

# Livewell Southwest CIC

## Inspection report

Local Care Centre Mount Gould Hospital  
200 Mount Gould Road  
Plymouth  
Devon  
PL4 7PY  
Tel: 08451558100  
[www.livewellsouthwest.co.uk](http://www.livewellsouthwest.co.uk)

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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 organisation. 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.

This report is a summary of our inspection findings. You can find more detailed information about the service and what we found during our inspection in the related Evidence appendix.

## Ratings

### Overall rating for this Organisation

Good 

Are services safe?

Good 

Are services effective?

Good 

Are services caring?

Outstanding 

Are services responsive?

Good 

Are services well-led?

Good 

We rated well-led (leadership) from our inspection of organisation 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.

# Summary of findings

## Background to the Organisation

Livewell Southwest, formerly known as Plymouth Community Healthcare, is an independent social enterprise providing integrated health and social care services for people in Plymouth, South Hams District Council area and West Devon as well as some specialist services for those living in Devon and Cornwall.

It provides community health services and mental health community and inpatient services for around 270,000 people in Plymouth as well as some specialist services for those living in Devon and Cornwall.

The organisation officially formed on 1 October 2011 as an independent health services provider, working as part of the NHS family in a similar way to GP's, Dentists and Pharmacies and offering community, physical and mental healthcare. On 1st April 2015, Livewell Southwest took over the adult social care assessment service from Plymouth City Council.

The organisation is currently working towards a closer working relationship with University Hospitals Plymouth NHS Trust.

## Overall summary

**Our rating of this organisation stayed the same since our last inspection. We rated it as Good**   

## Key questions and ratings

We inspect and regulate healthcare service providers in England.

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs, and well-led?

Where we have a legal duty to do so, we rate the quality of services against each key question as outstanding, good, requires improvement or inadequate.

Where necessary, we take action against service providers that break the regulations and help them to improve the quality of their services.

## What we inspected and why

Although Livewell Southwest is a community interest company, we have inspected it in the same way that we inspect NHS trusts. This is because it is of a similar size to many NHS trusts with a large number of services, and has similar governance structures.

# Summary of findings

We plan our inspections based on everything we know about services, including whether they appear to be getting better or worse.

We inspected five mental health services:

- Child and adolescent mental health wards
- Wards for older people with mental health problems
- Mental health crisis services and health-based places of safety
- Specialist community mental health services for children and young people
- Long-stay or rehabilitation mental health wards for working age adults

And two community health services:

- Community health inpatient services
- Community end of life care

We did not inspect the organisation's other services, as our review of intelligence suggested there were no identified risks to patients.

Our comprehensive inspections of NHS trusts have shown a strong link between the quality of overall management of a trust and the quality of its services. For that reason, all trust inspections now include inspection of the well-led key question at the trust level. Therefore, we conducted an inspection of Livewell Southwest's leadership team. Our findings are in the section headed *Is this organisation well-led?*

## What we found

### Overall organisation

Our rating of the organisation stayed the same. We rated it as good because:

# Summary of findings

- We rated four of the key questions, 'are services safe, effective, responsive and well-led' as good and the key question, 'are services caring' outstanding. Our rating for the organisation took into account the previous ratings of services not inspected this time.
- Staff took the time to interact with people who used the service and those close to them in a respectful and considerate way. Staff were highly motivated and inspired to offer care that was kind and promoted people's dignity.
- Staff demonstrated understanding of patient's care needs and wishes and showed an encouraging, sensitive and supportive attitude to patient's and their relatives / representatives.
- Patient's were encouraged to be involved in the development of the service and were involved in their care planning, and carers were also involved where appropriate. We saw excellent examples of patient centred care.
- Patients and carers gave positive feedback about the care received.
- In the majority of the services we inspected, we found that staff managed access to and discharge from the service well. This was reflected in the time it took for patients to receive an assessment and then their treatment, and in the way the inpatient staff in the majority of the services we inspected worked to help patients to be ready for discharge.
- The organisation's senior leadership team had the skills, knowledge, and experience necessary to successfully oversee a large organisation. The board were actively working hard to ensure a positive approach to the closer working relationship with Plymouth Hospitals University NHS Trust. A new chief executive had been appointed in March 2018 whose focus was ensuring an appropriate balance between working towards the working relationship and the day to day strategic management of the organisation. The chief executive and vice-chair both had a clear understanding of the challenges and strategic direction of the closer working relationship with University Hospitals Plymouth NHS Trust.
- The provider had worked hard on its recruitment and retention plan with some success. For example, there was now a fully recruited district nursing workforce.
- We saw some examples of excellent leadership at all levels with many dedicated, compassionate staff who were striving to deliver the best care for their patients.

However,

- We rated two services as requires improvement, the child and adolescent mental health inpatient ward and community end of life care.
- On the child and adolescent mental health inpatient ward, improvements were needed to the governance of the service, care plans and risk assessments.

# Summary of findings

- Whilst we noted some improvements within community end of life care, further work was needed to ensure consistency in record keeping and training for staff.

## Are services safe?

Our rating of safe stayed the same. We rated it as good because:

- Staff we spoke with demonstrated an understanding of safeguarding and understood the types of abuse that might be found. Staff knew how to identify abuse and how to safeguard patients. Staff ensured safeguarding information was clearly highlighted on the electronic recording system and knew where to access information about safeguarding.
- Environmental risks were assessed and managed by good infection control tools and assessments, environmental assessments and audits, regular checks of furniture and fitting and mattress audits.
- The services had good medicines management procedures and received support from a pharmacist. When incidents occurred, staff reported them and we saw examples of learning from incidents.

However,

- In the community end of life care service, we found that not all documentation had a record of discussion with family members about the end of life wishes of their relative. There was limited improvement in the quality of Treatment Escalation Plans ("TEP") since the previous inspection. A TEP is a document that aids staff, patients and their relatives in planning ahead in case of deterioration in a patient's condition.
- In the child and adolescent ward care plans were not generalised and not specific to the needs of individual children and young people; key information was missing or incomplete and risk assessments were not robust.

## Are services effective?

- Our rating of effective stayed the same. We rated it as good because:
- Staff were able to access and were supported to complete additional training relevant to their roles. This ensured they were able to meet the identified care needs of patients competently.
- Services had a range of suitably skilled healthcare professionals who provided input and supported the needs of patients. These include medical staff, matrons, ward managers, qualified nursing staff, clinical psychologists, occupational therapists, pharmacists and activities coordinators.
- Written and verbal consent was obtained from patients prior to the delivery of care and treatment. Mental capacity assessments were carried out to ensure that treatment plans were delivered in the best interests of the patients, particularly if the patient did not have capacity to express their wishes.

# Summary of findings

- Staff based the care and treatment delivered on national best practice guidelines and relevant legislation. The organisations' policies and procedures were available to staff on the intranet and were kept up to date and in line with national guidance.

## Are services caring?

Our rating of caring improved. We rated it as outstanding because:

- Staff took the time to interact with people who used the service and those close to them in a respectful and considerate way. Staff were highly motivated and inspired to offer care that was kind and promoted people's dignity.
- Staff demonstrated understanding of patients care needs and wishes and showed an encouraging, sensitive and supportive attitude to patients and their relatives / representatives.
- Patients were actively encouraged to be involved in the development of the service and were involved in their care planning; carers were also involved where appropriate. In older people's mental health wards, we saw outstanding examples of person centred care.

## Are services responsive?

Our rating of responsive stayed the same. We rated it as good because:

- Services were planned and delivered to meet the needs of local people. The provider met with external organisations and stakeholders to develop and plan services within the local areas.
- Staff had worked to reduce delays in patients being discharged. However, where delays occurred these were due to a lack of suitable placements for patients in the wider community.
- Interpretation and translation services were available for patients whose first language was not English and staff had made arrangements to support patients in this way.
- Patients were informed on how to make a complaint should they need to do so. Complaints were taken seriously, investigated and action taken when necessary to reduce the risk of similar circumstances reoccurring. Staff could describe how they has learnt from complaints and how practices had changed as a result.

## Are services well-led?

Our rating of well-led stayed the same. We rated it as good because:

- Staff and stakeholders commented positively on the integrity of the board and senior leadership team. Feedback from stakeholders was that the senior leadership team had an open, honest and transparent approach. Similarly, staff said the leadership team brought a professional approach underpinned by the organisations values.

# Summary of findings

- The chief executive and vice-chair both had a clear understanding of the challenges and strategic direction of the organisation working closer with University Hospitals Plymouth NHS Trust. Non-executive directors demonstrated that they all understood challenges faced across the services it provided, and the ability to work with partners to resolve these.
- The new chief executive had led a recent review of organisation priorities and a renewed strategy was in place. The new strategy took account of the strategic direction for the organisation within the context of the Devon sustainability and transformation plan. The overall risk management framework had also been revised within the last two months in recognition of the need to address it.
- Senior leaders understood the challenges to quality and sustainability that the organisation faced with the developing of a closer working relationship with University Hospitals Plymouth NHS Trust. They identified this as a key challenge and the need to engage effectively with staff to take them through the development of a closer working relationship and improve the staff survey results. They were able to explain clearly the actions they had taken and the plans they had in place to further address those challenges.
- All of the directors and the chair of the audit committee were able to articulate the governance framework. All locality managers had a local assurance framework which was reviewed in a monthly locality meeting and contained quality, safety and performance indicators. The locality managers attend a monthly operational performance meeting where again all of these indicators are reviewed across the whole organisation and key themes across a particular service line could be identified.
- The organisation was aware of its performance through the use of key performance indicators and other metrics. This data now fed into the board assurance framework following its restructure two months ago. Team managers had access to a range of information to support them with their management role. This included information on the performance of the services, staffing and patient care.
- Livewell CIC had operated with a financial surplus over the past year and was able to continue investing in wellbeing initiatives for the local population.
- Senior leaders had made frequent visits to front-line teams, and this was about to include a series of meetings across the patch with both chief executives to inform staff about the development of a closer working relationship with University Hospitals Plymouth NHS Trust. Many of the staff we spoke with expressed pride in working for the organisation. They told us they felt valued and were able to raise concerns freely and in an atmosphere of openness. The organisation was committed to learning from when things go well and when they went wrong, promoting training, research and innovation to share learning across the staff groups.
- We saw clear evidence of how appropriate action was taken by senior leaders to address staff performance that was inconsistent with the organisations values.

# Summary of findings

- The organisation had effective systems in place to ensure that teams discharged their specific powers and duties according to the provisions of the Mental Health Act, 1983 (MHA). It also dealt effectively with any enquiries relating to mental health legislation. Regular MHA monitoring visit reports were responded to effectively and in a timely way.
- Quality improvement methodology had been adopted in mental health services. It had been initiated through the involvement of Livewell in the regional mental health patient safety collaborative. The organisation had supported this initiative with resources to coordinate and coach staff through their projects.

However:

- In 2017 only 27% of staff had completed the staff survey. Whilst the organisation recognised it needed to do more to improve this result and engage with staff so it understood how they were feeling and thinking it was exploring alternative methods of getting staff feedback this year.
- The organisation did not have an overarching strategy in place for patient engagement and feedback.

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## Ratings tables

The ratings tables in our full report show the ratings overall and for each key question, for each service, and for the whole organisation. They also show the current ratings for services or parts of them not inspected this time. We took all ratings into account in deciding overall ratings. Our decisions on overall ratings also took into account, for example, the relative size of services and we used our professional judgement to reach fair and balanced ratings.

## Outstanding practice

We found examples of outstanding practice in the community health inpatient service, long stay or rehabilitation mental health wards for working age adults, wards for older people with mental health problems and community end of life care.

For more information, see the Outstanding practice section of this report.

## Areas for improvement

We found areas for improvement including nine breaches of regulations and served four requirement notices – these set out the legal requirements that the organization must put right. We identified 40 areas of practice the organisation should improve to improve the quality of the services it provides.

For more information see the areas for improvement section of this report.



# Summary of findings

## Action we have taken

We issued requirement notices to the organisation. That meant they had to send us a report saying what action it would take to meet these requirements.

For more information on action we have taken, see the sections on Areas for improvement and Regulatory action.

## What happens next

We will make sure that the organisation takes the necessary action to improve its services. We will continue to monitor the safety and quality of services through our continuing relationship with the organisation and our regular inspections.

## Outstanding practice

We found examples of outstanding practice in the following services:

### Long stay or rehabilitation mental health wards for working age adults

- Patients on Greenfield Unit could not only attend psychological groups and therapies whilst being on the ward but could continue to attend psychological therapies up to three months post discharge due to long waiting list for such therapies in community. The ward psychologist from Greenfield Unit was also providing education sessions to the community teams on risk management of patient to better support patients upon discharge.
- Staff on both wards embraced quality improvement work in their delivery of care to patients, such as enhanced weekly physical health checks and monitoring. Staff ran food education sessions for patients. We saw a display of some high sugar content foods and drinks, the amount of sugar each contained in the communal area as part of an increase awareness program in Greenfield Unit. Both wards ran groups such as “fake away” where by healthier versions of take away was cooked by patients and staff.

### Wards for older people with mental health problems

- On Cotehele ward, there was a designated staff member that spent the first three days after admission with every patient. This was to get to know the patient very well and fully understand their needs and preferences. This information was used to provide person centred care in much detail.
- On Edgumbe ward, all assessments and care plans were exceptionally detailed and well written. Also on this ward, managers ensured patients were taken to visit care homes before discharge to have a choice in their care and familiarise themselves with staff.

# Summary of findings

## Community health inpatient services

- The service supported staff to be part of current local and national research projects. A number of research projects and involvement in national initiatives were being participated in at the time of our inspection.
- The service were proactive in promoting staff wellbeing. Yoga classes were available to staff in areas local to their place of work.
- Staff carried out health promotion work in the local community. For example, the stroke specialist nurses had arranged to attend local community events to provide the public with opportunities to have their blood pressure and pulse checked and information regarding healthy lifestyles.

## Areas for improvement

Action the organisation **MUST** take is necessary to comply with its legal obligations. Action a organisation **SHOULD** take is to comply with a minor breach that did not justify regulatory action, to prevent it failing to comply with legal requirements in future, or to improve services.

### Action the organisation **MUST** take to improve:

We told the organisation that it must take action to bring services into line with legal requirements. This action related to two core services.

## Child and adolescent mental health wards

Action the provider **MUST** take to improve:

- The provider must review its risk assessments and blanket restriction policy. This includes the blanket restrictions imposed on the young people and the non-individualised assessment of the restrictions. (Regulation 12).
- The provider must ensure that regular team meetings take place and are recorded. (Regulation 17).
- The provider must ensure there are robust procedures for sharing of information and learning following incidents. (Regulation 17).

# Summary of findings

- The provider must ensure supervision and appraisal of staff members happen regularly. (Regulation 17).
- The risk register must be updated appropriately and more accurately reflect key risks (Regulation 17).
- The provider must ensure that fridge temperatures and checks are recorded daily. (Regulation 15).

## Community end of life care

Action the provider **MUST** take to improve:

- The provider must ensure that the healthcare assistants have appropriate end of life training to work with patients and their families or those close to them (Regulation 18).
- the provider must take steps to ensure all medications administered by the service have an up to date, accurate and legible prescription to include doses, in line with the NMC Standards for Medication Administration (Regulation 12).
- The provider must ensure the monitoring and auditing of quality and effectiveness of the community end of life service. Improve measures of patient outcomes specific to specialist end of life care (regulation 17).

Action the organisation **SHOULD** take to improve:

- We told the organisation it should take action either to comply with a minor breach that did not justify regulatory action, to avoid breaching a legal requirement in future or to improve services.

## Child and adolescent mental health wards

Action the provider **SHOULD** take to improve:

- The provider should ensure that cleaning schedules are adequately recorded and any gaps in the cleaning record explained on the record.
- The provider should improve the risk assessment process. The risk assessments should be more specific and include a detailed description of antecedents and action plans.

# Summary of findings

- The provider should improve the young people's care plans. These should be person centred, individualised and not generic.
- The provider should evidence young people's involvement in their care plans and to evidence that a young person was offered a copy of the care plan.
- The provider should identify staff that require training in Gillick competence and provide training, as well as recording their attendance.
- The provider should ensure proper medicines management. This includes the correct storage, disposal and ordering of medication.
- The provider should identify staff that require Mental Health Act training, support them to attend training and keep a record of their attendance.

## **Long stay or rehabilitation mental health wards for working age adults**

Action the provider SHOULD take to improve:

- The provider should provide adapted bathroom or toilet facility for people with disabilities and impaired mobility.
- The provider should record staff supervision in line with the organisation's policy.
- The provider should provide staff training in the Mental Capacity Act in line with the provider's guidance and promote staff's understanding of their role in assessing patients' mental capacity.
- The provider should ensure that staff should carry out risk assessment such as STORM assessment for all patients with high risk of self-harm and suicide risk in line with the organisation's policy.
- The provider should ensure that care plans are written in a consistent style for all patients in line with provider's policy.
- The provider should ensure the risk assessments are written in a consistent way to capture risk of patient to self, to others and from others.

# Summary of findings

- The provider should ensure that staff follow the self-administration of medication policy consistently.
- The provide should ensure that work to remove ligature points are carried out in line with the action plan to address and mitigate ligature risks.

## **Mental health crisis services and health-based places of safety**

Action the provider SHOULD take to improve:

- The provider should ensure that staff in the home treatment team are clear on the vision of the service and the future of the organisation, as much as possible.
- The provider should ensure patients are involved in the creation of their care planning
- The provider should ensure discussion around risks are structured and recorded appropriately
- The provider should ensure risks are consistently translated to care plans
- The provider should ensure external stakeholders are clear on the function of the home treatment team
- The provider should ensure the home treatment team has a system to monitor and log safeguarding activity.

## **Specialist community mental health services for children and young people**

Action the provider SHOULD take to improve:

- The provider should ensure the managers monitor the number of safeguarding referrals to the local authority.
- The provider should ensure that all young people receive a copy of their care plan.

## **Wards for older people with mental health problems**

Action the provider SHOULD take to improve:

# Summary of findings

- The provider should ensure that all staff complete Mental Health Act training.
- The provider should ensure that staff write the 'opened date' on all liquid medication after opening, in line with the provider's policy.
- The provider should record staff supervision in line with the organisation's policy.
- The provider should ensure that learning from incidents is recorded and disseminated to all staff.

## **Community end of life care**

Action the provider SHOULD take to improve:

- Take significant steps to improve staff attendance in mental capacity act and deprivation of liberty safeguards and ensure that the reporting template captures this information.
- Improve the standard of records for do not attempt resuscitation and treatment escalation plans.
- The staff understanding of the vision and values and how they fit with the end of life strategy.
- The standard of the corporate risk register and addition of recognised and relevant risks.
- The District Nursing day team to provide a handover to the Out of Hours district nursing team.
- Register to take part in the National Audit of Care at End of Life ("NACEL").
- Re-establish multi-disciplinary team meetings in the district nursing service.

## **Community health inpatient services**

Action the provider SHOULD take to improve:

## Summary of findings

- The provider should ensure prompt action is consistently taken when potential safeguarding concerns are identified.
- The provider should ensure that staff consistently report incidents promptly.
- The provider should ensure that individualised and specific information is consistently recorded within the patient medical records. The information should direct and inform staff of the action they are required to take to meet the assessed care and treatment needs for each patient. This should include full guidance on specific equipment being used. Patient monitoring documents should be completed in full.
- The provider should review the storage arrangements on the community hospital wards to ensure that patients, staff and visitors to the hospital have clear access to all areas.
- The provider should ensure that medicines are consistently stored securely at all times.
- The provider should ensure that appropriate arrangements are consistently made for patients whose first language is not English to access translation and interpretation services.

## Is this organisation well-led?

Our comprehensive inspections of NHS trusts have shown a strong link between the quality of overall management of a trust and the quality of its services. For that reason, we look at the quality of leadership at every level. We also look at how well a trust manages the governance of its services – in other words, how well leaders continually improve the quality of services and safeguard high standards of care by creating an environment for excellence in clinical care to flourish.

Whilst Livewell CIC is not an NHS trust we have used the same methodology as we would to inspect NHS trusts as it is a similar size and complexity and is organized in a similar way. However, there are some distinct difference and we have taken this into account in undertaking the inspection.

Staff and stakeholders commented positively on the integrity of the board and senior leadership team. Feedback from stakeholders was that the senior leadership team had an open, honest and transparent approach. Similarly, staff said the leadership team brought a professional approach underpinned by the organisations values.

The chief executive and vice-chair both had a clear understanding of the challenges and strategic direction of the closer relationship of the organisation with University Hospitals Plymouth NHS Trust. Non-executive directors demonstrated that they all understood challenges faced across the services it provided, and the ability to work with partners to resolve these.

# Summary of findings

The new chief executive had led a recent review of organisation priorities and a renewed strategy was in place. The new strategy took account of the strategic direction for the organisation within the context of the Devon sustainability and transformation plan. The overall risk management framework had also been revised within the last two months in recognition of the need to address it.

Senior leaders understood the challenges to quality and sustainability the organisation faced with the impending working relationship with University Hospitals Plymouth NHS Trust identified as a key challenge and the need to engage effectively with staff to take them through the proposed relationship with University Hospitals Plymouth NHS Trust and improve the staff survey results. They were able to explain clearly the actions they had taken and the plans they had in place to further address those challenges.

All of the directors and the chair of the audit committee were able to articulate the governance framework. All locality managers had a local assurance framework which was reviewed in a monthly locality meeting and contained quality, safety and performance indicators. The locality managers attend a monthly operational performance meeting where again all of these indicators are reviewed across the whole organisation and key themes across a particular service line could be identified.

The organisation was aware of its performance through the use of key performance indicators and other metrics. This data now fed into the board assurance framework following its restructure two months ago. Team managers had access to a range of information to support them with their management role. This included information on the performance of the services, staffing and patient care.

Livewell CIC had operated with a financial surplus over the past year and was able to continue investing in wellbeing initiatives for the local population.

Senior leaders had made frequent visits to front-line teams, and this was about to include a series of meetings across the patch with both chief executives to inform staff about the relationship with University Hospitals Plymouth NHS Trust. Many of the staff we spoke with expressed pride in working for the organisation. They told us they felt valued and were able to raise concerns freely and in an atmosphere of openness.

The organisation was committed to learning from when things go well and when they went wrong, promoting training, research and innovation to share learning across the staff groups.



## Ratings tables

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 organisation

Safe	Effective	Caring	Responsive	Well-led	Overall
Good →← Apr 2018	Good →← Apr 2018	Outstanding ↑ Apr 2018	Good →← Apr 2018	Good →← Apr 2018	Good →← Apr 2018

The rating for well-led is based on our inspection at organisation 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 community health services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community health services for adults	Good Oct 2016	Good Oct 2016	Good Oct 2016	Good Oct 2016	Good Oct 2016	Good Oct 2016
Community health services for children and young people	Good Oct 2016	Good Oct 2016	Good Oct 2016	Good Oct 2016	Good Oct 2016	Good Oct 2016
Community health inpatient services	Good ➡️ Apr 2018	Good ➡️ Apr 2018	Good ➡️ Apr 2018	Good ➡️ Apr 2018	Good ➡️ Apr 2018	Good ➡️ Apr 2018
Community end of life care	Requires improvement ➡️ Apr 2018	Requires improvement ➡️ Apr 2018	Good ➡️ Apr 2018	Good ➡️ Apr 2018	Requires improvement ➡️ Apr 2018	Requires improvement ➡️ Apr 2018
Sexual Health Services	Good Oct 2016	Good Oct 2016	Good Oct 2016	Good Oct 2016	Good Oct 2016	Good Oct 2016
<b>Overall*</b>	Good ➡️ Apr 2018	Good ➡️ Apr 2018	Good ➡️ Apr 2018	Good ➡️ Apr 2018	Good ➡️ Apr 2018	Good ➡️ Apr 2018

\*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.

## Ratings for mental health services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Acute wards for adults of working age and psychiatric intensive care units	Good Oct 2016	Good Oct 2016	Outstanding Oct 2016	Good Oct 2016	Outstanding Oct 2016	Outstanding Oct 2016
Long-stay or rehabilitation mental health wards for working age adults	Good ↑ Apr 2018	Good →← Apr 2018	Good →← Apr 2018	Good →← Apr 2018	Good →← Apr 2018	Good →← Apr 2018
Forensic inpatient or secure wards	Good Oct 2016	Good Oct 2016	Good Oct 2016	Good Oct 2016	Good Oct 2016	Good Oct 2016
Child and adolescent mental health wards	Requires improvement ↓ Apr 2018	Good →← Apr 2018	Good →← Apr 2018	Good →← Apr 2018	Requires improvement ↓ Apr 2018	Requires improvement ↓ Apr 2018
Wards for older people with mental health problems	Good ↑ Apr 2018	Good →← Apr 2018	Outstanding ↑ Apr 2018	Good →← Apr 2018	Good →← Apr 2018	Good →← Apr 2018
Community-based mental health services for adults of working age	Good Aug 2017	Good Aug 2017	Good Aug 2017	Good Aug 2017	Good Aug 2017	Good Aug 2017
Mental health crisis services and health-based places of safety	Good →← Apr 2018	Good ↑ Apr 2018	Good →← Apr 2018	Good →← Apr 2018	Good →← Apr 2018	Good →← Apr 2018
Specialist community mental health services for children and young people	Good →← Apr 2018	Good →← Apr 2018	Good →← Apr 2018	Good ↑ Apr 2018	Good ↑ Apr 2018	Good ↑ Apr 2018
Community-based mental health services for older people	Good Oct 2016	Good Oct 2016	Good Oct 2016	Good Oct 2016	Good Oct 2016	Good Oct 2016
Community mental health services for people with a learning disability or autism	Good Oct 2016	Good Oct 2016	Outstanding Oct 2016	Outstanding Oct 2016	Good Oct 2016	Outstanding Oct 2016
<b>Overall</b>	Good ↑ Apr 2018	Good →← Apr 2018	Outstanding ↑ Apr 2018	Good →← Apr 2018	Good →← Apr 2018	Good →← Apr 2018

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.

# Community health services

## Background to community health services

Livewell Southwest CIC is an independent social enterprise providing integrated health and social care for approximately 270,000 people in Plymouth, South Hams and West Devon, as well as some specialist services for those living in Devon and Cornwall.

The organisation provides physical health services in the community and inpatient settings.

The organisation provides the following community health services:

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

We inspected the following core services: community health inpatient services and end of life care. Our last inspection had been in 2016 where we inspected all of the community core services.

The organisation provided care for adults in three community hospitals; South Hams, Tavistock and Mount Gould care centre. End of life care was provided by community nursing teams and on inpatient wards in three community hospitals (Mount Gould hospital, South Hams hospital in Kingsbridge and Tavistock hospital). In addition, there was a dedicated end of life care multi-visit team made up of healthcare assistants who worked with specialist charity carers to provide end of life care in patients' own homes.

## Summary of community health services

**Good**   

Our rating of these services remained the same as at the last inspection and are rated overall as good.

- Community inpatients remained good for all five key questions. Although improvements were seen in how community end of life care was led since the last inspection it continues to require improvement.
- The community health inpatient service provided a safe, effective, caring, responsive and well led service.
- Staff were caring and treated patients with dignity and respect.
- The community hospitals were clean and hygienic in appearance and staff promoted the control of infection when delivering care and treatment to patients.

# Summary of findings

- Staff maintained accurate and up to date records which reflected the care and treatment provided to patients whilst at the community hospitals. Discharge planning was detailed and supported by the multidisciplinary team. This assisted patients to experience a well-planned discharge with the appropriate care and support to enable them to get home safely.
- Patients were supported to receive their medicines in a manner suitable for them and when necessary staff followed safe systems to administer medicines.
- The nutritional and hydration needs of patients was assessed and patients were provided with a varied menu. When required assistance was given to patients to ensure they were able to eat and drink adequate amounts for their needs. Patients were protected from abuse due to the training, policies and procedures that were in place to support staff to recognise and deal with suspected abuse. Staff reported incidents and the provider took action to investigate and reduce the risk of such incidents reoccurring.

However:

- Further improvements were required within community end of life care to ensure consistency on the completion of treatment escalation plans and 'do not attempt resuscitation' forms on the inpatient wards.
- No quality improvement programmes had been delivered for the patients in the community receiving end of life care and there were no audits to monitor quality or effectiveness.
- Health care assistants had no end of life specific training to equip them to safely identify deteriorating patients or communicate effectively and with compassion to patients and those close to them at their end of life.

# Community end of life care

**Requires improvement**   

## Key facts and figures

During our inspection we visited Mount Gould, Tavistock & South Hams hospitals and visited nine patients in their own homes where we observed care being delivered by district nurses. We also observed care being delivered by healthcare assistants working in the multi-visit team. We spoke with three patients and seven relatives. We spoke with the board end of life lead within the organisation and members of the multi-visit team, including the service managers.

We met with members of two district nursing teams and spoke with staff including the out of hours manager. In addition we spoke with community inpatient staff including matrons, ward managers, medical staff, ward nurses, allied healthcare professionals, health care assistants and ward clerks. In total we spoke with 26 staff. We looked at the records of 14 patients identified as receiving end of life care and nine treatment escalation plans (TEPs) that included records of DNACPR (do not attempt cardiopulmonary resuscitation) decisions.

## Summary of this service

Livewell Southwest CIC is an independent social enterprise organisation that provides community health and social care services for the people of Plymouth, South Hams and West Devon.

End of life care was provided by community nursing teams and on inpatient wards in three community hospitals (Mount Gould hospital, South Hams hospital in Kingsbridge and Tavistock hospital). In addition there was a dedicated end of life care multi-visit team made up of healthcare assistants who worked with specialist charity carers to provide end of life care in patients' own homes. Specialist palliative care was not provided as part of Livewell Southwest but they worked closely with local hospice and other services to ensure collaborative care delivery.

Our rating of this service stayed the same. We rated it as requires improvement because:

There had been very little improvement on the completion of treatment escalation plans and do not attempt resuscitation form on the inpatient wards. No quality improvement programmes had been delivered for the patients in the community and no audits to monitor quality or effectiveness.

Health care assistants had no end of life specific training to equip them to safely identify deteriorating patients or communicate effectively and with compassion to patients and those close to them at their end of life.

## Is the service safe?

**Requires improvement**   

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

- In the completed care records we reviewed, we found not all documentation had a record of discussion with family members about the end of life wishes of their relative.
- We looked at 14 sets of patient records and nine of these had Do Not Attempt Cardio Pulmonary Resuscitate orders (DNACPR) in place. We saw evidence in five of the nine that staff had discussed these with patients and their families. This was a concern identified in the previous inspection.

# Community end of life care

- There was limited improvement in the quality of Treatment Escalation Plans (“TEP”) compared to the previous inspection. A TEP is a document that aids staff, patients and their relatives in planning ahead in case of deterioration in a patient’s condition.
- Individual medication lists for patients were only completed on the electronic system on the initial primary visit and was not updated again. In one of the records reviewed the health needs assessment showed the list of medications a patient was on. However, following a visit to that patient it was evident that she was on different medication and different doses.
- In two instances we found medications were not clearly prescribed and although the service did not prescribe medication, nurses were responsible for ensuring accuracy before administering medication. We were not assured this was happening routinely. For example, on one prescription Hyoscine was written. It did not state if this should be hyoscine hydro-bromide or hyoscine butyl-bromide. This meant there was a risk for the patient being given the wrong medication.
- In the second instance we found a patient had been prescribed a strong steroid and had been taking them since Jan 2018. There had been no review of this medication and the patient had become non-compliant in taking their secondary medication to protect their stomach from the side effects of the steroid.

However;

- Staff we spoke with demonstrated an understanding of safeguarding and understood the types of abuse that might be found. Staff knew where to access information about safeguarding through the intranet and where they could get advice about potential safeguarding concerns.
- The service controlled infection risk well. Staff kept themselves, equipment and the premises clean. They used control measures to prevent the spread of infection.
- The provider audited hand hygiene and infection prevention control measures (“IPCM”). The last audit was in December 2017 where the End of Life team scored 100% for both audits.
- District nursing staff were able to access a syringe driver and other equipment whenever it was needed. We found they stored securely and all sundry equipment within the boxes in date. The provider had a guidelines and policy on the use of syringe drivers.
- Risks to end of life patients were assessed and responded to by the nurses. The care record in the last days of life combined re-assessments of patients’ needs to minimise the risk of uncontrolled pain and maximise their symptom control.

## Is the service effective?

**Requires improvement**   

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

- At the time of the onsite inspection visit, we did not see measures of patient outcomes specific to specialist end of life care. The quality lead told us clinical outcomes on end of life care were not being measured by the provider
- General end of life outcome measures were taken from data collected from the friends and family test leaflets. This meant information was limited and would not deliver the provider with a wide range of measure outcomes to monitor effective treatment of care.

# Community end of life care

- There was no audit programme for community end of life care. The provider was unable to provide evidence for example, on how many patients had died in their preferred place of death.
- It was of concern the health care assistant (HCA) band 2 staff who worked as part of the multi-visit service were not trained in any specific end of life competencies. For example recognition of acutely unwell or deteriorating patients, or enhanced communication skills for end of life care.
- The organisation reported that only 67% of nursing staff had attended Mental Capacity Act (MCA) training as part of their mandatory training. This was a concern identified in the 2016 report and remains a concern.
- There was no handover from the day team to the out of hours team that identified end of life patients. Staff in the out of hours team believed this would be useful to identify and prioritise patients who were vulnerable.
- The district nurses did not hold multi-disciplinary team (MDT) meetings with the local hospice. The service has said that these meetings will be re-introduced.

However;

- The District Nurses undertook a training induction which includes recognising acute physical illness and deterioration (“RAPID”), Syringe Driver training and specialist end of life training.
- The provider was currently working towards accreditation of provision of end of life care using the Gold Standard’s Framework. Many acute trusts and hospices are currently working towards the Gold Standards Framework as this is considered to be best practice
- End of life care was delivered by a range of generalist nursing staff that participated in annual appraisals and had access to further generalist training as required.
- We observed a shared responsibility for care and treatment delivery by the district nurses employed by the provider and end of life clinical nurse specialists employed by the hospices.
- Patients who were considered to be in the last days or weeks of life were appropriately prescribed anticipatory medicines for symptoms experienced by patients at the end of life, these included pain, nausea, agitation and anxiety .
- The provider had “just in case bags”. These bags contain medication prescribed to cover all eventualities (symptoms that could arise). This is good practice to forward plan and have “just in case bag” medications in place in response to a potentially deteriorating patient.

## Is the service caring?

**Good** ● ➡ ➡

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

- Staff took the time to interact with people who used the service and those close to them in a respectful and considerate way. Staff were highly motivated and inspired to offer care that was kind and promoted people’s dignity.
- We spoke with seven friends and family members of patients who were at the end of life. The relatives described the care and support as excellent and said they felt well informed by the staff.
- Patients we spoke with all stated that staff could not do enough to help and were always kind and respectful. Staff that were interviewed stated that they would spend as much time with a patient as was required and friends and family reported that they never believed a visit was rushed.



# Community end of life care

- A family member of one patient described how a district nurse helped to clear up the house following a patient having an accident in several rooms of the house.
- We witnessed staff offering emotional support to family members, taking time to talk to them in a separate room, to discuss fears and worries and the forthcoming changes that the patient may experience.
- District nursing staff told us they provided a bereavement service and that they visited each family at least once after the patient had died to offer them support.
- Staff communicated clearly and sensitively with patients and their families, ensuring that they understood what staff were doing.
- Patients and family members we spoke with told us they felt involved in the care delivered. We saw staff discussed care issues with patients and relatives where possible and these were clearly documented in patient's notes.
- We observed discussions between patients and staff about options for alternative pain medication and other suggestions to make the patient more comfortable.
- District nursing staff told us that they provided a bereavement service and that they visited each family at least once after the patient had died to offer them support.

## Is the service responsive?

Good  ➡ ➡

Our rating of responsive stayed the same. We rated it as good because:

- End of life care services were planned and delivered to meet people's needs, wishes and choices. End of life patients' wishes were met in a timely manner by the provider working together with other end of life service providers to deliver appropriate end of life care packages.
- Nursing staff listened to the patients' needs and responded quickly. There were good systems in place to ensure patients' had received the right care and treatment which included medications and equipment.
- There were good working relationships between district nursing teams and the community specialist palliative care nurses from the local hospice. District nurses were happy with the support they received from the community palliative care nurses in relation to their end of life care needs.
- The combination of services and shared working practices between provider, hospice and charity allowed for more seamless transfers of care and improved the likelihood that patients' needs were responded to in a timely manner.
- The combination of services provided care to patients in a place of their choosing, supported by family and other healthcare professionals with the added flexibility to allow for changes of preference as the patient became closer to their end of life.
- Complaints were recognised and lessons learned from concerns raised by patients and their families. Nursing staff responded quickly to complaints to ensure it was resolved swiftly. Any lessons learned were shared during staff meetings.

However;

- The North team had more difficulty in finding care packages. This was mostly during the winter months.

# Community end of life care

## Is the service well-led?

**Requires improvement** ● ➡ ➡

Our rating of well-led stayed the same. We rated it as requires improvement because:

- Quality monitoring and the limited audit programme in community end of life services meant leadership were unable to understand the quality of care that was being provided by its service nor understand the implications on care if changes were made.
- There was little action taken by management on some issues raised by the last CQC inspection in 2016 such as quality of TEP's and mental capacity act training.
- The vision and strategy was not well known by community staff. During the inspection we regularly asked staff what the vision for end of life care was and did they know the objectives of the end of life care strategy? Only few of the staff could tell us.
- South Hams hospital found that 92% of the treatment escalation plan forms audited fell short of meeting the expected standards. There were some common themes across the different areas such as staff not correctly filling out questions three, four and five which related to the Mental Capacity Act.
- The corporate risk register did not make any reference to the poor treatment escalation plan audit and related issues found by the CQC in the previous inspection.
- Some of the audits conducted by the provider, such as an audit of "just in case bags" simply showed the dispersal of bags across the region. There was no performance related data collected such as use, frequency or effectiveness of using these bags.

However;

- The approach to service delivery was proactive. In February 2017 the service linked up with the local hospice and cancer charity (under a memorandum of understanding) in order to ensure better service integration and continuity of care for end of life patients in its localities.
- It was clear much work had been done in the previous year to improve end of life care but delivery of that work had not yet been rolled out.
- The end of life care leadership, the organisational culture, its vision and values encouraged openness and transparency and promoted good quality care. Staff were involved in planning of end of life care and their input was encouraged and valued.
- The board lead for end of life continued to work to further implement the end of life strategy and associated work streams. There was an end of life champions group to help take end of life care forwards and maintain responsibility for provision of end of life care.
- All of the frontline staff we spoke with felt engaged at a local level in end of life care. Staff were encouraged to contribute ideas to influence the development of end of life care services.
- The end of life care leadership and the culture encouraged openness and transparency and promoted good quality care. People who used the service and staff were involved in planning of their care and their input was sought after.
- The culture we saw within the service was open and caring. The interactions we saw between staff, families, and people using the service were kind and professional.

# Community end of life care

## Outstanding practice

We found examples of outstanding practice in this service. See the Outstanding practice section above.

## Areas for improvement

We found areas for improvement at this service. See the Areas for Improvement section above.

# Community health inpatient services

Good   

## Key facts and figures

The community inpatient services provided by Livewell Southwest CIC were provided from three community hospitals; Tavistock, South Hams and Mount Gould.

We visited all three hospitals as part of an announced inspection of Livewell Southwest CIC. Staff knew we were coming to ensure that everyone we needed to talk to was available. At Tavistock hospital we visited the ward and theatre department. At South Hams hospital we visited the ward. At Mount Gould hospital we visited Skylark and Kingfisher wards and Plym Neurological Rehabilitation Unit.

Admissions to the hospital wards were mainly patients transferred from the acute trust for rehabilitation and care and treatment prior to being discharged home. The theatre department at Tavistock hospital provided a service for NHS patients referred from the local acute trust. The surgeons were employed through the NHS and managed lists at the theatre. The service was for adults, there had been no care provided to patients under the age of 18.

During the inspection we spoke with 68 staff including; nurses, doctors, therapists, hospitality staff and managers. We spoke with 16 patients and two visitors who were at the hospital to visit their relatives. We reviewed eight sets of patient medical and nursing records.

## Summary of this service

Our rating of this service stayed the same. We rated it as good because:

Patients received a safe, effective, caring, responsive and well led service.

Patients were protected from abuse due to the training, policies and procedures that were in place to support staff to recognise and deal with suspected abuse.

Staff reported incidents and the provider took action to investigate and reduce the risk of such incidents reoccurring.

The community hospitals were clean and hygienic in appearance and staff promoted the control of infection when delivering care and treatment to patients.

Staff maintained accurate and up to date records which reflected the care and treatment provided to patients whilst at the community hospitals.

Discharge planning was detailed and supported by the multidisciplinary team. This assisted patients to experience a well-planned discharge with the appropriate care and support to enable them to get home safely.

Patients were supported to receive their medicines in a manner suitable for them and when necessary staff followed safe systems to administer medicines.

The nutritional and hydration needs of patients was assessed and patients were provided with a varied menu. When required assistance was given to patients to ensure they were able to eat and drink adequate amounts for their needs.

Clear evidence supported that staff worked well together in multidisciplinary teams to provide continuity of care and good outcomes for patients on the wards and within the theatre department at Tavistock hospital.

# Community health inpatient services

Written and verbal consent was obtained from patients prior to the delivery of care and treatment. Mental capacity assessments were carried out to ensure that treatment plans were delivered in the best interests of the patients, particularly if the patient did not have capacity to express their wishes.

Staff demonstrated compassion, kindness, empathy and showed patients respect when delivering care and treatment. Patients were included in the planning of their care and treatment plans and independence was promoted. Patients were provided with sufficient information to make informed choices regarding their care and treatment.

The service responsive to the needs of local people and additional services, such as weekend theatre lists, were planned to meet those needs. The organisation worked with commissioners and stakeholders to develop the services in response to identified needs.

The leadership of the organisation was open and transparent and staff felt supported and valued. The provider had knowledge of the service and key issues due to the governance and risk management frameworks in place.

However:

Staff had not always taken prompt action when potential safeguarding concerns had been identified.

Patient records did not consistently direct and inform staff of the action they are required to take to meet the assessed care and treatment needs for each patient. Patient monitoring documents were not always completed in full.

Patient medicines were not stored securely at all times. We observed there were medicines left on tables in the dayroom and bedside which meant other patients and visitors to the ward potentially had access to these.

## Is the service safe?

**Good**   

Our rating of safe stayed the same. We rated it as good because:

Patients were protected from abuse and avoidable harm. The organisation provided staff with training to ensure they were able to recognise potential safeguarding incidents.

Incidents were reported and monitored. Investigations took place following reported incidents and lessons were shared with teams to ensure learning took place.

The community hospitals provided a safe environment for patients to receive care and treatment with sufficient equipment in place to meet their needs. The areas used for patient care were clean and hygienic in appearance.

Patient records were maintained, up to date and stored securely to ensure personal and confidential information was not accessible to patients and visitors to the hospital.

However:

Staff had not always taken prompt action when potential safeguarding concerns had been identified.

Patient records did not consistently direct and inform staff of the action they are required to take to meet the assessed care and treatment needs for each patient. Patient monitoring documents were not always completed in full.

Patient medicines were not stored securely at all times. We observed there were medicines left on tables in the dayroom and bedside which meant other patients and visitors to the ward potentially had access to these.

# Community health inpatient services

## Is the service effective?

Good  → ←

Our rating of effective stayed the same. We rated it as good because:

Staff based the care and treatment delivered on national best practice guidelines and relevant legislation. The organisations' policies and procedures were available to staff on the intranet and were kept up to date and in line with national guidance.

Patients were provided with adequate pain relief.

The nutritional and hydration needs of patients was assessed and patients were provided with a varied menu. When required assistance was given to patients to ensure they were able to eat and drink adequate amounts for their needs.

Staff were able to access and were supported to complete additional training relevant to their roles. This ensured they were able to meet the identified care needs of patients competently.

Clear evidence supported that staff worked well together in multidisciplinary teams to provide continuity of care and good outcomes for patients on the wards and within the theatre department at Tavistock hospital.

Discharge planning was given priority throughout the patient stay in the community hospitals. Multidisciplinary meetings ensured that all staff members were clear and working towards safe and timely discharges.

Written and verbal consent was obtained from patients prior to the delivery of care and treatment. Mental capacity assessments were carried out to ensure that treatment plans were delivered in the best interests of the patients, particularly if the patient did not have capacity to express their wishes.

## Is the service caring?

Good  → ←

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

Patients were treated with kindness, dignity, respect and compassion within the community hospitals. Confidentiality was respected and promoted, particularly regarding personal and confidential information contained within records.

Staff demonstrated understanding of patients' care needs and wishes and showed an encouraging, sensitive and supportive attitude to patients and their relatives / representatives.

Patients were provided with sufficient information to make informed choices regarding their care and treatment.

## Is the service responsive?

Good  → ←

Our rating of responsive stayed the same. We rated it as good because:

Services were planned and delivered to meet the needs of local people. The provider met with external organisations and stakeholders to develop and plan services within the local areas.

# Community health inpatient services

Additional services and nurse services were accessible to staff and patients to ensure the care needs of patients with complex care needs were fully met. For example, patients living with dementia or a learning disability.

Interpretation and translation services were available for patients whose first language was not English and we saw that staff had made arrangements to support patients in this way.

Patients were informed on how to make a complaint should they need to do so. Complaints were taken seriously, investigated and action taken when necessary to reduce the risk of similar circumstances reoccurring.

However:

Arrangements had not consistently been made to ensure that patients whose first language was not English had access to appropriate translation and interpretation services.

## Is the service well-led?

Good   

Our rating of well-led stayed the same. We rated it as good because:

The leadership, management and governance of the organisation promoted an open and fair culture. Staff were able to access management support at all times and found the senior managers were supportive and approachable.

The organisation had a vision and strategy which was published and staff had access to. Staff evidenced an understanding of the vision and values of the organisation through their work and attitudes.

The governance frameworks provided the organisation with assurances that risks were assessed and managed to ensure the safety of patients and staff.

Feedback from patients had led to developments within the services and patient comments were welcomed by the staff and organisation.

## Outstanding practice

We found examples of outstanding practice in this service. See the Outstanding practice section above.

## Areas for improvement

We found areas for improvement in this service. See the Areas for Improvement section above.

# Mental health services

## Background to mental health services

Livewell Southwest, formerly known as Plymouth Community Healthcare, is an independent social enterprise providing integrated physical and mental healthcare health and social care services for people around 270,000 people in Plymouth, South Hams and West Devon as well as some specialist services for those living in Devon and Cornwall.

The organisation officially formed on 1 October 2011 as an independent health services provider, working as part of the NHS in a similar way to GP's, Dentists and Pharmacies and offering community, physical and mental healthcare. On 1st April 2015, Livewell Southwest took over the adult social care assessment service from Plymouth City Council.

In February 2018 Professor Steve Waite retired from his post as Chief Executive and Dr Adam Morris was appointed as the new Chief Executive for Livewell CIC.

Livewell Southwest provides the following mental health services:

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

Child and adolescent mental health wards

Community mental health services for people with learning disabilities and autism

Community-based mental health services for adults of working age

Community-based mental health services for older people

Forensic inpatient/secure services

Long stay/rehabilitation mental health wards for working age adults

Mental health crisis services and health-based places of safety

Specialist community mental health services for children and young people

Substance misuse services

Wards for older people with mental health problems

## Summary of mental health services

**Good**   

At this inspection we inspected five mental health services:

- Child and adolescent mental health wards
- Wards for older people with mental health problems
- Mental health crisis services and health-based places of safety



# Summary of findings

- Specialist community mental health services for children and young people
- Long-stay or rehabilitation mental health wards for working age adults.

Our overall rating of these services remained the same as at the last inspection.

- Services we inspected provided were caring. Patients were positive about the care they received.
- In older people's mental health wards we saw outstanding care by staff that was person centred.
- On Greenfields ward and Syrena House, staff had built good relationships with patients. The service had been re-designed with regular fortnightly ward rounds that focused on multi-disciplinary and multi-agency working.
- There was good working with other agencies across mental health services. For example, staff in the health-based place of safety demonstrated good partnership working with relevant agencies. Regular multi-agency meetings were held to ensure robust partnership working.
- We found improvements in specialist community mental health services for children and young people. Young people were seen quickly by the service. Those on the waiting list were monitored by the multidisciplinary team to ensure their needs were met. There was an out of hours provision for young people. Young people admitted to hospital at the weekend were quickly assessed by CAMHS staff. The manager promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.

However,

- Plymbridge House, the child and adolescent mental health ward was rated as requires improvement for safe and well led. This was because improvements were needed to supervision records and arrangements for staff supervision, staff appraisals, team meetings, care plans and risk assessments.
- There was confusion within the home treatment team around their identity and overall place in the wider crisis pathway.

# Long stay or rehabilitation mental health wards for working age adults

Good   

## Key facts and figures

The Livewell South West CIC has two long stay/rehabilitation mental health wards for working age adults. Greenfields is a nine bedded, single storey ward for women co-located with other services on the Mount Gould hospital site.

Syrena House is a nine bedded, two storey ward for men set in a large house in the town of Plymstock.

Greenfields unit admitted patients from female acute mental health wards or supported living. The service aimed to provide rehabilitation treatment to enable the women to live independently.

Syrena House admitted patients from male low secure services, acute mental health wards and the community. At the time of our inspection the patient group on Syrena House were of complex nature and had complex needs. The ward aimed to provide rehabilitation treatment to enable the patients to move on to independent or supported living.

We last inspected the service in June 2016. At that time, we rated the service as good overall but told the provider it must:

- adhere to the safeguarding policy and must raise safeguarding alerts when appropriate to do so. Staff must ensure that alerts are escalated to the Local Authority safeguarding team and the Care Quality Commission.

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

Our inspection on the 17 and 18 April 2018 was announced. We looked at all five key domains; safe, effective, caring, responsive and well led.

During this inspection, the inspection team:

- visited both rehabilitation wards at the two sites and looked at the quality of the ward environment and observed how staff were caring for patients
- spoke with five patients who were using the service, but two refused to talk to us
- spoke with one carer
- spoke with the ward managers
- spoke to two deputy managers
- spoke to the modern matron
- spoke with 11 other staff members; including a psychologist, occupational therapist, pharmacist, social workers, nurses, health care assistants and a student nurse
- attended and observed two hand-over meetings, two morning planning meetings, one psychology group and one therapy group.
- looked at 12 treatment records of patients
- reviewed 16 medicine prescription charts
- reviewed 20 staff records
- Looked at a range of policies, procedures and other documents relating to the running of the service.

# Long stay or rehabilitation mental health wards for working age adults

## Summary of this service

Our overall rating of this service stayed the same. We rated it as good because:

- On both wards staff had built good relationships with patients. Staff gave patients information about the service and what treatments were available. The information was provided in a number of formats and was available to patients and upon their request at any later date.
- The service had been re-designed with regular fortnightly ward rounds that focused on multi-disciplinary and multi-agency working. There had been recruitment on the wards to improve staffing numbers since our last inspection in 2016. New staff were provided with induction and a personal development program with regular reviews with managers and supervisors.
- Both ward used staffs from clinical support team to cover sickness and vacancies. The clinical support team work across the service to fill shifts.
- Staff assessed the needs of patients. Assessments were updated regularly.
- Staff assessed and managed physical health through weekly monitoring.
- Patients said that staff were kind and caring. They said they felt safe on the wards.
- Staff had access to services in the organisation and external services to help meet patients' needs. These included regular visits by the independent Mental Health Act advocacy service (SEAP – Support Empower Advocate Promote).
- Staff understood safeguarding and when to report safeguarding and followed the organisation's safeguarding policy.
- There was good leadership from ward managers.

However:

- There was no adapted bathroom or toilet facility for people with physical disabilities at Syrena house. The showers were 'walk in' showers, but there was no other adaptation for people with impaired mobility.
- Visitors, including children could only meet with patients in communal areas or staff meeting rooms on the female ward.
- Patients care plans at Syrena House were not holistic and lacked patients views and involvement.

## Is the service safe?

Good  

Our rating of safe improved. We rated it as good because:

- Staff completed risk assessments for all patients and these were regularly updated.
- Environmental risks were assessed and managed by good infection control tools and assessments, environmental assessments and audits, regular checks of furniture and fitting and mattress audits.
- The ward environments were clean, the furniture was in good condition.
- Staff had a good understanding of the needs of patients. Where they identified that a vulnerable person was at risk, they knew how to raise a safeguarding alert, and information on how to raise concerns was displayed on the ward.

# Long stay or rehabilitation mental health wards for working age adults

- Staff completed a risk assessment prior to a patient using community leave.
- Managers were able to increase staffing numbers in response to clinical need.
- When incidents occurred, staff reported them and we saw examples of learning from incidents.
- The level of restraints and restrictive practice was low taking into account the complexity of patients group and the complexity of their needs.

However:

- Specialised risk assessments, such as STORM (skills-based training on risk management for suicide prevention) assessment for all patients with high risk of self-harm and suicide risk were not always completed.
- Staff were not consistently following the self-administration of medication policy across the two wards.

## Is the service effective?

**Good**   

Our rating of effective stayed the same. We rated it as good because:

- Both wards had a good multi-disciplinary team and were working collaboratively in delivering patients care.
- There were psychological therapies available on both wards. On Greenfields unit the psychologist ran psychological intervention groups and two 1:1 session for patients a week. The psychologist also ran education session to staff to promote better understanding of personality disorder.
- Patients had access to meaningful activities on the ward. They were also encouraged to access groups and activities run by the community recovery teams.
- The ward had a system in place to allow patients to self-administer medication.
- Staff assessed their performance using a variety of audits. Staff responsible for completing audits were named and the results were shared.
- Patient's` needs were assessed on both wards in order to plan their care effectively.
- Staff worked individually with patients to help them achieve their recovery goals, as well as providing a basic activities timetable. Patients could access art therapy, cooking and baking groups.
- The ward had a range of experienced staff. There had been a period of recruitment and new staff were receiving an induction appropriate to their role. Staff said they could request specialist training to help them meet the needs of their clients.
- Staff met as a team regularly. They reported positive working relationships with other clinical teams in the organisation, as well as with the Mental Health Act office.
- Staff were knowledgeable about the need for consent to treatment, both within the remit of the Mental Health Act, but also working within the principles of the Mental Capacity Act.

However:

- Ward staff were required to deliver group activities had not received group facilitation training.
- Supervision was not recorded in line with the provider`s policy.

# Long stay or rehabilitation mental health wards for working age adults

- Staff on Syrena House had not received Mental Capacity Act training in line with the provider's guidance.
- Staff at Syrena House did not understand their role in assessing patients' mental capacity.

## Is the service caring?

**Good** ● → ←

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

- Patients said that staff treated them with respect and courtesy. They said that staff genuinely cared for them and were welcoming when they were admitted.
- Patients said the induction process to the ward was helpful.
- Ward staff ran daily planning meetings, which enabled patients to plan their day and make requests for leave and any activities they wanted to attend or participate in.
- We saw evidence in care plans that staff had sought the views of patients, and these were recorded in care records and care plans at Greenfields unit.
- Staff collected feedback about the running of the ward from patients weekly in "Friday feedback group".
- We saw that staff acted on learning and made changes to observation rota. This meant staff were positioned in areas as patients requested.
- Patients had access to advocacy services.
- Patients could involve their family and friends in their care and staff promoted the triangle of care where it was possible.

## Is the service responsive?

**Good** ● → ←

Our rating of responsive stayed the same. We rated it as good because:

- The service used referral criteria to ensure that patients were treated in a setting appropriate for their needs. Once admitted, staff kept patients beds for them if they went on leave.
- Staff had worked to reduce delays in patients being discharged. However, these delays were due to a lack of suitable placements for patients in the wider community. The stay time for patients at Syrena House was 6-9 months. On Greenfields unit, this time was reduced as the psychologist delivered training on care pathways to better support and manage patients upon discharge into their placement.
- Senior managers and staff met weekly in "whiteboard meetings" to discuss discharges and to monitor the care pathway to ensure that patients were receiving appropriate care.
- Patients had access to facilities to help meet their needs. These included rooms for activities, lounges, secure storage in their rooms and access to outdoor space.
- The organisation had access to translation services for patients that did not speak English as a first language and staff could request meals to meet dietary and cultural needs

# Long stay or rehabilitation mental health wards for working age adults

- There was information on how to complain displayed in the ward and staff knew how to manage complaints.

However:

- There was no adapted bathroom or toilet facility for people with disabilities at Syrena House. At Greenfields unit there were 'walk in' showers, but there was no other adaptation for people with impaired mobility.

## Is the service well-led?

**Good** ● ➡ ➡

Our rating of well-led stayed the same. We rated it as good because:

- Staff benefitted from strong local leadership. They said that the managers and newly appointed psychiatrists worked well together and provided stability to the wards.
- Senior members of the team had been involved in developing the new service model on Greenfield unit, which involved better multi-disciplinary and multi-agency working.
- Staff felt comfortable in raising any concerns or complaints and felt these would be listened to.
- There were good governance systems in place to ensure that managers had access to up to date performance data. This helped them to monitor and improve performance on the ward.
- Staff on both wards embraced and delivered quality improvement work to the service and in the delivery of patient care, such as enhanced weekly physical health checks and monitoring.

## Outstanding practice

We found examples of outstanding practice in this service. See the Outstanding practice section above.

## Areas for improvement

We found areas for improvement in this service. See the Areas for Improvement section above.

# Child and adolescent mental health wards

Requires improvement  

## Key facts and figures

Plym Bridge House child and adolescent unit is a purpose built 12 bedded inpatient mental health ward for children and young people requiring inpatient admission who live in Plymouth, Devon, Cornwall and Torbay. The unit opened in 2011.

Young people can be admitted informally, by parental consent (if under 16 years of age) or if detained under the Mental Health Act 1983. The unit is a mixed sex ward and treats young people aged between 12 and 18 years. They provide 24 hour specialist psychiatric care and treatment for those with a variety of mental health difficulties, which can include anxiety, depression, eating disorders and psychosis.

The unit has an on-site place of safety facility and education facilities. The education facilities were inspected by the Office for Standards in Education, children's services and skills (Ofsted) in November 2013 and received a rating of good. Details of the inspection of the children's place of safety will be in the crisis section of this report.

The service was last inspected in June 2016 and was rated as good overall and in all key questions.

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

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

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

During the inspection visit, the inspection team:

- Visited one ward and looked at the quality of the ward environment and observed how staff were caring for patients
- Spoke with seven young people who were using the service
- Spoke to two parents and carers
- Spoke with the manager of the ward
- Spoke with other staff members; including doctors, nurses and social workers
- Attended and observed a multi-disciplinary meeting

We also:

- Looked at 12 treatment records of patients
- Looked at 11 care plans
- Carried out a specific check of the medication management on the ward

# Child and adolescent mental health wards

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

## Summary of this service

Our rating of this service went down. We rated it as requires improvement because:

- Leadership was lacking on the ward. There was poor supervision records, with some staff members not having supervision for several months at a time and some staff not knowing who their supervisor was. Only half the staff had had an appraisal meeting in the last 12 months. Team meetings were not happening on a regular basis and the meetings that did occur were not recorded so that sharing of information and learning could be disseminated.
- Care plans were not specific and contained missing or incomplete information. For example there was limited information regarding antecedents, triggers or planned actions following an event.
- Risk assessments were not specific to the overall risk profile. They did not include possible triggers or detailed action plans in the event of a risk occurring.
- Recording and sharing of information about young people such as changes in medication, therapy plans or recent mood/behaviour was poor. There were no regular formal team meetings, with no minutes and therefore sharing of information was further limited.
- The recording of fridge temperatures was poor and there was no recorded action taken if the temperature was not within recommended limits. This was in all fridges on the ward.
- Staff had not received Mental Health Act training. Only 11 staff had received training, but they had good knowledge of and applied the Mental Health Act well.
- There were blanket restrictions applied on the young people and no documented rationale provided for these restrictions. For example young people were not allowed to keep mobile phones on their person and were not allowed electronic devices in their bedrooms.
- Young people were not offered or given a copy of their care plan.
- Staff and management were not confident in their knowledge of Gillick competence. This included explaining the rights of informal patients to leave. The Gillick competencies were being applied, however, staff were not aware that this was the framework they were following. . Mental Capacity Act training was well attended, however staff and management were not aware of Gillick competence.

However:

- Leadership was visible and the young people knew the staff and management well.
- The young people felt cared for and told us the staff were always approachable.
- Staffing levels were good and young people rarely missed activities or leave.

## Is the service safe?

**Requires improvement**  

Our rating of safe went down. We rated it as requires improvement because:



# Child and adolescent mental health wards

- Cleaning schedules were not recorded consistently. There was no reason given on the cleaning records to state why an area was being missed. However, the ward was clean and well furnished.
- There was no oversight for the management of fridges. This was both in the clinic room and with the other fridges in the ward, such as the Occupational Therapist or kitchen fridge. There was no evidence that fridges were checked daily. For example, fridge temperatures were not being recorded daily, there was food that was out of date and there was also food that did not have labels stating when it was opened and to be used by.
- The risk assessments documented were incomplete and did not reflect the risks presented by the patients. There were no specific risk plans for the identified risks.
- Due to a lack of sharing of information, from poor recording of meetings or learning from incidents and complaints, there was a risk of staff missing information regarding young people's care. This poor communication limited staff ability to manage risk effectively. With the increase in incidents over the last 12 months there should be a robust procedure for learning from incidents to prevent further incidents from occurring.
- Staff applied blanket restrictions on the young people without documented rationale. This included a ban on electronics in bedrooms, including mobile phones.
- Medicines were not managed in line with national guidelines. For example, staff who monitored fridge temperatures recorded the fact that sometimes the fridge temperature was too high but did not take action to remedy this in line with the medicines management policy. There was no record of medicines disposal or storage following temperatures that were not in line with recommended limits.
- Medicine ordering was also not consistent. There were instances where medicines were not ordered on time and there was no recorded action following this untimely ordering. For example, a young person's medication was not ordered in time to start with the scheduled time, it was only ordered two days later.

However:

- The layout of the ward meant that staff could observe patients at all times.
- The ward was given permission to put up decorations and this had improved the feel and look of the ward.
- Staffing levels were in line with the established staffing levels. There was always enough staff to ensure safe care for the young people. It was reported that leave was rarely cancelled due to low staffing levels.
- Staffing levels allowed the young people adequate one to one time with the key workers.
- Staff were knowledgeable of safeguarding and felt confident in reporting any potential safeguard concerns.

## Is the service effective?

Good   

Our rating of effective stayed the same. We rated it as good because:

- Physical health monitoring was good. Young people were assessed on admission and then had weekly follow ups, or increased levels if required. This was well documented.
- Young people had a wide range of treatment and therapies available to them. This included psychological therapies, family therapy and numerous activities on the ward.
- Young people were actively encouraged to go outside and outdoor activities were made available to them.

# Child and adolescent mental health wards

- Young people's nutritional and hydration needs were well looked after. There was always something to drink and healthy snacks available.
- There was a skilled multi-disciplinary team on the ward. This included psychiatrists, psychologists, nurses, occupational therapists, education staff and family therapists.

However:

- Although staff provided care and a range of treatments that met the patients' needs, these were not reflected in the written care plans. Care plans were generic and used standard statements that did not show personalised care.
- Staff and managers were not confident in their knowledge of Gillick competencies. This included explaining the rights of informal patients to leave. The Gillick competencies were being applied, however staff were not aware that this was the framework they were following. Mental Capacity Act training was well attended, however, staff and management were not aware of Gillick competence.
- Mental Health Act training compliance rates were low, at 31%. Staff did however know how to apply the Mental Health Act.

## Is the service caring?

Good   

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

- Staff interacted and engaged well with the young people. Young people were very complimentary of the staff and the level of care available to them.
- Young people's bedrooms were personalised and had en-suite facilities. Young people were able to personalise their rooms.
- Young people had active engagement in both internal and external services.
- Staff were able to raise concerns or complaints confidently and without fear of discrimination or retribution.
- The ward had support and guidance for young people who may be lesbian, gay, bisexual or transgender.
- Young people had good access to advocacy. The advocate would visit the ward at least once a week.
- Families and carers were involved in line with the triangle of care guidance.
- Access for parents and carers to visit the young people on the ward was well facilitated by staff.

However:

- The voice and opinion of the young person was not evident in their care plans. This was noted in the way care plans were written in the third person.

## Is the service responsive?

Good   

Our rating of responsive stayed the same. We rated it as good because:

# Child and adolescent mental health wards

- As a result of comprehensive discharge planning, patients were only discharged once an appropriate placement became available. This ensured that their next placement was the safest and best for that young person. However, this resulted in a high proportion of delayed discharges which were discussed and addressed in MDT meetings.
- There was a full range of facilities for the young people, including an art room, occupational therapist kitchen, outdoor areas and games rooms.
- Staff encouraged young people to attend education classes on weekdays and this was evident due to the high attendance rate for classes.
- Young people knew how and with whom they could raise concerns or complaints. The young people reported that they felt listened to and could approach any member of staff at any time.

However:

- Learning from complaints and incidents was poorly evidenced. Due to a lack of team meetings and recording of meetings it could not be guaranteed that information was being shared appropriately to ensure learning across all staff members. This meant that staff may miss information and limited their ability to catch up on information if they missed a handover or MDT meeting.

## Is the service well-led?

**Requires improvement** ● ↓

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

- Due to the increased acuity of patients and associated pressures, as well as previously unstable leadership with periods of temporary management and a modern matron covering a wider portfolio of services, some governance arrangements were not in line with the provider's expectation. For example, there were no regular team meetings, minutes from meetings were poorly recorded and there was no formal sharing of information. We could only be shown three recorded meetings from the last six months and the quality of the minutes was poor.
- The meetings that were held such as MDT meetings were not recorded. This lack of recording meant that minutes could not be shared with all staff. Therefore, it could not be guaranteed that all staff received information. This was the case with all essential information, for example recommendations from serious incidents. There was no governance procedure to share information with all staff.
- Audits were not acted upon. For example the fridge temperature audit revealed that fridge temperatures were not being recorded daily and there was no governance procedure in place to address this issue.
- The risk register was not up to date and did not give any detail as to the risks on it. Only two risks were added since January 2017 to present, and these did not include the increase in incidents or the increased acuity of the young people. There was no description of the risk, the reason it was on the register or any action plan to mitigate the risk. For example, a risk labelled equipment was on the register on three separate occasions with different ratings for each but no more detail.

However:

- Leadership was very visible. Young people reported that the manager was on the ward daily and could be approached at any time.
- Managers attended the weekly community meetings.

# Child and adolescent mental health wards

- Managers were in the process of empowering the staff team through the allocation of lead roles, for example giving one of the team the position of quality improvement lead.

## Areas for improvement

We found areas for improvement in this service. See the Areas for Improvement section above.

**A rating of requires improvement will result in an action the provider MUST take.**

# Mental health crisis services and health-based places of safety

Good   

## Key facts and figures

Livewell Community Interest Company (CIC) is an independent social enterprise which provides NHS services to local people.

The provider has one home treatment team which offers an alternative to hospital admission and provides a service to people who are acutely mentally unwell. The service accepts patients who have been seen and assessed prior to referral by either a consultant, care co-ordinator or other mental health services. This service currently accepts patients aged 18 to 65 years of age.

The team also help facilitate early discharge from hospital when there is appropriate support at home.

The home treatment team provides a service within a crisis pathway. They work alongside the community mental health team (CMHT), voluntary agencies and liaison psychiatry who together provide support 24 hours a day, 7 days a week.

The provider has two health-based places of safety, also known as section 136 suites. A place of safety is where people may be detained when they are subject to either section 135 or 136 of the Mental Health Act. Police officers have powers under section 136 to detain a person in a place of safety in order to have their mental health assessed, if they believe they have a mental disorder.

There are two health-based places of safety. One is for adults, based at Glenbourne Hospital in Plymouth and one is for children and young people in Plymbridge, Plymouth. The children and young people's health-based place of safety is currently under further development.

Our inspection was announced (staff knew we were coming) to ensure that everyone we needed to talk to were available.

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

During the inspection visit, the inspection team:

- Visited the home treatment team and both health-based places of safety
- Interviewed the manager for each team and also the senior managers
- Reviewed 21 care records across the sites
- Spoke with five patients of the home treatment team
- Spoke with 15 staff
- Reviewed a number of policies, meeting minutes and procedures related to the services
- Observed a home visit and staff members interacting with patients.

## Summary of this service

Our rating of this service stayed the same. We rated it as good because:

# Mental health crisis services and health-based places of safety

- During our previous inspection in June 2016 we rated mental health crisis services and health-based places of safety as good overall. We rated safe, caring, responsive and well-led as good and rated effective as requires improvement. In 2016 the provider was not meeting all requirements under Regulation 17 HSCA (regulated activities) Regulations 2014 (good governance). We found that the provider had met these requirements during this inspection.
- The policies for both adults and young people's health-based place of safety had not been updated since the revised Mental Health Act Code of Practice had been introduced in April 2015. During this inspection this had been rectified.
- The adult place of safety was separate to the children and young people place of safety. Staff in both services managed risk well both in the environment and clinically. Staff knew patient risks and managed them appropriately. There were robust lone working procedures in place.
- The home treatment team caseloads were significantly reduced since the previous inspection, making the workload more manageable for the team. Managers reviewed and monitored caseloads regularly.
- Care records showed that patients received good care. Staff completed risk assessments and comprehensive assessments based on their needs.
- Staffing levels were good in the health-based places of safety and the home treatment team. Managers used a robust model to ensure staffing levels met the needs of the service.
- There was good medicines management practices in all locations. All teams had access to medical support out of hours.
- Staff followed the Mental Health Act Code of Practice when receiving and assessing patients detained in the health-based place of safety. They also ensured patients understood the reason for their detention. Both units collected regular data on response times for all section 136 (MHA) information.
- Staff in all teams demonstrated good knowledge and skill in their relevant field. Staff had opportunities to develop. Staff received annual appraisals and regular supervision.
- Staff in the health-based place of safety demonstrated good partnership working with relevant agencies. Regular multi-agency meetings were held to ensure robust partnership working.
- The teams were caring and compassionate and treated people with dignity and respect. Patients in the home treatment team described their care and support as positive and kind.
- The home treatment team provided 24 hour a day, 7 days a week support to people. Other professionals could access the service for advice and the team worked well as part of the wider crisis pathway. The children and young people's health-based place of safety was due to undergo a refurbishment to provide a purpose built suite.
- There was good, clear leadership on both health-based places of safety. The overall manager was enthusiastic and driven to provide a quality service. The leaders in the home treatment team were knowledgeable and experienced and were supportive of the team. Managers provided supervision and appraisals, which was a requirement following the previous inspection.

However:

- The home treatment team was located in an environment that was clean but not ideally suited for their purpose. Access to security was poor, particularly out of hours.
- Patients were not always involved in the development of their initial care plans.
- Due to inability to recruit to additional posts, this specific service could not provide the enhanced crisis service out of hours. Their model was to work as part of a partnership between the CMHT and the mental health liaison service to provide this service.

# Mental health crisis services and health-based places of safety

- There was confusion within the home treatment team around their identity and overall place in the wider crisis pathway. Staff told us they did not feel involved in discussions around the teams' future.
- Discussion around risk within multi-disciplinary meetings was not structured.
- Identified risks were not consistently translated to care plans.

## Is the service safe?

Good   

Our rating of safe stayed the same. We rated it as good because:

- Staff managed risk well in both the home treatment team and health-based places of safety. Staff had a good understanding of individual risks.
- Staffing levels were good and the services ensured good medical cover out of hours.
- Caseloads were managed well in the home treatment team.
- There were robust lone working protocols and staff understood their responsibilities around lone working.
- Staff knew their responsibilities around safeguarding adults and children, and reported concerns well.
- The services had good medicines management procedures and received support from a pharmacist.
- Staff knew how to report incidents and we saw evidence of learning from incidents.

However:

- There was poor access to security at the home treatment team site, particularly out of hours.
- Risks were not always clearly translated into care plans.
- The environment was not ideally suited towards the team's purpose.

## Is the service effective?

Good  

Our rating of effective improved. We rated it as good because:

- During the previous inspection in 2016 staff had not updated policies in line with the Mental Health Act Code of Practice in the children and young people's health-based place of safety. We found during this inspection this had been rectified.
- Staff ensured they monitored physical healthcare and used recognised outcome ratings.
- All patients in the home treatment team had full risk assessments in place.
- Staff in the health-based places of safety were aware of and followed Mental Health Act Code of Practice guidelines.
- Managers provided supervision; team meetings and appraisals. Staff had access to training and development.
- Staff were qualified and experienced in working with people in a crisis.
- There was good partnership working between the health-based place of safety and other relevant agencies.

# Mental health crisis services and health-based places of safety

## Is the service caring?

Good  ➡ ⬅

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

- Patients told us staff were caring and compassionate and were treated with dignity and respect.
- Staff involved families and carers where appropriate in the care and support of the patient.
- Patients were able to provide feedback on care provided.

However:

- Patients in the home treatment team were not involved in the creation of their care plans at all times.

## Is the service responsive?

Good  ➡ ⬅

Our rating of responsive stayed the same. We rated it as good because:

- The home treatment team did not have a waiting list.
- The adult health-based place of safety was fundamental in the reduction of patients detained in police cells to zero in their area.
- The provider collected detailed data each month to monitor admissions to the children and young person's and adult health-based place of safety.
- Patients knew how to make a complaint if necessary and staff knew how to handle complaints appropriately.

However:

- The home treatment team's role in the wider 24 hour a day crisis pathway did not appear to be understood by other external agencies or clearly defined by the provider.

## Is the service well-led?

Good  ➡ ⬅

Our rating of well-led stayed the same. We rated it as good because:

- During the previous inspection in 2016, managers had not consistently provided supervision. We found during this inspection, staff received both clinical and management supervision.
- There were governance systems in place in both the home treatment team and health-based places of safety. Managers monitored the majority of service activity well.
- Leaders were approachable and knowledgeable and supported their teams, and morale was good.
- Staff felt respected and valued, and were positive and proud of their work.

However:



# Mental health crisis services and health-based places of safety

- There was confusion within the home treatment team around their identity and overall place in the wider crisis pathway. Staff told us they did not feel involved in discussions around the team's future.
- Leaders in the home treatment team did not have any robust system for monitoring safeguarding activity.

## Areas for improvement

We found areas for improvement in this service. See the Areas for Improvement section above.

# Specialist community mental health services for children and young people

Good  

## Key facts and figures

Livewell Southwest child and adolescent mental health service (CAMHS) provided a wide range of community child and adolescent services across Plymouth and at Mount Gould Hospital. Two years ago the service reorganised to include the community team, the multidisciplinary complex care team, the neurological development team, the infant mental health team, the outreach team, the severe learning disability team and the children in care team.

At the last inspection in June 2016 we rated the community children and adolescent mental health team as requires improvement overall with requires improvement in the responsive and well led domains and a rating of good in the safe, effective and caring domains.

Before the inspection visit, we reviewed information that we held about these services, and asked a range of other organisations for information.

During the inspection visit, the inspection team:

- visited the community mental health team, the complex care team, the neurological development team and the children in care team in Mount Gould Hospital.
- interviewed the manager for each of the teams and the two service managers
- reviewed 20 care records
- spoke with nine carers of two young people that were using the service
- spoke with twelve children and young people
- spoke with twenty five staff in two focus groups from all of the teams.
- reviewed a number of policies, meetings minutes and assessments related to the running of the service.
- Observed staff members working with the children and young people in one individual session.

## Summary of this service

Our rating of this service improved. We rated it as good because:

- Staff had access to up to date, accurate and comprehensive information about children and young people in their care and treatment plans. They ensured that care plans and crisis plans were up to date and comprehensive, assisting the teams' delivery of safe care and treatment to young people. Staff members ensured there was an effective system in place to assess the risks to all young people
- The staff team ensured incidents were consistently reported and there was learning from each incident.
- Staff involved children and young people and those close to them in decisions about their care and treatment. Children and young people spoken with were very positive about the care and treatment they received. The team listened to feedback from parents and young people, supported them and made changes because of the feedback.
- Young people were seen quickly by the service. Those on the waiting list were monitored by both the team managers and the service managers at their monthly business meetings to ensure their needs were met.

# Specialist community mental health services for children and young people

- Young people could access the service when they needed it. There was an out of hours provision for young people. Young people admitted to hospital at the weekend were quickly assessed by CAMHS staff.
- Staff were well trained to carry out their roles. There was suitably skilled and experienced staff to support children and young people's needs.
- The manager promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values. Staff morale was good and staff felt positive about their team.

However:

- The service managers did not monitor the number of safeguarding referrals to the local authority. The individual team managers knew how many safeguarding referrals each clinician had made to the local authority.
- The staff team did not ensure all young people received a copy of their care plan.

## Is the service safe?

Good   

Our rating of safe stayed the same. We rated it as good because:

- All children and young people had a thorough risk assessment and where appropriate crisis plans. The risk assessments and crisis plans we reviewed were comprehensive and up to date.
- Staff knew how to identify abuse and how to safeguard young people. Safeguarding processes were followed. Staff members ensured safeguarding information was clearly highlighted on the electronic recording system.
- The staff team ensured incidents were consistently reported and there was learning from each incident.

However:

- The service managers did not record or monitor the number of safeguarding referrals they made. The individual team managers knew the how many safeguarding referrals each clinician had made to the local authority.

## Is the service effective?

Good   

Our rating of effective stayed the same. We rated it as good because:

- Staff had access to up to date, accurate and comprehensive information about children and young people's care plans and treatment. All staff had access to an electronic records system that they updated.
  - Staff followed the requirements of the Mental Health Act and the Mental Capacity Act. Staff understood that the Mental Capacity Act only applies to young people aged 16 years and over and that for children under the age of 16, the young person's decision making ability is governed by Gillick competence. There was evidence of consideration of capacity and consent in all files reviewed.
- Staff used recognised assessment tools to measure severity and progress. Outcome measures were used and these were audited for their completion and effectiveness.

# Specialist community mental health services for children and young people

- Multidisciplinary team meetings were effective and occurred regularly. Staff worked closely with schools and social services.
- Staff members received regular one to one managerial supervision.

## Is the service caring?

Good  → ←

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

- Staff treated children and young people with compassion. Feedback from young people confirmed that staff treated them well and with kindness.
- Staff involved children and young people and those close to them in decisions about their care and treatment.
- Staff ensured children and young people were involved in the recruitment of staff.

However:

- All young people did not receive a copy of their care plan.

## Is the service responsive?

Good  ↑

Our rating of responsive has improved. We rated it as good because:

- Young people could access the service when they needed it. There was an out of hours provision for young people. Young people admitted to hospital at the weekend were quickly assessed by CAMHS staff.
- Staff members investigated and learnt from informal complaints from children and young people or their representatives.
- Young people were seen quickly by the service. Those on the waiting list were monitored by both the team managers and the service managers at their monthly business meetings to ensure their needs were met.
- Staff ensured adjustments had been made to provide a service to those with a physical disability. Interpreters were available and there was information in different languages.

## Is the service well-led?

Good  ↑

Our rating of well-led has improved. We rated it as good because:

- The service collected, analysed, managed and used information well to support all its activities. There was an effective governance system in place to ensure consistency in standards and work processes across the team.
- The service had effective systems for identifying risks to patients. The team were committed to improving the service by learning from when things go well and when they go wrong. They ensured learning from incidents and promoted training.

# Specialist community mental health services for children and young people

- The leadership team worked well with the clinical leads.
- Staff were well trained to carry out their roles. There was suitably skilled and experienced staff to support children and young people's needs.
- The senior managers promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values. There was a clear statement of vision and values, staff knew and understood the values of the provider.
- The manager ensured staff received sufficient regular one to one managerial supervision
- Staff morale was good and staff felt positive about their team and senior managers. Staff were enthusiastic and motivated. They were aware of the whistleblowing policy and were confident they would use it if needed.
- The team engaged well with children, young people and their families, they listened to feedback from parents and young people, supported them and made changes as a result of the feedback.

## Areas for improvement

We found two areas for improvement in this service. See the Areas for Improvement section above.

# Wards for older people with mental health problems

Good   

## Key facts and figures

Livewell CIC had two wards for older people with mental health problems, providing care for patients who are aged over 65 and require hospital admission for their mental health diagnosis.

As part of our inspection of this core service we inspected the following locations:

- Cotehele Unit, Mount Gould Hospital, Plymouth
- Edgcumbe Unit, Mount Gould Hospital, Plymouth

Cotehele ward was a 15 bed, mixed sex ward. It provided assessment and treatment for older adults with functional mental illness like depression and psychosis.

Edgcumbe ward was a 10 bed, mixed sex ward. It was a specialist ward providing short term assessment and care for older people with organic mental illness or cognitive impairment, such as dementia.

At the last inspection, this service was rated as requires improvement in safe, good in effective, good in caring, good in responsive and good in well-led. Overall the provider was rated as good.

We inspected all five key questions.

Before the inspection visit, we reviewed information that we held about these services, and asked a range of other organisations for information.

During the inspection visit, the inspection team:

- Visited two wards
- Interviewed one ward manager
- Interviewed one modern matron (who was acting ward manager for Cotehele Unit at the time of inspection)
- Spoke with 11 staff members, including consultant psychiatrists, qualified nurses, healthcare assistants, occupational therapists, occupational therapy technicians and activities coordinators
- Checked two clinic rooms
- Reviewed all the medication charts on Cotehele unit and Edgcumbe unit.
- Reviewed 23 care records
- Spoke with 7 patients
- Spoke with 8 carers carers
- Observed daily activities and staff interactions with patients
- We reviewed policies and procedures, meeting minutes, training and supervision records and audits.

## Summary of this service

Our rating of this service stayed the same. We rated it as good because:

# Wards for older people with mental health problems

- The care plans and risk assessments were comprehensive, holistic, recovery orientated and up-to-date. They were regularly reviewed and updated as required.
- Staff were open to patient and carer feedback, and had used it to improve their quality of care.
- The wards had sufficient numbers of skilled and experienced staff to deliver the service. Staff came from a variety of professional disciplines and this helped them to meet a wide range of patients' needs.
- Staff spent quality time with patients to ensure they provided the highest quality, person centred care. Staff treated patients with respect, dignity and were passionate about their roles
- During our inspection of Cotehele ward in October 2016, there was a blanket restriction on patients accessing their bedrooms during the day. This has been resolved.

## Is the service safe?

Good  

Our rating of safe improved. We rated it as good because:

- The blanket restriction on patients on Cotehele ward accessing their bedrooms during the day had been resolved. The ward was now assessing and managing the risks on each individual's needs, avoiding any unnecessary blanket restrictions.
- Collapsible curtain rails and anti-barricade doors were being fitted to all patients' bedrooms on Cotehele ward.
- Cotehele ward and Edgecumbe ward were clean, odour-free and well maintained, with good furnishings and fittings. Both wards provided a safe environment for patients and staff.
- Clinic rooms on both wards were clean, organised and stored medication and equipment safely.
- Both wards were staffed appropriately and steps had been made to mitigate the small number of vacancies they had.
- Staff received most of the training they required to carry out their roles safely and effectively.
- Staff on both wards had completed comprehensive and up to date risk assessments for each patient which were individual and personalised.
- Safeguarding concerns were appropriately recorded and closely monitored by staff on both wards.
- Staff on both wards managed prescribing, storage and administering of medicines well.

However:

- During our inspection of Cotehele ward, we found liquid medication that had been opened and did not have an 'opened date'. This is important as these medications often have a short shelf-life once opened and may not work as intended if they have been open for a long time.
- Learning from incidents was not always recorded and disseminated to all staff.

## Is the service effective?

Good   

Our rating of effective stayed the same. We rated it as good because:

# Wards for older people with mental health problems

- The wards had a range of suitably skilled healthcare professionals who provided input into the service and supported the needs of patients on the wards. These include consultant psychiatrists, ward managers, qualified nursing staff, clinical psychologist, occupational therapists, pharmacists and activities coordinators.
- The multi-disciplinary team members showed evidence of effective teamwork. The handovers on both wards were comprehensive and covered a range of aspects in the patients' care.
- Clinical audits were completed regularly to improve the quality of care and the environment.
- All staff members, including bank and agency, were provided with a good induction so that they were familiarised with the ward environment and the service provided.
- Staff adhered to the Mental Health Act Code of Practice and we saw evidence of correctly filled paperwork and updated care plans for detained patients. Staff also applied the Mental Capacity Act and we saw evidence of patients being assessed for capacity to treatment, and consenting to the sharing of information.

However:

- In the 12 months leading up to the inspection, staff had not had access to regular supervision sessions. According to the provider's policy, substantive staff were meant to have four supervision sessions in twelve months, along with yearly appraisals.
- Compliance of staff completing Mental Health Act training was 22% which was below the provider's target of 90%.

## Is the service caring?

**Outstanding** ☆ ↑

Our rating of caring improved. We rated it as outstanding because:

- Staff attitudes and behaviours towards their patients were discreet, respectful, and responsive. We observed positive, patient centred interactions between staff and patients.
- Staff supported patients to understand and manage their care, treatment or condition.
- Staff understood the individual needs of patients including their personal, cultural, social and religious needs. Patients were supported by staff to meet these individual needs.
- Staff on both wards gave all patients and carers a welcome pack containing information that helped orient them to the wards.
- Staff maintained confidentiality of information about patients at all times.
- Patients were encouraged to be involved in the development of the service.
- Patients were fully involved in their care planning, and carers were also involved where appropriate.
- Staff on Cotehele ward carried out home visits to patients before they were admitted on to the ward so the patient could familiarise themselves with staff.
- Cotehele ward had a designated member of staff who completed detailed assessments during the first three days after a patients' admission to ensure a comprehensive care plan could be written. Staff then used these care plans to provide care that is respectful of, and responsive to them.
- Cotehele ward had invented a 'sleep trolley' which had items to aid patients if they were experiencing difficult falling asleep at night.



# Wards for older people with mental health problems

- Staff on Edgumbe ward had completed a 'This is Me' for patients detailing their life histories, likes, dislikes, hobbies and interests so staff could engage them in activities that were meaningful for them.
- All assessments and care plans completed on Edgumbe ward were exceptionally detailed, recovery orientated and completed in a very timely manner. Staff actively sought appropriate discharges very soon after admission to ensure patients were not using the service for longer than they needed to. Staff also took patients to see care homes when discharge planning, to encourage patients to make choices about their placements.
- Edgumbe ward had pictures of all snacks and drinks available to patients throughout the day. This was useful for the patient group on the ward to make informed nutritional and hydration choices.

## Is the service responsive?

Good   

Our rating of responsive stayed the same. We rated it as good because:

- Both wards had a full range of rooms and equipment available, including a patient kitchen, outdoor spaces and rooms for therapeutic activities and treatment.
- The wards were recovery orientated and provided a suitable environment for the patient group.
- Bedroom doors were marked with pictures and colours to make them more recognisable and personalised. Edcumbe ward also had dementia-friendly fittings, images and sensory equipment on the walls. Edgumbe ward also had facilities to accommodate bariatric patients and had coloured toilet seats to aid identification.
- Staff were meeting the diverse needs of all patients that used their service.
- Both wards had displayed information about complaints, advocacy and local resources.
- Staff supported patients to maintain contact with their family and friends.
- Food was of a good quality on both wards and met the dietary requirements of religious and ethnic groups when required.
- Staff on both wards showed care and consideration when patients were moved or discharged.

However:

- Patient bedrooms on Edgumbe ward were fitted with motion sensor taps. This was not appropriate for the patient group as people who have dementia often do not know how to operate them. Staff told us that patients have mistaken them for other bathroom furniture and some patients did not know how to start or stop the water flow.

## Is the service well-led?

Good   

Our rating of well-led stayed the same. We rated it as good because:

- Both wards had strong leadership who had a good understanding of the services they managed. Management used their skills, knowledge and experience to ensure the wards remained safe for staff and patients.
- Staff members reported that the morale on the wards was good and they felt supported in their roles.

# Wards for older people with mental health problems

- The providers' senior management photographs and job roles were on display on information boards on both the wards. Staff and patients knew who the senior management team were and that they felt confident to approach them if they had any concerns.
- Staff we spoke to understood the vision and strategic objectives of the organisation.
- Staff felt respected, supported and valued by the organisation. Staff felt positive and proud about their teams working cohesively and working hard to deliver high quality care.

However,

- Staff did not receive line management supervision and clinical supervision in line with the provider's policy.
- Learning from incidents was not always recorded and clearly disseminated to all staff.

## Outstanding practice

We found examples of outstanding practice in this service. See the Outstanding practice section above.

## Areas for improvement

We found areas for improvement in this service. Please see the Areas for Improvement section above.

This section is primarily information for the provider

## Requirement notices

### Action we have told the provider to take

The table below shows the legal requirements that the service provider was not meeting. The provider must send CQC a report that says what action it is going to take to meet these requirements.

For more information on things the provider must improve, see the Areas for improvement section above.

**Please note:** Regulatory action relating to primary medical services and adult social care services we inspected appears in the separate reports on individual services (available on our website [www.cqc.org.uk](http://www.cqc.org.uk))

**This guidance** (see [goo.gl/Y1dLhz](http://goo.gl/Y1dLhz)) describes how providers and managers can meet the regulations. These include the fundamental standards – the standards below which care must never fall.

#### Regulated activity

#### Regulation

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

Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

Diagnostic and screening procedures

Treatment of disease, disorder or injury

#### Regulated activity

#### Regulation

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

Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment

Diagnostic and screening procedures

Treatment of disease, disorder or injury

#### Regulated activity

#### Regulation

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

Regulation 17 HSCA (RA) Regulations 2014 Good governance

Diagnostic and screening procedures

Treatment of disease, disorder or injury

#### Regulated activity

#### Regulation

Diagnostic and screening procedures

Regulation 18 HSCA (RA) Regulations 2014 Staffing

Treatment of disease, disorder or injury

This section is primarily information for the provider

## Enforcement actions

We took enforcement action because the quality of healthcare required significant improvement.

# Our inspection team

This inspection was led by Karen Bennett-Wilson, head of hospital inspections. An executive reviewer, William Jones, director of operations at a similar sized provider, supported our inspection of well-led for the organisation overall.

The team included one head of hospital inspections, four inspection managers, seven inspectors, one executive reviewer, 13 specialist advisers, two mental health act reviewers, one specialist pharmacy inspector and five experts by experience.

Executive reviewers are senior healthcare managers who support our inspections of the leadership of trusts and organisations. Specialist advisers are experts in their field who we do not directly employ. Experts by experience are people who have personal experience of using or caring for people who use health and social care services.