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	Trust Headquarters	Camel	PL31 2QT
RJ8X7	Trust Headquarters	Valency	PL31 2QT
RJ8X7	Trust Headquarters	Coombe	TR18 4NY
RJ8X7	Trust Headquarters	Cober	TR15 2SP
RJ8X7	Trust Headquarters	Gannel	TR15 2SP
RJ8X7	Trust Headquarters	Fal	TR1 3SP
RJ8X7	Trust Headquarters	Tamar and East	PL14 4EN
RJ8X7	Trust Headquarters	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?	Requires improvement 
Are services caring?	Outstanding 
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

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Overall summary

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

- Staff were risk aware, and despite a low number of serious incidents, staff demonstrated an understanding of how to report, deal with and learn from incidents.
- Staffing levels were sufficient to meet the needs of the patients.
- Staff demonstrated a good understanding of safeguarding.
- Care plans were completed well and involved the patients and carers in the process, and were made in accordance with National Institute for Health and Care Excellence guidance. Risk assessments and crisis plans were completed comprehensively to ensure safety.
- Patients were monitored effectively and supported. If their needs changed, staff took appropriate action, utilising the necessary assessment tools to ensure appropriate care was provided.
- Staff were skilled in their jobs and there were tools in place to ensure professional development.
- Staff demonstrated that they went over and above the call of duty, for example staying beyond their working hours. They exhibited a passion and enthusiasm for their job in delivering care of the highest standard, and this was supported by testimonials from patients and carers.
- There was no waiting list at the service due to the efficiency with which referrals were handled.
- Support was offered to patients in various forms, from providing information, intermittent assessment and treatment, increasing accessibility to premises and a complaints process.
- The service was well-led with visible management. Performance was monitored and training, supervision and appraisals were all offered to staff.
- Good governance was displayed through reviewing and learning from incidents, complaints and practice within the service.

However:

- Some actions from the previous inspection had not been addressed. There was still limited psychology input and there was no formal out of hours support.
- The environments did not always appear to be well maintained, for example the environment at Penzance appeared tired and in need of updating.

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:

- There was a low number of serious incidents. Staff were risk aware and understood how to report incidents. Learning from incidents was shared in the service in order to aid learning and avoid similar issues occurring.
- The 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. They completed risk assessments comprehensively and completed crisis plans. There was a separate risk assessment used for patients at risk of suicide.
- There was a low vacancy rate across the service, caseloads were managed and assessed but numbers were higher in Redruth. There were arrangements in place to cover sickness and annual leave. Staff received mandatory training.
- Staff were aware of the safeguarding arrangements in the trust.

However:

- Sickness rates at the time of the inspection were above the trust target of 4.5%.
- The physical environments at some team bases were not well maintained.
- PCDP staff felt there was little career progression in that role, as a result turnover was above the trust average.

Are services effective?

Requires improvement

We rated effective as requires improvement because:

People accessing the mental health service as an older person are entitled to National Institute for Health and Care Excellence recommended therapies. At the previous inspection, we found that there was no psychology input for patients with an organic illness. Psychology input was in the early stages of development. The complex care and dementia services had appointed a psychology lead who had developed programme starting with the inpatient ward. This was due to develop into the community. Staff trained in therapeutic interventions were not having their skills utilised due to them carrying caseloads and not receiving appropriate supervision.

However:

Summary of findings

- Staff completed care plans for all patients and we found that the patients were included in the care planning process.
- Staff followed National Institute for Health and Care Excellence guidance and we found that steps were taken to ensure the service met the guidance.
- The primary care dementia practitioners (PCPD) service ensured that patients were monitored and supported in the community. Cognitive stimulation groups were available to help people with a diagnosis of dementia. Complex care staff supported patients when care needs and risks increased.
- 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.
- Staff were skilled in their roles and they received appraisal and supervision. Staff used forums to access training and progress their job roles with the aim of improving patient care.
- There were regular multi-disciplinary team meetings to share concerns and discuss new referrals. There were good links with external services.

Are services caring?

Outstanding ☆

We rated caring as outstanding because:

- Staff went over and above their call of duty and they presented as passionate and enthusiastic. There were universally positive reports from patients and carers and that staff had made a genuinely life changing impact.
- Staffs interactions were positive and we found that they had good knowledge of individual care needs of the patients on their caseloads.
- Staff listened to patients to provide a service that met their needs. The men's horticultural group proved to be a popular addition and was made in response to the need at the time. Staff had set up dementia cafes and worked with local groups to ensure they continued.
- Staff referred carers for assessments and advocacy support when needed. They ensured they collected feedback through surveys to evaluate the work they were doing.

Summary of findings

Are services responsive to people's needs?

Good

We rated responsive as good because:

- The service responded quickly to urgent referrals, routine referrals were seen within the prescribed 28 day target. There was no waiting list as patients were allocated immediately following assessment. Staff were proactive in following up patients that did not attend their appointments.
- Intermittent assessment and treatment was available and allowed staff to increase support to patients in the community or to arrange an admission to a care home for medication titration.
- Staff were aware of the complaints process. There was a low number of complaints coming into the service and learning from complaints was shared with the team.
- Adjustments had been made to the buildings to allow for disabled access. Information was available to patients and there was an interpreter when needed.

However:

- At the previous inspection we found that there was no formal out of hours support to people with an organic illness. We found that this was still the case.

Are services well-led?

Good

We rated well-led as good because:

- Staff were aware of the trust's vision and values. They knew the executive team of the trust.
- Managers used key performance indicators to gauge the performance of their teams and responded appropriately to areas of improvement.
- Staff were appraised, supervised and trained. There was leadership training available and there was a strong focus on research within the service.
- There were good governance arrangements to review incidents, complaints and practice within the service. Outcomes from the group ensured that change occurred and that staff were well informed.
- Staff felt able to raise concerns and felt supported in their work.

However:

Summary of findings

- There were 'shoulds' from the previous inspection that had not been given due attention to ensure that positive change was made. Staff were concerned that the service was not a priority within the trust.
- Staff morale was variable and was sensitive to external pressures on the teams. Staff felt that they were not always consulted about changes within the service.

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. The service provides community support for patients with a diagnosis of dementia and a diagnosis of mental illness over the age of 75. The service specification includes supporting patients living with a range of mental health needs with the increased complexity associated with physical ill health and the physiology of ageing.

The service was previously inspected in April 2015 and was rated as good in all areas but with the following areas for improvement:

- 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.

Our inspection team

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

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

The team that inspected this core service comprised a Care Quality Commission (CQC) inspector, David Harvey (inspection team lead) and one other inspector, an assistant inspector, three specialist advisors with experience in working with older people and one expert by experience. An expert by experience is a person that has experience of using services directly or through supporting a member of a family who is accessing services.

Why we carried out this inspection

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

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

How we carried out this inspection

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?

Summary of findings

Before the inspection visit, we reviewed information that we held about these services, asked a range of other organisations for information and sought feedback from patients at focus groups.

During the inspection visit, the inspection team:

- visited five locations and toured the environments,
- interviewed four managers, a senior manager, the nurse consultant and a clinical director,
- interviewed four occupational therapists, six primary care dementia practitioners, two health care assistants, a research lead, one mental health liaison worker, the lead for memory assessment and four band six nurses,
- spoke with four consultants,
- reviewed 31 health care records for patients accessing the service ,
- spoke with 11 patients and their carers,
- attended four home visits to observe care being provided,
- checked supervision records,
- observed one multi-disciplinary team meeting.

What people who use the provider's services say

Carers and patients we spoke with said the service was excellent with the level of support and care offered, very professional and we heard that staff were wonderful and their help was life changing. Staff went out of their way to ensure that patients within the service were comfortable and got the care they required.

Good practice

Staff forums were in place so that staff could meet to discuss practice and share thinking associated with their job role. We found this to be an excellent example of staff on the shop floor moving their jobs forward through reflection and training and making change based on their experience of the work. Change made as a result of the forums enhanced patient care and focussed the service on where their attention needed to be directed.

Gardening sessions had been set up between the trust and a local housing charity and staff had secured funding for a small amount of materials to start the project. Staff had also arranged for a minibus to collect patients to take to the group. The results had been very positive and staff had noticed that patients had begun to take the initiative in tasks and had remembered how to do things from previous weeks. The passion for the group was clear and while the effect of the group had yet to be audited the staff were able to provide insight into the positive effects it had on patients mental health. Staff had gone onto the Radio Cornwall to promote their service as primary care dementia practitioners PCDP's and the gardening group.

The service had introduced a memory screening tool for the memory assessment service. The new screening tool had reduced the amount of time taken to assess and screen people with memory problems. Out of 106 referred there were 44% diagnosed with dementia, 6% mild cognitive impairment and 41% not diagnosed. The GPs using this form were positive about the change, there was also positive feedback from commissioners of the service.

Staff kept a top-ten of patients most at risk of being admitted to hospital. The top-ten list ensured that patients received regular support from staff in order to prevent an admission to hospital, staff provided increased support through visits and referrals to medical staff. Health care assistants were available to provide increased support through visits. This approach ensured that the service was able to more effectively gate keep hospital beds and at times prevent admission to hospital.

Summary of findings

Areas for improvement

Action the provider MUST take to improve

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

Action the provider SHOULD take to improve

- 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.

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	PL31 2QT
Valency	PL31 2QT
Coombe	TR18 4NY
Cober	TR15 2SP
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Fal	TR1 3SP
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Fowey	PL25 4QW

Mental Health Act responsibilities

Mental Health Act responsibilities and Mental Capacity Act and 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.

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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

Our findings

Safe and clean environment

- Interview rooms we inspected at the services were fitted with alarms. The alarms situated in the interview rooms were there for staff to call for assistance in the event of an emergency or risk situation where staff support was needed. We found that the alarms worked and at the Penzance site the alarms were connected to the Police station, the police attended when they were triggered.
- Staff had access to clinic rooms that were well equipped with the necessary equipment to carry out physical observations on site and in their homes. The equipment was clean, well-maintained and had been calibrated.
- There was information regarding infection control for staff and there were bins for clinical waste and sharps to be disposed of effectively and safely.
- Although the team bases that we visited were generally clean, they were not always well maintained. The sites at Penzance and at Redruth appeared rundown and in need of re-decoration. For example at Penzance there was paint chipping off the walls and we found that areas around radiators were mouldy. Staff told us that these had been reported to the maintenance department but there had not been any response to the issues. While there was no patient access to the staff offices in Bodmin, the areas were looking neglected and needed refurbishment. However, the Bodmin Clinic and the clinic at St Austell where patients were seen were light and well looked after with a high level of maintenance and modern facilities.

Safe staffing

- Managers within the service said staffing levels were calculated according to budget and the needs of the area, however, we found variable amounts of pressure on teams due to sickness and team capacity. Primary care dementia practitioners (PCDP) felt that there was little incentive to stay in their jobs due to being band five with no career progression up the bands in that role. As a result the staff felt there was a high turnover rate for their roles. The annual turnover rate was above the average for the service.
- There was an overall sickness rate of 5% for the year ending 31st May 2017 but this had risen to 7% at the time of the inspection.
- Vacancies within the Bodmin team meant that staff carried higher caseloads but we heard from staff that the capacity of the service met the demand when all vacancies were filled. The vacancies had caused some stress and staff said that they were feeling stretched as a result.
- Caseloads for the Complex Care and Dementia (CCD) service ranged from 25 – 30 patients per full time staff member. However at the Redruth team the caseloads were slightly higher although there were no vacancies. The Primary Care Dementia Practitioners (PCDP's) had much higher caseloads of up to around 150 patient's, this was due to less frequent appointments. There were no patients awaiting allocation to a caseload as the service did not operate a waiting list, this meant that following assessment patients were allocated immediately to either a CCD or PCDP staff member. Caseloads were assessed regularly through the supervision process. PCDP's had the highest caseloads. The PCDP service was designed to hold higher case list numbers and was within the commissioned expectations of the service. However, the PCDP service had completed caseload reviews to identify patients that could be discharged back to the GP. This had meant that caseloads could be freed up in order to ensure that they provided high quality care to those that needed it.
- There were arrangements in place for sickness, vacant posts and annual leave, however these differed across the trust. Bank or agency staff were not used to cover for sickness and annual leave unless it was absolutely essential. Despite the different approaches to covering for sickness, annual leave and vacant posts we found that the response of each team adequately mitigated the risks.

Good

Are services safe?

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

- Psychiatrists provided medical cover in work hours and out of hours. A consultant psychiatrist was on call 24 hours a day. Staff felt that the medical cover was supportive and easy to access both routinely and in an emergency.
- Staff received mandatory training and this was split into core training and essential. Across the teams inspected there was an average compliance rate of 87% against the trusts target for 85%. This included training related to safeguarding adults and children.

Assessing and managing risk to patients and staff

- Risk assessments were undertaken for people accessing the service. Staff we spoke with were all risk aware and were competent in identifying the risks of patients accessing the service.
- We reviewed 31 care records and all of the records had a risk assessment that was in place and up to date. Information provided by the trust showed an average of 83% of risk assessments were up to date across the teams. Staff explained that they completed a risk assessment on first contact with the service through triaging referrals to assess their suitability. Risk assessments were then completed face to face in order to gauge how to respond. For example, if a patient was expressing suicidal ideation then a separate STORM (skills based training on risk management) risk assessment would be completed. The STORM assessment as a self-harm management tool aimed at preventing suicide. We found that there was appropriate use of the STORM assessment in the care records we reviewed.
- The previous inspection had shown that crisis plans were not completed to an acceptable level. On this inspection we found that staff were aware of the need for crisis plans and how to respond to a crisis. Of the 31 sets of notes we reviewed we found that 100% of them had a completed crisis plan which was informative and appropriate for the reason the patient was accessing the service. The completion of crisis and contingency plans and risk assessments fed into monthly performance meetings. The data showed that an average of 76% of patients accessing the service had a crisis plan in place.
- Staff kept a top-ten of patients most at risk of being admitted to hospital. The top-ten list ensured that patients received regular support from staff in order to prevent an admission to hospital, staff provided increased support through visits and referrals to medical staff. Health care assistants were available to provide increased support through visits. This approach ensured that the service was able to more effectively gate keep hospital beds and at times prevent admission to hospital.
- The service did not keep a waiting list for people accessing the service as they allocated patients on referral into the team.
- Staff received training in safeguarding and there were robust arrangements in place to safeguard patients from abuse. The trust had its own in house safeguarding contact for staff to refer into so that they could have a discussion and receive guidance before starting a routine enquiry to the local authority. Staff had a good understanding of the safeguarding process.
- Staff were aware of personal safety procedures put in place by the service. There was an emergency process in place for staff at risk in the community.

Track record on safety

- The service had four serious incidents requiring investigation over the past year. One of these involved a homicide that they had completed an investigation and shared an action plan and learning.

Reporting incidents and learning from when things go wrong

- Staff we spoke with were aware of the incident reporting process and were aware of what needed to be reported and how.
- We saw evidence of the duty of candour being used and staff demonstrated the importance of being open and honest with patients when there was an incident.
- There was evidence that learning had been shared with teams following incidents within the trust. For example, the importance of completing the STORM assessment when patients were at risk of suicide.
- Learning was discussed in clinical governance groups before being shared with staff. Staff showed that they discussed incidents in team meetings and that they received updates from a newsletter.

Good

Are services safe?

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

- We found that there was support for staff following an incident through de-brief and supervision.

Are services effective?

Requires improvement

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

Our findings

Assessment of needs and planning of care

- Staff completed a comprehensive assessment of all patients accessing the service. We found evidence of a holistic assessment in the patients care records in all of the 31 sets of care records that we reviewed. The information from these assessments then informed the care planning process so that patient need was appropriately met.
- The care plans we reviewed were reflective of the care being provided by the service. For example, patients receiving support from the complex care and dementia (CCD) team had holistic and up to date care plans that covered a variety of areas aimed at supporting the patient and their carer through practical and medicinal support. The primary care dementia practitioners (PCDP) created care plans for patients that reflected the lower level of support being provided by the service. For example, a six monthly medication review care plan.
- In the previous inspection we found that staff did not always evidence that they shared the care plan with patients and carers or collect their views. We found on this inspection that patient views were sought but that staff did not always evidence that a care plan had been shared with the patients. Care plans were written with the patient and their carer's, it was evident that these were regularly reviewed, however, the electronic systems did not make it clear that the care plan had been shared with the patient.
- Staff used an electronic records system to store clinical information. There were laptops available for staff to use in patients' homes in order to record information.

Best practice in treatment and care

- Staff demonstrated that they had a good understanding of National Institute for Health and Care Excellence (NICE) guidance related to care of people with memory problems. Staff were able to offer cognitive enhancer medication for people with suspected Alzheimer's disease. We found evidence of the service being reviewed against NICE guidance in discussions logged in the governance meeting minutes. The aim was to ensure that they became a NICE compliant service. Staff understood the importance of providing physical health support as well as mental health support. Staff had received training based on NICE guidance.
- Memory assessments were provided by dedicated memory assessment nurses. The service then provided a two stage approach to support with memory problems in the community. The PCDP were in place to provide support for patients accessing the service who needed intermittent support through the monitoring of cognitive enhancer medication and signposting into community support initiatives such as memory cafes. The PCDP service ensured that patients stayed in less restrictive primary care treatment with medication prescribed by their GP. PCDP staff screened for risk and if there was an increase in risk that was not able to be managed by them or by the GP then they were able to refer into the CCD team for more intense support. PCDP staff felt that the CCD team were supportive and that there was always someone to provide support in the event of increased risk. Dementia liaison nurses were in place to assess and support patients with dementia who were in nursing and residential homes.
- In the previous inspection we found that there was limited psychological therapy support for patients in the community. We found on this assessment that there continued to be a gap in the provision of psychological support for patients. A psychologist was established in the inpatient service and plans were in place to move them to the community teams. The resource was limited and included work with the dementia liaison team. Patients needing support for functional rather than organic illnesses were able to be referred into the adult psychological therapies team but we found that the waiting list for this service was extensive. Some staff within the service were trained in therapies such as Cognitive Behavioural Therapy (CBT) but that they were not able to utilise these skills due to a lack of supervision. Discussions had taken place in staff forums and governance group in order to find a way to utilise the skills of the work force. The auditing against NICE guidance had showed that the deficit of CBT being available was not in accordance with the guidance.
- Despite the limited psychological support there were staff able to offer functional assessments and support through the occupational therapists. Post diagnostic

Are services effective?

Requires improvement

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counselling was conducted by staff in the community in order to help people come to terms with their diagnosis although staff did not receive specific training in this. Cognitive stimulation groups were in place in line with NICE guidance for people with mild to moderate dementia. We found that staff provided one to one cognitive stimulation to patients in their own home if there were difficulties accessing groups. Staff told us that this involved teaching partners and carers how to use cognitive stimulation in order to stimulate and engage patients with dementia.

- The service used a recognised tool for ensuring that patients were appropriate to access the service, this was the clustering on the Health of the Nation outcome scale for people over 65 (HoNOS 65+).
- Staff had a number of rating scales to aid them when working with patients. This included the Addenbrookes Cognitive Examination to assess cognitive performance and the Geriatric Depression Scale to measure depression.
- Staff ensured that physical healthcare was screened appropriately before referral to the service. This included taking dementia-screening blood tests in line with NICE guidance and ensuring that a urine test was carried out to rule out a physical cause. We found evidence that physical health monitoring took place staff referred patients to their GP and local physical health services if there was a concern.
- The service had introduced a memory screening tool for the memory assessment service. This was a study due to the length of time it took to assess and screen people with memory problems and complete the resulting paperwork. The new screening tool reduced the amount of hours and increased the diagnosis rate from 27% to 44%. Out of 106 referred there were 44% diagnosed with dementia, 6% mild cognitive impairment and 41% not diagnosed. The GP's using this form were positive about the change, there was also positive feedback from commissioners of the service.
- There was evidence of audits undertaken against NICE guidance. Audit results were discussed in staff forums and the governance meetings. For example, an audit of record keeping evidenced that staff were using the HONOS clustering tool outcomes in care plans to ensure an accurate description of presenting problems and show a holistic plan of care. There was a plan to re-audit this to show how effective it had been.

Skilled staff to deliver care

- Staff across the service received supervision and appraisal in line with trust policy. Staff told us that they received regular formal supervision as well as informal support amongst the team. Appraisal compliance for the service was 85% in line with the trusts target.
- Staff new to the service received a comprehensive induction into the service on commencement of their employment. Both mandatory and specialist training was accessible and we found examples of staff being able to access university courses such as master's degrees top ups funded by the trust. Nurses had been able to access the non-medical prescribing course.
- Managers of the teams demonstrated how poor staff performance was addressed and that it was done effectively. Human resources were available to support managers with the process if needed.
- Medical staff received supervision and appraisal appropriate to their role. Revalidation was supported within the trust.
- Staff forums were in place so that staff across the discipline could meet to discuss practice and share thinking associated with their job role. Changes made as a result of the forums enhanced patient care and focussed the service on where their attention needed to be directed. For example, the PCDP staff whose caseloads were very high noticed that they were receiving patients whose diagnosis was not that of dementia. As a result they reviewed their caseloads and presented to the Operational Assurance Group (OAG) changes to ensure patients on their caseload received high quality care. This included patients whose diagnosis was one of mild cognitive impairment were to be discharged back to the GP for monitoring, patients with capacity and do not want the service to be discharged back to the GP and clinics for cognitive enhancements to be set up and their effectiveness audited. The OAG reviewed this approach and agreed

Are services effective?

Requires improvement

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for it to be implemented. We found examples from CCD and HCA forums of this approach to job roles and the progression of the roles with the aim to improve patient care and outcomes.

Multi-disciplinary and inter-agency team work

- Multi-disciplinary team meetings occurred weekly and we found that these worked effectively to discuss new referrals and current patients. Staff from a range of disciplines were available to discuss a patients care and to share ideas for working with them going forwards. This meeting facilitated effective handover, for example of patients going from the PCDP service to the CCD.
- There was effective inter agency working in place. This included: regular meetings with the local GP's to discuss patients in primary care, the dementia liaison nurse liaised with local nursing and care homes to share practice and to educate staff on how to manage complex behaviours.
- Staff felt they had good working links with external voluntary services and social services. Staff demonstrated how they had worked with social services to arrange packages of care for patients such as intermittent admissions to nursing homes.

Adherence to the MHA and the MHA Code of Practice

- Staff were trained in understanding the Mental Health Act (MHA)and its associated Code of Practice.
- Staff were aware of how to access support for the MHA, how they would arrange for a MHA assessment and to go to consultants, for example, for specialist knowledge.
- There was one patient across the service subject to a community treatment order (CTO). We reviewed the section paperwork and care plans for this patient and found them to be in line with the code of practice.

Good practice in applying the MCA

- Staff we spoke with had a good understanding of the Mental Capacity Act and Deprivation of Liberty Safeguards. Training was provided by the trust as part of the mandatory training package.
- In the previous inspection we found that there was variable quality in the documentation of capacity assessments. On this inspection we found that the quality had generally greatly improved across the teams. There was clear evidence of reference to best treatment decisions and evidence of capacity being assessed for a variety of reasons. We found that there were some fantastic examples of the process of assessing capacity with clear documentation of the process and the principles associated with the act. It was clear in the majority of the notes that capacity was assessed appropriately and that capacity was assumed unless there was a reason to believe otherwise.

Outstanding ☆

Are services caring?

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

Our findings

Kindness, dignity, respect and support

- We spoke with patients and carers and observed care being delivered in patients' homes. Staff showed a passion and zest for their jobs and the interactions we observed were of a high calibre. We found that staff listened actively and exhibited empathy towards patients and carers. Staff were open and honest with patients and demonstrated knowledge of their care and situation without the need for checking notes. Staff showed a high level of professionalism, they were clear in explanations and were able to back up their interactions with knowledge and theory related to their work. Patient's needs were respected and confidentiality was maintained.
- Carers and patients we spoke with felt the service was excellent, very professional and we heard that staff were wonderful and provided life changing help. Staff went out of their way to ensure that patients within the service were comfortable and got the care. On one occasion we found that staff popped in to a patients home if they were on their way past to make sure everything was ok. Anecdotally we heard of staff staying late into the evening to deal with emergency situations when they didn't need to be there and that another staff member had driven well out of their way out of county to help a patient on their caseload. Staff demonstrated warmth towards their job roles that was over and above their call of duty.
- We found from our interactions with staff throughout the week of the inspection that they made changes with the patients' needs in mind. Staff consistently communicated that they were there for patients accessing the service. They educated families in cognitive stimulation for the benefit of the patients and despite pressures on them they would always try and find time to visit or answer a call. Staff described that their ethos, despite limited resources, was always to keep a patient at home with their family for as long as possible.

The involvement of people in the care they receive

- Staff included patients and carers in their care planning. Staff included carers in the discussions and asked the patient if they had permission to do so. Care plans were shared with patients and their families.
- Staff in the trust had set up a number of community initiatives that they had then passed over to voluntary groups to keep running. One of these was the memory cafes. There are 39 cafes across Cornwall and were aimed at patients who were diagnosed with memory problems. The aim was to help people maintain their memory, to meet others, socialise, take part in activities and re-build patients confidence. PCPD workers used these cafes to help patients and carers build social networks and access valuable support on a regular basis. Staff said they used the cafes also as an opportunity to monitor patients on their caseload and see them in a different setting.
- Following feedback that the memory cafes did not always cater for male patients with memory problems staff had set up a men's only horticultural group. Patients had said that they wanted to do something more practical. The gardening sessions had been set up between the trust and a local housing charity and staff had secured funding for a small amount of materials to start the project. They had also arranged for a minibus to collect patients to take to the group. The results had been very positive and staff had noticed that patients began to take the initiative in tasks and had remembered how to do things from previous weeks. The passion for the group was clear and while the effect of the group had yet to be audited the staff were able to provide insight into the positive effects it had on patients mental health. Staff had gone onto the Radio Cornwall to promote their service as PCDP's and the gardening group.
- Staff referred carers onto local social care services for a carers' assessment. Staff arranged carers support groups and a variety of specific sessions for carers such as lunches and pamper days at the local college. Carers were included in care plans when appropriate. Carers had been used on panels to interview new staff.
- Advocacy was available via an external service. Staff referred patients into this service when needed.
- The trust had put on 'our say' days in order to gain feedback from patients and carers about the way the

Are services caring?

Outstanding ☆

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

trust was working with them. Staff handed out a 'meridian survey' similar to the friends and family test so that they could get feedback about sessions that had been attended.

Are services responsive to people's needs?

Good

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

Our findings

Access and discharge

- The service offered a self-referral system into the service as well as one from GP and health professionals. The agreement with commissioners of the service was always to see urgent referrals within five days and to see routine referrals within 28 days, they nearly always met this target.
- There were no specific targets for referral to treatment times within the service but the service with the longest referral to treatment time was the PCDP service with an average of 46 days. The memory assessment service averaged an initial contact to referral to onset of treatment time of 25 days and the complex care service averaged 15 days. The longer referral to treatment time for the PCDP service reflected that they saw people much less urgently and frequently than the others.
- The service was open to people of any age that required an assessment for memory which meant that the service was a dedicated memory service rather than one exclusively for older people. Staff reported that they had cared for people in their 50's that had an early onset dementia.
- A change within the community teams to take on patients over the age of 75, which was in line with the Royal College of Psychiatry review and research evidence of the care of older people had caused a high level of anxiety amongst some community staff. Staff felt that they did not have the resources or capacity to take on functional patients without being provided with the means to do so. As a result of feedback from staff, targeted training had been planned. This had resulted in a delay to the plan to move the care and treatment of patients from 70 years of age which was being further reviewed to ensure resources were available to effectively support this patient group.
- The previous inspection had found that there was no commissioned out of hours specialist support for people living with dementia. The home treatment team provided a service to patients of all ages with functional mental health difficulties, mental health act assessments and out of hours for all adults, including people living with dementia. On this inspection we found that this had not changed. Staff felt that this was not an issue and we only found one situation where there was a historical issue with the lack of provision for the service. Staff said that if there was a crisis out of hours then it would be a potential mental health act assessment situation. The operational policy for the service directed the need for an urgent out of hour's response to the duty doctor.
- Intermittent assessment and treatment was available for people that were becoming unwell but did not warrant a hospital bed or required a change in treatment. We found this pathway was utilised effectively in a number of situations and the outcomes had been positive. For example a resources were provided for a patient to be titrated on medication in a care home rather than in a hospital, this had meant that the patient had a less restrictive and more homely environment. Staff could buy in a care agency to monitor medication and behaviour to continue to support the patient in their own home.
- Staff expressed concern at the lack of inpatient beds available to them for their patients. We found examples of patients being admitted far out of the county due to the lack of local hospital beds. This meant that it would have been harder for patients families and carers to visit.
- Staff told us that patients forgetting their appointments was a part of working in the service. As a result they had a robust response to patients that did not attend appointments and were proactive in following them up. Staff saw patients in their own homes more than in the team bases.

The facilities promote recovery, comfort, dignity and confidentiality

- Staff told us that rooms at the community sites were often hard to book due to them being shared with other services. Clinic rooms were available on each community site.
- Staff had information on hand to provide to patients should they have questions. This included information about the services provided by the trust, medicines and external support services such as the dementia cafes, fishing groups and men's group.

Meeting the needs of all people who use the service

Are services responsive to people's needs?

Good

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

- Adjustments had been made to allow disabled access. Staff told us that generally if there was a mobility issue then they would try their best to see patients in their own homes.
- Information was available in different languages if needed and there was an interpretation service.

Listening to and learning from concerns and complaints

- Information provided by the trust prior to the inspection showed that out of a total of 109 complaints, this service accounted for just three of these. The complaints made were regarding clinical treatment.
- Staff provided patients and carers with information on how to complain when they met for the initial assessment. Where possible we found that complaints were addressed locally in order to address the issue immediately. The patient advice and liaison service (PALS) were available to those that wanted to make a formal complaint. Staff all knew the complaints process and how to respond to complaints.
- Staff received feedback regarding investigations into complaints via the local business meetings. Prior to learning being shared, complaints were discussed in the operational assurance group.

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.

Our findings

Vision and values

- Staff were aware of the trust values and these were displayed around the community sites. We were told that the executive team visited the sites and provided staff with the opportunity to express their views on working within the trust.

Good governance

- There had been little progress since the previous inspection in 2015 with psychology input, and access to out of hours crisis care. Psychology was in the early stages of roll out to the community but had not yet had any impact. Staff told us that they did not feel that they were a priority due to the relatively small size of the service in the context of the trust.
- Managers within the service used key performance indicators to gauge the performance of their team. Data around care plan completion, risk assessments, finance and training for example allowed managers to approach their team with data to ensure essential areas of practice were maintained.
- Staff received a yearly appraisal, mandatory training and were supervised both formally and informally within their teams. We found there to be good learning from complaints and incidents and staff were made aware of how to report incidents appropriately. Managers gave feedback to staff on every incident that occurred.
- There were monthly governance meetings (operational assurance group). This meeting allowed the service to evaluate the performance of the team using information gained from the key performance indicators. Managers fed incidents into the operational assurance group for the service to review them collectively. Learning across the service and trust was then shared with teams in their business meetings. The staff forums fed into the group for changes to be approved, for example the review of the PCDP caseloads.
- Managers felt they had enough authority to do their jobs and that they felt supported by senior management in the service.
- Staff were able to submit items to the trust risk register, for example, one risk recorded was in relation to the lack of care home places delaying patients discharge from hospital.

Leadership, morale and staff engagement

- Staff had felt the pressure of sickness due to having to cover others caseloads and responsibilities but this was managed well.
- There was one case of bullying and harassment across the service. This had been dealt with effectively.
- Staff told us they felt confident of using the whistleblowing process and were aware of how they would do this. Staff said they felt able to raise concerns within the team and that the team were strong enough to challenge each other appropriately.
- Staff told us there was variable morale but that they felt supported and had job satisfaction. Morale depended on the pressure on the team and the changes that were made. For example, the recent inclusion of patients with a functional illness over the age of 75 had caused a lot of stress within the team. When they were told that they were likely going to have patients over the age of 70 with a functional illness they felt there was little consultation with them. Staff felt that there was no capacity to take on more patients or responsibilities without an increase in capacity.
- Staff were passionate in their roles and supported each other working as teams. Staff said they could go and get support from a colleague at almost any time.
- We heard examples of staff accessing leadership training in order to progress through into management.
- Staff recognised the need to be open and transparent to patients when things went wrong with their care.
- The staff forums for their particular job role allowed staff to discuss concerns of themes in that particular area of the trust. One solution was the referral form that was created and sent to GP's and community hospitals in order for them to receive the correct information on referral. We found examples of staff training each other in areas of interest that may not be supplied by the trust and staff raising ideas to the operational assurance group in order to improve patient care.

Commitment to quality improvement and innovation

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.

- 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 LGBT in dementia and in auditing antipsychotic use across the CCD team.