Some staff were aware of the chief executive but fewer were aware of the wider executive team.

Good governance

- Teams within the service had access to systems of governance which enabled managers to have a good understanding of the services and provide information to management within the trust and through reporting systems. For example, data was collected on a team level about caseloads per member of staff, referral rates, discharges, work completed and referrals into the service, as well as staff training records, supervision and appraisal rates and sickness and vacancy rates.
- Staff turnover was at 28.69%. While this was at a high level, the reasons were understood within the context of changes within the service and particularly around the PCDP whose funding had recently been confirmed on a long term basis.
- There were various meetings which took place in the service to ensure information was shared. Through a series of meetings from the operational assurance meetings and operational management meetings which took place monthly, to the individual team meetings and meeting for groups for teams across the county, for example, the meetings for the memory assessment service clinicians and the primary dementia care practitioners.
- The processes for risks to be added to the service line and trustwide risk register were clear to team managers. The service had a risk register which was updated and discussed within the service monthly.
- The service manager and team managers had a clear understanding of the goals of the service and where its strengths and weaknesses lay.

Leadership, morale and staff engagement

- Staff we spoke with were positive about the management within the service. All the staff we spoke with told us that they felt comfortable raising concerns and would know how to do so.
- The service had undergone a reconfiguration about 18 months prior to the inspection visit. Some staff told us that there had been some difficult times with staffing levels but that the service was improving in this respect. We saw that additional appointments had been made and staff were generally positive about the future.
- The service provided a specific newsletter quarterly which ensured information was shared through the service and the county and helped to build a cohesive identity for complex care and dementia services.
- One member of staff explained to us how they had approached the chief executive directly when they were concerned about a decision which had been made which affected their service. They said that changes had been made as a result of this.
- Some comments from members of staff to us included "we look after each other", "this is a good, supportive trust to work for", "we have a lovely manager". This reflects the general feedback we received from staff across the county.
- The service has initiated a number of activities to build and promote staff engagement and morale, including away days and emphasising positive feedback through team meetings.

Commitment to quality improvement and innovation

- Tamar memory service has been accredited as 'excellent' through the Royal College of Psychiatrists' memory service national accreditation programme.
- There is a research service within the trust and some research work had been undertaken specifically within dementia services. Papers which have been or which were to be published by staff within the service included one related to dementia and people who were transgender, an audit of referrals of younger people with

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dementia to memory services and end of life planning. This work had had a direct impact on the work which was carried out and there was a research culture within the service.