Cornwall Partnership NHS Foundation Trust

Inspection report

Carew House
Beacon Technology Park, Dunmere Road
Bodmin
PL31 2QN
Tel: 01208834600
www.cornwallft.nhs.uk

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Ratings

Overall trust quality rating	Requires Improvement
Are services safe?	**Requires Improvement**
Are services effective?	**Requires Improvement**
Are services caring?	**Outstanding** ☆
Are services responsive?	**Requires Improvement**
Are services well-led?	**Requires Improvement**

Our findings

Our reports

We plan our next inspections based on everything we know about services, including whether they appear to be getting better or worse. Each report explains the reason for the inspection.

This report describes our judgement of the quality of care provided by this trust. We based it on a combination of what we found when we inspected and other information available to us. It included information given to us from people who use the service, the public and other organisations.

We rated well-led (leadership) from our inspection of trust management, taking into account what we found about leadership in individual services. We rated other key questions by combining the service ratings and using our professional judgement.

Overall summary

What we found

Overall trust

We carried out this short notice announced comprehensive inspection of acute wards for adults of working age and psychiatric intensive care unit (PICU), community-based mental health services for adults of working age, specialist community mental health services for children and young people and child and adolescent inpatient wards of this trust as part of our continual checks on the safety and quality of healthcare services. At our last inspection we rated the provider as good.

We also inspected the well-led key question for the trust overall. We inspected four services and rated one as good (child and adolescent inpatient wards) and three as requires improvement (acute wards for adults of working age and psychiatric intensive care unit (PICU), community-based mental health services for adults of working age and specialist community mental health services for children services). Overall, we rated safe, effective, responsive and well led as requires improvement. We rated caring as outstanding.

We also inspected the trust's urgent and emergency care services in February 2022 as part of our urgent and emergency care programme. The service was rated good. This report is published separately on our website.

Cornwall Partnership NHS Foundation Trust delivers community health, mental health and learning disability services to people living in Cornwall and the Isles of Scilly. Cornwall and the Isles of Scilly have a population of 545,000 with a higher than average aging population. This increases by an average of 300,000 during the summer holidays with a total of 41 million visitors per year. The trust runs over 80 services in 130 sites across Cornwall and the Isles of Scilly. The trust has over 4,300 inpatient admissions annually across the 12 community health hospital sites and over 550 inpatient admissions to the mental health wards. The trust operates ten minor injury units with over 93,000 attendances per year. The trust employs over 4,100 staff.

Our rating of services went down. We rated them as requires improvement because:

- We rated safe, effective, responsive and well-led as requires improvement.

Our findings

- We rated one of the trust's services as good. This was the child and adolescent mental health ward (which had not previously been inspected). We rated acute wards for adults of working age and psychiatric intensive care unit as requires improvement overall, with an inadequate rating in the safe domain. This had gone down from the rating of good given at our inspection in February 2018. We rated community-based mental health services for adults of working age as requires improvement. This had gone down from the good rating given at our last inspection in April 2019. We rated specialist community mental health services for children and young people as requires improvement, with an inadequate rating in safe. This had improved from the overall inadequate rating given following our inspection in April 2019. In rating the trust overall, we included the existing ratings of the nine previously inspected services.
- We found environments at a number of the locations we visited to be in poor condition and not fit for purpose. This was a safety risk for patients using these services. On the acute wards for adults of working age and psychiatric intensive care unit the ward environments were not well maintained which caused staff difficulties in safely managing patients within the environments. For example, we found a ligature risk assessment on one ward that was not up to date and on two of the wards there were blindspots. On each ward there were areas of the environment that were not safe or were unfit for purpose and posed risks to the safety of the patients. All the wards we visited needed updating and maintenance work completed to make them more safe, therapeutic and comfortable for patients. For example windows on two of the wards were damaged and had been requiring repair for some months. In the specialist community mental health services for children and young people not all of the premises where young people were seen were safe, clean, well equipped, well maintained and furnished and fit for purpose. Only half of the services visited had environmental risk assessments. In one location there were ligature points such as screws protruding from the walls. In the same location furniture was not compliant with fire regulations. In the community-based mental health services for adults of working age not all of the locations we inspected were fit for purpose and required maintenance work to be undertaken. Three of the six teams inspected were located in premises that required maintenance works to be completed for issues such as damp, poor décor and damaged walls.
- The trust's estates issues were a key risk to the organisation. The trust was experiencing significant challenges arranging maintenance works across the service. The trust only owned 16% of their estate and in some locations were reliant on external contracts. There were ongoing issues in the management of external contacts to ensure appropriate repairs were carried out in a timely fashion. Some locations were operated through PFI providers. The trust had been experiencing significant difficulties in getting the PFI provider to complete maintenance in a timely manner. The trust informed us that they believe PFI's were performing at a standard that was considerably below the standard expected in all areas. The trust had engaged NHSE/I, DHSC and the Cabinet office to support rectification of this situation. The estates team were working through these issues and in the process of developing a strategy.
- The trust were facing workforce issues and a number of the teams we visited did not have enough staff and high vacancy rates. In the community-based mental health teams for adults of working age teams had only between 40% and 60% of the staff they should have. As a consequence, there were long waiting lists for patients to be seen and long waits for a range of therapies due to a lack of clinical psychologists and occupational therapists. The specialist community mental health services for children and young people had similar issues with staffing and the teams were not always able to provide treatments as the teams did not have access to the full range of specialist staff. Young people on the external waiting lists were not always monitored to detect, and respond to, increases in their level of risk. The acute wards for adults of working age and psychiatric intensive care unit had high vacancy rates for registered nurses and healthcare assistants. The services had to use high numbers of agency staff to ensure shifts were filled. Patients' escorted leave or activities were often delayed or cancelled as there weren't enough staff to facilitate these. In addition, the wards could not always provide patients with timely access to the full range of treatment and therapy options due to a lack of clinical psychologist.

Our findings

- As part of a governance review it had been identified there were issues in the way the trust was managing and investigating complaints. The trust was not classifying complaints and concerns accurately with a risk of complaints not being reviewed and investigated in line with requirements. The trust had 254 complaints open, 176 of these were outside the trust target of 60 days.
- The trust did not have a current strategy which clearly defined objectives and deliverables aligned to trust and partner strategies. The trust also had a number of strategies which were out of date at the time of the inspection, this included the estates strategy and financial strategy.

However:

- We rated the caring domain as outstanding.
- Since our last comprehensive inspection of the trust in March 2019 there had been significant changes to the trust board and a number of new appointments, including a new chair, chief executive, chief operating officer, chief medical officer, chief information officer, chief nursing officer, executive director of finance and an executive director of corporate affairs and assurance. Several members of the executive board were undertaking their first executive appointments. These board members had been offered a mentor and undertook leadership training.
- The trust executive board had a range of skills and knowledge to perform its role and deliver community health services and mental health services. The trust leadership demonstrated awareness of the priorities and challenges facing the trust and had acted at pace during the pandemic. The trust had been in a critical incident for a prolonged period of time and had been working to manage this situation.
- The trust had reviewed governance arrangements and developed a Governance Improvement Plan (GIP). The work around governance identified a number of areas that required improvement. This work had been on going and a significant number of areas related to governance had been incorporated into the GIP. Improvements were on going and were in the process of being embedded to support the overall governance structure of the organisation.
- The director of governance had identified areas of improvement required around risk management within the trust. An internal audit had validated these findings. The trust had taken steps to address this and developed a new risk management strategy which incorporated policy requirements. The implementation of the policy trust wide was early in its adoption and the trust were in the process of embedding a new risk management structure. There was a positive change in the risk culture apparent in the trust. Risk management had been a key focus for the trust and it was evident this work was gathering pace.
- The trust had responded positively to previous inspection findings in 2019. For example, we saw improvements in the way the specialist community mental health services for children and young people age monitored patients on the internal waiting lists to keep them safe and respond to changing risks. This service had been rated inadequate in our previous inspection.
- The trust leadership team had actively engaged with staff following negative staff survey results. The chair had commenced a culture review when new in post and recognised the need for this work with staff. The review had given staff the chance to share their views with the leadership team and make suggestions about improvements they would like to see being made. The leadership in the organisation had developed a plan to address the views and concerns of staff following the findings of the review in the form of a 'You said, We did' action plan.
- The trust had introduced a Patient Leader programme. The programme had recruited and trained a number of patient volunteer leaders to ensure the patient and public voice was well represented in all aspects of service design and delivery. Patient leaders supported and co-produced quality improvement projects, review of services and participated in staff recruitment.

Our findings

- The board were committed to quality and inclusion. There was an active focus on equality, diversity and inclusion represented at board level. There were several staff networks who met regularly.

How we carried out the inspection

We used CQC's interim methodology for monitoring services during the COVID-19 pandemic including on site and remote interviews by phone or online.

We visited six of the trust's community-based mental health teams for adults of working age, we visited the West, Central and North East locality teams for the specialist community mental health services for children and young people, we visited the child and adolescent mental health ward and four acute wards for adults of working age and psychiatric intensive care unit (PICU).

During the community--based mental health teams inspection, the inspection team:

- visited six ICMHTs (integrated community mental health team) over three days visiting the Team bases and speaking with multidisciplinary team members within each of the teams
- spoke to all managers leading each of the teams
- spoke to the overall teams community matron for service
- interviewed six nurses
- reviewed the quality of the environments
- conducted three staff focus groups with 17 staff members including, employment coordinators, clinical lead occupational therapy, occupational therapy student, nurses, administrative staff, social workers, preceptorship mental health nurse and clinical psychologists
- reviewed six clinic rooms
- spoke to six patients
- reviewed 34 care and treatment records including risk assessments.
- reviewed two team meeting minutes
- attended two multidisciplinary team meetings
- looked at a range of policies and procedures.

During the specialist community mental health services for children and young people inspection, the inspection team:

- visited the West, Central and North East locality teams. We also interviewed staff from the eating disorder service, the learning disability team, the intensive support team and the access team
- interviewed the manager for each team and the overall service managers
- reviewed 18 care records
- spoke with three young people and seven parents or carers
- spoke with 26 staff from all the teams

Our findings

- reviewed a number of policies, meeting minutes and assessments related to the running of the services
- observed two therapy sessions
- observed several staff members in two multidisciplinary team meetings

During the child and adolescent mental health ward inspection, the inspection team:

- visited the site and looked at the quality of the ward environments and observed how staff were caring for young people
- spoke with six young people who used the service and six parents and carers
- reviewed five electronic and paper copies of care and treatment records
- spoke with 11 members of staff including a specialist paediatric pharmacist, the operational lead for inpatient CAMHS (child and adolescent mental health services) and urgent care pathway, a speciality doctor, a family therapist and family liaison officer. We also spoke to healthcare assistants and nurses
- reviewed a range of documents relating to the running of the service
- looked at medicines management, including medicines charts and electronic systems.

During the acute wards for adults of working age and psychiatric intensive care unit (PICU) inspection, the inspection team:

- visited four inpatient wards: Carbis and Perran ward at Longreach House and Fletcher and Harvest ward at Bodmin Hospital. We were unable to enter Cove ward due to an outbreak of COVID-19 on the ward
- spoke with 17 members of nursing staff including registered nurses, health care assistants, agency nursing staff and student nurses
- spoke with seven multidisciplinary team members including occupational therapists, social inclusion officers, pharmacists, and a clinical psychologist
- spoke with leaders of services, including modern matrons, clinical and quality leads, ward managers, a nurse consultant and members of the estates team
- completed a focus groups with mental health advocates that visited the ward
- spoke to members of the estates team
- interviewed 16 patients and five relatives of patients
- reviewed 18 patients' care and treatment records
- carried out a specific check relating to medication management on the wards and reviewed medicines administration records for 19 patients
- looked at a range of policies, procedures and other documents relating to the running of each service.

You can find further information about how we carry out our inspections on our website: www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

Our findings

Outstanding practice

We found the following outstanding practice:

- At the child and adolescent mental health ward educational opportunities and facilities for young people were of a high standard and collectively with the additional 20 weeks 'enrichment' provision, this gave the young people a 52 week continuum of opportunity of learning opportunities where educational and ward staff worked collaboratively to make this possible. Meaning young people were able to keep up with key stages of curriculum and additionally explore and take part in other chosen areas of interest.
- At the child and adolescent mental health ward, onsite accommodation was available for parents and carers, who could stay in this accommodation for agreed periods of time to assist with admission and visiting opportunities when distance from home was an issue. This meant young people were able to be supported by families in person post admission where distance from home would normally hinder this.
- The specialist community mental health services for children and young people eating disorders team offered home remote health monitoring for those children who had a high level of risk. This method proved successful over the pandemic and the team had 63 home monitoring kits for families across the county to use. This meant that some hospital admissions were avoided as young people did not need to go into hospital to perform this function.
- The specialist community mental health services for children and young people Restormel team offered appointments at the beach in an attempt to connect with young people who found it difficult to engage with the service.
- The trust wide integrated infection prevention and control team and the integrated safeguarding team had undertaken notable practice.

Areas for improvement

Action the trust MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the trust MUST take to improve:

We told the trust that it must take action to bring services into line with fifteen legal requirements. These actions related to three services.

Trust wide

- The trust must ensure that all estates and premises used by the services are well maintained, fit for purpose and safe (Regulation 12)
- The trust must establish and operate effectively an accessible system for identifying, receiving, recording, handling and responding to complaints by service users and other persons in a timely fashion (Regulation 16)
- The trust must ensure there are enough numbers of suitably qualified staff available to deliver care and treatment to patients in all services (Regulation 18)

Our findings

Community-based mental health services for adults of working age

- The trust must ensure that waiting times are managed effectively and all patients are seen within the required waiting times target. (Regulation 12)
- The trust must ensure all premises and equipment used by the service are fit for purpose and properly maintained. (Regulation 15)
- The trust must ensure that patients can access psychological therapy in a timely manner. (Regulation 9)
- The trust must ensure there are sufficient numbers of staff with the right skills to ensure the that patients are kept safe and receive a good quality service safely (Regulation 18)
- The trust must ensure governance processes provide robust oversight of the service and that action is taken in a timely manner when required improvements are identified. (Regulation 17)

Specialist community mental health services for children and young people

- The trust must ensure there are enough, suitably qualified, competent, skilled and experienced staff deployed to meet the needs of children and young people in a timely manner (Regulation 18).
- The trust must ensure that all premises used by the service are well maintained, fit for purpose and safe. (Regulation 12 & 15)
- The trust must work towards reducing wait times for young people to be assessed and then seen for treatment in Caradon. (Regulation 9)
- The trust must monitor and review young people on the external waiting list whilst they wait for an assessment. (Regulation 12)

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

- The trust must ensure the premises used are safe and any safety risks have been mitigated. (Regulation 12)
- The trust must ensure all premises and equipment used by the service is secure, fit for purpose and properly maintained. (Regulation 15)
- The trust must ensure enough numbers of suitably qualified staff are available to deliver care and treatment to patients. This includes delivery of psychological interventions that meet national guidance and best practice. (Regulation 18)

Action the trust SHOULD take to improve:

Community-based mental health services for adults of working age

- The trust should ensure staff receive mandatory training and recommence the training programme.
- The trust should ensure all staff receive an annual appraisal
- The trust should ensure patients are aware interview rooms have CCTV in use
- The trust should ensure carers groups are re-established
- The trust should ensure information is available to all patients in their preferable language.

Our findings

Specialist community mental health services for children and young people

- The trust should ensure that young people are weighed in a private area.
- The trust should calibrate the weighing scales at North Cornwall.
- The trust should consider reviewing locality staffing budgets so team leaders have more autonomy to be able to manage their own rotas.
- The trust should review out of hours arrangements so young people using the service and their families can access emergency specialist medical support when required.
- The trust should audit the completion of crisis plans for young people using the service.
- The trust should ensure staff document when medical reviews are due to take place for young people using the service.
- The trust should ensure all care plans are up to date and reflective of outcome measures, current risk and need.
- The trust should consider building in systems to review and monitor the physical health of young people.
- The trust should ensure staff upload their supervision records onto the shared electronic database.
- The trust should review how intensive support can be available for young people with eating disorders.
- The trust should make use of any participation groups which enable children and young people to input into the development of the service.
- The trust should ensure young people who are planning to transition into adult services have appropriate plans well in advance of their transfer.
- The trust should review the discharge process for young people, so they are not staying on staff caseloads for longer than required.
- The trust should consider providing a more child appropriate setting in Carrick, North Cornwall and Caradon.
- The trust should ensure all clinical rooms are sound proofed.

Child and adolescent mental health ward

- The trust should make sure the all emergency medicines are in date and tamper-evident according to trust policy**.**
- The trust should review the physical environment of the seclusion room to ensure it meets the Mental Health Act (1983) code of practice.
- The trust should ensure controlled drugs are stored within cupboards meeting the legislative requirements.
- The trust should ensure that physical health monitoring is robustly recorded according to policy following initiation of high dose antipsychotic medicines.
- The provider should review food options available to young people to ensure they have varied vegetarian and vegan options available.
- The trust should ensure sound proofing works are completed to minimise excessive noise in communal areas.

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

Our findings

The trust should:

- ensure future plans to re-engage with families and carers are implemented. This includes re-instating the collection of feedback using the family and friends test.
- ensure that emergency medicines are stored in line with the provider's policy or regulation and out of date stock is removed from wards.
- ensure all patients are involved in the care planning process in a meaningful way.
- ensure staff receive appropriate formal supervision and an appraisal as is necessary to enable them to carry out the duties they are employed to perform.
- ensure that local policies and procedures in relation to the storage and access of cigarettes is carried out consistently and fairly across all wards.
- ensure that local governance systems and processes are prioritised to ensure thorough oversight of service quality and ensure issues are identified and rectified in good time.
- ensure that it meets the Accessible Information Standard in line with section 250 of the Health and Social Care Act 2012, and proactively monitors how well the information or communication needs of patients with a mental health condition which affects their ability to communicate are met.
- ensure that agency staff fulfilling the 'named nurse' role for patients have access to adequate support and training to help them fulfil this role safely, including supervision where the trust has deemed this appropriate.
- ensure that the community consultant model meets the needs of patients and does not cause delays to the time taken for patients to have their care reviewed by their responsible clinician.
- ensure that information management systems are accessible to all relevant staff, this includes agency staff accessing electronic prescribing and medicines administration (EPMA) and RiO and inputting of supervision records onto the Healthcare Appraisal and Revalidation Portal (HARP)
- ensure all patients have easy access to and information about independent mental health advocacy services.

Is this organisation well-led?

Our rating of well-led went down. We rated it as requires improvement.

Leadership

Since our last comprehensive inspection of the trust in March 2019 there had been significant changes to the trust board. The trust had appointed a new chair, chief executive, chief operating officer, chief medical officer, chief information officer, chief nursing officer, executive director of finance and an executive director of corporate affairs and assurance (who was working on a fixed term basis while recruitment to the permanent position was completed).

The trust executive board had the appropriate range of skills and knowledge to perform its role and deliver community health services and mental health services. Several members of the executive board were new in post and undertaking their first executive appointments. These board members had been invited to be allocated a mentor and undertook specific board development leadership training. The board had also completed a skills audit. The trust board consisted of the chair, chief executive, eight non-executive directors (NEDs) and seven executive directors. The team had clear areas of responsibility. The executive directors had the support needed to give them capacity to undertake their roles.

Our findings

The NEDs had the appropriate range of skills, knowledge and experience. They all had experience as senior leaders in a range of organisations and brought a variety of skills such as a knowledge of finance and strategic development.

All board members had lead areas of responsibility including non-executive directors who chaired specific committees or were leads on areas of work. The NEDs sat on each other's committees. Emerging themes could be identified and discussed in each of the committees they sat on. Feedback was shared between the NEDs and executive team.

The trust had an appropriate process for carrying out their duties in respect of the Fit and Proper Person Regulation. Fit and Proper Person checks were in place and had been undertaken. Files were fully compliant and there was a yearly check and update process in place.

The trust leadership demonstrated a high level of awareness of the priorities and challenges facing the trust. The trust had been in a critical incident, owing to pressures created in the Cornwall wide system due to the pandemic, for a prolonged period of time and had been working to manage this challenging situation. The trust leadership had demonstrated an ability to adapt at a fast-changing pace during the COVID-19 national pandemic. The portfolios of the executives had been reviewed and refreshed during this period and were finalised in February 2022. Leaders spoke with insight about the need to continue to work with external partners to meet the needs of the local population. The trust were actively preparing and making arrangements for the go live date of July 2022 for the Integrated Care System (ICS) in Cornwall.

Board members and NEDs visited wards regularly to meet staff and review services. This had continued virtually during the pandemic and board members and NEDs told us they felt it was important to remain connected with frontline staff at such a pressurised time. When visits were undertaken during the pandemic careful consideration had been given to which services were appropriate to visit. Staff we spoke with during the core service inspections told us leaders were generally visible and approachable.

Directors and senior staff we met all said the board members were open and challenged each other professionally and openly. We observed this when we attended the board meeting prior to the inspection. We also observed good challenge at committees below the board.

Feedback about the leadership style of the new executive team was positive. We were told changes that were being put in place were starting to have an impact across the trust.

Vision and Strategy

The trust's vision was "Delivering high quality care" which was underpinned by strategic objectives that had been updated in February 2022. These were:

- Great care - deliver safe, high-quality, consistency and personalised care based on best practice. To work to be a responsive organisation that listens and learns
- Great organisation – work to be a green organisation with a sustainability plan to deliver NHS net zero targets. Support quality care, research and innovation. Work would be underpinned by clear and transparent principles and systems
- Great people – work together with staff to create an organisation that supports collective health and well being. Attract, retain and develop great people and embed a caring, open, inclusive and restorative just culture that supports them to deliver quality care

Our findings

- Great Partner – work with partners to deliver health care that improves people's quality of life, prevents ill health and reduces inequalities. Spend their money wisely to achieve high quality outcomes that matter to local people.

The objectives were supported by the trust's CARE values which were:

- Compassionate services
- Achieving high standards
- Respecting individuals
- Empowering people.

The trust had a collection of themes which were in the process of being developed into an overarching strategy to link them all together along with key priorities, milestones and measurable outcomes. The trust had a lack of a current strategy which clearly defined objectives and deliverables aligned to trust and partner strategies. The trust also had a number of strategies which were not up to date at the time of the inspection, this included the estates strategy and financial strategy. The previous versions were in the process of being re-written and refreshed to take account of the changed landscape in health and social care since the pandemic. These issues had been identified as a risk on the trust's board assurance framework and control measures were in place to ensure work progressed towards board approval later in 2022. Leaders who we spoke with were well cited on the work around the new strategy and were committed to refocusing and aligning the strategy to both local and national priorities.

Culture

Staff were proud to work for the trust and showed a dedication and passion towards patient care. Staff put patients at the centre of everything they did. Morale among some staff groups was low. This was in part due to working tirelessly through the pandemic in difficult circumstances but also linked to staffing issues and ongoing maintenance issues at some locations.

The chair oversaw a culture review at the trust in early 2021 shortly after taking up post. This was part of the Undertakings following a notice from NHSEI. The review aimed to give staff an opportunity to discuss their views on the trust and improvements they would like to see being made. Interviews and listening workshops were held to gather staff opinion. The headlines from the review were that staff felt leadership had not previously understood frontline business, a perception of a 'command and control' culture where staff described not feeling valued or listened to, fears about raising concerns, concerns about corporate functions, systems and process issues, lack of knowledge around the trust's strategic direction and low morale with staff feeling frustrated, emotional and exhausted. The review highlighted that staff felt a sense of pride in their work and they valued team work within the organisation. The findings of the review were presented to the Executive and Non-executive directors and NHSEI as part of the review of Undertakings. The leadership in the organisation had developed a plan to address the views and concerns of staff following the findings of the review in the form of a 'You said, We did' action plan. Senior leadership in the trust continued to hold conversations to engage further with staff and to facilitate the co-design of cultural changes within the trust.

The trust had a Freedom to Speak Up Guardian (FTSUG). The FTSUG had good relationships with the executives and non-executive directors. The FTSUG had been involved in the culture review workshops. The role of the FTSUG had been actively promoted to staff to raise awareness of the role. This had been achieved by attending teams live meetings with the chief executive and implementing a screen saver on staff members computers raising awareness about the role and providing contact information. The trust also had FTSUG champions within teams to promote the role. The FTSUG had

been contacted by local managers within teams to join meetings and become part of the wards. The FTSUG was actively engaged with staff networks. The FTSUG reported to the board annually, the people committee quarterly and regularly met with the executive team. The FTSUG was aware of hotspot areas in the trust and was planning to regularly visit these areas. Staff generally told us they felt safe to raise concerns and understood speak-up procedures.

The trust had initiated a 'Just Culture' programme. There were dedicated 'Just Culture' leads in place to support managers and teams to raise awareness of the programme. There were 50 'Just Culture' champions across the trust. A monthly working group was being held to review progress and the embedding of the 'Just Culture' programme.

The trust also had 116 well being champions across the trust to support staff with health and well being matters. The trust had 54 mental health first aiders to support staff in the trust.

Staff Survey 2021

The results of the NHS Staff Survey 2021 had a response rate of 40% and was completed by 1601 staff members. The response rate was below the median response rate for NHS trusts which was 52%. The response rate for the trust had slightly increased from 37.5% in 2020.

The themes of the NHS Staff Survey 2021 were amended and each question sat within one of seven 'People Promise Elements'. The themes were 'we are compassionate and inclusive', 'we are recognised and rewarded', 'we each have a voice that counts', 'we are safe and healthy', 'we are always learning', 'we work flexibly', 'we are a team', 'staff engagement' and 'morale'. Staff engagement and morale were themes that had remained from the 2020 survey and the trust scored lower this year when compared to the 2020 staff survey.

The trust scored lower than average in all nine of the people promise elements when benchmarked against other organisations. The trust also scored the same as the worst benchmarking group in five out of the nine elements.

The trust had developed a detailed action plan to address the key issues highlighted in the staff survey results. A report for each directorate had also been created to involve operational leads and frontline staff. The trust had been very open that a lot of work was still required to rebuild morale among staff and the results of the staff survey were being used to drive this work.

Workforce Race Equality Standard (WRES)

The Workforce Race Equality Standard (WRES) became compulsory for all NHS trusts in April 2015. Trusts have to show progress against nine measures of equality in the workforce.

The trust produced an annual report and action plan against WRES. The black, Asian, minority ethnic (BAME) workforce of the trust was 2.45% as of September 2021. This was an increase from 2.08% in 2020 and 1.08% in 2019. The total number of BAME staff had increased in all staff groups (clinical, non-clinical and medical) in the last year. The representative BAME population of Cornwall (from the 2011 Census) was 1.8%.

The report identified that the likelihood of white staff being appointed from shortlisting, compared to BAME staff, had reduced from 2.11 to 1.87. Despite the decrease, the trust recognised this was still a significant difference.

There were no BAME staff who had entered a formal disciplinary process during 2020/21.

Our findings

The likelihood of white staff accessing non-mandatory training and CPD, compared to BAME staff, had reduced from 2.11 to 1.4. Despite the decrease, the trust recognised this was still a significant difference.

The NHS Staff Survey 2021 results showed the number of BAME staff experiencing bullying, harassment and abuse had reduced (from both patients/service users and staff). The number of BAME staff believing the organisation provides equal opportunities for career progression and promotion had increased. The number of BAME staff experiencing discrimination at work had increased by 9%.

As part of the WRES annual report an action plan had been developed in collaboration and consultation with the trust's BAME staff network. The action plan had a focus on key priority areas for BAME staff which were identified in the WRES annual report and the staff survey. The priority areas had been identified as senior representation and awareness, bullying and harassment and career progression and development.

The BAME staff network was well-established and met regularly. The group were to meet regularly with the Inclusion and diversity to lead to progress the objectives outlined in the action plan. The group also regularly reported to the Inclusion and Diversity steering group and then into the People Committee.

Through the trust's talent management programme there was an emphasis on supporting and encouraging BAME staff into more senior roles to ensure all opportunities for development were fully inclusive.

The trust were also developing a Reverse Mentoring programme to address concerns about senior representation and awareness to provide development opportunities for BAME staff.

Workforce Disability Equality Standard (WDES)

The WDES came into effect on 1st April 2019. The standard is designed to improve representation and the experiences of disabled staff across the NHS.

The trust produced an annual report and overview of the trust's performance against the WDES. The report also included an action plan to address the key issues highlighted in the annual report.

The findings of the trust's 2020/21 report showed as of September 2021 6.3% of staff had declared a disability. This was an increase from 2019/20 and 2018/19.

The WDES annual report for 2020/21 highlighted that disabled staff generally reported a poorer experience of the workplace when compared with non-disabled staff. Recruitment data showed that non-disabled job applicants were 1.45 times more likely to be appointed through shortlisting. This had increased from 1.07 times in 2019/20. Data from disciplinary action showed that disabled staff were 4.04 times more likely to enter a formal performance management process compared against non-disabled staff. This was an increase from 3.28 in the 2019/20 report. The report highlighted 26% of disabled staff reported harassment, bullying or abuse, compared to 17.7% of non-disabled staff. 79.8% of disabled staff reported that they believed they had equal opportunities for career progression. 35.7% of disabled staff said they felt valued, this compared to 44.4% of non-disabled staff.

As part of the WDES annual report an action plan had been developed in collaboration and consultation with the trust's disability staff network. The network worked collaboratively with the Inclusion and Diversity Lead to address and work

on the areas identified in the action plan. The network had been reviewing the trust policies as part of the 'Just Culture' programme. The trust had introduced a Health and Wellbeing conversation as part of staff appraisals. A reverse mentoring programme was scheduled to begin in 2022 to raise awareness of issues faced by those with a disability and address the challenges and barriers in the workplace.

The trust had also formed a neurodiverse staff network which was becoming actively involved in initiatives.

Staff networks

As part of the trust's work around equality, diversity and inclusion there were seven established staff networks. The networks were focused on the promotion of diversity in the workplace. The networks were comprised of peer groups of staff who provided feedback to the trust on areas of improvement.

The networks in the trust were:

- Black Asian Minority Ethnic (BAME) staff network
- Lesbian, gay, bi-sexual, trans, queer, intersex, asexual and more (LGBTQI+) staff network
- Women's network
- Men's network
- Neurodiverse network
- Disability and long term conditions (LTC) network
- Equality Allies

The networks each had an action plan in place for delivery in 2022/23.

Staffing

Vacancies

The trust had a high number of vacancies for staff across all directorates. As of April 2022 the trust had vacancies for 450 WTE staff. Gaps had been filled by bank staff and block booking agency staff to fill shifts.

Staff sickness

Overall staff sickness absence had been above 6% since September 2021. This was above the trust target of 4%. The increased rate of staff sickness was mainly due to the increased numbers of COVID related illnesses.

Mandatory training compliance

Training across the trust had been disrupted due to the pressures within the trust. Some training had been stood down or was unable to be completed due to training not being able to be delivered face to face. The trust were working to recover the statutory and mandatory training compliance rates. The overall compliance rate for mandatory training was 87%. This was above the trust target of 85%.

Our findings

Appraisal

As of March 2022, the trust had a low percentage of staff appraisals completed with only 34% completed. The trust target was 85% for completion. The low percentage had been related to the operational pressures within the trust and issues related to COVID working. The trust had developed a plan and communication with staff to increase compliance.

Supervision

The trust compliance rate for supervision was 43%. This number had been impacted by the introduction of a new recording system and staff not always recording supervisions had been completed. The use of the new system was being promoted trust wide on different platforms such as management meetings and the intranet. Operational pressures had also impacted on the compliance rates. Staff we spoke with during the inspection visits generally said they received informal supervision and support from their line managers.

Governance

The trust had initiated a review of governance arrangements and developed a Governance Improvement Plan (GIP) during 2021. The work around governance identified a number of areas that required strengthening, redesigning and redefining. This work had been on going and a significant number of areas related to governance which required action had been incorporated into the GIP to ensure progress was being made against each area. Progress was on going with this work and some improvements required further embedding to support the overall governance structure of the organisation.

The trust had structures, systems and processes in place to support delivery. There were sub-board committees, divisional committees and team meetings. Leaders regularly reviewed these structures. Board members understood their portfolio, remit and were able to challenge each other appropriately.

The trust's governance structure had been recently revised and introduced a new Regulatory compliance committee. The board was supported by seven committees: Audit and risk committee, Charitable funds committee, Renumeration and terms of service committee, Performance, finance and Sustainability committee, Quality assurance committee, People and culture committee and the Regulatory compliance committee. Each of these committees were supported by a range of sub-committees and a number of these had been recently established.

The NEDs were clear and well cited on their areas of responsibility. They chaired board sub-committees and had Executive Leads who had defined areas of responsibility. They worked to ensure there was an appropriate level of communication between the sub-committees and the trust board.

The board was organised well and met monthly. The board meetings had a clear agenda with standing items. The public board meeting opened with a patient story. This story was used to inform the board on a particular topic. Patients were invited to record stories which were presented to the board to tell their story. The board then reviewed the previous meeting minutes and progress on any actions arising from the previous meetings. The Chair and Chief Executive presented reports to the board. The board discussed quality, performance and strategy, governance, board committees and associated reports from each committee and any escalated risks and the board assurance framework (BAF). Papers that fed into the board were detailed and to a high standard. They demonstrated discussion at committees was robust

and escalated when appropriate. The meeting concluded with an evaluation of effectiveness session; reflections which allowed for improvements or views on the meeting to be discussed and implemented at future meetings. There was an appropriate level of challenge and healthy discussion during the board meeting. The topics discussed in the confidential part of the board meeting were appropriate.

Complaints

The trust received 264 complaints between 1 September 2021 and 30 March 2022. The trust had a significant backlog of complaints.

As part of the governance review in 2021 it was identified there were deficits in the way the trust was managing and investigating complaints prior to April 2021. The trust was not classifying complaints and concerns accurately with a risk of complaints not being reviewed and investigated in line with regulations. The review also identified there was a backlog of complaints requiring investigation. The backlog was mainly due to deficits in the previous process and further worsened by the pandemic. During the first wave of the pandemic NHS organisations had been permitted to pause complaint handling so staff could focus on frontline duties. This was part of 'reducing the burden and releasing capacity to manage the Covid-19 pandemic' part of arrangements for NHS providers and commissioners, which resulted in many NHS trusts developing a backlog of complaints.

Following the governance review a resolution department was formed in July 2021 to address the concerns around complaints. This was to support the investigation and resolution of complaints. The backlog of complaints transferred to the newly formed team at that time. Immediate changes were put in place in July 2021. Recruitment was initiated for a PALS officer role and a standard operating procedure was implemented for complaints handling. Systems and processes were redesigned and overhauled.

As of 01 March 2022 the trust had 254 complaints open. 176 of these were outside the trust target of 60 days. The trust had an ongoing programme of improvement and actions to reduce the backlog. This included the development of a new policy for the trust's management of complaints which was being revised following an initial consultation. Training was being rolled out to PALS officers around complaints management and the regulations and frameworks. The trust were also in the process of recruiting additional permanent staff to work on complaints. The backlog was being reviewed from the oldest complaint first but a number of these were being re-reviewed due to previous issues with categorisation and investigation.

Compliments

The trust had received several hundred compliments since 01 September 2021. Local teams received compliments via phone calls, letters and postcards. Compliments were not recorded centrally at the time of the inspection but we were provided with evidence compliments had been received. A new electronic recording system had been purchased to record quality metrics which would include compliments centrally. The trust was also planning to use Care Opinion to enable members of the public to record their experiences of care and treatment within the trust.

Management of risk, issues and performance

For the past two years the trust had been operating under an emergency financial regime put in place during the pandemic. The trust's financial position was stable with a projected breakeven position in the financial year, albeit with an underlying deficit which needed to be addressed.

Our findings

However, the operating financial environment has reverted to a more normalised position for the 2022/23 financial year. The trust will need to achieve efficiencies through its 'Cost Improvement Plan' (CIP). The trust were in the process of identifying opportunities to improve services while also delivering financial improvement and realising recurrent savings. In support of this, the trust will be required to continue to develop its quality improvement programme and ensure that it has the right capacity and capability within its programme management office to deliver improvement initiatives and CIP programmes. It is important that trust strategies which were in development were aligned and reflected within its financial plans. The trust strategy was currently being reviewed and, once complete, all subsidiary strategies required are to be finalised at pace.

Arrangements were in place for identifying, recording and managing risks, issues and mitigating actions. The director of governance had identified areas requiring improvement in the risk management arrangements and the Board Assurance Framework (BAF) An internal audit in 2021 validated these areas of improvement required around risk management. The trust had developed a new risk management strategy and policy to address these concerns which was signed off at board in March 2022. The implementation of the strategy trust wide was early in its adoption and the process was ongoing at the time of the inspection. The trust were in the process of embedding a new structure of risk management to support effective management of risk. There was on going training being completed across the trust at all levels of staff from the risk team and business partners. This improvement programme was ongoing which included the review of all risks for consistency in identification, assessment, management and reporting of risk. There was a positive shift in the risk culture evident in the trust. The newly appointed governance business partners were working with the risk team and their areas of responsibility to standardise local variability in risk management and assurance which is shared through their local groups. The processes around risk management had been a focus for the trust and work was gathering pace in this area across the trust. The board assurance framework (BAF) had been stood down in 2021 as it required an overhaul. The trust had refreshed the BAF and it had been reintroduced in 2022.

Risks were escalated as necessary. Services maintained their own risk register entries on the trust's electronic risk management system. All staff had access to the risk register and were able to effectively escalate concerns as needed. Staff concerns matched those on the risk register.

The trust's workforce issues were highlighted as a key risk and required the use of high-cost agency to fill gaps. The trust were working hard on a recruitment and retention strategy. The staff turnover rate had reduced from 15% to 10% since joining the NHS retention programme. The trust had also implemented a retention framework to address staffing and turnover. This included an approach to engaging with staff who were thinking of leaving the trust. There were also multiple initiatives in place to address recruitment and being creative with recruitment. For example, the trust now managed their own bank and offered more flexibility in working arrangements for staff. The trust now offered annualised contracts for staff which gave flexibility for students or parents and carers to work more flexibly across the year. This enabled people to work for the trust who may have been limited previously. The trust had also introduced zone recruitment whereby staff were recruited to work in zones and considered for multiple vacancies at the point of recruitment. This meant staff could work in several areas and be moved around depending on pressures in the system.

The trust's estates issues were also highlighted as a key risk to the organisation. The trust only owned 16% of their estate and in some locations were reliant on external contracts. We found during the core service inspections there were a number of estates issues relating to maintenance at several locations. The trust acknowledged in their internal reports and risk management systems that some of the estate was in a poor condition. This had led to some inpatient locations restricting bed capacity. The reduction in capacity meant some wards were operating with high occupancy rates. There were ongoing issues in the management of external contacts to ensure appropriate repairs were carried out in a timely fashion. The estates team were working through these issues and in the process of developing a strategy. While this was in development it was highlighted as a key risk to the organisation.

Our findings

Information Management

The trust used an integrated performance report (IPR) which provided a board level summary across a number of key performance indicators. The indicators reviewed performance, quality, finance and HR. The trust were in the process of developing their System Oversight Framework (SOF). Data in the SOF was still being developed at the time of the inspection with more indicators being added. There had been a number of data quality related internal audits which had highlighted issues with some data quality.

The trust had a chief information officer who was a board member. The role was joint across the trust and the neighbouring acute trust. The chief information officer was also the lead for the ICS digital strategy. Across the two organisations there was significant alignment and shared use of IT systems. This was still not fully integrated but work was ongoing to align systems. The two organisations had individual digital strategies, however, the intention was to have an overarching aligned strategy.

The trust had good access to information technology (IT) equipment across the whole geography of the trust. The trust had worked at pace during the pandemic to expand and develop IT systems and access for staff.

The trust had moved to a single electronic patient record system which had been in use since the end of 2021. The trust had also rolled out electronic prescribing and medicines administration (EPMA). This was a dual trust project with the neighbouring acute trust. The roll out of EPMA had generally been good across the organisation but some local business change issues had hindered full adoption.

The board were supportive of digital solutions within the trust and had recently run a Digital Board Thinking development session which had been led by NHS Professional.

Engagement

The trust utilised a number of communication methods such as the intranet and newsletters to ensure staff, patients and carers could access the most up to date information. There were opportunities for patients, carers and staff to feedback on the service. The trust had the friends and family test in place. The trust were also using Care Opinion to capture patient and carer feedback.

The trust had introduced the Patient leader programme in the summer of 2021. This was a joint initiative between the trust and two local acute trusts which aimed to put the voice of patients, carers and families at the heart of trust business and the vision of delivering high quality care. The aim of the programme was to recruit volunteers who were interested in working with the organisations to design and review services to improve patient care. The programme was managed by the patient experience team at the trust. The programme had recruited and trained a number of patient volunteer leaders to ensure the patient and public voice was well represented in all aspects of service design and delivery. Patient leaders supported and co-produced quality improvement projects, review of services and participated in staff recruitment. To date the trust had taken on the first cohort of patient leaders and trained 13. In the summer of 2022 a second recruitment campaign was due to commence.

The trust engaged with the local Healthwatch and used information to feed into monthly reports to the board. The trust also engaged with Kernow Clinical Commission group and held monthly meetings where all patient experience managers from local trusts met to discuss any issues or themes emerging.

Our findings

The trust had also undertaken a number of staff engagement initiatives. The acting Chair instigated a culture review at the trust in early 2021 shortly after taking up post. The trust recognised a need to undertake a review due to the undertakings within the trust and pressures on services, the significant leadership changes and uncertainty in the wider health and social care system within Cornwall. The review aimed to give staff an opportunity to discuss their views on the trust and improvements they would like to see being made. Interviews and listening workshops were held to gather staff opinion. An action plan had been developed as a result of feedback and work on the culture review and associated actions was on going.

Staff well-being was actively promoted. The trust had introduced a 'COVID café' which was led by two consultant psychiatrists. The café was a remote teams venue where staff could drop in to have a conversation and offered a chance for reflection. The trust also used Schwartz rounds as a way for staff to offering reflections.

Learning, continuous improvement and innovation

NHS trusts can take part in accreditation schemes that recognise services' compliance with standards of best practice. Accreditation usually lasts for a fixed time, after which the service must be reviewed. The trust had a range of services accredited with national organisations.

The trust undertook a mortality review process to learn from deaths. The trust mortality review process had not been fully implemented or embedded. The risk that assurance of learning from deaths had been reported through the trust's risk register. The trust began transitioning to the Patient Safety Incident Response Framework (PSIRF) as an early adopter site and implemented the PSIRF response plan in October 2021. This happened alongside the trust declaring a critical incident due to system pressures. Deaths that were previously reviewed under the serious incident framework were now reviewed through the trust's mortality review process. The critical incident had impacted on clinical capacity to undertake structured judgement reviews. Staff who had previously been trained in the structured judgement review methodology no longer felt competent to complete the reviews without refresher training since receiving the training in 2020. The trust had scheduled a mental health masterclass for structured judgement review methodology in the spring of 2022 to refresh and re-equip staff to undertake structured judgement reviews.

During the pandemic the trust had adapted and used innovation to support the local population and other organisations. The trust had introduced falls cars to respond to falls at home and to relieve pressure on the ambulance service. The trust used response cars, staffed by highly skilled pre-hospital care professionals, to ensure the fallen person was provided with care and support. The trust had also used virtual wards to support over 400 people at home to prevent hospital admissions. The trust offered digital clinical triage for COVID medicines. The trust also had used joint bank staff to provide support in care homes when the system was experiencing the most pressure.

Key to tables

Ratings	Not rated	Inadequate	Requires improvement	Good	Outstanding
Rating change since last inspection	Same	Up one rating	Up two ratings	Down one rating	Down two ratings
Symbol *	➔➔	↑	↑↑	↓	↓↓

Month Year = Date last rating published

* Where there is no symbol showing how a rating has changed, it means either that:

- we have not inspected this aspect of the service before or
- we have not inspected it this time or
- changes to how we inspect make comparisons with a previous inspection unreliable.

Ratings for the whole trust

Safe	Effective	Caring	Responsive	Well-led	Overall
Requires Improvement ➔➔ Jul 2022	Requires Improvement ➔➔ Jul 2022	Outstanding ➔➔ Jul 2022	Requires Improvement ↓ Jul 2022	Requires Improvement ➔➔ Jul 2022	Requires Improvement ➔➔ Jul 2022

The rating for well-led is based on our inspection at trust level, taking into account what we found in individual services. Ratings for other key questions are from combining ratings for services and using our professional judgement.

Ratings for a combined trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Mental health	Requires Improvement	Requires Improvement	Outstanding	Requires Improvement	Requires Improvement	Requires Improvement
Community	Requires Improvement	Good	Good	Good	Good	Good
Overall trust	Requires Improvement →← Jul 2022	Requires Improvement →← Jul 2022	Outstanding →← Jul 2022	Requires Improvement ↓ Jul 2022	Requires Improvement →← Jul 2022	Requires Improvement →← Jul 2022

The rating for the well-led key question is based on our inspection at trust level, taking into account what we found in individual services. Ratings for other key questions take into account the ratings for different types of service. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Rating for mental health services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Acute wards for adults of working age and psychiatric intensive care units	Inadequate ↓↓ Jul 2022	Requires Improvement ↓ Jul 2022	Good →← Jul 2022	Requires Improvement ↓ Jul 2022	Requires Improvement ↓ Jul 2022	Requires Improvement ↓ Jul 2022
Long stay or rehabilitation mental health wards for working age adults	Good Feb 2018	Outstanding Feb 2018	Outstanding Feb 2018	Good Feb 2018	Good Feb 2018	Outstanding Feb 2018
Forensic inpatient or secure wards	Good Feb 2018	Good Feb 2018	Good Feb 2018	Good Feb 2018	Good Feb 2018	Good Feb 2018
Wards for older people with mental health problems	Good Jul 2019	Good Jul 2019	Outstanding Jul 2019	Outstanding Jul 2019	Good Jul 2019	Outstanding Jul 2019
Mental health crisis services and health-based places of safety	Good Feb 2018	Good Feb 2018	Good Feb 2018	Good Feb 2018	Good Feb 2018	Good Feb 2018
Specialist community mental health services for children and young people	Inadequate →← Jul 2022	Requires Improvement →← Jul 2022	Good →← Jul 2022	Requires Improvement ↑ Jul 2022	Requires Improvement ↑ Jul 2022	Requires Improvement ↑ Jul 2022
Community-based mental health services for older people	Good Feb 2018	Requires improvement Feb 2018	Outstanding Feb 2018	Good Feb 2018	Good Feb 2018	Good Feb 2018
Community mental health services for people with a learning disability or autism	Good Feb 2018	Good Feb 2018	Outstanding Feb 2018	Good Feb 2018	Good Feb 2018	Good Feb 2018
Community-based mental health services of adults of working age	Requires Improvement →← Jul 2022	Requires Improvement ↓ Jul 2022	Good →← Jul 2022	Requires Improvement ↓ Jul 2022	Requires Improvement ↓ Jul 2022	Requires Improvement ↓ Jul 2022
Child and adolescent mental health wards	Good Jul 2022	Good Jul 2022	Good Jul 2022	Outstanding Jul 2022	Good Jul 2022	Good Jul 2022
Overall	Requires Improvement	Requires Improvement	Outstanding	Requires Improvement	Requires Improvement	Requires Improvement

Overall ratings for mental health services are from combining ratings for services. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Rating for community health services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community health services for children and young people	Good Feb 2018	Good Feb 2018	Good Feb 2018	Good Feb 2018	Good Feb 2018	Good Feb 2018
Community end of life care	Requires improvement Jul 2019	Good Jul 2019	Good Jul 2019	Good Jul 2019	Good Jul 2019	Good Jul 2019
Community health services for adults	Good Jul 2019	Good Jul 2019	Good Jul 2019	Good Jul 2019	Good Jul 2019	Good Jul 2019
Community health inpatient services	Requires improvement Jul 2019	Good Jul 2019	Good Jul 2019	Good Jul 2019	Good Jul 2019	Good Jul 2019
Community urgent care service	Good May 2022	Good May 2022	Good May 2022	Good May 2022	Good May 2022	Good May 2022
Overall	Requires Improvement	Good	Good	Good	Good	Good

Overall ratings for community health services are from combining ratings for services. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Child and adolescent mental health wards

Good

Is the service safe?

Good

We rated safe as good.

Safe and clean care environments

All wards were safe, clean well equipped, well furnished, well maintained and fit for purpose.

Safety of the ward layout

Staff completed and regularly updated thorough risk assessments of all wards areas and removed or reduced any risks they identified. The environmental risk assessment and ligature risk assessment had specific items that required remedial work. We saw evidence that these items were completed.

Staff could observe young people in most parts of the ward. Where this was not possible, staff were in attendance with the young people or observed by line of sight. Children and young people had their own ensuite bedrooms located in an area for males and separate one for females and so complied with guidance on mixed sex accommodation.

Staff knew about any potential ligature anchor points and mitigated the risks to keep young people safe. Staff had easy access to alarms and young people had easy access to nurse call systems. Bedrooms were ligature anchor point free and doors had integrated alarms with door sensors which notified staff if weight was applied. Staff regularly tested these were operational.

Maintenance, cleanliness and infection control.

Ward areas were clean, well maintained, well-furnished and fit for purpose. and staff made sure cleaning records were up-to-date and the premises were clean.

For the most recent Patient-Led Assessments of the Care Environment (PLACE) in 2019, Sowenna scored better than similar locations across England for condition, appearance and maintenance.

Staff followed infection control policy, including handwashing.

Seclusion room

The Seclusion room allowed two-way communication, access to outside space and had a clock, but did not allow for clear observation. However, the service mitigated this by using a CCTV system which allowed staff to view all areas of the seclusion suite. Managers were aware of this issue and had submitted a business case to improve the seclusion suite and high dependency area environments to senior leaders. We saw managers had documented this concern on the risk register with timelines, actions and up-to-date progress documented. The seclusion room was not classed as a functioning seclusion room and was used for de-escalation.

Child and adolescent mental health wards

Clinic room and equipment

Clinic rooms were fully equipped, with cleaned, maintained and checked accessible resuscitation equipment and emergency drugs that staff checked regularly. However, during checks, staff did not identify that grab bags were not tamper-evident.

Safe staffing

The service had enough nursing and medical staff, who knew the young people and received basic training to keep people safe from avoidable harm.

Nursing staff

The service had enough nursing and support staff to keep children and young people safe. Managers used bank and agency staff and made sure they had a full induction and understood the service before starting their shift. At the time of our visit there were four band 5 nurse vacancies advertised. The service had 18 registered nurses employed at the time of our visit.

Managers accurately calculated and reviewed the number and grade of nurses and healthcare assistants for each shift. Bank and agency staff were used to complement staffing levels. Block booking was used where possible to ensure continuity and familiarity of staff.

The ward manager could adjust staffing levels according to the needs of the young people and had regular one to one sessions with nursing and support staff.

Young people rarely had their escorted leave or activities cancelled, even when the service was short staffed. The service had enough staff on each shift to carry out any physical interventions safely.

Staff shared key information to keep young people safe when handing over their care to others.

Medical staff

The service had enough daytime and night-time medical cover and a doctor available to go to the ward quickly in an emergency. The unit had a consultant psychiatrist and dedicated speciality doctor who provided specialist care and treatment to the young people. There was 24/7 cover from a senior house officer (SHO) on call rota and an approved clinician rota.

Mandatory training

The mandatory training programme was comprehensive and met the needs of young people and staff. Managers monitored mandatory training and alerted staff when they needed to update their training. Staff met the trust target of 85% for mandatory training compliance.

Assessing and managing risk to children and young people and staff

Child and adolescent mental health wards

Staff assessed and managed risks to young people and themselves well and followed best practice in anticipating, de-escalating and managing challenging behaviour. Staff used restraint and seclusion only after attempts at de-escalation had failed. The ward staff participated in the provider's restrictive interventions reduction programme.

Assessment of patient risk

Staff completed risk assessments for each young person on admission and reviewed these regularly, including after any incident. All five records we reviewed detailed risks comprehensively for each young person. The multi-disciplinary team (MDT) reviewed risks for each child and young person on a regular basis.

Management of patient risk

Staff knew about any risks to each young person and acted to prevent or reduce risks. They identified and responded to any changes in risks. For example, we saw a detailed individual plan for a young person with specific needs. This plan was focused on reducing potential incidents of physical restraint to ensure physical health needs were being met.

Staff followed procedures to minimise risks where they could not easily observe young people. Staff we spoke to explained the procedures of observation if children and young people moved to areas out of line of sight. Staffing levels meant they were able to observe and accompany children and young people around Sowenna as needed.

Staff followed trust policies and procedures when they needed to search young people or their bedrooms to keep them safe from harm. Staff had scanning equipment available to aid searching bedrooms and young people when required.

Use of restrictive interventions

Levels of restrictive interventions were reducing and staff made every attempt to avoid using restraint by using de-escalation techniques and restrained young people only as a last resort to keep the young person or others safe. Staff used verbal de-escalation techniques prior to the use of physical restraint to ensure the safety of a young person.

Staff participated in the provider's restrictive interventions reduction. Intervention techniques used by the service met the requirements of the restraint reductions network training standards (RRN).

Staff followed National Institute for Health and Care Excellence guidance when using rapid tranquilisation. They understood the Mental Capacity Act definition of restraint and worked within it. We saw that the use of rapid tranquilisation was rare and the service used an in house devised audit tool to ensure its safe use and safety of the child or young person after administration.

When a child or young person was placed in seclusion, staff kept clear records. There were 10 recorded incidents of seclusion within the past 12 months.

Safeguarding

Staff understood how to protect young people from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it. The provider had a named nurse and doctor for child safeguarding and the teams had a safeguarding lead.

Staff received training on how to recognise and report abuse, appropriate for their role and kept up-to-date with their safeguarding training. The ward had a social worker and a safeguarding lead who maintained up to date safeguarding records and liaised with local authority safeguarding teams when needed. Staff also received specific training related to domestic abuse, suicide prevention and Prevent. Prevent is a multi-agency programme aimed to stop terrorism by radicalisation in the UK.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff discussed safeguarding concerns in staff team meetings and actions were taken forward as required.

Staff access to essential information

Staff had easy access to clinical information and it was easy for them to maintain high quality clinical records – whether paper-based or electronic.

Young people's notes were comprehensive and all staff could access them easily. When young people transferred to a new team, there were no delays in staff accessing their records. Records were stored securely and staff had individual log in details to maintain confidentiality. Staff also kept paper copies of young people's records on the ward, such as the folder used to store Section 17 leave documentation.

Medicines management

The service had systems and processes to prescribe, administer, order and record medicines safely. However, controlled drugs were not stored in a cupboard that met the legislative requirements. Emergency 'grab bags' did not have the tamper proof tag evidence but it was clear they had not been tampered with.

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines. The trust had introduced an electronic prescribing and medicines administration system (EPMA) since the last inspection. The system had improved the way that children and young people's medicines were managed. One EPMA system was used in all hospital services in Cornwall. This had improved the accuracy, availability and security of medicines prescribing and administration throughout the county.

Medicines advice was available from a specialist clinical pharmacist. The ward was also supported by a pharmacy technician and technical officer.

Staff could order medicines needed for young people admitted to Sowenna through a pharmacy order portal. This allowed for quick delivery from the acute hospital trust. Where specialist medicines were not stocked, prescribers could write prescriptions to be dispensed in the community.

Staff reviewed young people's medicines regularly and provided specific advice to young people and carers about their medicines. Medicines were reviewed daily by the pharmacist, either in person or remotely via EPMA.

The pharmacist took part in the weekly multi-disciplinary team meeting and rapid review. Information about medicines was available in a range of formats, for example large print, easy read, very easy read and in different languages.

The pharmacist held a regular 'ask the pharmacist' drop-in session where young people could ask for advice or raise concerns about their medicines. We saw an example where one young person had raised concerns about weight gain that had led to a change in their prescribed medicine.

Staff stored and managed all stock and young people's own medicines, and prescribing documents in line with the provider's policy. Access to medicines was restricted to authorised staff. Room and fridge temperatures were monitored, recorded and in range.

However, emergency medicines and controlled drugs were not stored in line with the provider's policy or legislation. Controlled drugs were stored securely but the controlled drug cupboard did not meet the legislative requirements. The controlled drugs cabinet was in the middle of the clinical area and not double locked at the time of the inspection. Service leads were aware of this and had raised this through the risk register for maintenance. Medicines storage cupboards did not allow for suitable separation of preparations and had been identified for replacement. Medical 'grab bags' for use in an emergency were stored within a locked area. The trust's policy stated that all emergency medicines must be sealed using a numbered plastic tamper tag. There was no tag in place on the 'grab bags' we reviewed but it was evident that they had not been tampered with.

Prescription stationery was stored securely and the use was tracked to monitor use.

Staff followed current national practice to check children and young people had the correct medicines. We looked at electronic medicines records for seven young people. All had medicines reconciliation completed from multiple sources of information.

The service had systems to ensure staff knew about safety alerts and incidents, so young people received their medicines safely. The trust acted rapidly to ensure children and young people were kept safe considering alerts or highlighted risks. In addition to this practice, the trust proactively used electronic systems to complete internal audits of prescribing so that actions could be taken quickly to advance practice and support ongoing learning.

Decision making processes were in place to ensure young people's behaviour was not controlled by excessive and inappropriate use of medicines. The service had completed an audit of rapid tranquillisation (intramuscular injections of medicines to quickly sedate a person who may be at risk of harm to themselves or others). The audit asked eight questions of each incident of rapid tranquilisation, this showed strengths and weaknesses to specific practices. Action plans were put in place to address identified shortfalls in practice and processes.

Staff monitored young people's physical health to make sure they were not experiencing adverse effects from prescribed medicines. However, daily monitoring of blood pressure, pulse and temperature was not recorded for one young person who had recently commenced high dose anti-psychotic treatment. When asked, a nurse told us the monitoring had not taken place.

Track record on safety

Reporting incidents and learning from when things go wrong.

The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave young people honest information and suitable support.

Staff knew what incidents to report and how to report them in line with trust policy. Staff we spoke to gave examples of a range of incidents including near misses that would be reported and how this would be undertaken on the online risk management system and reviewed by managers.

Child and adolescent mental health wards

Staff understood the duty of candour. They were open and transparent and gave young people and families a full explanation if and when things went wrong. Documentation we reviewed detailed incidents, actions taken and included responses to young people, parents and carers when appropriate.

Managers investigated incidents thoroughly and supported staff after any serious incident. Documentation reviewed on-site evidenced detailed descriptions of events, assessment, recommendation and outcomes. Staff were supported after serious incidents. We reviewed an incident which had been distressing for the staff involved and the young people. We saw that ongoing support for some individuals was continuing in relation to this incident at the time of our visit.

Staff received feedback from investigation of incidents internal to the service and staff met to discuss the feedback and look at improvements to patient care. The operational lead completed monthly performance data reports that were available for staff. Summary headings included outcomes of incidents and progress of open incidents. Staff discussed learning from incidents and received feed back in team meetings.

Is the service effective?

Good

We rated effective as good.

Assessment of needs and planning of care

Staff assessed the physical and mental health of all young people on admission. They developed care plans which were reviewed regularly through multidisciplinary discussion and updated as needed.

Staff developed a care plan for each young person that met their mental and physical health needs. Young people were assessed soon after admission and regularly reviewed during their time on the ward.

Staff regularly reviewed and updated care plans when children and young people's needs changed. All care plans we reviewed had been updated as needs changed or following incidents or significant events. Staff who were allocated to a young person upon admission reviewed and updated care plans in collaboration with members of the medical team.

Care plans were not always personalised and recovery-orientated. Of the five care records we reviewed, three were not personalised, written in the first person or used language appropriate to the relevant age group. Staff did not identify goals and strengths within the records we reviewed.

Best practice in treatment and care

Staff provided a range of treatment and care for young people based on national guidance and best practice. They ensured that young people had good access to physical healthcare and supported them to live healthier lives. Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives.

Staff provided a range of care and treatment suitable for young people in the service. They had access to physical health care with access to specialists when required. Staff discussed physical health needs at multi-disciplinary meetings and updated care plans when things changed.

Staff met young people's dietary needs and assessed those needing specialist care for nutrition and hydration. They encouraged young people to live healthier lives by supporting them to take part in programmes or by giving advice. We saw evidence of smoking cessation advice being given to one young person within the service and a detailed, staged plan to assist in recovery for a young person with an eating disorder.

Staff used recognised rating scales to assess and record the severity of young people's conditions and care and treatment outcomes. The service used the revised children's anxiety and depression scale (RCADS) which assessed symptoms of depression and anxiety in children and adolescents.

Staff took part in clinical audits, benchmarking and quality improvement initiatives and used results from audits to make improvements. All nurses undertook audits of the digital records reporting system as well as audits on infection prevention control (IPC). Medical staff took part in numerous research projects including prevalence of pathogenic antibodies in psychosis (PPIP2), eating disorders genetic initiative, genetic links to anxiety and depression (GLAD) and far away from home which was a surveillance study to understand the impact of current practices for accessing inpatient care for adolescents with mental health difficulties.

The service had also recently submitted an application with supporting information for quality network for inpatient CAMHS (QNIC) accreditation.

Skilled staff to deliver care

The ward team included or had access to the full range of specialists required to meet the needs of young people on the ward. Managers made sure they had staff with the range of skills needed to provide high quality care. They supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.

The service had a full range of specialists to meet the needs of the young people. Specialists available included a consultant psychiatrist, psychologists, a family therapist, a social worker, activity co-ordinators and an occupational therapist.

Managers ensured staff had the right skills, qualifications and experience to meet the needs of the young people in their care. Staff received a full induction to the service before they started work and supported all staff through constructive, yearly appraisals of their work.

Medical staff were encouraged and supported to undertake further training in speciality areas of interest. Staff said this was motivating and a good benefit to the service after completing relevant training.

Managers supported all staff through constructive clinical supervision of their work. Staff told us they regularly discussed concerns and issues with their peers and managers. Seventy nine percent of staff had received supervision which was above the trust target of 75%.

Managers made sure staff attended regular team meetings or gave information from those they could not attend. We saw up-to-date meeting minutes were available to staff and placed within the staff room.

Managers recognised poor performance, could identify the reasons and dealt with these. Staff told us about a situation that had been identified and resolved by managers relating to poor performance.

Child and adolescent mental health wards

Multi-disciplinary and interagency team work

Staff from different disciplines worked together as a team to benefit young people. They supported each other to make sure children and young people had no gaps in their care. The ward teams had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.

Staff held regular multidisciplinary meetings to discuss young people and improve their care. They made sure they shared clear information about children and young people and any changes in their care. Documentation we reviewed showed meetings were well attended with discussions around actions from previous meeting, standing items, community meeting feedback, issues arising and actions to implement.

Ward teams had effective working relationships with other teams in the organisation and had effective working relationships with external teams and organisations. Community CAMHS teams were involved during meetings where a young person was due to be discharged from Sowenna. Effective links were also established between the local authority, which meant referrals were prompt and ensured there were no barriers with information sharing when the local authority held parental responsibility for a young person.

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

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and discharged these. Managers made sure that staff could explain young people's rights to them.

Staff made sure young people could take Section 17 leave (permission to leave the hospital) when this was agreed with the Responsible Clinician or with the Ministry of Justice. Staff discussed young people's leave arrangements in regular multi-disciplinary team (MDT) meeting minutes and rationale for decisions made as a result.

Staff received and kept up-to-date with training on the Mental Health Act and the Mental Health Act Code of Practice and could describe the Code of Practice guiding principles. Staff told us they always attempted to implement the least restrictive practices possible.

Children and young people had easy access to information about independent mental health advocacy. Communal area notice boards displayed information on advocacy services.

Staff stored copies of young people's detention papers and associated records correctly and staff could access them when needed. Staff explained to each young person their rights under the Mental Health Act and recorded it in their care notes.

Good practice in applying the Mental Capacity Act

Staff mostly supported young people to make decisions on their care for themselves. They understood the trust policy on the Mental Capacity Act 2005 applied to young people aged 16 and 17 and the principles of Gillick competence as they applied to children under 16 at the point of admission.

Staff received and kept up-to-date with training in the Mental Capacity Act and had an understanding of at least the five principles. Staff encouraged young people to make decisions for themselves, advice on treatment was made available and consent to admission and share information was documented.

Staff supported children under 16 wishing to make their own decisions under Gillick competency regulations. They knew how to apply the Mental Capacity Act to young people aged 16 to 18 and where to get information and support on this.

Child and adolescent mental health wards

Is the service caring?

Good

We rated caring as good.

Kindness, privacy, dignity, respect, compassion and support

Staff treated children and young people with compassion and kindness. They respected young people's privacy and dignity. They understood the individual needs of children and young people and supported them to understand and manage their care, treatment or condition.

Staff were respectful, and responsive when caring for children and young people and gave them help, emotional support and advice when they needed it. Young people told us they felt the nursing and support staff were kind and respectful. We observed support staff engaging with young people, playing football outside and offering other activities to engage in. We saw feedback from young people who had stayed at Sowenna that included comments around Sowenna staff being like a family during their stay. However, some young people told us they felt medical staff were sometimes negative when discussing their treatment.

Staff understood and respected the individual needs of each young person and felt that they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards young people.

Staff followed policy to keep patient information confidential.

Involvement in care

Staff involved young people and their families in care planning and risk assessment and actively sought their feedback on the quality of care provided. They ensured that children and young people had easy access to independent advocates and to child helplines.

Involvement of children and young people

Staff involved young people and gave them access to their care planning and risk assessments. Young people felt they were involved in making decisions around their medication. However, not all care plans were written in a child friendly way and some lacked personalisation.

Staff made sure young people understood their care and treatment. Staff involved children and young people in decisions about the service, when appropriate. For example, young people had been involved in designing and the decoration of the family accommodation on site. This involved mapping out a floorplan, designing artwork for the walls, budgeting for furnishings and fittings before purchasing these items with the support of staff. Young people had been on interview panels for staff recruitment but this hadn't happened for some time.

Young people could give feedback on the service and their treatment and staff supported them to do this. Community meetings were held daily for young people and a ward round form was offered to them if they were not able to verbalise their concerns. Staff supported young people to do this.

Staff made sure young people could access advocacy services, relevant posters about advocacy were displayed in communal areas. In two of the five care records we reviewed, young people had not yet seen an advocate. However, parents and carers of these young people told us they would raise concerns with staff rather than using advocacy services.

Involvement of families and carers

Staff informed and involved families and carers appropriately.

Staff supported, informed and involved families or carers and helped families to give feedback on the service. The family liaison role within the service involved communication with parents and carers. Parents and carers were given an admission information pack which included an overview of the service, staffing compliment and specialisms, visiting arrangements, care planning, leave arrangements and other aspects of what to expect for their young person residing at Sowenna.

Parents and carers were further included in a weekly support group to discuss a wide range of topics and to connect with other people with similar questions and concerns. Topics covered to inform parents and carers about what specific treatments included, medication, psychology and other topics to help parents and carers better understand how best to meet the needs of their children and young people.

Feedback from parents and carers was very positive about their child or young person's experience at Sowenna.

Is the service responsive?

Outstanding ☆

We rated responsive as outstanding.

Access and discharge

Staff planned and managed the discharge of children and young people well. They worked well with services providing aftercare and managed children and young people's move out of hospital. Services were tailored to meet the needs of individual young people and delivered in a way to ensure flexibility, choice and continuity of care.

Managers regularly reviewed the length of stay for children and young people to ensure they did not stay longer than they needed to. They worked to make sure they did not discharge children and young people before they were ready and did not discharge at night or very early in the morning. When there were rare delays in discharge, the social worker had links with the local authority social care and community CAMHS teams to keep informed of progress with potential ongoing placements.

The service had low out-of-area placements. Managers told us that a majority of the placements were from the local region and assisted in finding placements closer to home for young people when they were from out of the area. When out of area placements did occur, parents and carers were able to stay at the attached accommodation to assist with the admission process and visit regularly.

When children and young people went on leave there was always a bed available when they returned.

Discharge and transfers of care

Managers monitored the number of young people whose discharge was delayed. The reasons young people experienced a delay to their discharge was mainly because of issues sourcing appropriate community placements.

Staff carefully planned children and young people's discharge and worked with care managers and coordinators to make sure this went well. They supported children and young people when they were referred or transferred between services. At the point of admission, discharge plans were put together with the young people and community CAMHS team. Managers told us that nurses and healthcare assistants worked with parents and carers to arrange overnight leave and supported integration back into local schools where appropriate.

Facilities that promote comfort, dignity and privacy

The design, layout, and furnishings of the ward supported children and young people's treatment, privacy and dignity. Each child and young person had their own bedroom with an en-suite bathroom and could keep their personal belongings safe. There were quiet areas for privacy. The food was of good quality and children and young people could make hot drinks and snacks at any time.

Each young person had their own bedroom, which they could personalise. We saw that some young people had personalised their bedrooms with pictures, posters and other items of personal value.

Children and young people had a secure place to store personal possessions. There was a dedicated room within Sowenna that was kept locked to keep young people’s valuable and personally valuable possessions safe. There were also personal lockers available for young people to use for storage of personal items.

Staff used a full range of rooms and equipment to support treatment and care. We saw there was a fully equipped gym available for young people to access. There was access to quiet rooms where young people could meet visitors and could make phone calls in private.

The service had an outside space that children and young people could access easily. The outdoor court yard located within the centre of Sowenna was decorated, furnished appropriately and was viewable and accessible through multiple points around the unit. Other outdoor space included a sports pitch with artificial turf and sports related equipment where young people could play a variety of sports and games. This area was under cover so it could be utilised in poor weather. Other outdoor space we viewed was a large outdoor area with raised beds for plants and seating. All perimeter fencing was fully covered with digital imaging of the Cornish coast line which greatly enhanced the environment.

Children and young people could make their own hot drinks and snacks and were not dependent on staff. The service offered a variety of good quality food. However, young people told us they did not feel there was enough vegetarian or vegan options available.

Children and young people's engagement with the wider community

Staff supported children and young people with activities outside the service and made sure children and young people had access to high quality education throughout their time on the ward.

Staff made sure children and young people had access to opportunities for education and supported them. We saw the education facility was fully equipped with up-to-date modern teaching equipment and young people were offered a

wide variety of educational subjects and interests they could take part in. Staff told us a sculptor visited regularly and young people took part in sculpting their own models and pieces of art which we saw displayed in many areas around Sowenna. Young people also had access to a music room where they were in the process of making an album with the assistance of a musician who was contracted to come into the unit. Young people had access to a fully equipped kitchen area to support cooking and wet activities. During our visit, we saw young people actively engaged with various educational activities and there were enough staff to ensure they could support them to learn. All young people were able to access educational provision in line with their appropriate key stage including accredited courses including the arts award and Duke of Edinburgh. The service offered a 52 week provision of education availability, this included 20 weeks called 'enrichment' which happened outside of school term times. This meant young people were always able to take part in areas of individual interest and needs, staffed by suitably qualified community and hospital education service (CHES) staff alongside staff within Sowenna.

Staff helped children and young people to stay in contact with families and carers. There was separate accommodation attached to Sowenna which allowed families living further away to stay in and visit their child.

Meeting the needs of all people who use the service

The service met the needs of all children and young people – including those with a protected characteristic. Staff helped children and young people with communication, advocacy and cultural and spiritual support. The service had a proactive approach to understanding the needs of different groups of people and to deliver care in a way that meets these needs and promotes equality. This included young people who were in vulnerable circumstances or who had complex needs.

The service could support and make adjustments for disabled people and those with communication needs or other specific needs. There was a sensory room with a range of sensory equipment available for young people. The unit also had a treatment room that was equipped with a hoist with washing and toileting facilities to assist young people with mobility issues.

Staff made sure children and young people could access age appropriate information on treatment, local service, their rights and how to complain. We saw a range of information on notice boards related to local services and their right to complain in communal areas.

Managers made sure staff, children and young people could get help from interpreters or signers when needed and young people had access to spiritual, religious and cultural support. The service had a multi faith room and managers told us other resources such as interpreters and cultural specific food could be resourced as and when required.

Listening to and learning from concerns and complaints

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and wider service.

Children, young people, relatives and carers knew how to complain or raise concerns. The service clearly displayed information about how to raise a concern in communal areas.

Staff understood the policy on complaints and knew how to handle them. Managers investigated complaints and identified themes. Managers included complaints, concerns and compliments on completed monthly reports that were displayed for staff to view in the staff room. Feedback to complaints was discussed in operational management group meetings and cascaded to other team meetings for all staff.

Child and adolescent mental health wards

Is the service well-led?

Good

We rated well-led as good.

Leadership

Leaders had the skills, knowledge and experience to perform their roles. They had a good understanding of the services they managed and were visible in the service and approachable for young people, families and staff.

Most staff members felt supported and spoke positively about support they had received. Managers knew the service well and were able to discuss all operational processes and arrangements for the young people and staff. A recent staff survey showed 70% agreed or strongly agreed their line manager led them well. We saw the weekly session timetable for the parent support group included a range of leaders that were available to parents and carers. We observed good levels of interaction between management and staff who worked with the young people.

Vision and strategy

Staff knew and understood the provider's vision and values and how they were applied to the work of their team.

Staff were aware of the values of the organisation and worked within them. Staff were passionate about achieving the best outcomes for young people and utilised all specialisms available within the service. Staff told us they were never asked to work outside of their comfort zone. A recent staff survey showed 80% agreed or strongly agreed to the statement 'I understand how my role contributes to the wider vision of my team and the trust'. However, recent survey results showed 40% agreed or strongly agreed trust managers communicated clearly with staff about what they were trying to achieve.

Culture

Staff felt respected, supported and valued. They said the trust provided opportunities for development and career progression. They could raise any concerns without fear.

Staff felt they could raise concerns without fear and they were given opportunities to undertake further training and supported to progress with their careers. A recent staff survey showed 90% felt supported to develop new skills. Managers told us they had an open-door policy and all staff grades were welcomed into multidisciplinary team (MDT) discussions. Staff told us there was a healthy level of disagreement in the MDT meaning the decision-making process was not driven by any one person.

Governance

Our findings from the other key questions demonstrated that governance processes operated effectively at team level and that performance and risk were managed well.

Managers were able to demonstrate a good understanding of the service and what processes and specialisms were required in all areas of the care provided. Multidisciplinary and 'huddle' meetings were held regularly and well attended

by a range of professionals and clinicians. Staff discussed and evidenced issues and risks and agreed any actions. Team handover minutes were detailed and covered a range of information related to young people's care. We saw core staffing numbers did not drop below proposed staffing levels and managers ensured additional staff were sourced to provide enhanced staffing levels when observation and risk levels were elevated.

Management of risk, issues and performance

Teams had access to the information they needed to provide safe and effective care and used that information to good effect.

Staff had access to the information they needed to provide safe and effective care and used that information to good effect. The trust had ensured that staff had log-in details to access electronic care records. Staff also used information boards within the ward office to display and update information on young people's needs and arrangements.

Managers had systems and dashboards in place to support them in their role. We saw that managers had oversight of areas that included supervision, training and the risk register which all staff could add to.

Information management

Staff had access to sufficient equipment and information technology in order to do their work. The secure record keeping system was easily available to staff to update patient care records and to review when needed.

Learning, continuous improvement and innovation

The service took part in national quality improvement projects. Some national quality improvement projects included integrating smoking cessation treatment into IAPT care, the psychological impact of COVID-19 and the identification and treatment of PTSD in young people.

Specialist community mental health services for children and young people

Requires Improvement ↑

Is the service safe?

Inadequate →←

Our rating of safe stayed the same. We rated it as inadequate.

Safe and clean environments

Three out of six of the clinical premises where children and young people received care were safe, clean, well equipped, well furnished, well maintained and fit for purpose.

Staff in those sites did not complete and regularly update thorough risk assessments of all areas and did not remove or reduce risks they identified.

Three out of six of the localities had completed an environmental risk assessment. Staff did not complete ligature risk assessments at any of the locality sites where young people were seen. Staff told us that young people were never left unattended in a treatment room and if a young person used the toilet, staff waited outside. However, at Penwith, staff could not open the toilet door from the outside in case of emergency.

At Penwith, staff had not removed obvious ligature points in clinical areas. There were screws loose in the walls, wardrobes with fixed bars and fixed window blind cords in most of the windows. Entrances to corridors were secured with keypads that were difficult to unlock and created a potential risk as they could not be opened quickly. There were no fire extinguishers in two of the clinical rooms. There was a fire escape in the grounds at Penwith that led onto a roof and had not been cordoned off. This had been escalated to the estates team but no action taken to make it safe.

All interview rooms had alarms and staff available to respond.

Not all clinic rooms had the necessary equipment for children and young people to have thorough physical examinations. Weighing scales and height measurers were left out in corridors. At Penwith, we saw young people being weighed and measured in corridors and not in the clinical room which could compromise their privacy and dignity.

Not all areas were well maintained, well furnished and fit for purpose. The furniture at Penwith was threadbare and needed replacing. Some furniture was not compliant with fire regulations. Some furniture such as wardrobes with fixed ligature points, were not required in the room. Some clinical rooms were being used for storage, which for example, meant an observation room linked to a family therapy room could not be used. There was visible mould in some clinical rooms and a smashed window in one room.

There was a lack of clinical space for staff and young people to use at Carrick. The rooms were bleak, stuffy and three out of the five clinical rooms had no windows.

The eating disorders team had no designated space to see young people. This made it difficult, on a daily basis, for the team to organise suitable family therapy appointments as they did not know ahead of the appointment what space would be available for them. Room bookings were often cancelled by other teams who took priority.

Specialist community mental health services for children and young people

Young people at Caradon said they found the clinic rooms uncomfortable, the lights too bright and were often distracted by the outside noise.

Staff made sure cleaning records were up-to-date and the premises were clean. Staff were responsible for wiping down high touch areas of rooms used for appointments or assessments after session use.

Staff always followed infection control guidelines, including handwashing.

Staff did not always make sure equipment was well maintained, clean and in working order. At Penwith, staff had removed fire extinguishers from clinical rooms so they were not used as a weapon but had not replaced them. The scales in North Cornwall were out of date for calibration.

Safe staffing

The service did not have enough staff, who knew the children and young people to keep them safe from avoidable harm. However, staff had received appropriate training to enable them to which meet the needs of the children and young people. The number of children and young people on the caseload of the teams, and of individual members of staff, was not too high to prevent staff from giving each patient the time they needed.

Nursing staff

The service did not have enough nursing and support staff to keep children and young people safe. All localities carried staff vacancies which impacted on the service's ability to deliver treatment to young people in a timely way. The trust were struggling to recruit into vacant posts. Some vacant posts were not backfilled. Some staff said they did not have enough time to fully complete care records which should have been updated to reflect current risks.

Managers made arrangements to cover staff sickness and absence. Absence was covered within the teams and team managers stepped in to undertake clinical duties when required.

Managers limited their use of bank and agency staff and requested staff familiar with the service.

Managers made sure all bank and agency staff had a full induction and understood the service before starting their shift.

The service had high turnover rates. There was a high turnover of clinical associate psychologists within most teams. Staff reported a lack of career progression and development within these roles.

Managers supported staff who needed time off for ill health. Some staff had been absent from work due to Covid and these people were supported to work from home or come back on a phased return to work.

Sickness levels were high due to the impact of Covid. Managers monitored sickness levels every month.

Teams comprised of staff from other budgets into their rotas. This meant they were not able to plan their rotas effectively as they could not control when these staff were able to work in their locality. When some staff left the locality service, their budget left with them; for example, clinical associate psychologists came out of a separate budget. Issues with managing the staffing budget showed a disparity between regions where managers were not able to recruit into posts which they could not authorise.

Specialist community mental health services for children and young people

The number and grade of staff did not match the provider's staffing plan. There were not enough skilled staff to provide the therapies required for young people using the service.

Medical staff

The service did not have enough consultant psychiatrists within children's services to deliver a safe and effective service. Diagnosis and treatment were delayed which resulted in increased mental health issues in young people.

Managers could use locums when they needed additional support or to cover staff sickness or absence.

The service could not get support from a psychiatrist quickly when they needed to. There was no out of hours CAMHS consultant psychiatrist cover other than from the inpatient unit. This consultant was not commissioned to respond to community emergencies.

Mandatory training

Staff had completed and kept up to date with their mandatory training. Staff completed the trust's cohort targeted training requirements for the role. All sites had good levels of training compliance.

The mandatory training programme was comprehensive and met the needs of children and young people and staff.

Staff received an email when their mandatory training was due to be refreshed. Managers supported staff to have time off on the rota to complete their training.

Assessing and managing risk to children and young people and staff

Staff assessed and managed risks to children and young people and themselves well. Staff worked with children and young people and their families and carers to develop safety plans. Staff followed good personal safety protocols.

However, they could not always respond promptly to a sudden deterioration in a patient's health if they were still waiting for an assessment. Staff did not monitor children and young people on the external waiting list to detect and respond to increases in level of risk.

Assessment of patient risk

Staff completed risk assessments for each patient on admission / arrival, using a recognised tool, but did not always update this information, including after any incident. The CAMHS access team received self referrals, referrals from parents, schools or GPs. Referrals into the service were processed by band six clinical staff, then risk assessed, rated and either signposted out to the relevant service or were referred for a CAMHS assessment. Once the referral was received by CAMHS, the young person was risk assessed and graded according to the level of risk identified, within one week of the referral being received. If high risk, the access team requested an urgent assessment with the locality team. If there was not one soon enough, the access team contacted the intensive support team. The intensive support team began the initial work with the young person to make them safe then began the transfer over to the locality team who assessed the young person. Assessments were carried out in pairs. Staff in the mid and west teams were carrying out between four to eight assessment clinics per week including Saturday clinics. However, staff in the east only had capacity to carry out two assessment clinics per week. This added to the delay in young people being seen by staff in this team.

Staff completed a safety plan which formed the initial risk assessment in their assessment. This was formed with the young person and their family. A safety information sheet was sent out to young people and their parents, and sometimes to the school or college.

Staff included young people and their families in the completion of a risk assessment. However, in North Cornwall, staff did not routinely update current risks into the risk summary, which meant other practitioners were not aware of these risks when they viewed it.

Staff used a recognised risk assessment tool. Staff reviewed historical and dynamic risk plus risk protective factors. Staff completed a 'I Cared and Shared' document for a suicide risk assessment.

Staff did not recognise when to develop and use crisis plans and advanced decisions according to patient need. Although staff created safety plans when first referred into the service, staff did not routinely complete and document crisis plans for young people. We only saw crisis plans for those who scored as high risk.

Management of patient risk

Staff created alerts for each young person on the shared electronic database. Staff used the ‘situation background assessment recommendation decision’ (SBARD) process for alerting clinicians to assess young people who had deteriorated. Staff also discussed any sudden deterioration in young people's health in caseload supervision. Staff discussed all outcome measures and changes in regular multi-disciplinary meetings and clinical team meetings.

Staff informed families and young people about the crisis line in the event of them requiring support suddenly. Staff involved the intensive support team (IST) to support young people where the risk was high. They carried out home visits and school visits and could increase the level of support in line with the young person's presentation.

Staff did not always continually monitor children and young people on waiting lists for changes in their level of risk and respond when risk increased. When young people were referred into the service, they were put on an external waiting list whilst they waited for an assessment. Although there was evidence of some low level treatment being offered by the voluntary sector for these children whilst they waited, no-one from the CAMHS team routinely monitored these children. Staff gave the referrer direction on how they could contact the early help hub to escalate any new concerns or change in presentation.

Staff at all locations undertook welfare calls for young people on the internal waiting list where young people had been assessed and were waiting for treatment. Staff noted the level of risk for each young person and the frequency of welfare calls.

Staff reviewed their caseloads during monthly supervision and weekly MDT meetings. Staff discussed each case during these meetings and together identified and reviewed the appropriate care pathway. Caseloads were weighted appropriately. Caseload weighting depended on how often the care co-ordinator saw the patient. Managers had created a measure to weight caseloads. This was recorded on the caseload supervision tool.

Managers were not supposed to hold a caseload but young people were assigned to managers on the shared electronic database when staff left. The electronic record system did not allow children to be unallocated

Specialist community mental health services for children and young people

Staff followed clear personal safety protocols, including for lone working. Staff were clear about what to do when lone working and understood the trust's lone working policy. There were 'in and out' boards in most localities which indicated when staff were on site or out on a visit. Staff had access to a lone working app on their phones.

Safeguarding

Staff understood how to protect children and young people from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it. The provider had a named nurse and doctor for child safeguarding and the teams had a safeguarding lead.

Staff received training on how to recognise and report abuse, appropriate for their role. There was a safeguarding lead and named nurse for safeguarding within the teams. The safeguarding lead provided safeguarding supervision every six weeks during multidisciplinary team meetings.

Staff kept up to date with their safeguarding training. All locality teams were up to date with their safeguarding training.

Staff could give examples of how to protect children and young people from harassment and discrimination, including those with protected characteristics under the Equality Act. Staff completed mandatory diversity and inclusion training. Staff had an awareness of economic struggles from completing home visits and school visits to assess and identify concerns and risks. Staff offered a flexible approach taking into account social inequalities.

Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them. Staff identified children at risk via the shared electronic database which highlighted alerts on the system.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff had developed good working links with other agencies when making safeguarding referrals to the local authority and the multi-agency referral unit (MARU) when staff identified concerns.

Staff access to essential information

Staff kept detailed records of children and young people's care and treatment. Records were clear, up-to-date and easily available to all staff providing care.

Patient notes were comprehensive and all staff could access them easily. Staff had access to work laptops and mobile phones for hybrid or home working. However, internet access was poor in Caradon.

When children and young people transferred to a new team, there were no delays in staff accessing their records.

Records were stored securely.

Medicines management

The service used systems and processes to safely prescribe, administer, record and store medicines. Staff regularly reviewed the effects of medications on each patient's mental and physical health.

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines.

Medical staff used paper prescribing. Regular or on-going prescriptions were generally administered or managed by the patient's GP. Medical staff prescribed, monitored and reviewed medication. The medical secretary re-issued prescriptions for repeat prescriptions and this was held on a monthly spreadsheet.

Medical staff prescribed medication and sent a letter to the GP with requirements regarding potential side effects and physical health monitoring. If there were any concerns, the GP sent a letter to the medical staff to inform of any issues which prompted a medical review if appropriate.

Staff reviewed children and young people's medicines regularly and provided specific advice to children and young people and carers about their medicines. Medical staff discussed medication options with young people and parents and gave them time to make an informed choice. The trust had recently implemented a system that allowed primary care physicians to contact their locality CAMHS psychiatrist for medication prescribing advice.

However, it was not always clear when medical reviews were due or how frequently they were supposed to happen.

Staff stored and managed medicines and prescribing documents in line with the provider's policy. Staff stored prescriptions in a locked safe in each locality.

Staff followed current national practice to check children and young people had the correct medicines. Medical staff completed medicines reconciliation which followed GP shared guidelines. Young people stayed under the care of the service consultant and were reviewed every four weeks until they stabilised. Following a successful trial of medication, the GP took over prescribing and the consultant reviewed the young person every six months unless needed before. The young person's care coordinator also reviewed them every six months.

Staff offered talking therapies in preference to long term medication. Staff discussed psychological interventions and re-formulation in multi-disciplinary (MDT) meetings especially if medication was not helping.

The service had systems to ensure staff knew about safety alerts and incidents, so children and young people received their medicines safely.

Decision making processes were in place to ensure people's behaviour was not controlled by excessive and inappropriate use of medicines.

Staff reviewed the effects of each patient's medication on their physical health according to NICE guidance. Medical staff reviewed the effect of medication on young people regularly. Medical staff monitored physical health in terms of height, weight, blood pressure and pulse. GPs monitored results from blood tests and electrocardiogram (ECGs).

Medical staff offered treatment before medicine was offered to a young person. Historical information was taken into account. During the initial assessment symptoms were discussed with the young person and their family then medication was discussed. Medical staff could prescribe medication after the initial assessment but they also had the option of a second appointment so they could take information away with them to consider choice.

Track record on safety

The service had a good track record on safety.

Reporting incidents and learning from when things go wrong

Specialist community mental health services for children and young people

The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents but some teams did not share lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave children and young people honest information and suitable support.

Staff knew what incidents to report and how to report them. Staff reported incidents onto a shared electronic database which everyone had access to. Staff incident reported when issues such as a lack of available clinical space impacted on the welfare of young people using the service.

Staff did not always raise concerns and report incidents and near misses in line with trust policy. Staff in the eating disorders team said they did not incident report their issues with access to clinical space anymore because it had gone unresolved for so long.

Staff reported serious incidents clearly and in line with trust policy.

Staff understood the duty of candour. They were open and transparent and gave children and young people and families a full explanation if and when things went wrong.

Managers debriefed and supported staff after any serious incident. Staff told us that the debriefs following serious incidents they received were supportive and helpful.

Managers investigated incidents thoroughly. Children, young people and their families were involved in these investigations. When staff reported an incident, an email was automatically generated to their manager to alert them. Managers reviewed the incident reporting system once a week. Managers then provided feedback to staff once the incident had been reviewed.

Staff received feedback from investigation of incidents, both internal and external to the service. Staff felt well informed about the outcome of incidents.

Staff did not always meet to discuss the feedback and look at improvements to patient care. Teams in Caradon and Carrick had stood down business meetings where learning from incidents and complaints were discussed as a group.

There was evidence that changes had been made as a result of feedback. Recent serious incidents had led to a re-bolstering of child at risk alert (CARA) reporting. Police reported every incident where a young person was involved with social care. This was then directed to the allocated care coordinator for review. It led to staff reassessing all risk and safety plans. Staff who were the initial responders to these serious incidents received counselling and support from the trust to return to work.

Is the service effective?

Requires Improvement 

Our rating of effective stayed the same. We rated it as requires improvement.

Assessment of needs and planning of care

Specialist community mental health services for children and young people

Staff assessed the mental health needs of all children and young people. They worked with children and young people and families and carers to develop individual care plans but did not always update them as needed. Care plans reflected the assessed needs, were personalised, holistic and recovery oriented.

Staff completed a comprehensive mental health assessment of each patient.

Staff made sure that children and young people had a full physical health assessment and knew about any physical health problems. GPs carried out physical examinations for young people seen by the service. Psychiatrists within the teams measured blood pressure and weight for prescribing medication. Staff in the eating disorders team worked with a local authority team to continually monitor the physical health of these young people.

Staff developed a comprehensive care plan for each patient that met their mental and physical health needs. Staff did not always regularly review and update care plans when children and young people's needs changed. Initial care plans were in place for all records we looked at. However, not all were up to date and not reflective of current risks or needs. Not all outcome measures were reviewed and updated.

Care plans were personalised, holistic and recovery orientated. Staff recorded the goals and activities identified to meet young people's needs and broke them down to how they would be achieved. Staff recorded the young person's voice clearly within care plans.

Best practice in treatment and care

Staff could not always provide a range of treatment and care for children and young people based on national guidance and best practice. They ensured that children and young people had good access to physical healthcare and supported them to live healthier lives. Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives.

Staff could not always provide a range of care and treatment suitable for the children and young people in the service. Therapy options included speech and language therapy, art therapy, video interaction, dialectical behaviour therapy (DBT), eye movement desensitisation and reprocessing (EMDR) therapy and play therapy. However, when a locality team did not have a appropriate member of staff in their team to provide a specific treatment, then young people living in this locality did not receive it. Not all localities had access to a family therapist. There was only two art therapists across the county. There was a lack of psychology and psychotherapy in most teams. There was no day therapy available for children with eating disorders. There was a lack of ADHD services for young people which resulted in long waits to access treatment.

Staff delivered care in line with best practice and national guidance (from relevant bodies eg NICE). Staff followed care pathways for each identified disorder which were modelled on NICE guidelines. These were seen in the CAMHS care pathway process maps. Medical staff reviewed NICE guidelines when they reviewed care pathways especially around the main diagnosis.

Staff made sure children and young people had support for their physical health needs, either from their GP or community services. Staff recorded heights and weights then further physical health observations were undertaken by the GP on request of medical staff when prescribing medication. Staff working in the locality teams did not regularly record or monitor physical health. It was not built into the initial assessment. Young people said they either had their physical health cared for in the acute hospital or their mental health treated with CAMHS.

The eating disorders team offered home remote health monitoring for those children at high risk. This method proved successful over the pandemic and the team had 63 home monitoring kits for families across the county to use. This meant that some hospital admissions were avoided as young people did not need to go into hospital to perform this function.

Staff supported children and young people to live healthier lives by supporting them to take part in programmes or giving advice. Staff regularly signposted young people and families to organisations outside of the service who supported young people to live healthier lives.

Staff used recognised rating scales to assess and record the severity of patient conditions and care and treatment outcomes. Staff used child specific outcome scales at every initial assessment which had goal-based outcomes for the young person. However, staff did not always record outcome measures in care plans.

Staff used technology to support children and young people.

Staff took part in clinical audits, benchmarking and quality improvement initiatives.

Managers used results from audits to make improvements. Managers completed caseload notes audits once a month. Any improvements were addressed with the individual staff member during supervision. Staff were given administrative time to catch up on their notes. Despite this, we saw that not all care notes were updated.

Skilled staff to deliver care

The teams did not include or have access to the full range of specialists required to meet the needs of children and young people under their care. Managers made sure that the staff they had had the range of skills needed to provide high quality care. They supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.

The service did not have access to a full range of specialists to meet the needs of the children and young people. The locality teams should have comprised of team leads, clinical leads, consultant psychiatrists, family therapists, clinical psychologists, therapists, trainees, clinical associate psychologists, administrative staff and medical secretaries. The CAMHS learning disability service, eating disorders service and autism service also fed into the community CAMHS teams and provided support for those who were referred in to use these services. However, there was a lack of psychology and psychotherapy in most teams. There was only one art therapist across the county. Not all localities had access to a family therapist. A lack of family therapists meant that young people using the eating disorders service struggled to access this therapy even though the model of care indicated it to be the most beneficial form of therapy for them. 26 young people with an eating disorder were waiting for family-based treatment following assessment.

Managers made sure that the staff they had had the right skills, qualifications and experience to meet the needs of the children and young people in their care, including bank and agency staff. Staff were encouraged to undertake further training in courses of choice and interests that add to the skills within the service.

Managers gave each new member of staff a full induction to the service before they started work.

Managers supported staff through regular, constructive appraisals of their work.

Managers supported non-medical staff through regular, constructive clinical supervision of their work. Staff received caseload supervision, clinical supervision and safeguarding supervision. Staff confirmed they received regular supervision. However, there were some issues around staff uploading their own records in a timely way, meaning supervision rates looked lower than they were. For example, supervision compliance rates were particularly low with the intensive support teams, access team and psychology teams.

Managers made sure staff attended regular team meetings or gave information from those they could not attend. Managers compiled a weekly newsletter for staff to communicate information about training opportunities, feedback from events and meetings.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Some staff had received funding for specialist training such as EMDR.

Managers recognised poor performance, could identify the reasons and dealt with these. Managers undertook audit spot checks and would add comments or update notes for the staff members for reminders or to express concern over issues found in the spot checks. However, this did not appear to be overly effective considering some care plans had not been regularly updated.

Multidisciplinary and interagency teamwork

Staff from different disciplines worked together as a team to benefit children and young people. They supported each other although children and young people still had gaps in their care. The teams had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.

Staff held regular multidisciplinary meetings to discuss children and young people and improve their care.

Staff made sure they shared clear information about children and young people and any changes in their care, including during transfer of care.

Staff had effective working relationships with other teams in the organisation. Staff demonstrated effective working relationships with other services within the trust such as the intensive support team, the access team, the eating disorders team, the learning disability team and the autism team. However, the intensive support team did not provide wrap around support for young people with eating disorders. This meant that these children often had to be admitted to a physical health ward as least restrictive mental health alternative support in the community was not available. Some professionals' meetings did not include all the teams required to make a decision regarding a young person's treatment.

Staff had effective working relationships with external teams and organisations. Staff communicated effectively with schools via the clinical associate psychologists who were based in secondary schools in the county. Staff liaised with other external professionals, such as substance misuse services, to ensure a consistent and informed approach to a young person's recovery. Staff could access educational wellbeing practitioners training with the local university. The access team worked with the voluntary sector to provide support for children who had been referred in to CAMHS and either did not meet the criteria for an assessment or were waiting for an assessment. These support agencies were able to offer mental health support, early help, group work, drop ins and low intensity cognitive behavioural therapy.

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

Specialist community mental health services for children and young people

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice.

Staff received and were consistently up to date with training on the Mental Health Act and the Mental Health Act Code of Practice and could describe the Code of Practice guiding principles.

Staff had access to support and advice on implementing the Mental Health Act and its Code of Practice.

Staff knew who their Mental Health Act administrators were and when to ask them for support.

Staff followed clear, accessible, relevant and up-to-date policies and procedures that reflected all relevant legislation and the Mental Health Act Code of Practice.

Children and young people had easy access to information about independent mental health advocacy. Leaflets were available for young people but not all staff have a clear understanding of what was available for young people.

Staff explained to each patient their rights under the Mental Health Act in a way that they could understand, repeated as necessary in accordance with the Mental Health Act Code of Practice and recorded it clearly in the patient's notes each time. Staff clearly recorded when they read young people their rights under the Mental Health Act.

For children and young people subject to a Community Treatment Order, staff completed all statutory records correctly. Staff gave children and young people with Section 117 aftercare arrangements specific considerations for their assessment and needs. Staff supporting young people under a Community Treatment Order had completed Mental Health Act capacity assessments. Commissioners, educational services and CAMHS worked together to arrange S117 aftercare.

Care plans clearly identified children and young people subject to the Mental Health Act and identified the Section 117 aftercare services they needed. Staff held Section 117 planning meetings and recorded these clearly in care plans.

Good practice in applying the Mental Capacity Act

Staff supported children and young people to make decisions on their care for themselves. They understood the trust policy on the Mental Capacity Act 2005 applied to young people aged 16 and 17 and the principles of Gillick competence as they applied to people under 16. Staff assessed and recorded consent and capacity or competence clearly for children and young people who might have impaired mental capacity or competence.

Staff received and kept up to date with training in the Mental Capacity Act and had a good understanding of at least the five principles.

There was a clear policy on the Mental Capacity Act, which staff could describe and knew how to access.

Staff knew where to get accurate advice on Mental Capacity Act.

Staff gave children and young people all possible support to make specific decisions for themselves before deciding a patient did not have the capacity to do so. Staff considered the least restrictive options for each young person. For example, staff supported a patient in the community who was being managed with 6:1 staff rather than being detained under the Mental Health Act.

Specialist community mental health services for children and young people

Staff supported other services in preparation for a DOLS application by completing a safe home environment assessment tool. This helped mitigate the risk of the transition for the provider. The assessment covered transition issues, best interest meetings, hygiene issues, consent, parental involvement, sensory sensitivity, triggers, early warning steps, how to respond and features important to the person that made them feel safe.

Staff assessed and recorded capacity to consent clearly each time a patient needed to make an important decision. Staff recorded consent to treatment and consent to share information consistently in care plans. A mini mental state examination which formed part of the initial assessment prompted a conversation around capacity and consent to treatment. Consent issues were discussed in multidisciplinary team meetings.

When staff assessed children and young people as not having capacity, they made decisions in the best interest of children and young people and considered the patient's wishes, feelings, culture and history.

Staff understood how to support children under 16 wishing to make their own decisions and applied the Gillick competency principles when necessary. Staff were knowledgeable in the Gillick competencies and spoke with understanding about using least restrictive practice. Staff demonstrated how they were able to avoid admission into hospital for young people by providing intensive support in the community.

Staff knew how to apply the Mental Capacity Act to children and young people aged 16 and 18 and where to get information and support on this.

Is the service caring?

Good 

Our rating of caring stayed the same. We rated it as good.

Kindness, privacy, dignity, respect, compassion and support

Staff treated children and young people with compassion and kindness. They understood the individual needs of children and young people and supported children and young people to understand and manage their care, treatment or condition.

Staff were discreet, respectful, and responsive when caring for children and young people.

Staff made families feel at ease and explained how assessments would be completed. Staff offered young people appropriate space in the absence of their parent if required.

Staff explained that information was kept confidential but that some information might be shared with the GP and possibly schools.

Staff took an interest in the young person and their families and were empathetic and non-judgemental.

Staff acknowledged young people's questions and behaviours with respect and positively suggested how to move forward.

Specialist community mental health services for children and young people

Staff gave children and young people help, emotional support and advice when they needed it. Staff demonstrated a high level of empathy throughout sessions with young people and families and were particularly sensitive when discussing personal issues.

Staff supported children and young people to understand and manage their own care treatment or condition. When young people became distressed, staff offered lots of reassurance and discussed various coping strategies. Staff supported young people in developing a self-soothing folder for them to use at times of crisis.

Staff directed children and young people to other services and supported them to access those services if they needed help.

Children and young people said staff treated them well and behaved kindly.

Staff understood and respected the individual needs of each patient.

Staff felt that they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards children and young people and staff. Staff told us they felt at ease raising any concerns without fear of retribution and stated that the management structure is very open and considerate.

Staff followed policy to keep patient information confidential.

Involvement in care

Staff involved children and young people in care planning and risk assessment and actively sought their feedback on the quality of care provided. They ensured that children and young people had easy access to independent advocates. Staff informed and involved families and carers appropriately.

Involvement of children and young people

Staff involved children and young people and gave them access to their care plans. Young people were involved in writing their care plan. They were also involved with creating school safety plans. During professionals' meetings, there was a strong focus on making sure the young person had been consulted and what their view was.

Staff made sure children and young people understood their care and treatment (and found ways to communicate with children and young people who had communication difficulties). The learning disabilities team created accessible easy read care plans for those who required accessible information. Staff engaged with young people in a way they could understand and were thorough in explaining the process of what was going to happen next. Young people knew what medication they were on and what it was for.

Staff did not involve children and young people in decisions about the service, when appropriate. There was a participation group in the trust but it was not well utilised across community services.

Children and young people could give feedback on the service and their treatment and staff supported them to do this.

Staff supported children and young people to make decisions on their care. However, not all care plans were written in the first person, were personalised or child friendly.

Specialist community mental health services for children and young people

Staff made sure children and young people could access advocacy services.

Involvement of families and carers

Staff supported, informed and involved families or carers. Staff carried out welfare check calls for families when there were concerns. Staff arranged appointments with parents and involved them in the assessment and the plan. Throughout treatment they were involved via parent led cognitive behavioural therapy (CBT) and family therapy. Families told us they were involved throughout with everything, felt included and were able to share their thoughts and had these listened to.

Staff helped families to give feedback on the service. Young people and families could feedback about the service they received by scanning a quick response (QR) code on discharge letters and completing a form. Some localities had linked in with voluntary sector agencies who supported young people to get involved in staff recruitment.

Staff gave carers information on how to find the carer's assessment.

Is the service responsive?

Requires Improvement 

Our rating of responsive improved. We rated it as requires improvement.

Access and waiting times

The service was not easy to access. Children and young people who did not require urgent care waited too long to start treatment. Staff followed up children and young people who missed appointments.

The service did not always ensure that children and young people, who would benefit from care from another agency, made a smooth transition. This included ensuring that transitions to adult mental health services took place without any disruption to the patient's care.

The service had clear criteria to describe which children and young people they would offer services to and offered children and young people a place on waiting lists. Staff working in the access team signposted young people and families to alternative services if they did not meet the criteria for accessing CAMHS.

The service did not always meet trust target times for seeing children and young people from referral to assessment and assessment to treatment. The team in Caradon only provided two assessment slots per week which meant their wait times were longer than they needed to be. There were not enough staff available to effectively reduce the waiting list in this team. Parents and carers described a long wait for therapy. Parents and carers described how they had to push the service to be seen.

There were 44 young people waiting for an initial assessment in Caradon and the maximum wait time was 186 days. Twenty-nine young people (66%) had exceeded the trust waiting time of 28 days for waiting. There were 39 people waiting for treatment. Twenty-seven young people (69%) were waiting past the trust's target time for treatment. The longest wait was 287 days from assessment to treatment.

Specialist community mental health services for children and young people

In the eating disorders team, 72 young people were waiting for assessment and 39 of those young people (54%) were breaching the 28 day wait time for an initial assessment. The longest wait for assessment was 178 days. There were 58 young people were waiting for treatment following assessment. The longest wait for treatment was 166 days.

However, the central, west and north Cornwall teams had put on additional Saturday assessment appointments on top of their weekly assessment clinics. Their wait times for assessment and treatment were significantly reduced as a result.

Staff saw urgent referrals quickly and non-urgent referrals within the trust target time. The acute trusts gave initial urgent support to children and young people. The intensive support team then followed up urgent referrals with a visit within seven days. The community locality teams then followed up treatment with these young people.

Staff tried to engage with people who found it difficult, or were reluctant, to seek support from mental health services. Staff offered young people a variety of settings for their appointments to help them feel more at ease and likely to engage.

Staff tried to contact people who did not attend appointments and offer support. Staff made multiple phone calls to children and young people who had missed appointments, wrote letters, considered if they were on the correct risk support pathway, received oversight from a psychologist and held a multidisciplinary team meeting before discharging the patient.

Children and young people had some flexibility and choice in the appointment times available. Staff offered young people video calls if they could not make a face to face appointment. They also offered video calls to try and reduce their wait time for a face to face appointment. However, some therapies, such as family therapy were only available on set days.

Staff worked hard to avoid cancelling appointments and when they had to, they gave children and young people clear explanations and offered new appointments as soon as possible.

Appointments ran on time and staff informed children and young people when they did not.

The service did not use systems to help them monitor waiting lists. The trust's electronic system did not recognise when young people on the external waiting list had been offered support. Although young people who had been referred in and were waiting for an assessment were visible on a locality's spreadsheet, teams did not take responsibility for these young people until they had been assessed. However, at most sites, managers had implemented strategies to lower the waiting lists with extra weekly assessments and Saturday assessment sessions which were both effective. Children and young people on the internal waiting list (following initial assessment and waiting for treatment) received welfare calls monthly and this was recognised on the system. Priority assessment slots were made available to young people who urgently required them.

Staff did not support children and young people in a timely manner when they were referred and transferred between services. Staff did not always plan the transfer of young people over to adult services in a timely way. Transferring over to an adult service was not built into the initial assessment and there were not always clear transition plans in place. Staff did not always discharge young people from the service in a timely manner. This impacted on the throughput of the service and meant wait times for treatment were longer than they needed to be.

The facilities promote comfort, dignity and privacy

Specialist community mental health services for children and young people

The design, layout, and furnishings of treatment rooms did not always support children and young people's treatment, privacy and dignity.

Not all services had a full range of rooms and equipment to support treatment and care. The clinical space in Carrick was limited and the environment there and at North Cornwall and Caradon were not child friendly. Restormel and Penwith were more child centred and had toys, games and drawing boards inside.

Not all interview rooms in the service had sound proofing to protect privacy and confidentiality.

Meeting the needs of all people who use the service

The service met the needs of all children and young people – including those with a protected characteristic. Staff helped children and young people with communication, advocacy and cultural and spiritual support.

The service could support and make adjustments for people with disabilities, communication needs or other specific needs. Staff recorded the communication needs of a young person clearly in their care plans. Staff recorded personal information about young people's preferred gender sensitively in care records.

However, the premises at Carrick were at the top of a steep hill and parking was very limited at the top.

Staff made sure children and young people could access information on treatment, local service, their rights and how to complain.

The service provided information in a variety of accessible formats so the children and young people could understand it more easily. The learning disabilities team provided easy read information for young people using the service.

Interpreters were available for staff to book if they were aware a young person spoke another language, as well as signers. There was adequate disability access for people with mobility issues in other sites than Carrick.

The service had information leaflets available in languages spoken by the children and young people and local community. There was information at both sites about how to complain. Leaflets were available to explain various treatments.

Managers made sure staff and children and young people could get hold of interpreters or signers when needed. Staff had access to interpreters but we saw delays in assessments when one was actually required to complete an assessment.

Staff created educational care plans with young people and accessed specialist education at local colleges. Staff worked creatively to support young people at work and educational placements whilst completing cognitive assessments. Some young people had one to one care packages, funded by social services and the clinical commissioning group (CCG). However, if these were lacking, staff looked for funding to outsource educational health care plans.

Listening to and learning from concerns and complaints

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, but did not always share these with the whole team and wider service.

Specialist community mental health services for children and young people

Children and young people, relatives and carers knew how to complain or raise concerns.

Staff understood the policy on complaints and knew how to handle them. Staff knew how to raise concerns via their Freedom to Speak Up Guardian.

Managers investigated complaints and identified themes. Complaints were clear in acknowledging the concerns or complaints raised and staff recorded a clear description of what happened with a full chronology and final conclusion of the situation. Staff applied duty of candor. Staff informed young people or families how to escalate a complaint further if they required. Staff protected children and young people who raised concerns or complaints from discrimination and harassment.

Staff knew how to acknowledge complaints and children and young people received feedback from managers after the investigation into their complaint.

Managers did not always share feedback from complaints with staff and learning was used to improve the service. Business meetings had been stood down in Caradon and Carrick which meant complaints were not routinely discussed in groups.

Is the service well-led?

Requires Improvement 

Our rating of well-led improved. We rated it as requires improvement.

Leaders had the skills, knowledge and experience to perform their roles. They had a good understanding of the services they managed and were visible in the service and approachable for children and young people and staff.

Staff described their managers as supportive and helpful. New team managers had leadership opportunities to support their development. Staff said the senior leadership team were accessible and that they had started to see positive change occur as a result of being listened to and their ideas being implemented.

Managers knew senior managers within the organisation and noted that some of them regularly visited the service.

Managers spoke of the accessible training opportunities, including a level five qualification in leadership and management and other masters level courses. The trust provided leadership coaching in house and 'this is us' compassionate leadership training. Staff also had the opportunity to complete coaching and mentoring training and access to the King's Fund leadership programme.

Vision and strategy

Staff knew and understood the provider’s vision and values and how they were applied to the work of their team. Staff were aware of the trust's vision and values. Managers understood the vision and values of the organisation and spoke of the improvement in the implementation of values as the culture had become a lot more empowering for staff and was a much nicer place to work. Staff attended annual team away days to focus on their vision for the service and how to improve services for young people. There were regular reviews of the team's service development business plans.

Specialist community mental health services for children and young people

Culture

Staff did not always feel respected, supported and valued. They said the trust promoted equality and diversity in daily work but did not provide opportunities for development and career progression for all posts. They could raise any concerns without fear. Staff said that working in under resourced teams impacted negatively on their morale. Staff who took calls from families on the waiting list felt frustrated at not being able to offer them a timely appointment. Administrative staff felt stressed due to fielding the phone calls from parents who were struggling to support their family member. Staff working in localities that needed refurbishment found their working environment challenging. Staff felt under pressure to meet the trust's target to assess young people within 28 days and worried about these young people as once they had assessed them, they had no-one to allocate them to.

However, all managers said they felt respected and valued in their roles. We saw that staff spoke fondly of their colleagues and their immediate management.

Managers told us they felt supported by senior managers and there was investment available for the teams to implement strategies and access a large array of training. Managers told us that most senior managers were approachable and would always listen to them.

Managers told us that relationships were good between senior staff there was no fear of challenging views and ideas.

Managers told us they felt there were no issues with raising concerns and would have no issues using the freedom to speak up process if they needed to without fearing victimisation.

In the west team, there was a strong focus on staff wellbeing. Staff had organised an optional team sea swim every week after the MDT meeting and monthly meals out together. A therapy dog often visited the office.

Governance

Our findings from the other key questions demonstrated that governance processes did not always operate effectively at team level and that performance and risk were not always managed well.

There was a disparity of access to resource across the locality teams. Teams in the west, North Cornwall and central regions performed well against targets yet the Caradon team still struggled to meet their targets.

Managers carried out spot checks on young people's case notes. However, this did not appear thorough enough from our findings at North Cornwall care records.

Managers had access to the waiting list and were able to review the young people waiting for assessment and treatment from a mix of priority and waiting time to address the progressing decline in waiting times and waiting list.

Managers were also able to view supervision, training, access and discharge numbers as well as missed appointments in an accessible format in the computer. These were used to inform the service of what areas to prioritise.

Mangers met monthly to review their dashboards for training, supervision, referral data and access to treatment.

Management of risk, issues and performance

Teams had access to the information they needed to provide safe and effective care and used that information to good effect.

Staff were able to raise risks on the risk register themselves. The risk register was reviewed regularly by the service manager.

Managers considered developments to services or efficiency changes and the impact these had on services when completing monthly audits.

The trust had developed innovative ideas around their struggles to recruit. For example, the trust were unable to recruit to a band six post so they advertised a band five developmental post which attracted more candidates.

Information management

Staff collected analysed data about outcomes and performance and engaged actively in local and national quality improvement activities.

Staff had sufficient access to IT equipment needed to undertake their roles and access to the information they needed. Teams used virtual platforms effectively to share information, create virtual huddle meetings and ask for support. However, the internet connection was poor in Caradon and staff said they preferred to work from home to avoid this in the office.

Managers engaged actively with other local health and social care providers to ensure that an integrated health and care system was commissioned and provided to meet the needs of the local population. Managers from the service participated actively in the work of the local transforming care partnership. Teams met with integrated care teams to evaluate their performance and governance and to discuss additional funding. They held monthly meetings to discuss the impact of their services within the system and fed back their findings to commissioners.

Engagement

Managers engaged actively other local health and social care providers to ensure that an integrated health and care system was commissioned and provided to meet the needs of the local population. Managers from the service participated actively in the work of the local transforming care partnership.

Managers reviewed initiatives during multi-disciplinary meetings with the staff team.

The CAMHS staff clinical board created a platform for ward to board discussions so staff could feedback on services and input into service development.

All managers felt they had enough authority to do their job. Staff said they were able to suggest certain alterations to their role that enabled them to perform better.

Managers worked closely with other local healthcare services and organisations (schools, public health, local authority, voluntary and independent sector) to ensure that there was an integrated local system that met the needs of children and young people living in the area. There were local protocols for joint working between agencies involved in the care of children and young people.

Specialist community mental health services for children and young people

Learning, continuous improvement and innovation

The eating disorders team linked in with the local university to share good practice and get involved in research. Staff from this team had recently attended an international conference.

Community-based mental health services of adults of working age

Requires Improvement ↓

Is the service safe?

Requires Improvement →←

Our rating of safe stayed the same. We rated it as requires improvement

Safe and clean environment

Not all clinical premises where patients received care were safe, well equipped, well furnished, well maintained and fit for purpose.

Staff did not complete and regularly update thorough environmental risk assessments of all areas.

We were unable to access risk assessments of the environment in some of the locations we inspected. This was due to a combination of reasons, either the building did not belong to the service provider and therefore risk assessments were not available, or the senior staff did not have access to this information.

At Alexandra House, the administration manager made this their responsibility and was able to evidence where improvements had been made to the safety of the building through maintenance work requests. There was also a plan in place to continue this until they felt the building had all repairs and modifications completed.

In the other services we inspected we were told maintenance issues had been escalated to the trust and they were awaiting works to be undertaken.

Not all areas were well maintained, well furnished and fit for purpose. The clinical premises we inspected were generally clean in areas where people who use the service had access. All reception areas were staffed throughout the working day. Not all of the bases we inspected were fit for purpose. At Bothilo House in Penzance the walls were damp, there was peeling paint and a leak in the roof. During our inspection there was building work being undertaken to remedy these issues. This work generated noise which could have an effect on individuals attending for treatment appointments.

At Bothilo House there was no dedicated staff room and the building was impacting on staff wellbeing as there was nowhere to go to have a break or store personal items . Managers told us that they had been raising this issue for a considerable amount of time and had asked senior management if the building could be repaired or if they could move to other premises but they had not heard anything further.

All interview rooms had alarms and staff available to respond in the event of an emergency. Interview rooms had either alarms or CCTV cameras. Staff also had access to personal portable alarms which they would have on their person when in interview rooms. The cameras were monitored by reception staff and administration staff. However, we saw no evidence of signage for the cameras being in use or of consent in individuals care plans.

Clinic rooms had the necessary equipment for patients to have thorough physical examinations. All clinic rooms had the required equipment for the purposes of health checks, medication administration and recording systems.

Staff always followed infection control guidelines, including handwashing. We saw evidence of hand cleaning facilities and hand sanitiser. PPE was also readily available.

Staff always made sure equipment was well maintained, clean and in working order. Any equipment used by the staff was kept in good order and reported if maintenance was required.

Safe staffing

The service did not have enough staff, who knew the patients and did not receive all the training they needed to help then meet patients needs. They were only in receipt of safeguarding and suicide prevention training due to poor staffing levels. Staff had been told to focus on these two training areas until further notice, although information provided by the trust identified that all staff had completed training in the use of the Mental Health Act and Mental Capacity Act. However at Banham House in Bodmin staff access to additional training where needed

The number of patients on the caseload of the teams, and of individual members of staff, was too high and prevented staff from giving each patient the time they needed.

Nursing staff

The service did not have enough nursing and support staff to keep patients safe. In each of the team there was a deficit in nursing staff. The only exception to this was Banham House in Bodmin, who had a full complement of staff. Staffing levels in the other community teams we inspected ranged from between 40% and 60% and had high vacancies for staff.

The teams were trying to fill vacancies and were starting to show some signs of positive recruitment. Each team had a nurse whose responsibility was to ensuring depots and clozapine were administered appropriately and safely and that robust monitoring took place.

The teams had low or no agency use. This was because the teams had either been unable to secure agency into the roles appropriately, or there was not a need as the teams had developed a safe way of working together. When they did use agency staff managers limited their use of bank and agency staff and requested staff familiar with the service and made sure all bank and agency staff had a full induction and understood the service before starting their shift.

Managers made arrangements to cover staff sickness and absence.

The services generally had high turnover of staff. In two of the teams we inspected, Kerrier and Truro, turnover rates were at 30%.

Managers supported staff who needed time off for ill health. We saw evidence of support and management of staff with ill health in the services we inspected. Staff said they felt very well supported if they needed time off due to ill health.

Sickness levels were reducing. Sickness levels had been high during the pandemic.

Managing safe levels of staffing was a key focus of the team manager's role. Managers tried to ensure their teams were covered and patients were prioritised. However, there were staffing gaps which caused additional pressure on staff. Staffing was regularly reviewed in daily huddles.

Community-based mental health services of adults of working age

Medical staff

The service had enough medical staff.

Managers could use locums when they needed additional support or to cover staff sickness or absence. All teams worked in conjunction with GP surgeries and psychiatrists were in situ within each of the teams.

Managers made sure all locum staff had a full induction and understood the service.

The service could get support from a psychiatrist quickly when they needed to. The teams had access to a psychiatrist for advice when required and this included out of hours. The home treatment team also had access to an on-call psychiatrist. When a patient requested to have a face to face appointment with a psychiatrist this could be arranged. This was based on the patient's risk rating.

Mandatory training

Staff had all been informed by senior managers that they were only to focus on the safeguarding and suicide prevention training. This had been implemented during the pandemic as it was not possible to undertake all of the mandatory training due to the staff shortages. Staff were up to date with training in the use of the Mental Health Act and Mental Capacity Act training was up to date.

Assessing and managing risk to patients and staff

Staff assessed and managed risks to patients and themselves well. They responded promptly to sudden deterioration in a patient's health. When necessary, staff worked with patients and their families and carers to develop crisis plans. Staff monitored patients on waiting lists to detect and respond to increases in level of risk. Staff followed good personal safety protocols.

The duty team risk assessed patients who were open to the service when they required additional support. Urgent referrals were managed by the Single Point of Access Team.

Due to the high levels of patients on the waiting list the allocations caseload was managed by the CMHT who offered well being calls to those waiting. The home treatment teams responded to patients who were found to be in crisis and experiencing rapid deterioration after a full assessment of the patients care needs and risks had been completed. All patients were risk rated using a traffic light red, amber, green (RAG) system to identify the risk and urgency required. Red rated patients were seen within 24 hours, amber within five days and green within 28 days. There was a system to ensure all patients on the waiting lists were contacted on a weekly basis to keep them up to date with their waiting time and also to assess if the patient's risk had changed.

Assessment of patient risk

Staff completed risk assessments for each patient on admission / arrival, using a recognised tool. Staff used a risk assessment template within the trust's electronic records system for each patient. These were individualised. Staff were aware of how to locate these.

Risk assessments were completed during a patient's first assessment and crisis plans that were triggered would immediately be treated as a red rating. Advance decisions were made during the pandemic but is not a routine question to people who use the service.

Staff could recognise when to develop and use crisis plans and advanced decisions according to patient need. Staff discussed this at multi disciplinary team (MDT) meetings or at the morning huddle via the duty desk. All patients had a crisis plan where needed.

Management of patient risk

Staff responded promptly to any sudden deterioration in a patient's health. When the level of patient need and risk rose staff took action and re-rated them using the RAG system. For example, when a patient who was rated green experienced a crisis their RAG rating was changed to red and would then be seen within 24 hours.

Patients were monitored according to any change in their presentation. During the daily huddles all patients who were deteriorating were reviewed and if appropriate were prioritised to be seen. The single point of access team triaged referrals and offered an assessment accordingly. While patients were on the waiting list, the teams had implemented an initiative where support workers would ring people on the list as a means of better communication and reassurance.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Staff received training on how to recognise and report abuse, appropriate for their role. Staff kept up to date with their safeguarding training. All locality teams were up to date with their safeguarding training. During the pandemic staff teams were informed their priority was to focus on safeguarding and suicide prevention training. Evidence showed that the staff had received and updated their training requirements.

Staff were able to identify how and when to protect people who use the services, from discrimination and harassment and had knowledge of the Equality Act.

We saw evidence of good joint working in identifying those who were more at risk, this was evident at the morning meetings and MDT meetings.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. All staff we spoke to were able to describe the process for making a safeguarding referral.

Where staffing allowed, managers were present at serious case reviews, but this would be fed back if not, and actions discussed at MDT as how to progress and make the situation safe/safer.

Staff access to essential information

Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date and easily available to all staff providing care.

Community-based mental health services of adults of working age

Patient notes were comprehensive, and all staff could access them easily. All notes we reviewed were up to date and of a good standard, informative of the person's needs, risks and current status. There were no delays in the transferring of notes should someone move to a different team, as the electronic system allowed for confidential transfer of notes.

Records were stored securely. All electronic notes were password protected and stored safely.

Medicines management

The service used systems and processes to safely prescribe, administer, record and store medicines. Staff regularly reviewed the effects of medications on each patient's mental and physical health.

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines. Medications were reviewed regularly at MDT meetings and audits of medication administration, storage and review were conducted by the community pharmacist. The service had recently implemented a new electronic prescribing system. Staff told us there were sometimes gaps in recording if a patient had been admitted to an acute hospital for treatment and received a depot medication while in hospital. The trust were in the process of updating the prescribing system.

There was a designated nurse in each team who were responsible for the administration of medication. They dealt with administration of depot injections and olanzapine monitoring and administration. Audits of records were completed by the community pharmacist.

Records we saw were up to date and correct.

Staff stored and managed medicines and prescribing documents in line with the provider's policy. All medications held in the service were safely stored.

Staff followed national practice to check patients had the correct medicines when they were admitted or they moved between services.

Staff learned from safety alerts and incidents to improve practice. Following an incident of over medicating with a depot, the team had a lessons learned meeting and learned from the incident by ensuring that preceptees did not administer medication. A depot nurse was then redeployed within the team.

There was no evidence that people who use the service had their behaviours controlled through excessive use of medications and were regularly reviewed by the Psychiatrist (and GP for those non urgent cases) at the weekly MDT meeting.

All medications were prescribed, administered and stored within the NICE guidelines.

Track record on safety

The service had a good track record on safety.

Reporting incidents and learning from when things go wrong

Community-based mental health services of adults of working age

The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

Staff knew what incidents to report and how to report them.

Staff raised concerns and reported incidents and near misses in line with trust/provider policy.

Staff reported serious incidents clearly and in line with trust policy.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong. We saw evidence of this and was given a thorough explanation by the matron and managers as to how this was conducted.

Managers debriefed and supported staff after any serious incident. Staff we spoke to confirmed there were debriefs following an incident and support was available.

Although managers would investigate incidents thoroughly, due to staffing constraints and time, these were not always fed back at monthly meetings to the staff.

Staff received feedback from investigation of incidents, both internal and external to the service. Managers attended the monthly trust wide clinical quality action group where adverse events and incidents were reviewed, and the learning shared. Managers took feedback back to their local teams.

Staff discussed incidents at the weekly MDT meetings. There was evidence that incidents had changed practice

Is the service effective?

Requires Improvement

Our rating of effective went down. We rated it as requires Improvement

Assessment of needs and planning of care

Staff assessed the mental health needs of all patients. They worked with patients and families and carers to develop individual care plans and updated them as needed. Care plans reflected the assessed needs, were personalised, holistic and recovery oriented.

Staff completed a comprehensive mental health assessment of each patient. Comprehensive assessments were completely by staff when they started work with each patient. The assessment was usually undertaken within the first month.

Physical health monitoring was undertaken by the patient's GP. Physical health checks were requested and overseen by the patient's psychiatrist. Baseline health checks had been undertaken in the records we reviewed.

Community-based mental health services of adults of working age

Staff developed a comprehensive care plan for each patient that met their mental and physical health needs.

Staff regularly reviewed and updated care plans when patients' needs changed. Care plans were updated every six months or when the needs of a patient changed.

Care plans were personalised, holistic and recovery-orientated.

Best practice in treatment and care

Staff could not always provide a range of treatment and care for patients based on national guidance and best practice. They ensured that patients had good access to physical healthcare and supported them to live healthier lives. Staff used recognised rating scales to assess and record severity and outcomes. However, there was a lack of participation in clinical audit, benchmarking and quality improvement initiatives.

Staff could not always provide a range of care and treatment suitable for the patients in the service. Due to the vacancies for clinical psychologists, some therapies had long waiting lists. To mitigate this, the service was training other staff in Cognitive Analytical Therapy (CAT) for complex emotional difficulties and Dialectic Behavioural Therapy (DBT). Staff were also assisting in the running of group therapies such as emotional coping skills. However, despite this there were still long waiting lists for therapies. Staff were running groups in the absence of clinical psychologists which added additional pressures staff members while holding a caseload.

Staff made sure patients had support for their physical health needs, either from their GP or community services.

Staff supported patients to live healthier lives by supporting them to take part in programmes or giving advice.

During the pandemic many of the appointments were via screen technology. For those unable to use or access computers, there was a text messaging service available whereby people were sent a text message to remind them of their depot appointment or medication administration. This helped support people to remember their treatments and this service had continued to be provided as patients found it useful.

Teams did not engage in regular clinical audits. The only regular audits being completed were medication audits undertaken by the pharmacists.

Skilled staff to deliver care

Not all teams included or had access to the full range of specialists required to meet the needs of patients under their care. Managers made sure that staff had the range of skills needed to provide high quality care. They supported staff with supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.

The service did not have access to a full range of specialists to meet the needs of each patient. Five of the six teams we inspected had vacancies for staff, including clinical psychologists and occupational therapists.

Managers made sure staff had the right skills, qualifications and experience to meet the needs of the patients in their care, including bank and agency staff.

Community-based mental health services of adults of working age

Managers gave each new member of staff a full induction to the service before they started work.

Most of the staff in the teams had not had appraisals since the beginning of the pandemic and these had been made a 'non priority' activity throughout the service and no records available.

Managers supported non-medical staff through regular, constructive clinical supervision of their work.

Supervision was held every four to six weeks, recorded and training requirements discussed. Staff confirmed they received regular supervision. However, there were some issues around staff uploading their own records in a timely way to the new recording system. This meant supervision rates looked lower than they were.

Managers made sure staff attended regular team meetings and gave information to those who could not attend. Minutes were distributed electronically to all staff.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Some staff told us trying to find the time to be able to undertake additional training was not always possible due to the work pressures and poor staffing levels.

Managers recognised poor performance, could identify the reasons and dealt with these.

Multidisciplinary and interagency teamwork

Multidisciplinary team meetings were held every week in each of the teams. Meetings were well attended and included doctors, social workers, nurses and employment specialists. We observed two of these and they were both thorough and needs led, with risk identified and addressed in detail. All staff members were able to input into the discussions during the meetings.

Staff made sure they shared clear information about patients and any changes in their care, including during transfer of care. Each of the teams held daily huddle meetings.

Although each of the teams were aware of the other community mental health team (CMHTs) in the service, they were very much focused on what they needed to do and how to deliver their care, this was complicated by the fact that there was such a shortage in staff and that the basic urgent needs were priority, therefore little time to understand the other teams work.

We saw that there were good links with other community service provisions, GPs, police, employment services and training for people who use the services.

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

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice.

Staff received and kept up to date with training on the Mental Health Act and the Mental Health Act Code of Practice and could describe the Code of Practice guiding principles.

Staff had access to support and advice on implementing the Mental Health Act and its Code of Practice.

Community-based mental health services of adults of working age

Staff knew who their Mental Health Act administrators were and when to ask them for support. There was a central team that supported the teams to complete Mental Health Act documentation correctly.

Staff followed clear, accessible, relevant and up-to-date policies and procedures that reflected all relevant legislation and the Mental Health Act Code of Practice.

Patients had easy access to information about independent mental health advocacy.

Staff explained to each patient their rights under the Mental Health Act in a way that they could understand, repeated as necessary and recorded it clearly in the patient's notes each time.

For patients subject to a Community Treatment Order, staff completed all statutory records correctly.

Care plans clearly identified patients subject to the Mental Health Act and identified the Section 117 aftercare services they needed.

Mental Health Act and Mental Capacity Act training was at 100% throughout the service.

Good practice in applying the Mental Capacity Act

Staff supported patients to make decisions on their care for themselves. They understood the trust policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly for patients who might have impaired mental capacity.

Staff received and kept up to date with training in the Mental Capacity Act and had a good understanding of at least the five principles.

There was a clear policy on the Mental Capacity Act, which staff could describe and knew how to access.

Staff knew where to get accurate advice on Mental Capacity Act.

Staff gave patients all possible support to make specific decisions for themselves before deciding a patient did not have the capacity to do so.

Staff assessed and recorded capacity to consent clearly each time a patient needed to make an important decision.

When staff assessed patients as not having capacity, they made decisions in the best interest of patients and considered the patient's wishes, feelings, culture and history.

The service monitored how well it followed the Mental Capacity Act and made changes to practice when necessary.

We saw no evidence of audits having been completed.

Community-based mental health services of adults of working age

Is the service caring?

Good 

Our rating of caring stayed the same. We rated it as good.

Kindness, privacy, dignity, respect, compassion and support

Staff treated patients with compassion and kindness. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.

Staff were discreet, respectful, and responsive when caring for patients. We observed positive interactions between patients and staff during the inspection.

Staff gave patients help, emotional support and advice when they needed it.

Staff supported patients to understand and manage their own care treatment or condition. Patients were provided with a copy of their care plan.

Staff directed patients to other services and supported them to access those services if they needed help.

Patients said staff treated them well and behaved kindly.

Staff understood and respected the individual needs of each patient.

Staff felt that they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients and staff.

Staff followed policy to keep patient information confidential.

Involvement in care

Staff involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided. They ensured that patients had easy access to independent advocates.

Involvement of patients

Staff involved patients and gave them access to their care plans. Where patients did not want a copy of their care plan we saw that it was noted that they had been offered, and refused a copy.

Staff made sure patients understood their care and treatment and found ways to communicate with patients who had communication difficulties. We saw evidence that people had the opportunity to discuss their care plans and were given easy read documents if required.

Staff involved patients in decisions about the service, when appropriate.

Community-based mental health services of adults of working age

Patients could give feedback on the service and their treatment and staff supported them to do this.

Staff supported patients to make advanced decisions on their care.

Staff made sure patients could access advocacy services. We saw evidence that this had been offered in care plans and that information was available in the reception areas on how to contact the advocacy services.

Staff informed and involved families and carers appropriately.

Involvement of families and carers

Staff supported, informed and involved families or carers. However, there were no carer support groups operating.

Staff helped families to give feedback on the service. This was implemented by offering the carers the opportunity to do this if they wished, and how to access the complaints procedure should they need to.

We saw no evidence of staff supporting carers in how to obtain the carers assessment.

Is the service responsive?

Requires Improvement 

Our rating of responsive went down. We rated it as requires improvement.

Access and waiting times

The service was easy to access. Its referral criteria did not exclude patients who would have benefitted from care. Staff assessed and treated patients who required urgent care promptly. However, patients who did not require urgent care waited too long to start treatment. Staff followed up patients who missed appointments.

The service had clear criteria to describe which patients they would offer services to and offered patients a place on waiting lists. New referrals were discussed by the MDT and then allocated to the staff team. Patients were followed up on a weekly basis with a phone call to maintain contact and update their current position on the waiting list. The teams were in the process of modifying their referral criteria as the teams felt it was currently too broad and led to some inappropriate referrals.

Waiting lists were long and staff caseloads were high. Most teams had a waiting list of between 100 and 168 referral. This had an impact on the times that service users were seen and received treatment and therapy.

Staff tried to engage with people who found it difficult, or were reluctant, to seek support from mental health services.

Staff tried to contact people who did not attend appointments and offer support. The teams had adopted a system whereby people who use the service were contacted by phone or text to re-arrange appointments and highlighted to the duty team if the staff felt the risk was likely or had increased.

Patients had some flexibility and choice in the appointment times available.

Staff worked hard to avoid cancelling appointments and when they had to, they gave patients clear explanations and offered new appointments as soon as possible. Unfortunately, due to the long waiting lists this proved an area of dissatisfaction and concern for people who used the service.

Appointments ran on time and staff informed patients when they did not.

The service used systems to help them monitor waiting lists/support patients. Weekly phone calls were made to ensure people who used the service were kept up to date with their current appointment status.

Staff supported patients when they were referred, transferred between services, or needed physical health care. Referrals on to GPs and close liaison with GP surgeries ensured that physical health care was accounted for and reviewed.

The facilities promote comfort, dignity and privacy

The design, layout, and furnishings of treatment rooms supported patients' treatment, privacy and dignity.

The service had a range of rooms and equipment to support treatment and care. Although at some of the team bases the building was not fit for purpose and not conducive to the mental well being of the patients who were attending appointments. The environments in three of the six teams we inspected required maintenance works to be completed for issues such as damp, poor décor and damaged walls.

Interview rooms in the service had sound proofing to protect privacy and confidentiality. They were alarmed or had cameras in them for safety/risk purposes.

Meeting the needs of all people who use the service

The service met the needs of all patients – including those with a protected characteristic. Staff helped patients with communication, advocacy and cultural and spiritual support.

The service could support and make adjustments for people with disabilities, communication needs or other specific needs. Following assessments of their needs the service would identify if there were special concessions to be made, and the staff would make every effort to do so or refer to someone in the team who could or within the local community.

Staff made sure patients could access information on treatment, local services, their rights and how to complain.

The service provided information in some accessible formats so the patients could understand more easily.

The service had no information leaflets available in languages spoken by the patients and local community. We were unable to see any of these in reception or that provision had been made for individuals.

Managers made sure staff and patients could get hold of interpreters or signers when needed.

Listening to and learning from concerns and complaints

Community-based mental health services of adults of working age

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and wider service.

Patients, relatives and carers knew how to complain or raise concerns.

Staff understood the policy on complaints and knew how to handle them.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint.

Managers investigated complaints and identified themes.

Staff protected patients who raised concerns or complaints from discrimination and harassment.

Managers shared feedback from complaints with staff and learning was used to improve the service. This was limited during the pandemic due to the varying degrees of staff shortages.

The service used compliments to learn, celebrate success and improve the quality of care. Lessons learned were recorded following discussions, this could be in the form of supervision notes or the MDT meeting minutes in relation to the whole team inclusion.

Is the service well-led?

Requires Improvement 

Our rating of well-led went down. We rated it as requires improvement.

Leadership

Leaders did not have the skills, knowledge and experience to perform their roles. They did not have a good understanding of the services they managed and were not visible in the service and approachable for staff.

Staff in all teams spoke positively about their team leaders and managers. They acknowledged their hard work in very difficult circumstances. They felt that during the pandemic they were firefighting and there was a lack of cohesive management strategy to fill the vacancies, reduce waiting lists and caseloads. Senior staff members within the service who could be instrumental in driving cohesive change were unable to fulfil their own roles as they were redeployed to manage local teams. Some senior staff members had been managing two teams whilst trying to undertake their own role. Other managers had only been in post a few months.

Staff members in all teams expressed concerns about the visibility of the more senior managers in the trust. Some staff said they had only seen senior managers virtually.

Vision and strategy

Community-based mental health services of adults of working age

Staff did not all know and understand the trust's vision and values and how they (were) applied to the work of their team.

Not all staff were able to relay the vision and strategy of the service, not only were they extremely tired and starting to burn out, they felt all their energy was being used up on trying to provide the best service possible for their service users.

They tried to provide a high standard of care and treatment for the patients, but felt they were struggling with waiting lists, heavy caseloads and the inability of the service to employ more MDT members essential to provide the required services completely.

Culture

Not all staff did not feel respected, supported and valued. They said the trust promoted equality and diversity in daily work and provided opportunities for development and career progression. They could raise any concerns without fear.

Managers across the service did not promote a positive culture that supported and valued staff, creating a sense of common purpose based on shared values. Despite efforts by managers and the matron, staff across all teams did not feel respected, supported and valued.

Staff felt stressed, worn-out, frustrated and anxious. Staff members described the work as overwhelming. They acknowledged the work of the immediate managers but the immensity of the work, high number of referrals, competing demands on their time like covering duty, managing a portfolio and running groups like the emotional coping skills group meant the job had become untenable.

Staff said the trust overall promoted equality and diversity in daily work and provided some opportunities for development and career progression.

Most staff stated they could raise any concerns without fear. All staff knew how to access the freedom to speak up policy.

Some staff reported that there had been bullying in the past and this made working difficult, but that with the recent new management this was now easing and bullying was rare.

Staff members spoke about the pride they had despite the challenges the teams were facing. Staff were proud about the quality of the work they were able to undertake despite the pressures on the service.

Governance

Our findings from the other key questions demonstrated that governance processes did not operate effectively at team level.

Management of risk, issues and performance

Teams did not have access to the information they needed to provide safe and effective care and used that information to good effect.

Community-based mental health services of adults of working age

The teams did not always have access to the information they needed to provide safe and effective care. Managers stated the did not have confidence that the data was reliable. For example, the service had changed how supervision completion was recorded on the data management system. The supervisee was expected to record sessions as complete on new the electronic system. In Truro supervisor levels were less than 20% completion but the paper copies held by the manager confirmed that supervision in the last three months was 100%.

Teams had access to the information they needed to provide safe and effective care and used that information to good effect. All risk assessments for individuals using the services were of a good standard

Information management

Staff did not collect and analysed data about outcomes and performance and engaged actively in local and national quality improvement activities.

There were no audits available to see the measurement of success or failure within the services.

There was limited evidence of outcome measures. The emotional coping group had some outcomes measures recorded but this was not routinely monitored for all outcome measures.

Engagement

Managers engaged actively other local health and social care providers to ensure that an integrated health and care system was commissioned and provided to meet the needs of the local population. Managers from the service participated actively in the work of the local transforming care partnership. Managers were working towards taking into account the restrictions under which they were working in respect of staffing and available therapy and treatment available.

All teams were working hard to develop engagement with local and national improvement activities, using local services to work alongside and provide care that was needed. For example, in Truro there were good links with ‘Stepping Stones’, a local resource centres which fed into the community mental health team.

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

Requires Improvement ↓

Is the service safe?

Inadequate ↓↓

Our rating of safe went down. We rated it as inadequate.

Safe and clean environments

Patients and staff were exposed to potential risks due to environmental issues on all four wards. Where possible, staff had taken steps to mitigate these risks and the trust had plans in place to improve each ward. Most of these plans had been delayed by external factors including the COVID-19 pandemic or had not yet started.

Safety of the ward layout

On each ward there were areas of the environment that were not safe or were unfit for purpose.

Staff could not easily observe patients in some parts of each ward. For example, on Carbis and Perran wards there were blind spots in the garden. CCTV that had been installed did not cover these spots.

Mirrors had not always been installed on wards to help staff see into blind spots. For example, on Perran ward a mirror, that had been due to be installed more than 12 months before our inspection, was still not in place.

Call alarms on wards did not always work, meaning patients and staff could face delays if calling for help. The alarm system at Bodmin hospital, where Fletcher and Harvest ward were based, were due for replacement. On Fletcher ward there had been two serious incidents where a delay or failure in the alarm system had been noted as an issue. Problems with the alarm had been added to the service risk register and prioritised by the estates team for replacement.

On Carbis ward the fixed call alarms had been recently damaged by a patient, meaning the emergency pull fixtures was missing.

On Carbis and Perran there were two bedrooms on each ward with doors that opened inwards and were not removable from their hinges. This meant that patients could potentially barricade themselves in their bedrooms. Other bedrooms doors opened outwards but were not removable. Staff mitigated this risk through individual risk assessment. On Fletcher and Harvest ward the anti-barricade doors required replacing. The trust was arranging the replacement of these doors and had found a temporary solution to the issue which meant the doors could be removed if needed.

Ligature risks were not always well managed or removed in good time.

Ligature risk assessments of the environment were not always kept up to date and did not include some ligature anchor points on the ward. During our inspection we found a potential ligature anchor point on Perran and Carbis ward that had not been identified on the wards ligature risk assessment. After we raised this the trust took swift action to rectify the issue. The ligature risk assessment for Fletcher ward was out of date. The trust had developed a new ligature risk assessment tool, but this had not yet been completed on any of the wards.

Plans for removing some environmental ligature risks had been delayed for a significant amount of time. For example, following the death of a patient in 2019, windows across Perran and Carbis ward had been due to be replaced with a new frame that presented a lower risk of ligature. Whilst most bedroom windows had been replaced there were still three bedrooms with the old-style windows. As a solution the trust had sealed the windows shut, meaning patients in these rooms could not open them. Managers were aware of these delays and monitored ligature anchor points on the wards. The trust had plans to replace known anchor points present on all wards with anti-ligature fixtures, but progress had been slow due to issues with external providers and building owners.

Some aspects of ward spaces were not always fit for purpose. On Fletcher ward there was a lack of therapeutic areas such as de-escalation rooms and quiet areas. This meant staff sometimes had to restrain patients in their bedroom. Staff had raised concerns about the impact and risks this posed to patients and themselves. As a temporary solution staff had identified an unoccupied bedroom that they could use to work with patients and de-escalate them if needed.

Outside areas of all four wards were not always secure. On Carbis, Perran and Fletcher ward, there had been incidents where patients had taken unauthorised absence by climbing over garden fences. On Fletcher ward additional CCTV had been installed to overcome this issue and some outdoor spaces had been closed to stop patients accessing these areas.

All wards complied with guidance on safely managing mixed sex accommodation. Bedrooms corridors were split into male and female only areas. Staff risk assessed potential risks for individual patients and took action to manage these risks.

Maintenance, cleanliness and infection control

Wards were not well maintained and impacted the ability of staff to safely manage the environment. The trust was aware of this issue and told us they were facing significant challenges in arranging maintenance work across all services. Some delays in completing maintenance work related to national supply chain shortages and others were linked to the trust's arrangement with the external property maintenance provider.

On Perran and Carbis ward several windows had been damaged and boarded up with wooden panels. Some windows had been damaged for several months. As well as effecting the cosmetic appearance of the ward, in some cases the use of these wooden boards had impaired staff's line of sight. For example, one patient's glass viewing pane in their bedroom door had been boarded up due to historical damage, this meant staff had to open the door at night to carry out any observations, which would potentially disturbed the patient.

On Harvest Ward the internal door locking mechanisms had been damaged overtime. This had sometimes led to areas of the ward being insecure; temporary repairs had been made where possible and areas of the wards closed off. The flooring in patients' bedrooms required replacing and, in some areas, furniture had been ripped off the wall exposing bare plaster and fittings.

Staff were able to request maintenance from the external provider and escalated issues with the environment to senior management appropriately. However, the trust had faced many delays in getting the work completed due to wider issues with the external maintenance provider and property owner.

Senior managers were aware of the issues with the environment and had taken action to manage the risks posed by the environmental issues on each ward and monitored them carefully. For example, on Harvest ward the number of beds available had been reduced to four and staffing increased to help manage the risks.

The estates team had arranged for specialist health planners to outline a plan and work schedule to upgrade the wards.

Despite issues with the maintenance and layout of wards, all wards we visited were clean. Cleaners attended the ward on a regular basis and kept up to date records. Patients we spoke to told us wards were clean.

Staff followed infection control policy, including handwashing to protect people working and using the service from contracting infectious diseases including COVID-19. Throughout the pandemic staff had responded to national guidelines and taken action to keep people safe where possible. Staff and patients had access to PPE and tested themselves for COVID-19 appropriately. Social distancing had been introduced on the wards where possible. Where COVID-19 breakouts had occurred, these had been appropriately managed.

Seclusion room

Harvest ward did not have access to a fully functioning seclusion room. This did not meet national best practice standards for psychiatric intensive care units (PICUs).

In December 2021 the door frame of the seclusion room had been damaged effecting how easily the door could close. This had made the room unsafe and posed risks to staff when trying to leave the room quickly. Following this, managers had decommissioned the room until the door could be replaced.

Whilst repairs were carried out, staff had taken steps to mitigate the risks of having no seclusion room available. This included a reduction in bed numbers on the ward to allow more space and staffing resource to focus on de-escalation of patients without the need of seclusion. Overall, the use of seclusion had decreased within the last twelve months. Staff were also able to utilise an alternative seclusion room off the ward when needed.

However, during our visit staff told us there had been a recent incident where the decommissioned seclusion room had been used to seclude a patient. This was not in line with national best practice guidance. Managers were aware of the incident and said the room had been used as a last resort due to the alternative seclusion room not being available, a thorough risk assessment had been completed and a decision had been taken to use the room to ensure the safety of the patient and others.

There was no seclusion room on site at Longreach house, where Carbis and Perran wards were based. Staff on these wards commented they did not have easy access to a designated seclusion room.

Clinic room and equipment

Clinic rooms were clean, fully equipped, secure and only accessible to authorised staff.

However, on Carbis and Perran wards we found medical ‘grab bags’ were stored securely but had not been sealed with a tamper evident tag. This was not in line with the trust’s policy which stated all emergency medicines must be sealed using a numbered plastic tamper tag. We also found some emergency medicines were out of date. This had not been identified at the last weekly stock check. As soon as we raised these issues staff took action to rectify them.

Safe staffing

Nursing staff

The service did not always have enough nursing and support staff, this affected the quality of care patients received.

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

The service had vacant posts for registered nurses and health care assistants that had been difficult to recruit to. At the time of our inspection there were 29.4 whole time equivalent (WTE) registered nursing vacancies across the wards and 14.76 WTE vacancies for health care assistants. Perran and Carbis ward had the highest vacancy rates of the four wards. The difficulties the trust faced in filling these posts reflected the regional and national staffing crisis.

Levels of sickness amongst staff were higher than the national average. Following the effects of the COVID-19 pandemic there had been an increase in the level of short-term sickness reported on wards. Senior staff also noted there had been an increase in the number of staff away from work due to anxiety and stress.

The service had increasing rates of bank and agency nurses and health care assistants. Staff said the use of agency staff had started to stabilise. However, at the time of our inspection data was only available until January 2022. Despite staffing issues there had been no shifts, in the three months prior to our inspection, that were staffed only by agency.

Managers accurately calculated and reviewed the number and grade of nurses and healthcare assistants for each shift. Where managers requested more staff to meet the specific needs of patients it was not always possible for these requests to be fulfilled.

Some patients did not have regular one to one sessions with their named nurse.

Patients' escorted leave or activities were sometimes cancelled when the service was short staffed. We received reports from staff, patients and carers, that where patients had been granted section 17 leave, this had sometimes been cancelled, reduced or delayed and had not always been recorded.

There had been a high turnover of staff since the start of the COVID-19 pandemic. The turnover rates of staff had increased on Fletcher, Carbis and Harvest wards in the six months prior to our inspection. Carbis ward had the highest turnover rate of staff of all four wards which was 33% in February 2022, the most recent data available during our visit.

The trust had taken steps to address the staffing challenges on each ward and monitored the associated risks closely. A reduction in bed numbers had been trialled on Perran and Carbis ward but had not been operationally feasible. The number of incidents relating to safe staffing on the wards had decreased since June 2021.

Managers tried to limit the impact of the use of bank and agency staff where possible. For example, they requested staff familiar with the service and had assigned agency staff to 'home wards'.

Managers made sure all bank and agency staff had an induction before starting their shift.

Staff shared key information to keep patients safe when handing over their care to others.

Medical staff

The service had enough daytime and night time medical cover. We reviewed eight incidents where duty doctors had attended the wards out of hours to provide support to patients and staff.

Additional medical cover was available when needed. Medics from the dementia and older people's mental health services were also available to support the wards.

Mandatory training

Some staff had not completed or kept up-to-date with their mandatory training.

According to data from the trust, 70% of staff on Carbis & Perran ward had completed the required mandatory training. On Harvest ward 82% of staff had completed their mandatory training and on Fletcher wards 87% of staff had completed mandatory training.

Senior managers were aware this was an area for improvement. Managers and a central learning team monitored completion of mandatory training and alerted staff when they needed to complete it. In some cases, the COVID-19 pandemic had prevented face to face training sessions from taking place.

During our inspection some staff raised concerns that agency staff had not completed the trust's training in restraint. On occasion this had meant that agency staff had been unfamiliar with the holds being used to restrain a patient. Although we found no examples where this had impacted patient safety, it did pose potential risks to staff and patients. Following our inspection, the trust confirmed all agency staff who regularly worked on wards would be required to complete elements of its mandatory training programme, including training on how to restrain patients.

Assessing and managing risk to patients and staff

Staff assessed and managed risks to patients and themselves well and followed best practice in anticipating, de-escalating and managing challenging behaviour. **Staff used restraint and seclusion only after attempts at de-escalation had failed.**

Assessment of patient risk

Staff completed risk assessments for each patient on their arrival, using a standardised tool.

Risk assessments were updated and reviewed regularly, including after any incident.

The trust had developed a specialised risk assessment and management tool titled 'I cared and shared'. This tool was used with patients to help them assess and manage individual risks of suicide and self-harming behaviour.

Management of patient risk

Most staff knew about risks faced by each patient and had acted to prevent or reduce those risks. Staff routinely assessed all patients for risk of self-harm, and barricading and took steps to mitigate the potential risks where possible. This included using enhanced observations to monitor patients where appropriate and completing daily checks on the safety of the environment.

However, on Perran and Carbis wards some newer members of staff were not always familiar with ligature anchor points on the ward. The trust had introduced a new ligature risk folder and staff had signed to say they were aware of anchor points, the high turnover of staff and usage of agency staff may have led to some gaps in the familiarity of anchor points of staff working on the ward. Staff on Harvest and Fletcher ward knew and understood ligature anchor points on the wards and took steps to mitigate potential risks. Staff on Fletcher ward had also completed simulation training on how to use ligature cutters.

Staff responded to changes in risks to, or posed by, patients. Staff on each ward attended 'RAG' meetings to discuss specific risks of individual patients and used therapeutic observations appropriately to respond to changes in individual patient risks.

Staff followed trust policies and procedures when they needed to search patients or their bedrooms to keep them safe from harm.

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

Use of restrictive interventions

Levels of restrictive interventions were relatively low across all four wards. Where restrictive practice was used it was used appropriately.

The service was committed to finding ways to reduce the use of restrictive interventions. The trust's restrictive practice policy was under review at the time of our inspection to incorporate the Mental Health Units (Use of Force) Act 2018. The trust had a Nurse Consultant who monitored the use of restraint across the trust and was in the progress of delivering new reporting tools to help ward managers evaluate the use of restraint on their ward.

Staff made every attempt to avoid using restraint by using de-escalation techniques and restrained patients only when these failed and when necessary to keep the patient or others safe. We spoke with patients and staff and reviewed records relating to use of restraint on wards. Where staff had used restraint, it had been used as a last resort. Patients were offered support following the use of restraint by staff.

The wards were in the process of introducing the use of 'safety pods' to better support patients who require episodes of restraint.

Staff understood the Mental Capacity Act definition of restraint and worked within it.

Staff followed National Institute for Health and Care Excellence (NICE) guidance when using rapid tranquilisation. The use of rapid tranquilisation had decreased over last 12 months.

When a patient was placed in seclusion, staff kept clear records and followed best practice guidelines.

Staff followed best practice, including guidance in the Mental Health Act Code of Practice, if a patient was put in long-term segregation.

Although the trust implemented national legislation in relation to smoking, some patients and advocates felt there had been occasions where staff had been overly restrictive. For example, on Fletcher ward we found one example where a patient had their leave rescinded as they had smoked whilst on escorted leave. On Harvest ward we were told that some patients had not been allowed to use specific brands of e-cigarettes as it had caused tensions with other patients.

On Carbis and Perran wards, local restrictions dictated that patients were only allowed their cigarettes back if they were taking overnight leave. On Fletcher ward patients were only allowed access to cigarettes once they had been discharged from the service completely. We found some examples where these local restrictions had not been explained to patients and cigarettes had been confiscated on their return from unescorted leave. This had encouraged patients to store cigarettes in the grounds of the hospital which was undignified and posed potential security risks.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Staff received training on how to recognise and report abuse, appropriate for their role. Staff kept up-to-date with their safeguarding training.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

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

Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them.

Staff followed clear procedures to keep children visiting the ward safe. Visiting could be facilitated in rooms located off the wards.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Each ward had a safeguarding lead and the trust had a safeguarding team who staff could go to for advice. Ward managers told us they also had good links with external safeguarding teams.

Managers took part in serious case reviews and made changes based on the outcomes.

Staff access to essential information

Most staff had access to clinical information and maintained clear clinical records.

Patient notes were comprehensive. We reviewed records relating to the care and treatment of 18 patients across all wards inspected and found records had been kept up to date.

Records were stored securely on the trust electronic record keeping system.

When patients transferred to a new team, there were no delays in staff accessing their records.

However, staff highlighted that agency staff sometimes faced delays in gaining access to the electronic record keeping system. This meant some newer agency staff did not always have access to patient records and could not update them in a timely way. The trust was aware of this issue and had taken steps to mitigate it where possible. The delay was caused by multiple factors, some of which were outside the trust's control.

Medicines management

The service used systems and processes to safely prescribe, administer and record medicines. Staff regularly reviewed the effects of medications on each patient's mental and physical health.

Staff followed systems and processes to prescribe and administer medicines safely. The trust had introduced an electronic prescribing and medicines administration system (EPMA) since the last inspection. The system had improved the way that patient's medicines were managed. One EPMA system was used in all hospital services in Cornwall. This had improved the accuracy, availability and security of medicines prescribing and administration throughout the county.

Staff reviewed patient's medicines regularly and provided specific advice to patients and carers about their medicines. Medicines were reviewed daily by the pharmacist, either in person or remotely via EPMA. The pharmacist took part in weekly multi-disciplinary team meetings on wards. The pharmacist held 1:1 sessions where patients could ask for advice or raise concerns about their medicines.

Staff stored and managed all stock and patient own medicines and prescribing documents in line with the provider's policy. Access to medicines was restricted to authorised staff. Daily checks made sure that room and fridge temperatures were in range and these were recorded. Controlled drugs were stored securely and recorded appropriately. Prescription stationery was stored securely and tracked to monitor use.

Staff followed national practice to check patients had the correct medicines when they were admitted or they moved between services. We looked at electronic medicine records for 19 patients. All had medicines reconciliation completed from multiple sources of information.

Staff learned from safety alerts and incidents to improve practice. The Trust acted rapidly to ensure patients were kept safe considering alerts or highlighted risks. In addition to this practice, the trust proactively used electronic systems to complete internal audit into prescribing so that actions could be taken quickly to advance practice and support ongoing learning.

The service ensured people's behaviour was not controlled by excessive and inappropriate use of medicines.

Staff reviewed the effects of each patient's medicines on their physical health according to NICE guidance.

Track record on safety

In the 12 months prior to our inspection staff reported there had been times where the ward had felt unsafe. This was due to a combination of factors including staffing shortages, issues with the ward environment and the acuity of individual patients. For example, there had been times where the number of self-harming incidents and incidents of patient on staff abuse had peaked.

However, staff felt that each ward was improving in terms of safety. Since December 2021 there had been an overall reduction in the number of incidents across all wards.

Reporting incidents and learning from when things go wrong

Overall, staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

Staff knew what incidents to report and how to report them.

Staff raised concerns and reported incidents and near misses in line with the trust's policy. On Carbis and Perrans ward some staff raised concerns that operational pressures sometimes limited the amount of time they had to report low level incidents. We did not find any specific examples where incidents had not been reported but raised it with the provider as a potential area for improvement.

Staff reported serious incidents clearly and in line with trust policy.

There had been no never events.

Staff understood duty of candour. They were open and transparent and gave patients and families a full explanation when things went wrong.

Managers supported staff after any serious incident. However, staff highlighted that due to gaps in psychology provisions debriefs did not always happen after every incident and were not always in depth.

Managers investigated incidents and involved patients and their families where appropriate.

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

Staff received feedback from investigations of incidents, both internal and external to the service. Weekly quality huddles took place between all wards where incidents and recent learning was shared. This included lessons learnt from incidents outside the service.

There was evidence that changes had been made as a result of feedback. Staff discussed feedback from investigations and considered how they could be used to achieve improvements in patient care. For example, following an incident on Harvest ward where the police were called to assist staff, learning was shared about how to handover information to the police more efficiently when they arrived on site.

Is the service effective?

Requires Improvement 

Our rating of effective went down. We rated it as requires improvement.

Assessment of needs and planning of care

Staff assessed the physical and mental health of all patients on admission. They developed individual care plans which were reviewed regularly through multidisciplinary discussion and updated as needed. Care plans reflected patients' assessed needs and were recovery-oriented.

Staff completed a comprehensive mental health assessment of each patient either on admission or soon after.

Patients had their physical health assessed soon after admission and regularly reviewed during their time on the ward. This was often done by the junior doctors based on site who supported the consultants based in the community.

Staff developed a care plan for each patient that met their mental and physical health needs.

Staff regularly reviewed and updated care plans when patients' needs changed.

Care plans were recovery-orientated and met the individual needs of patients. However, we found that care plans had not always been developed in a collaborative way with patients.

Best practice in treatment and care

Due to gaps in the multidisciplinary team, patients did not always have access to the full range of care and treatment options recommended by national guidance.

On Fletcher, Carbis and Perran wards there had been a long-term vacancy for a clinical psychologist which had limited the amount of therapy available to patients. For example, patients did not have easy access to cognitive behavioural therapy (CBT) and other psychological interventions that are recommended by the National Institute for Health and Care Excellence (NICE) for adult mental health inpatient services. Staff told us the absence of a psychologist had meant care and treatment provided had been based on a more medical model.

Staff did not always use recognised rating scales to assess and record the severity of patients' conditions and care and treatment outcomes. Staff said due to the lack of psychology available to the wards, scales such as Patient-reported outcome measures (PROMs) or Patient-reported experience measures (PREMs) were not used on the ward. The occupational therapy team did assess and monitor some outcomes and needs of patients, but managers recognised this was a gap.

Staff did not always have access to new technology to support patients. On Perran and Carbis the wards were awaiting the introduction of new tablets to allow them to complete care planning in a more interactive way with patients on the ward.

Operational pressures meant staff had limited time to partake in quality improvement initiatives. Ward managers were keen to undertake quality improvement projects on the ward once staffing levels had stabilised.

Staff identified patients' physical health needs and recorded them in their care plans. Staff made sure patients had access to physical health care, including specialists as required. For example, staff worked closely with pregnant patients or those who had recently given birth to ensure their pre- and post-natal health needs were met.

Staff met patients' dietary needs and assessed those needing specialist care for nutrition and hydration.

Staff helped patients live healthier lives by supporting them to take part in programmes or giving advice such as smoking cessation.

Staff completed audits to check the clinical quality of their work. Managers used results from these audits to make improvements.

Skilled staff to deliver care

Ward teams did not include the full range of specialists required to meet the needs of patients. There had been a vacant psychology post across Fletcher, Carbis and Perran for over 18 months.

The trust had taken steps to try and fill the gap in psychology provision. On Perran ward there had been some interim support provided by a psychologist who worked with the ward as part of an external research project. Harvest ward did have regular input from a psychologist which patients and staff said had greatly benefited them, particularly in managing and preventing incidents of aggression or violence. The trust had secured a new appointment who was due to start in the service in April 2022.

There was a passionate team of activity coordinators, occupational therapists and social inclusion officers that provided holistic care and support to patients on the ward. Activity coordinators were available seven days a week for all wards we visited.

Managers had been unable to complete regular, constructive appraisals with staff. This meant structured conversations about training needs and career progression did not always happen. During the pandemic, the completion of annual appraisals had been paused to prioritise delivery of care and treatment. The trust had re-instated the appraisal process in September 2021 but many of the pressures staff had faced had not eased. As a result, appraisal rates across all wards we visited were very low. On Perran, Harvest and Carbis ward less than 8 percent of staff had completed an appraisal. On Fletcher ward 25 percent of staff had completed an appraisal. The trust was aware of this issue and managers were taking steps to help staff complete appraisals.

Only 44 percent of eligible staff had received formal supervision. Ward managers and staff reported there had been a lot of informal supervision taking place on the ward and most staff we spoke to said they felt supported by their manager. However, teams had not always recorded these supervisions, as they found the new recording system difficult to use.

Some agency staff had been allocated to 'home wards' and were allocated as the named nurse for some patients on wards. The trust had stated it would support nurses fulfilling the named nurse role and provide them with access to regular supervision and additional training. However, out of the 57 eligible agency nursing staff members who had been offered supervision, only 1 had accepted supervision with the trust.

Regular team meetings did not always happen across all wards. For example, Perran ward had not had a team meeting since September 2021. Managers were aware of this issue and had plans to restart team meetings on a more regular basis. On some wards although monthly team meetings did not always take place staff did attend other meetings including handovers, safety huddles and ad-hoc reflective practice sessions. Ward managers also circulated important updates to staff via email or staff notice boards when appropriate.

Some staff had managed to complete specialist training for their role. For example, some had achieved qualification in fitness to support clients when using the onsite gym. The trust had also supported some staff to access further education to develop their nursing careers.

Managers recognised poor performance, could identify the reasons and dealt with these.

Multi-disciplinary and interagency team work

Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. The ward teams had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.

Staff held regular multidisciplinary meetings to discuss patients and improve their care.

However, patients sometimes experienced delays in having their care reviewed by their consultant at a multidisciplinary meeting. The trust used a community or 'continuity' consultant model. This meant that consultants were based in the community and allocated to patients based on where they lived in the county, rather than having a lead consultant based on the ward overseeing patients.

Although we found no incidents where this arrangement had impacted the safety of patients it had sometimes caused additional challenges for staff and patients. For example, several patients told us that they had to wait several days to see their doctor following admission to the ward. Staff explained that as each consultant only visited the ward once a week for ward round, if a patient was admitted the day after that ward round, they may have to wait until the next week to have their care reviewed with them by a consultant. If a community-based consultant was away from work some staff said it wasn't always clear who was providing cover which also caused some delays in reviewing care and treatment plans at multidisciplinary team meetings. Junior doctors were available to support the ward daily.

Staff made sure they shared clear information about patients and any changes in their care, including during handover meetings.

Ward teams had effective working relationships with other teams in the organisation.

Ward teams had effective working relationships with external teams and organisations. On Fletcher ward the team had worked closely with the local police force to improve joint working. Staff reported this had made handovers to the police more effective and had encouraged better reporting of crimes. There was also a police liaison officer working across the wards who had been jointly funded by the trust and local constabulary.

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

Staff received and kept up-to-date with training on the Mental Health Act and the Mental Health Act Code of Practice and could describe the Code of Practice guiding principles. All of the ward teams we visited had high levels of compliance with Mental Health Act training (Carbis 86%, Perran 80% , Fletcher 100%, Harvest 100%).

Staff had access to support and advice on implementing the Mental Health Act and its Code of Practice. Staff knew who their Mental Health Act administrators were and when to ask them for support. The service had clear, accessible, relevant and up-to-date policies and procedures that reflected all relevant legislation and the Mental Health Act Code of Practice.

Staff explained to each patient their rights under the Mental Health Act in a way that they could understand, repeated as necessary and recorded it clearly in the patient's notes each time.

Informal patients could leave the ward freely. However, on some wards posters informing patients of this had been removed by other patients or there were no notice boards available to display this information.

Staff stored copies of patients' detention papers and associated records correctly and staff could access them when needed. Staff requested an opinion from a Second Opinion Appointed Doctor (SOAD) when they needed to. Care plans included information about after-care services available for those patients who qualified for it under Section 117 of the Act.

Managers and staff made sure the service applied the Act correctly by completing audits and discussing the findings.

However, patients could not always take Section 17 leave (permission to leave the hospital) when this was agreed with the Responsible Clinician. Staff shortages had meant that some patients had their leave cancelled, delayed or shortened due to lack of staff on the ward available to facilitate this. When this happened, staff said this was not always recorded.

It was unclear how well patients were supported to access independent advocates. Five patients we spoke with were not aware of the independent mental health advocacy service available to them. Monthly mental health audits completed across the wards had also highlighted a small number of occasions where patients had not been referred to or had not received information about the advocacy service. This had not happened recently.

We spoke to three advocates who worked across the wards. Although they had sometimes been unable to visit the site due to COVID-19, they felt staff had been proactive in directing patients to the service and had supported them to arrange virtual meeting with patients. Advocates had attended ward rounds with patients.

Good practice in applying the Mental Capacity Act

Staff supported patients to make decisions on their care for themselves. They understood the trust policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly for patients who might have impaired mental capacity.

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

Staff received and kept up-to-date with training in the Mental Capacity Act and had a good understanding of at least the five principles.

There was a clear policy on Mental Capacity Act and deprivation of liberty safeguards, which staff knew how to access. Staff also knew where to get accurate advice on the Mental Capacity Act and deprivation of liberty safeguards.

Staff gave patients all possible support to make specific decisions for themselves before deciding a patient did not have the capacity to do so. Staff assessed and recorded capacity to consent clearly each time a patient needed to make an important decision.

When staff assessed patients as not having capacity, they made decisions in the best interest of patients and considered the patient's wishes, feelings, culture and history.

Staff made applications for a deprivation of liberty safeguards order only when necessary and monitored the progress of these applications.

Is the service caring?

Good 

Our rating of caring stayed the same. We rated it as good.

Kindness, privacy, dignity, respect, compassion and support

Staff treated patients with compassion and kindness. Staff cared about their patients and were discreet, respectful, and responsive when caring for patients. Patients said staff treated them well and felt staff always tried to provide the best care they could.

Staff gave patients help, emotional support and advice. However, staffing shortages on the wards had sometimes limited the amount of time available for staff to spend with patients.

Staff supported patients to understand and manage their own care treatment or condition. For example, information about care and treatment was available in a range of formats, for example large print, easy read, very easy read, different languages. Members of the pharmacy team spent time with individual patients answering questions on their medication.

Staff directed patients to other services and supported them to access those services if they needed help.

Staff felt that they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients. If allegations were made against individual staff members, the service took appropriate action to investigate these concerns and supported the staff and patients who were involved. In the twelve months prior to our visit, there had been six PiPoT (Persons in a position of trust) referrals made within the service. Three of the referrals had been upheld and learning from follow up investigations had been shared.

Staff followed policy to keep patient information confidential.

Staff understood and respected the individual needs of each patient. On Fletcher ward staff knew the individual dislikes and interests of patients well and used this knowledge to support patients in a person-centred way. Staff referred to each patient by name and had good knowledge and understanding of each patient.

However, the high usage of agency staff sometimes meant patients received care and treatment from people who were less familiar with their individual needs or processes on the ward. On Carbis ward we observed a patient's leave being delayed due to an agency nurse not being able to sign out the patient.

Involvement in care

Patients were not always involved in the planning of their care or risk assessments. Some patients reported they did not have easy access to independent advocates.

Involvement of patients

Staff introduced patients to the ward and the services as part of their admission. Patients were supposed to receive a welcome pack when they were admitted to the ward. On Perran and Carbis ward patients we spoke with said this did not always happen. Staff were aware of this and had apologised to patients. Staff had plans in place to improve the quality of the welcome pack and admission process.

Overall, care plans were specific to each patient, they identified their individual needs but it was not always evident that patients had been actively involved in developing them.

Four patients that we spoke to told us that staff had provided a pre-written care plan and they had not been involved in the process Staff were aware this was an issue and were looking to reimplement the 'triangle of care' (an initiative aimed at improving carer and patient involvement) and weekly care planning meetings on wards.

Patients on Fletcher and Harvest ward were involved in the care planning process. On Harvest ward care and risk management plans had been created in collaboration with patients and were person centred.

Staff made sure patients understood their care and treatment and found ways to communicate with patients who had communication difficulties.

Staff involved patients in decisions about the service, when possible. On Perran and Carbis one patient had also been selected from each ward to help choose new furniture for the ward.

Patients could give feedback on the service and their treatment and staff supported them to do this. Community meetings happened on a regular basis on all wards. Staff encouraged patients to share feedback on their experience of care and treatment and acted upon suggestions when possible. For example, following patient feedback on Perran ward, staff now joined patients at meal times. Patients and staff felt this had made meal times feel more therapeutic and allowed staff and patients to spend time with one another.

On Harvest ward patients had been involved in discussion about changes to policies and procedures in relation the introduction of the Mental Health Units (Use of Force) Act 2018. Patients had been asked what they thought about restrictive practice and what the new laws meant for them.

Staff supported patients to make advanced decisions on their care.

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

Involvement of families and carers

Staff informed and involved families and carers appropriately.

During the COVID-19 pandaemic staff had found it difficult to involve families and carers as much as they would like. Carers we spoke with said they had not been actively involved in the planning of patients' care and treatment and that ward rounds were not always easy to dial into as they changed time at short notice.

Staff recognised carer and family involvement had decreased during the pandemic, particularly when people had been unable to visit the wards. Staff had tried to involve them where possible. For example, some carers had been invited to attend ward rounds and had received updates form staff on a regular basis. On Fletcher ward we found clear examples where staff had attempted to involve carer and family members virtually. Staff were also considering introducing a welcome pack specifically designed for family and carers to help introduce them to the service more effectively.

Staff on all four wards had not collected regular feedback using the family and friends test. On Harvest ward staff said this data was too difficult to collect. On Carbis ward the staff member allocated as lead for collecting this feedback had left and the role had not been re-allocated.

Staff did not always give carers information on how to find the carer's assessment.

Families and carers did not have access to carer support groups.

Is the service responsive?

Requires Improvement 

Our rating of responsive went down. We rated it as requires improvement.

The service was responsive to patients' individual needs. However, the ward environment did not always promote patients' dignity or privacy.

Access and discharge

Staff managed beds well. Patients were not moved between wards except for their benefit. Patients did not have to stay in hospital when they were well enough to leave.

Bed management

Due to the high demand for mental health inpatient services locally and nationally, bed occupancy across all wards exceeded the trust target of 85%.

Managers regularly reviewed length of stay for patients to ensure they did not stay longer than they needed to. Ward staff, modern matrons and members of the home treatment team joined daily bed management meetings to plan discharges and admissions.

The service had low out-of-area placements. These had increased recently as the trust had started to subcontract four additional PICU beds from an independent provider outside of the county whilst Harvest bed numbers were reduced.

Patients were only moved between wards when there were clear clinical reasons, or it was in the best interest of the patient.

Discharge and transfers of care

Some patients did experience delays in their discharge. This length of delay varied between wards and was usually due to clinical reasons or a lack of suitable placement being available in the community. In the three months prior to our inspection, Fletcher ward had more patients who had experienced a delay to their discharge with a total of nine patients experiencing delays. There had been no patients who had experienced a delayed discharge from Harvest ward.

Managers monitored the number of patients whose discharge had been delayed and took action to reduce them. At the weekly 'RAG' meetings barriers to discharge were discussed for patients on every ward.

Managers and staff worked to make sure they did not discharge patients before they were ready.

When patients went on leave there was always a bed available when they returned. Staff did not move or discharge patients at night or very early in the morning.

Staff planned patients' discharge and involved the crisis and home treatment team. Social inclusion workers were present on wards and helped patients prepare for discharge. However, when there had been significant shortages in staff this work had not always been carried out. Ward staff had also noticed reduced involvement with some community mental health teams. They believed this was due to pressures these teams were also facing.

Staff supported patients when they were referred or transferred between services. Staff sometimes visited services with patients as part of their discharge planning.

The service followed national standards for transfer.

Facilities that promote comfort, dignity and privacy

The design, layout, and furnishings of the ward did not always support patients' treatment, privacy and dignity.

All four wards were in need of updating and maintenance to make them fully functional and create a more therapeutic, comfortable setting for patients.

Each patient had their own bedroom, which they could personalise, but they were not always well maintained. On Perran and Carbis ward several bedrooms had not been redecorated following the installation of new windows. Some rooms did not have anywhere for patients to hang their clothes or store their toiletries. In other bedrooms en-suite toilet doors, shower curtains and window curtains had been removed impacting patient privacy. Although the removal of furniture in bedrooms was sometimes in response to individual patient risks this was not always assessed, and some patients had furniture missing with no clear rationale. Two patients reported they had no toilet seat in their en-suite bathrooms; the seats had been removed for repair but had not been replaced.

Patients did not always have adequate facilities to store personal possessions. On Perran and Carbis ward patients did not have access to individual lockers to store personal possessions/items, instead patients' possessions were stored in plastic laundry buckets stacked on top of each other in cupboards on the ward.

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Staff did use the full range of rooms and equipment to support treatment and care, but some facilities required updating. On Fletcher and Harvest ward the trust had clear plans to expand the facilities on the ward. For example, the kitchen on Fletcher ward was small and had not been designed for staff to use with patients easily. Patients on wards had also requested better access to more modern facilities such as smart TVs and computer games. Two computers on Perran and Carbis wards in the communal areas for patients to use no longer worked and had not been removed.

On Fletcher ward one family of a previous patient had fundraised and donated the funds to the ward to modernise one of the patient lounges. This work had started at the time of our inspection.

Space on some wards was limited. On Carbis ward both the male and female lounge was out of use due to pending repairs. On Perran ward the female lounge was used to hold ward rounds and other meetings due to lack of alternative space on the wards. This limited the amount of quiet space available to patients away from the main communal area on the ward, which was sometimes noisy.

All wards had access to rooms where patients could meet with visitors in private. During the pandemic restrictions had been placed on visitors coming onto the ward.

Patients could make phone calls in private.

Outside spaces for patients to access were not fit for purpose. On Perran and Carbis ward both garden areas had blind spots, meaning patients were only allowed to access these spaces under staff observations. There was no furniture in these gardens and the area had not been well kept or used as part of patient's recovery.

On Fletcher ward, some outdoor spaces that patients had previously been able to access had been closed off. This was due to a lack of maintenance in these areas and poor structural security which meant patients could climb over fences. However, patients still had access to one main communal garden area.

Patients could not make their own hot drinks and snacks and were dependent on staff. On Perran and Carbis ward the communal drink making facilities had been closed during COVID-19 and had not re-opened due to patient damage. Patients we spoke to said they could ask staff for a drink at any time.

Patients' engagement with the wider community

Staff supported patients with activities outside the service, such as work, education and family relationships.

Staff made sure patients had access to opportunities for education and work, and supported patients.

Staff helped patients to stay in contact with families and carers but were not pro-active in engaging with carers and families as a service.

Meeting the needs of all people who use the service

The service met the needs of all patients – including those with a protected characteristic. Staff helped patients with communication and cultural and spiritual support.

The service could support and make adjustments for disabled people and those with communication needs or other specific needs. However, on Fletcher ward ensuite bathrooms were not accessible to wheelchair users due to the height of the shower tray. There was an assisted bathroom available on the ward, but staff felt that access needed improvement.

Patients could access information on treatment, local service, their rights and how to complain. The service had access to information leaflets available in languages spoken by the patients and local community.

However, on both Perran and Carbis there were no display boards with information posters for patients to review. These boards had been removed as they had been identified as an environmental risk. Staff had tried to overcome this issue by painting a wall with black board paint and providing chalk for staff and patients to write on the wall. New anti-ligature display boards were due to be installed.

Managers made sure staff and patients could get help from interpreters or signers when needed.

The service provided food to meet the dietary and cultural needs of individual patients. Patients fed back that the food was of average quality but several patients across the ward said an increased choice in the menu would be welcomed. For example, some patients said that they would prefer to be able to choose from a menu the day before. Some vegetarian patients commented there was limited options for them.

Patients had access to spiritual, religious and cultural support. A chaplain visited the wards on a regular basis and was treated as part of the ward team. On Carbis and Perran wards, multi-faith areas were not readily available to patients due to limited space or pending maintenance works.

Listening to and learning from concerns and complaints

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and wider service.

Patients, relatives and carers knew how to complain or raise concerns. Staff supported patients to make complaints when needed, for example by helping them contact the patient advice liaison service (PALS).

The service displayed information about how to raise a concern.

Staff understood the policy on complaints and knew how to handle them.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. We reviewed the response to four patient complaints. Although there had sometimes been delays in the trust sending a full written response to patient complaints all responses were written in a clear, compassionate way and the staff apologised when needed.

Managers investigated complaints and identified themes.

Staff protected patients who raised concerns or complaints from discrimination and harassment.

Patients received feedback from managers after the investigation into their complaint.

Managers shared feedback from complaints with staff and learning was used to improve the service.

The service shared compliments with teams, when received.

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Is the service well-led?

Requires Improvement 

Our rating of well-led went down. We rated it as requires improvement.

There had been many changes and new additions to the leadership team at all levels. This had contributed to positive changes in the culture and management of the ward. However, further time was needed for the effects of some changes and improvements to embed. Some governance processes had lapsed during the COVID-19 pandemic and were in the process of being re-instated.

Leadership

There was a clear leadership structure in place. Wards were led by managers; Fletcher ward also had an allocated deputy ward manager. These managers were then supported by clinical leads, modern matrons and other senior managers.

Leaders had the skills, knowledge and experience to perform their roles but there had been and continued to be gaps in the leadership team on some wards.

On Perran ward a new manager had been appointed shortly before our inspection. On Carbis ward there had not been a ward manager in post since November 2021, a new manager had been appointed but had not yet started. The ward was being supported by senior managers including the clinical lead for the site, but staff noted the absence of a ward manager had sometimes affected the management of the service. For example, staff had not attended a team meeting for some time. Some 'lead roles' that had once been allocated to staff had not been re-allocated.

Fletcher and Harvest ward had longer-standing ward mangers that had been in place for some time. Staff on the ward felt they had provided clear leadership and were driving improvements on the wards.

Leaders had a good understanding of the services they managed and the current challenges they faced. Managers could clearly explain areas for improvement and what plans had been put in place to address them.

Leaders were visible in the service and approachable for patients and staff. Many staff highlighted senior leaders were more visible on the wards. Some senior leaders had worked a shift as a health care assistant on the wards, this had been well received by staff on the wards. Modern matrons also attended the wards on a regular basis.

Vision and strategy

Staff knew and understood the provider's vision and values and how they applied to the work of their team.

Managers reviewed performance against the trust's quality accounts and priorities during the weekly quality huddle. For example, there was a clear four-year plan in place to fully embed a trauma informed approach to care which managers had discussed and were starting to reinstate on wards.

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Ward managers had the opportunity to contribute to discussions about the strategy for their service, especially where the service was changing. However, staff at ward level had not always been included in these conversations. On some wards team away days had been disrupted due to local COVID-19 outbreaks. Managers were keen to start engaging staff in more strategic conversations about the services they worked in.

Staff could explain plans to improve the quality of care and gave examples where the trust had allocated funding and resources to begin this work.

Culture

Staff felt respected but had experienced immense pressure during the COVID-19 pandemic. Some staff described how the impact of short staffing, the COVID-19 pandemic and acuity of individual patients had significantly affected their morale.

Staff sickness and absence had increased over the COVID-19 pandemic. There had also been increased reports of staff burnout, anxiety and stress within the last 12 months.

The trust was aware of this issue. The relatively new leadership team were making positive steps toward making staff feel more valued. For example, the trust planned to give a £500 bonus to all staff and provide an extra day of annual leave.

Staff had access to support for their own physical and emotional health needs through an occupational health service. A wellbeing hub provided staff access to resources to support their emotional health. Posters were displayed in staff rooms and toilets signposting staff to specific charities who offered support to health and care professionals. Managers supported staff who needed time off for ill health. The trust had also employed four new health and wellbeing advocates that would work across the trust.

Staff felt able to raise concerns without fear of retribution and knew how to use the freedom to speak up process. All staff knew about the role of the Freedom to Speak Up Guardian. The Freedom to Speak Up Guardian regularly visited the wards and engaged with staff. Managers had worked with staff to promote the reporting of any abusive behaviour they experienced.

Overall, teams worked well together and where there were difficulties managers dealt with them appropriately. Where concerns had been raised about the culture of a ward, senior managers had taken action to investigate and implement changes to rectify the issue. For example, on one ward senior staff completed a detailed investigation into the culture of the ward and relationships between staff members. Staff we spoke to said there had been an improvement in culture on all wards.

Staff reported that the provider promoted equality and diversity in its day to day work and as part of their career progression.

Staff were supported to develop in their career. Formal conversations about career development had not taken place during an annual appraisal but we found many examples of where staff had been supported with career progression on the wards. Managers we spoke to recognised the importance and value in developing their own staff by offering training and progression.

The provider recognised staff success within the service.

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Governance

Some governance processes had lapsed in response to operational pressures. However, managers had good oversight of key risks and challenges faced by teams and carried out most essential checks.

There was a clear framework of what must be discussed at ward and directorate level to ensure that essential information, such as learning from incidents and complaints, was shared and discussed. Staff attended weekly quality huddles and quarterly meetings to maintain oversight of pertinent issues and developments.

Some planned meetings did not always happen. For example, regular monthly team meetings were not happening across all wards. Potentially this meant information was not always being reviewed and disseminated in good time which could impact quality on the of care delivered to patients.

Some checks completed had not identified issues we found on the wards to ensure staff acted on the results when needed. For example, some emergency medicines at Longreach House were out of date and had not been identified at the last weekly stock check. On Perran ward we also found a fire extinguisher that had been removed from the cabinet on the wall and left in an assisted bathroom. Staff were not aware of when this had happened, and daily security checks had not highlighted this as an issue.

Wards had sometimes implemented policies on smoking and the storage of cigarettes inconsistently which effected patient experience.

Staff understood the arrangements for working with other teams, both within the provider and external, to meet the needs of the patients.

Management of risk, issues and performance

Teams had access to the information they needed to provide safe and effective care and used that information to good effect.

Managers dealt with poor staff performance when needed. Staff performance issues were addressed in line with organisational policy. Ward managers were able to access support from a central human resource team when needed.

Staff maintained and had access to the risk register at ward and directorate level. Staff at ward level could escalate concerns when required. Staff concerns matched those on the risk register. However, there were several outstanding actions on the service risk register that needed updating, this was due to be completed by April 2022.

The service had specific plans for managing emergency situations for example, adverse weather and managing the COVID-19 pandemic. Staff commented the ability of the trust to implement contingency plans had improved thorough out the pandemic and changes in national guidance had been well communicated.

Staff felt the trust was willing to fund changes to improve patient care and rectify issues. For example, the trust had already spent money on improving the environment where possible and had committed further funds to improve all wards. Senior managers also ensured that funding for small improvements was available when needed. Following our visit an additional £1000 was granted to one ward to buy new equipment for ward-based activities.

Information management

Staff collected analysed data about the performance of the service. Team managers had access to information to support them with their management role. This included information on staffing and patient care.

However, staff found some IT systems difficult to use. For example, agency staff did not always have access to the trust electronic record keeping system before they worked on wards. Some staff reported significant delays in agency staff accessing the record keeping system meaning they did not always have access to essential clinical information and could not update care records easily.

In addition, the new system that had been introduced to record staff supervision had not been implemented well. Staff said they found the system difficult to use and could not always record supervisions that took place. This meant information was not always recorded in a timely, accurate way.

Staff did have access to equipment they needed to do their work.

Information governance systems included confidentiality of patient records.

Staff made notifications to external bodies as needed including the CQC. However, staff did not always have time to record information needed for national mental health data sets. Senior managers were aware of this issue and were looking to find ways to streamline the inputting of this information.

Engagement

Engagement with staff, patients and carers had been identified as an area for improvement by the trust.

Further work was needed to ensure patients and carers had consistent opportunities to give feedback on the service and were more involved in the decisions about the service where appropriate. The trust had a expert patient programme in place but wards we visited had not been involved with the programme or were not aware of it.

Senior leaders recognised patient and carer engagement was an area for improvement and had plans in place. A new listening strategy was being implemented.

Managers made improvements in response to feedback that was received from patients, carers and staff.

Staff had access to up-to-date information about the work of the provider and the services they used for example, through the intranet, bulletins and newsletters. Senior leaders had also hosted virtual engagement meetings with staff.

Staff wellbeing and engagement was a regular item on weekly quality huddle.

Learning, continuous improvement and innovation

Due to the intense pressures the service had faced, a structured approach to quality improvement had not always been implemented on the wards. Staff had not always had time to complete quality improvements projects at ward level.

However, Staff did consider opportunities for improvement and innovation. We found examples where staff had responded to problems at ward level and implemented solutions. On Carbis ward staff had trialled changes to the handover process between shifts to improve the way information was shared between staff. On Perran and Carbis ward staff had also implemented the use of essentials oils as a therapeutic option for patients to help them manage their anxiety.

Where resources were available, staff and patients had opportunities to participate in research. When appropriate patients were asked to participate in research, often this work was led by teams who were not based on the ward.

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Staff did not participate in national audits relevant to the service. Wards did not participate in national accreditations schemes endorsed by the Royal College of Psychiatry. Instead wards participated in the trust's internal accreditation scheme 'ASPIRE'. Perran, Carbis and Fletcher ward had achieved the lowest level of accreditation within the scheme and staff were keen to implement improvements to achieve a better rating when operational pressures eased.

The trust had also organised for external support from the National Association of Psychiatric Intensive Care (NAPICU) to help guide improvements to Harvest ward.