Plymouth Community Healthcare CIC, also known as Livewell Southwest

Quality Report

Local Care Centre
Mount Gould Hospital
Plymouth
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Core services inspected	CQC registered location	CQC location ID
Acute wards for adults of working age and psychiatric intensive care units (PICUs)	Glenbourne Unit	1-297635140
Forensic inpatient / secure wards	Lee Mill Hospital	1-297651662
Long stay / rehabilitation mental health wards for working age adults	Local Care Centre Mount Gould Hospital Syrena House	1-297622270 1-297652081
Wards for older people with mental health problems	Local Care Centre Mount Gould Hospital	1-297622270
Child and adolescent mental health inpatient services	Plym Bridge House	1-297652203
Mental health crisis services and health-based places of safety	Glenbourne Unit Plym Bridge House Local Care Centre Mount Gould Hospital	1-297635140 1-297652203 1-297622270
Community-based mental health services for adults of working age	Local Care Centre Mount Gould Hospital	1-297622270

Summary of findings

Specialist community mental health services for children and young people	Local Care Centre Mount Gould Hospital	1-297622270
Community-based mental health services for older people	Local Care Centre Mount Gould Hospital	1-297622270
Community-based services for adults with learning disabilities	Local Care Centre Mount Gould Hospital	1-297622270
Substance misuse services	Local Care Centre Mount Gould Hospital	1-297622270
Community health services for adults	Tavistock Hospital South Hams Hospital Local Care Centre Mount Gould Hospital Cumberland Centre	1-2078154330 1-2078169826 1-297622270 1-297634914
Community health services for adult inpatients	Local Care Centre Mount Gould Hospital Tavistock Hospital South Hams Hospital	1-297622270 1-2078154330 1-2078169826
Community health services for children and young people and families	Local Care Centre Mount Gould Hospital Cumberland Centre	1-297622270 1-297634914
End of life care	Local Care Centre Mount Gould Hospital Tavistock Hospital	1-297622270 1-2078154330
Sexual health services	Cumberland Centre	1-297634914
Urgent care services	Cumberland Centre Tavistock Hospital South Hams Hospital	1-297634914 1-2078154330 1-2078169826

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

Summary of findings

Ratings

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

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

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

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

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

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

Summary of findings

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Summary of findings

Overall summary

When aggregating ratings, our inspection teams follow a set of principles to ensure consistent decisions. The principles will normally apply but will be balanced by inspection teams using their discretion and professional judgement in the light of all of the available evidence.

Despite rating Plymouth Community Healthcare CIC as good overall, we had concerns about the safety of patients accessing the Community Mental Health Teams for adults of working age. It is our view that the provider needs to take significant steps to improve the quality of this service and we find that they are currently in breach of regulations. We issued a Section 29 warning notice on 15 July 2016 which told the provider they must make significant improvements.

Following the June 2016 comprehensive inspection we issued the provider a section 29 warning notice which gives a strict timescale for them to improve. This related to the services provided by Plymouth CIC's community-based mental health services for adults of working age.

In October 2016 we carried out an unannounced focussed inspection of Plymouth CIC's community-based mental health services for adults of working age. This was to see if the provider had met the concerns raised in the warning notice. We found evidence of progress and improvement and at this time we will not be taking any further enforcement action. We will continue to monitor the provider's compliance with the warning notice. Further details can be found in the community-based mental health services for adults of working age core service report.

At the comprehensive inspection in June 2016 we found the service provided by Plymouth CIC to be good because:

- Across the inpatient and community services we saw that staff worked with patients and their families to deliver individualised care. Care plans were holistic, they documented detailed assessments of both the emotional and physical needs of patients, were patient centred and most had a strong recovery focus.
- We observed good assessment and management of risk throughout most services. For example ligature risk assessments were in place and well managed either by rectifying the issues identified or by actively managing the areas where risk was identified to reduce the risk to patients.
- Generally the wards and community environments were clean, bright and well furnished. The provider was committed to refurbishing environments which required it. For example, it had managed the refurbishment of the Glenbourne well; with particular focus on safety and patient involvement in the re-design.
- The provider had robust infection control policies and procedures and staff adhered to these across all environments.
- In the community team for learning disabilities and autism, staff understood the importance for patients of being close to their friends and family. The team had won an award for bringing patients who were staying in hospitals out of the area, back home to Plymouth.
- We observed that staff delivered care and treatment to patients in a kind, caring manner that respected their dignity. Where concerns had been expressed by patients and carers we saw that this had been addressed appropriately and in line with the expectations of duty of candour.
- The great majority of the patients that we spoke with on the wards were positive and complimentary about the support they received from staff. Staff interacted with patients positively and respectfully. They demonstrated that they knew the patients well in their interactions with patients and in their responses to them. Where it was appropriate we saw that carers and family members were involved in the care planning process and care plans documented patients' wishes and feelings about their treatment.
- Patients told us that food was good and there was a wide choice available to them. The Provider had been awarded five stars for food hygiene by South Hams district council on 29 August 2014, Mount Gould had received a five star rating for food hygiene by Plymouth City Council on 28 January 2014 as part of the scores on the doors rating system.
- Most staff had received training in and had a good understanding of safeguarding procedures.

Summary of findings

- There was a wide range of activities on the wards throughout the week that patients could benefit from.
- There were separate health based place of safety (HBPoS) for adults and young people. Staff in the HBPoS manged risk well, including environmental risks and safeguarding concerns. There had been a gradual reduction in the use of police custody for section 136 purposes for adults and since the introduction of the place of safety for young people, there had been no use of police custody for this patient group.
- Staff were positive about working for the provider as an employer and said they encouraged individual services to improve and had a 'no-blame' culture. Staff knew who senior managers and said they were visible. Senior managers and executive board members had visited all locations. Non-executive directors had a good understanding of the provider's strategy and presented appropriate challenge to the executive team.

However:

- In some clinical areas, the provider had not ensured that staff had the necessary skills or training. It had not always assessed whether healthcare assistants in the community hospital were competent before they were allowed to carry out initial clinical assessment of patients. Healthcare assistants were re-directing patients to other services before the patients had been assessed by a registered practitioner. Although all staff had received recent training in immediate life support for adults, there was no record of how many had received training in life support for children.
- The provider had processes in place to identify and report serious incidents. For example, we observed assessment and management of risk with locally held risk registers and use of a risk rating tool that identified problems and escalated these issues for action. However these were not used consistently across all core services, we saw that adaptations required following an incident on the older persons wards had not been made 12 months after the incident.
- Not all staff were receiving regular supervision in line with the providers' policy.
- There were some instances where the provider had not assessed or managed risk well. Staff had not conducted a risk assessment of child and adult resuscitation facilities at South Hams and Tavistock to ensure they were suitable for an isolated unit.
- Staff in the community mental health teams for adults did not always provide care and treatment in a safe way. Not all patients on waiting lists for treatment had been thoroughly risk assessed.
- Staff in the community inpatient team did not adhere to the medicines management guidance such as the use of patients own medicines as stock medicine.
- In the 'end of life care service treatment escalation plans' and 'do not attempt resuscitation decisions' forms were not always appropriately completed and recorded in line with organisation's policy.
- MHA training was considered essential for some teams and appeared to be regularly delivered and accessed by staff. However, there was no record of this held locally or at provider level to ensure the right staff had received the correct level of training.
- At South Hams hospital the provider did not always provide appropriate X-ray facilities when they were required by patients with suspected fractures.
- The staffing levels and skill mix within the district nursing service was not always safe, and staff were not always appropriately supported.
- The provider was not always adhering to the safeguarding policy and was not consistently raising safeguarding alerts to the Local Authority safeguarding team and the Care Quality Commission.
- Cothele ward had a blanket restriction in place which restricted the reasonable movement of patients.
- The provider did not always act in a timely way to implement learning from incidents.

Summary of findings

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

We always ask the following five questions of the services.

Are services safe?

We rated safe as requires improvement because:

- Staff in the Community Mental Health team for adults of working age did not manage the waiting lists effectively or safely. They did not follow a systematic process to ensure that risks for people waiting to be allocated to a key worker was safely managed
- In end of life care services, 'treatment escalation plans' and 'do not attempt resuscitation decisions' forms were not always appropriately completed and recorded in line with organisational policy.
- Healthcare assistants in urgent care services were not always assessed as being competent before they were allowed to carry out initial clinical assessment of patients.
- The staffing levels and skill mix across the organisation was not always safe, particularly within the district nursing service. Staff were not always appropriately supported and the wellbeing of staff was at risk of harm.
- The provider was not always adhering to the safeguarding policy and was not consistently raising safeguarding alerts to the Local Authority safeguarding team and the Care Quality Commission. At the time of our inspection there was a whole service section 42 safeguarding enquiry in place led by the Local Authority safeguarding team as result of alleged non-reporting of significant safeguarding concerns at Greenfields ward. A section 42 enquiry applies where a local authority has reasonable cause to suspect that an adult in its area who has needs for care and support is experiencing, or is at risk of, abuse or neglect, and as a result of those needs is unable to protect himself or herself against the abuse or neglect or the risk of it. The whole service enquiry was in place as the Local Authority needed to ensure that all patients at Greenfields were being protected from potential abuse.
- In the sexual health service there was no system in place to follow up patients this included those considered to be particularly at risk if they missed their appointments.

However:

- Inpatient wards were visibly clean and well maintained. The corridors were clear and clutter free. Bedrooms we inspected were visibly clean. Patients told us that wards were routinely clean and tidy.

Requires improvement

Summary of findings

- We observed good assessment and management of risk throughout most provider services. Ligature risk assessments were in place and well managed either by rectifying the issues identified or by actively managing the areas where risk was identified to reduce the risk to patients. The provider had a policy in place on the management of patient observations and we saw evidence that this was followed by ward staff.
- The provider was taking proactive steps to address their recruitment and retention issues.
- The provider had robust processes in place to identify and report serious incidents. For example, we observed good assessment and management of risk throughout most of the provider's services.

Are services effective?

Good

We rated effective as good because:

- Staff carried out comprehensive assessments of patients' needs. Most records we reviewed confirmed that these had been completed.
- Where staff had identified particular needs, they had put care plans in place to address these. In inpatient services, these plans addressed patients' physical as well as mental health care needs.
- Care plans were person centred and holistic; there was clear patient involvement in care planning.
- We found that effective multi-agency meetings took place that enabled staff to share information about patients and review their progress. We noted that different professionals worked together effectively to assess and plan patient care and treatment.

However:

- Not all staff received regular supervision and support in line with the organisations policy.
- MHA training was considered essential for some teams and appeared to be regularly delivered and accessed by staff. However, there was no record of this held locally or at provider level to ensure the right staff had received the correct level of training.
- Not all relevant policies and procedures we reviewed had been updated following the implementation of the revised MHA code of practice. For example the policies for both adults and under 18's HBPoS had not been updated since the revised MHA Code of Practice had been introduced in April 2015.

Summary of findings

Are services caring?

Good

We rated caring as good because:

- The majority of patients were positive about the staff, and their experience of care on the wards. Patients and their families or carers had the opportunity to be involved in discussions about their care. Many felt their mental health had improved as a result of the service they received from the provider.
- Staff demonstrated a good understanding of the individual needs of patients. Robust provider wide systems were in place to promote patient confidentiality.
- Most patients and their carers told us that patients were orientated to their ward on admission and were shown around the ward by staff.
- Staff demonstrated a high level of care in their interactions with patients across all services.
- In end of life care services patients and family members fed back that they felt involved and we observed an approach that cared for the whole family when supporting patients at the end of life.

Are services responsive to people's needs?

Good

We rated responsive as good because:

- Community health services provided by the organisation were planned and delivered to take into account the needs of local people.
- Generally access to the community health services was timely. The average wait time to treatment in the minor injury units was as good as, or slightly better than, urgent care centres nationally and people had access to timely assessment, care and treatment in the community inpatient areas.
- Planning of appointment times and venues was flexible; patients could be seen outside of core working hours and at a choice of venues suitable to them, including their own homes.
- Facilities were generally welcoming and promoted recovery and well-being; we saw refurbishment of outdated wards to make them more suitable for patients needs from a recovery perspective.
- Patients and carers knew how to make a complaint and would be supported to follow the complaints process if needed.
- Generally all facilities used by the provider were accessible to people with disabilities. The inpatient CAMHS unit had full disabled access and had been awarded a five star rating of disabled access and facilities by 'Disabled go' which was an access guide for the locations accessibility using access icons and other information regarding access.

Summary of findings

- In urgent care the needs of people with complex needs were well understood and addressed appropriately.
- Bed occupancy was high across the wards. However, patients were always able to return to their own bed when they returned from leave and leave beds were not allocated to another patient.
- In end of life care services a quarterly meeting of the service user and carer engagement forum enabled people to influence the future direction of the service development and delivery.

However:

- X-ray services were not always available when people needed them in the urgent care setting.
- Waiting times were not transparent in the CAMHS community service; the provider reported that all patients were seen within the 18 week waiting time. However, the provider considered the triage as the start of treatment, rather than the initial assessment. This meant that some young people had long waits to access treatment.

Are services well-led?

Good

We rated well-led as good because:

- Staff knew and understood the values of the provider. Most front line staff were aware of and could describe them.
- Staff knew who senior managers in the provider were and said they were visible. Senior managers and board members had visited all locations. Non-executive directors had a good understanding of the trust's strategy.
- Governance structures were robust. There were a range of polices and procedures in place and staff had access to relevant information to undertake their role.
- Staff were positive about the provider as an employer. They described an organisation that looked after their staff, encouraged individual services to improve and had a 'no-blame' culture.
- The provider had participated in a number of applicable Royal College of Psychiatrists' quality improvement programmes or alternative accreditation schemes across a range of core services.
- Action plans and lessons learnt were put in place following investigations in to serious incidents, risk registers were held at local level and staff knew how to contribute to these.

However:

Summary of findings

- Regular supervision and appraisals did not always take place and these were not documented in line with policy. The inspection team were not always able to say if supervision was appropriate and effective.
- Some staff side representatives did not all feel they had sufficient allocated time to address staff matters and did not always feel they were consulted in a timely way.

Summary of findings

Our inspection team

Our inspection team was led by:

Chair: Andy Brogan, executive director of mental health and executive nurse, South Essex Partnership University NHS Foundation Trust.

Head of Inspection: Pauline Carpenter, Care Quality Commission (CQC).

Team leader: Nigel Timmins, CQC.

The team included three CQC inspection managers, 19 inspectors, two assistant inspectors, two mental health act reviewers, two pharmacy inspectors, and an inspection planner. There were also three new inspectors who were shadowing this inspection.

There were also 32 specialist advisors from a variety of mental health and community health service backgrounds. Including medical directors, psychiatrists, consultants in community health services, social workers and registered mental health nurses operating in a range of roles and at various grades. Each specialist advisor had recent experience of working in services similar to these.

In addition, the team included one expert by experience that had personal experience of using both mental and community health services.

Why we carried out this inspection

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

How we carried out this inspection

To get to the heart of people who use services' experience of care, we always ask the following five questions of every service and provider:

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

Before the visit, the inspection team:

- Reviewed information that we hold on the provider.
- Requested information from the provider and reviewed that information.
- Asked a range of other organisations that the provider worked in partnership with for feedback. These included local clinical commissioning groups, Healthwatch, local authority overview and scrutiny committees, Health Education England, and other professional bodies.
- Met with a number of user and carer groups, both internal and external, to hear their views on the provider.
- Reviewed information from patients, carers and other groups received through our website.

During the announced inspection visit from 21 to 24 June 2016, the inspection team:

- Observed over 76 episodes of care and interactions between staff and patients in wards, clinics and visit's to people's homes.
- Spoke with 222 people who used the services, carers or their family members who used the services and reviewed 76 comment cards that we had left in patient areas before the inspection.
- Spoke with 422 staff who worked within the provider such as nurses, doctors, therapists and support staff.
- Interviewed the chair of the board, the chief executive officer and all the executive directors.

Summary of findings

- Held 18 focus groups with admin staff, both qualified and non-qualified nursing staff, black, minority and ethnic (BME) staff, the provider's governors, non-executive directors and union representatives.
- Interviewed the senior managers within the provider, including 79 managers of services, such as ward managers and team leaders.
- Reviewed 233 care and treatment records of people who use services.
- Visited all of Plymouth Community Healthcare CIC's registered locations.

Following the announced inspection:

- One unannounced inspection took place to gather additional information to support the findings of the main inspection.
- A number of data requests were also met by the provider.
- We received an update from the provider regarding the immediate actions taken as a result of the high level feedback provided at the end of the inspection.

Information about the provider

Plymouth Community Healthcare (trading as Livewell Southwest) is an independent social enterprise company. Plymouth Community Healthcare CIC Head Office, previously NHS Plymouth provider services, officially formed on 01 October 2011 as an independent health services provider separate to the commissioning organisation, NHS Plymouth. It provides community physical and mental healthcare for around 270,000 people in Plymouth as well as some specialist services for those living in Devon and Cornwall. Plymouth community Healthcare employs 2,900 staff and has an annual financial turnover of about £110 million.

Plymouth Community Healthcare CIC has been registered with the CQC since 30 September 2011 and is registered to carry out the following regulated activity:

- Nursing care
- Family planning services
- Treatment of disease, disorder or injury
- Assessment or medical treatment for persons detained under the 1983 Act
- Surgical procedures
- Diagnostic and screening procedures.

The CQC inspection covered 11 mental health and six community core services:

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

And:

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

The provider has been inspected three previous inspections on Plymouth Community Healthcare CIC Head Office. The most recent inspection occurred on 06 August 2013 – 08 August 2013 and was found to be compliant in each area inspected.

There were eight wards where patients were detained under the Mental Health Act. Seven of these had had an unannounced MHA reviewer visit between November 2014 and June 2016. The reports of these visits were broadly positive. However, there were between two and five issues requiring action for each ward. The most common issues were:

Summary of findings

- The involvement of patients and family members in care planning (including the development of advance statements of wishes and feelings).
- The explanation of patients' rights in accordance with section 132 of the MHA.
- The assessment of capacity and consent to treatment.
- Staff understanding of the updated MHA Code of Practice and its guiding principles and the review of policies in light of the updated code.

What people who use the provider's services say

- Most patients told us that they received kind and courteous support from staff.
- Many felt that their mental health had improved as result of the service they received from the provider.
- Carers of young people accessing the neuro development team and the severe learning disability team told us that when a key worker left or were on long term leave it was hard to get their child seen by the team, even when they felt their child was in crisis. Two carers told us that the multi-disciplinary team did not respond to their requests for support until their children were admitted to general hospital.
- Carers, children and young people told us about long waiting times to receive a service as the access to the community CAMHS service was not open and transparent. The provider was recording initial assessment as the start of treatment, even though people were placed on waiting lists for specialist treatment following initial assessment. The provider was not reporting this second wait as part of people's waiting times, so key performance indicators were not reflecting the true experience of children and young people.

Good practice

- Staff on wards for older people had put photographs on the outside of doors and non-patient areas to show patients what was behind the doors.
- Cothele ward had talking books and wind up radios for patients to use if they became unsettled at night time. This was used as a distraction technique and staff reported that patients became settled quickly when they listened to the talking books.
- The community learning disabilities team had been recognised for repatriation of people from long stay hospitals out of the area. They had successfully repatriated 18 people from out of area hospitals to their families, friends and communities. They were recognised nationally for this work and were awarded the Nursing Times Award for Learning Disabilities Team of the Year in 2015.
- Lee Mill hospital had taken a progressive approach toward managing issues relating to illicit substances previously referred to as "legal highs" within the ward environment in order to protect and maintain the safety of the patients and the staff team. This had been previously reported as a difficult issue to manage and was now being effectively managed with robust care planning and risk assessments to reduce the problem.
- There were opportunities for health care assistants to complete a training programme to enhance their skill levels as assistant practitioners, and to take on additional responsibilities at a higher banding with a view to developing their careers within the healthcare setting.
- The neuro development team were piloting a parenting skills course, Ascend, for parents of children with autistic spectrum conditions (ASC). As current practice within CAMHS teams nationally is only to diagnose ASC and then offer advice, this was a significant addition to what would be expected from similar services.
- On the acute ward every nurse carried a small ligature cutter that was safe to carry with their personal alarm. These personal, folded ligature cutters had been introduced in response to an incident a few years earlier.
- The Glenbourne Unit had a monthly carers' group meeting and a working group for carers regarding the triangle of care – a working model of how to involve carers as an integral part of patients' care.

Summary of findings

Areas for improvement

Action the provider MUST take to improve

Long stay and rehabilitation wards for adults

- The provider 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

Wards for older people with mental health problems

- The provider must ensure that patients can wake up and go to bed when they want to and have access to their bedrooms during the day.
- The provider must ensure that the wards have doctors on site 24 hours daily and access to the junior doctor rota.

Community based mental health services for adults of working age

We issued a Section 29 warning notice on 15 July 2016 which told the provider they must make significant improvements to the following areas:

- The provider must ensure that care and treatment is provided in a safe way for patients.
- The provider must ensure that they assess the risks to the health and safety of patients receiving care or treatment.
- The provider must ensure that they do all that is reasonably practicable to mitigate any such risks.
- The provider must ensure that persons providing care or treatment to patients have the qualifications, competence, skills and experience to do so safely.
- The provider must ensure the proper and safe management of medicines.
- The provider must ensure that systems or processes are established and operated effectively to assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of patients in receiving those services).
- The provider must ensure that systems or processes are established and operated effectively to assess, monitor and mitigate the risks relating to the health, safety and welfare of patients and others who may be at risk which arise from the carrying on of the regulated activity.
- The provider must ensure that sufficient numbers of suitably qualified, competent, skilled and experienced persons are deployed.
- The provider must ensure that persons employed by the service provider receive such appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform.

Mental health crisis services and health based places of safety

- The provider must update their policies forboth adults and young peoples' places of safety in line with the revised MHA Code of Practice which had been introduced in April 2015.

Specialist community mental health services for children and young people

- The provider must ensure that staff assess young people promptly after they have been referred and are transparent with people about waiting times.
- The provider must ensure that all staff including agency staff have current DBS checks in place before commencing work with children and young people.
- The provider must operate an effective complaints procedure.

End of life care

- The provider must ensure that treatment escalation plans and do not attempt resuscitation decisions are appropriately completed and recorded in line with organisational policy and that audits of these lead to measurable action plans used to improve performance.

Urgent care services

- The provider must ensure that healthcare assistants have been assessed as competent before carrying out initial clinical assessment of patients.

Summary of findings

- The provider must ensure that healthcare assistants do not re-direct patients to other services before the patients have been assessed by a registered practitioner.
- The provider must ensure that all practitioners have been trained in immediate life support for adults and children.
- The provider must carry out a risk assessment of child and adult resuscitation facilities at South Hams and Tavistock to ensure they are suitable for an isolated unit.
- The provider must ensure that patients in waiting areas can be observed by staff at all times.

Action the provider SHOULD take to improve

Long stay and rehabilitation mental health wards

- The provider should identify which staff require essential MHA training and keep a record of their attendance.
- The provider should ensure patients at Syrena House have dynamic recovery programmes based upon a comprehensive assessment of occupational need.
- The provider should ensure that the staff team at Syrena House have on site administrative support, to ensure that staff time is being utilised effectively.

Forensic inpatients/secure wards

- The provider should consider removing the ligature points found on the ward or replacing them with anti-ligature fittings so that patients can freely access all communal areas on the ward.
- The provider should identify which staff require essential MHA training and keep a record of their attendance.
- The provider should ensure the arrangements for the completion of the planned works to the reception area and the seclusion rooms is progressed in a timely way.

Child and adolescent mental health wards

- The provider should ensure that staff are familiar with task that are undertaken infrequently i.e. rapid tranquilisation and the use of seclusion to ensure that when required staff were skilled to deliver the necessary intervention.
- The provider should ensure that the clinical room fridge temperatures are recorded daily to ensure it is within the correct temperature range.
- The provider should log room temperatures in the clinic room to ensure that ambient temperature drugs are stored within the correct temperature range.
- The provider should ensure that all medicines are collected and disposed of safely within agreed timeframes.
- The provider should ensure that all staff complete mandatory training.
- The provider should identify which staff require essential MHA training and keep a record of their attendance.
- The provider should display notices next to locked exits and entrances explaining the rights of informal patients on the unit to leave the premises.
- The provider should ensure that transfers take place at a suitable time of the day.

Wards for older people with mental health problems

- The provider should ensure that all staff complete basic life support mandatory training.
- The provider should ensure that changes in the frequency of modified early warning score should be initialled and dated by staff making the changes to ensure that risk is calculated in relation to patients' physical health.
- The provider should ensure that rationale is documented when staff assess patients' capacity.
- The provider should ensure that care plans are updated following incidents with patients.
- The provider should ensure that staff monitor the clinic room temperature on Edgecumbe ward to ensure that medicines stored there are kept below the manufacturer's required maximum temperature.
- The provider should ensure that ligature assessments list dates

Community based mental health services for adults of working age

- The provider should ensure that information about advocacy is easily accessible for all service users.
- The provider should ensure that they encourage patient and carer participation in developing and improving the service.

Mental health crisis services and health based places of safety

- The provider should ensure that all statutory and mandatory training is completed by staff.

Summary of findings

- The provider should ensure that staff are receiving regular supervision and appropriate records are being kept.

Community based mental health services for older people

- The provider should provide staff with the appropriate support and engage in change management approaches when reviewing the service.
- The provider should consult with staff regarding service developments and proposed moves.
- The provider should address the issue of the functional team having five staff members absent from work with long term sickness.
- The provider should review the working arrangements and locations of social workers with a view to fully integrate them into the service.

Specialist community mental health services for children and young people

- The provider should ensure risk assessments are up to date and cover known risks for the people the provider supports, particularly people with severe learning disabilities.
- The provider should ensure that care plans are accessible to all relevant staff.
- The provider should ensure that the lone working policy is implemented including staff carrying appropriate alarms.
- The provider should ensure signs are in place so that people are aware when audio and video monitoring is taking place.
- The provider should ensure staff have training to understand mental capacity, Gillick competence, Fraser guidelines and best interest decision making.
- The provider should ensure that discharge planning is a key part of treatment and support plans.

Community mental health services for people with a learning disability

- The provider should consider a structured system and setting timeframes for assessing cases that were considered urgent.
- The provider should ensure learning from incidents and complaints is shared across the service.

Community health services for Adults

- The provider should continue to review the staffing levels and skill mix across the core service, particularly within the district nursing service. They should ensure staff are appropriately supported and the wellbeing of staff is improved. Patient safety should be assessed and confirmed staffing levels are not putting patients at risk.
- The provider should put in place a system to audit records that are completed on the electronic patient records system.

Community Health Services for children and young people

- The provider should ensure that staffing is assessed as appropriate for the needs of the community using national guidance tools.
- The provider should ensure all areas used by children and families are assessed to maintain standards of infection prevention and control.

Community health services for inpatient services

- The provider should regularly audit the supply and storage of medicines to monitor compliance with the organisation's Safe and Secure Handling of Medicines Policy, and ensure they are stored in line with the manufactures recommendations.
- The provider should review the supply of medicines to all wards and its impact on patients' timely access to medicines.
- The provider should support all patients to manage their own medicines where appropriate.
- The provider should ensure all wards have sufficient and regular input from pharmacy services to ensure patients have their medicines reconciled in a timely way, in line with NICE Guidance.
- The provider should ensure patients own medicines are not used as stock, when they are no longer needed.
- The provider should ensure there are plans in place to address the fire exit in Tavistock hospital to ensure this is easily serviceable to all patients.
- The provider should ensure the equipment put in place on Skylark ward is effective in maintaining an appropriate air temperature on the ward.

End of life care

- The provider should consider appointing an end of life care lead at board level.

Summary of findings

- The provider should ensure that there is a clear, consistent approach in relation to planning care for patients that is based on national and evidence-based guidance.
- The provider should ensure that a clear vision and strategy is developed that incorporates all aspects of community end of life care. Ensure that patient outcomes are measured and tools developed to monitor the quality of the community end of life care service as a whole.

Urgent care services

- The provider should appoint a lead nurse for children in the minor injuries units to ensure that their needs are met.
- The provider should introduce a more rapid assessment by a competent member of staff, within 15 minutes of arrival at the MIU.
- The provider should provide enough practitioners to ensure that units do not have to close at short-notice.
- The provider should improve consistency in the recording of clinical details across all three units.
- The provider should ensure that there is strategic oversight of the MIUs to support the integration of these services.
- The provider should include the minor injuries units in wider organisational governance arrangements.
- The provider should review all clinical guidelines to ensure that they reflect the most recent national guidance.
- The provider should consider the use of paediatric and adult pain scores to ensure consistency of treatment.
- The provider should ensure that X-ray equipment at South Hams hospital is appropriate for the accurate diagnosis of suspected broken bones.
- The provider should ensure that is makes the availability of x-ray facilities clear to the public and that patients may be advised to attend the nearest acute trust for x-ray.

Sexual Health services

- To have a formal system in place to follow up patients, particularly those considered to be at risk, when they did not attend a booked appointment.
- To have a written flow chart for administration staff to follow when managing telephone calls about clinical queries, particularly in the absence of a clinician to take the call. Advice should include details about the actions to take depending on the urgency of the symptoms, for example make a routine appointment; a clinician will call as soon as possible, or go to A & E.

Plymouth Community Healthcare CIC, also known as Livewell Southwest

Detailed findings

Mental Health Act responsibilities

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

- The operations of the Mental Health Act (MHA) were overseen and reviewed by the Mental Health Act Governance Group, which met quarterly. This group was chaired by the provider's mental health professional lead, who line managed the Mental Health Act manager. The terms of reference contained a membership list with members drawn widely from across the organisation. The organisation's non-executive directors had an open invitation to the governance group, but were not listed as full members. However, we were told that this had recently changed, so that there was, at the time of our visit, a full non-executive member of the group. The organisation's description of the group, given to us prior to the inspection, stated that it was chaired by a non-executive director, which was not the case. There was a comprehensive Scheme of Delegation for Functions of the Mental Health Act.
- The management and scrutiny of MHA paperwork appeared to be thorough and in accordance with the Code of Practice. Information about a person's detention and the paperwork was entered or uploaded onto the organisation's electronic record. The electronic record was also used to record dates (taken from a spreadsheet) for renewals, requests to the CQC for second opinion appointed doctors, and consent to treatment certificates.
- MHA training was considered essential for some teams and appeared to be regularly delivered and accessed by staff. However, there was no record of this held locally or at provider level to ensure the right staff had received the correct level of training.
- We observed copies of the Code of Practice 2015 on some of the wards visited and staff appeared to have a good knowledge of the Code and its guiding principles.

Further details can be found in the main body of this report.

Mental Capacity Act and Deprivation of Liberty Safeguards

- Training in mental capacity was not a mandatory training course for staff at the provider. We were told that there had been a recent audit of the use of the MCA and we saw the report of an audit of capacity assessments for Kingfisher ward and a subsequent action plan which identified the need for further training.

Detailed findings

- Practice within the organisation was guided by a clear and comprehensive policy. The policy outlined the MCA, the MCA Code of Practice and the interface between the MHA and the MCA. It also included a number of templates for staff use.
- Applications for DoLS were used frequently in some parts of the organisation, particularly in the small community hospitals, the neurological unit, and the mental health wards for older people. During 2015 there were 137 applications. Between January and June 2016 there were 70. At the time of our inspection there were 20 applications to the relevant local authorities, none of which had received an assessment. Generally fewer than 20% were authorised. Assessment and authorisation were subject to significant delays, and the majority of patients did not receive an assessment before discharge. Priority was given to mental health wards.
- Each unauthorised deprivation of liberty was reported as an incident and a weekly report was made to the executive team and the Integrated Safeguarding Committee. In addition, quarterly reports were made to the organisation's commissioners. It appeared that the advice to the organisation was to continue to complete applications.

Requires improvement

Are services safe?

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

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

Summary of findings

We rated safe as requires improvement because:

- Staff in the Community Mental Health team for adults of working age did not manage the waiting lists effectively or safely. They did not follow a systematic process to ensure that risks for people waiting to be allocated to a key worker was safely managed
- In end of life care services, 'treatment escalation plans' and 'do not attempt resuscitation decisions' forms were not always appropriately completed and recorded in line with organisational policy.
- Healthcare assistants in urgent care services were not always assessed as being competent before they were allowed to carry out initial clinical assessment of patients.
- The staffing levels and skill mix across the organisation was not always safe, particularly within the district nursing service. Staff were not always appropriately supported and the wellbeing of staff was at risk of harm.
- The provider was not always adhering to the safeguarding policy and was not consistently raising safeguarding alerts to the Local Authority safeguarding team and the Care Quality Commission. At the time of our inspection there was a whole service section 42 safeguarding enquiry in place led by the Local Authority safeguarding team as result of alleged non-reporting of significant safeguarding concerns at Greenfields ward. A section 42 enquiry applies where a local authority has reasonable cause to suspect that an adult in its area who has needs for care and support is experiencing, or is at risk of, abuse or neglect, and as a result of those needs is unable to protect himself or herself against the abuse or neglect or the risk of it. The whole service enquiry was in place as the Local Authority needed to ensure that all patients at Greenfields were being protected from potential abuse.
- In the sexual health service there was no system in place to follow up patients this included those considered to be particularly at risk if they missed their appointments.

However:

- Inpatient wards were visibly clean and well maintained. The corridors were clear and clutter free. Bedrooms we inspected were visibly clean. Patients told us that wards were routinely clean and tidy.
- We observed good assessment and management of risk throughout most provider services. Ligature risk assessments were in place and well managed either by rectifying the issues identified or by actively managing the areas where risk was identified to reduce the risk to patients. The provider had a policy in place on the management of patient observations and we saw evidence that this was followed by ward staff.
- The provider was taking proactive steps to address their recruitment and retention issues.
- The provider had robust processes in place to identify and report serious incidents. For example, we observed good assessment and management of risk throughout most of the provider's services.

Our findings

Safe and clean care environments

- Inpatient wards were visibly clean and well maintained. The corridors were clear and clutter free. Bedrooms we inspected were all clean. Patients told us that wards were routinely clean and tidy. We saw cleaning schedules and these were fully completed and dated, showing that the provider had a commitment to maintaining a clean and safe environment.
- Staff received mandatory training in infection control and all staff were up to date with this training at the time of our inspection. Hand gel was available in reception and soap was available in the staff and patient toilets.

Hand washing signs were displayed in communal toilets. We observed that staff followed correct hand washing procedures during the dispensing and administration of medication. Hand gels were available on entrances to wards. Staff conducted regular infection prevention and control audits, to ensure that patients and visitors were protected against the avoidable risks of infection.

- The provider had a ligature policy and staff adhered to it. A ligature point is the term used to describe a place or anchor point to which patients, intent on self-harm, might tie something to for the purposes of strangling themselves. Front line staff carried out regular ligature risk assessments and identified areas that needed improvement. Ligature cutters were available on the wards and staff knew where they were kept. Staff on the acute inpatient wards carried ligature cutters on their person at all times. The service mitigated against the likelihood of patients ligaturing in bathrooms and bedrooms, for example by installing ligature proof door handles and collapsible curtains.
- Some wards were purpose built with a layout that allowed full line of sight to the bedrooms and patient areas.
- The layout of both HBPoS enabled staff to observe patients safely whilst in the suites. We saw that there were ligature risk assessments undertaken and risks were mitigated by the presence of staff at all times. We observed on the risk assessment at the Glenbourne place of safety (HBPoS) that access to the shower was considered to be high risk but was mitigated by staff observation whilst patients used this room.
- All seclusion rooms had sight of a clock and some natural light, with the exception of the HBPoS which didn't have a clock. Each seclusion room contained a toilet. There was clear observation and one-way communication in each seclusion room.
- All wards were compliant with the Department of health guidance on same sex accommodation.
- Wards had fully equipped clinic rooms with emergency equipment which was accessed by staff in emergencies. Records showed that the emergency equipment was regularly checked and maintained by staff. The clinic room on Edgecumbe ward was warm and staff did not monitor the temperature. This meant that staff did not ensure that medicines stored there were kept below the manufacturer's required maximum temperature.
- In the CMHT east service, the examination couch had failed infection control standards as it was ripped. However, it had not been removed from the room. The east team clinic room was very hot, and there was no room thermometer so it could not be checked. The team said that they did not use the room with patients because of the heat and they found it was too cramped to use with patients who might be agitated.
- There was a strong focus on staff safety and personal alarms were available to ward and community based staff. All staff carried personal alarms. There were security alarms throughout the wards and in bedrooms. The ward's alarm system allowed staff to carry alarms throughout the ward and call for assistance if needed. Other staff could find the location of the caller via a display in the main reception office.
- Community staff had access to personal alarms if they were lone working. If staff required assistance, the alarms indicated the staff member's precise location via a global positioning system to the central security office.
- Some wards used regeneration ovens to re-heat meals, this was effectively monitored and staff demonstrated that food was kept at the appropriate temperature for the correct amount of time.
- Frontline staff informed the maintenance company or facilities department when any remedial work was required, and the improvements were carried out in a timely manner.
- Staff disposed of sharp objects, such as used needles and syringes, appropriately. The checklist cleaning logs in clinic rooms were up-to-date. The unit carried out regular safety tests for electrical items. Testing of items we looked at were mostly up to date.

Safe staffing

- We received data from the provider in regard to sickness, turnover and vacancies for the period 01/02/15-31/01/16; this showed that of 2530 staff there had been 373 staff leave the organisation, a percentage rate of 15% of all staff. Permanent staff sickness rates were at 5% during this period and there were 10% of staff substantive staff posts unfilled.
- We were informed and we saw that the organisation was making effort to recruit into the vacant nursing posts and were attempting to develop health care assistants within the organisation to be trained up into the registered nurse roles.

Requires improvement

Are services safe?

- The provider had a bank of staff which consisted of registered staff and HCAs who worked across the organisation and were available to work extra shifts. This meant that the wards were mostly able to call on consistent workers who were already known to the patients and staff to cover staff absence.
- Ward managers were able to bring in additional staff if patients' needs changed for example; we observed that when patients with challenging behaviour were admitted to Cothele, the ward manager brought in additional health care assistants to ensure there was safe staffing to meet the additional patient need.
- Generally the wards used agency and bank staff appropriately; all bank and agency staff used were familiar with the wards and needs of this patient group. All agency staff read the observation and organisation policies before working on the wards. However, at Plymbridge House we did see an agency member of staff in post without a disclosure and barring check. We raised this with the ward manager and the worker was removed from active patient duties until this could be resolved.
- There were sufficient staff on each shift to carry out physical interventions for example restraint if required, and back up staff were available. Rotas that we reviewed demonstrated that staffing complements had been mostly maintained despite some wards experiencing staff vacancies.
- The community mental health teams for adults of working age had significant issues recruiting and retaining staff in the south and west teams. The provider provided data for sickness and staff turnover from 1 February 2015 to 31 January 2016. This showed that the west team had a 33% vacancy rate, 10% sickness, and 48% staff turnover. The south team had a 15% vacancy rate, 6% sickness, and 20 % turnover. These difficulties in recruitment and retention were not experienced by the other community mental health teams across community mental health service and staffing in the east team was stable for all staff except doctors. Staff in the HTT told us that the issues in the CMHT meant that they patients stayed on their caseloads longer than they should as there was nowhere to safely refer them onto in the community.
- The provider was aware of the staffing difficulties in the east and west CMHT's and it featured on its corporate risk register. However, despite this, the provider had not undertaken a thorough analysis of staffing in order to understand the root causes of the difficulties or the reasons that some teams were affected more than others. The provider did not have a specific strategy in place for the community mental health teams to address these issues. Between 1 June 2015 and 31 May 2016, 2,444 visits and appointments were cancelled by the CMHT. The reasons for these cancellations were not recorded, but staff told us that appointments were often cancelled due to lack of staff.
- The provider compliance rate for mandatory training was 80%.

Assessing and managing risk to patients and staff

- We saw evidence that risk assessments and risk management was positive for most services.
- Mental health community patient care and treatment records contained crisis plans outlining what patients should do and who they should contact in an emergency. Crisis plans for these teams contained information on relapse indicators and warning signs.
- In the learning disability and autism service crisis plans and advance decisions and advance statements were created for patients. During a home visit we witnessed a discussion about advance decisions and advance statements both of which were explained clearly to the patient. Not all patients had crisis plans, crisis plans were only developed if it was felt necessary for the individual patient. The team worked hard to prevent crises by liaising with other agencies involved. For example, they asked care providers to complete a monthly form to identify if there were any forthcoming destabilising factors, such as a member of staff leaving the facility where a patient lived or spent time.
- There were good personal safety protocols to keep staff safe. There were personal alarms for staff going out to visit patients which could also record conversations and call the police. In the CAMHS community team however, we observed that many staff were not taking these devices with them when going out on visits. We discussed this with managers who showed us that enforcing the lone worker policy was a recognised issue in the service and was on the matron's risk register.
- Staff also had mobile phones and could use a code phrase when phoning the team base to denote they needed help and in some teams there was also a buddy system for working beyond normal working hours.

Requires improvement

Are services safe?

- Staff were required to sign the lone working policy to show they had read and understood it. The clinical records system had the facility to place warnings on patient notes, for example, to show the patient should only be visited in pairs.
- Most of the specialist teams told us that the risk assessment tools were comprehensive. However, the CAMHS community severe learning disability team told us that the tools did not cover all the risks that their client group could present. This included behavioural and physical health risks related to lack of mobility and behavioural risks such as being sexually uninhibited due to poor social awareness. Staff in this team relied on their experience and knowledge of risks to carry out effective risk assessments. We observed discussions on risks to children and young people accessing this service in multi-disciplinary meetings.
- Overall, the restrictions in place were appropriate for the core service. However, on Cothele ward there was a blanket restriction in place with regard to patients' waking and sleeping times. The ward was built on two floors (ground floor and lower ground floor) and the sleeping areas were situated on the lower ground floor. Due to the difficulty of staffing for patients on two floors at the same time, there was a timetable for getting up in the morning and going to bed at night so that staff concentrated their work together on one floor of the ward. Patients got up at 8am and had breakfast upstairs at 8.30am. They were allowed access to their bedrooms from 1pm to 2pm if they wished. In the evening they went downstairs after evening medication between 10pm and 10.30pm to sleep. This practice meant that patients did not have free access to their rooms throughout the day and did not have the choice to sleep into the morning or go to bed earlier if they wished. The manager told us staff were as flexible as possible and risk assessed staffing levels if a patient requested to go to their room at a time outside the timetable.
- The provider had policies and protocols tailored to meet the specific needs of different patient groups and staff had received recent physical intervention training that included de-escalation and restraint. Restraint was only used after de-escalation techniques had failed. Staff were trained in restraint techniques specific to older people who were frail. These included use of distraction (for example with music or by leading the patient away to a quieter part of the ward) and safe holding of patients. At Plym Bridge House there were up to date policies that staff were aware of that included managing seclusion and managing physical interventions safely with the minimum of restraint.
- Prone position restraint is when a patient held in a face down position on a surface and is physically prevented from moving out of this position. The latest Department of Health guidance stated that if such a restraint is unintentionally used, staff should either release their holds or reposition into a safer alternative as soon as possible. There were 153 episodes of restraint reported by the provider between 1 August 2015 to 31 January 2016, 33 were incidents of prone restraint, 26 of which resulted in rapid tranquilization. Restraint was used on 43 different service users.
- There were 79 incidents of the use of restraint at Bridford and Harford wards in the period from 1 August 2015 to 31 January 2016. Restraint had been used on 18 different patients. Prone restraint had been used 30 times, 24 of which had resulted in the use of rapid tranquilisation. We asked why prone restraint had been used on six occasions without rapid tranquilisation. We were told that the staff had thought they were going to have to use rapid tranquilisation but the patient had either calmed down or accepted oral medication.
- In end of life care services treatment escalation plans (that included do not attempt cardiopulmonary resuscitation) were not always completed in line with organisational policy, including an example with conflicting information relating to a resuscitation decision.
- At the Greenfields unit we saw positive risk management processes. We reviewed eight patient care and treatment records. Each record contained an assessment of risk at admission and had been updated following multidisciplinary team meetings or episodes of identified new risk. Assessments followed the SystemOne template for risk and in addition some staff were trained in the use of the Historical Clinical Risk management 20 tool (HCR-20). This tool enabled staff to understand how patients behaved in the past due to a set of circumstances in their lives at the time. This assisted in assessing the likelihood of a reoccurrence of this behaviour in the future, and ensured that risk management plans were put in place to prevent or minimise harm.
- We saw proactive engagement with patients at Greenfields unit and Lee Mill re the potential risk to

health posed by using illicit substances formerly known as legal highs. This was addressed through educational means rather than restricting patients' leave. Patients known to be at risk were provided with 1:1 educational guidance with regard to how these substances could impair their judgement and interfere with their recovery plans.

- A serious incident in December 2015 had highlighted the issue of risk management plans which were not clearly formulated and that the risk assessment tool on the electronic records only having options available to indicated yes or no rather than rating low, medium or high. No action had been taken as a result of this.
- In the CMHT patients on the waiting list for care coordination were not safely monitored. There was no formal guidance for staff about reviewing risk for people on the waiting list and no monitoring tool was used to ensure consistency.
- Medicines management was generally good. Medicines and intravenous fluids were kept in suitable locked cupboards or cabinets in rooms with restricted access to unauthorised people, medicines were mostly stored at suitable temperatures to maintain their quality and ensure that they were fit to use.
- Pharmacy cover and support varied across the provider locations with daily visits to review prescriptions at Mount Gould and weekly visits at South Hams and Tavistock hospitals. Where the pharmacist visited daily over 90% of patients had the correct doses of medicines. However this was not the case at the other locations. We saw one patient who had been regularly prescribed an incorrect dosage of an intravenous medication over several months.
- There were good self administration of medicines approaches in operation at Plym neurological unit, this included the use of easy read pictorial instructions for patients with literacy difficulties, reminder charts and lockable storage for patients to safely store their own medicines.
- Controlled drug procedures were followed and appropriate storage and security of controlled drugs was maintained, we saw evidence of daily stock checks and all FP10's were stored and manged appropriately.
- There were safeguarding leads for adults and for children in each team. They provided advice to colleagues on safeguarding matters. The majority of staff had received training in safeguarding and were able to identify what constituted a safeguarding concern and the process for escalating these as necessary. Generally the provider had robust systems in place for reporting and monitoring safeguarding concerns.
- However, staff on Greenfields ward were not raising safeguarding alerts when appropriate to do so, or ensuring alerts were passed on to the Local Authority and Care Quality Commission. Some women in their care who were at risk had not had appropriate safeguarding investigations completed or additional protection put in place to ensure their continued safety.

Track record on safety

- In the period 7 January 2015 to 26 January, the provider reported 42 serious incidents through its SIRI reporting system. Of these 37 were incidents that were unexpected or avoidable death or severe harm of one or more patients, staff or members of the public, of these two related to suicide and four unexpected deaths. There was one incident reported for attempted murder. 28 of these incidents related to grade three pressure ulcers. One was an incident of allegations, or incidents, of physical abuse and sexual assault or abuse.
- The provider did not report any 'never events' in the year prior to our inspection. These are defined as 'serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers'.
- CQC received three whistleblowing reports and 113 notifications in the 12 months leading up to the inspection up to 29 March 2016. The majority of notifications received fell into the category of serious injury, this accounted for 46 of the notifications, with 17 notifications received for unexpected death. There was an emphasis on reporting incidents throughout the provider services.
- The Safety Thermometer (a local improvement tool for measuring, monitoring and analysing patient harm and 'harm free' care and involves a monthly snapshot audit) was submitted monthly to the NHS Health and Social Care Information Centre by the community adults service. This data included current and new pressure ulcers, patient falls with harm, and catheter acquired urinary tract infections. Individual teams told us they monitored their safety performance and performed well against the national picture.

- The organisation monitored the incidence of pressure ulcers and had noted a 40% decrease of grade three and four pressure ulcers in the community from the 2014/15 year to the 2015/16 year. When asked why the team thought there had been such a decrease in grade three and four pressure ulcers they said they felt this was due to improved education and training provided to staff.

Learning from incidents

- Learning from incidents was mixed across the organisation; there was an incident investigation team within the organisation who reviewed incidents and gave feedback to include learning points for all teams. In some teams and services we saw pro-active and positive approaches to learning following incidents, in other teams implementation of agreed changes appeared to be slow.
- In the wards for older people we were told about an incident when staff could not gain access to a patient's bedroom and they had switched off their bedroom light so the room was in darkness. This incident meant that staff could not access the patient's room and could only see inside by using a torch. The team worked with the properties team to agree a solution. They agreed to install doors which could be opened in both directions and bedroom lights which could be operated from outside the bedroom in an emergency.
- In the learning disability and autism community team there was evidence the team were learning from incidents. The lone working process had been improved and revised following an incident in a patient's home. The team had undertaken a workplace violence assessment, which investigated how many people were using lone working devices and if they were not using them, why they were not using them. It was decided to give all staff laminated pocket sized cards with information about the lone working devices. The requirement for staff to sign the lone working policy and increased performance management around adherence to the policy was aimed at enforcing it more rigorously.
- On the older persons wards a patient death in 2014 led to a change in practice. Now junior doctors are encouraged to work with consultants in geriatric medicine to improve health care with older patients.
- Although staff were able to tell us what type of incidents would be reported, by whom and how, there had been under reporting of safeguarding alerts on Greenfields ward for a considerable amount of time, resulting in significant concerns for the Local Authority safeguarding team. Safeguarding incidents were therefore not reviewed as they should have been, risk management plans were not put into place to maintain patients' safety, and learning from reviews had not happened.
- The HBPoS held monthly multi-agency 'problems in practice' meetings which discussed many shared issues between the police, the emergency department, the ambulance service and the organisation, including sections 135 and 136. Any significant incidents were reported to the meeting and investigated.
- Every nurse on the acute wards carried a small ligature cutter that was safe to carry with their personal alarm. The ward managers explained to us that these personal, folded ligature cutters had been introduced in response to an incident a few years earlier. The investigation report to the incident had identified there had been a delay in cutting a ligature from a patient's neck because a staff member had to run to the nurse's office to get the cutters. Afterwards all nursing staff were issued with the small ligature cutters to carry with their keys and personal alarm.

Duty of Candour

- In November 2014 a CQC regulation was introduced requiring providers to be open and transparent with people who use services and other 'relevant persons' in relation to care and treatment and particularly when things go wrong.
- We saw evidence in response to complaints that the provider had been open and transparent in acknowledging where they had failed to meet their responsibilities in providing care to the patient or their carer.

Anticipation and planning of risk

- The organisation had a monthly quality and safety meeting which reported to the board and ensured that identified concerns were logged on the risk register. There was effective oversight of the risk register at board level.
- We saw provider wide contingency arrangements in place for adverse weather, IT failure and local systems for working collaboratively with local acute trusts for civil emergencies and major incidents.
- All teams were required to complete a quest form (Quality Effectiveness and Safety Trigger Tool), this form had 20 questions. Sixteen questions were mandatory

risk questions generic to the organisation and four were set locally for the service. The results were fed into the organisations quality and safety monthly meeting and if the score determined a high risk needing immediate action then this would go onto the organisational risk register. Heightened scores promoted a response from the locality or executive team to manage and mitigate any risks.

Good

Are services effective?

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

Summary of findings

We rated effective as good because:

- Staff carried out comprehensive assessments of patients' needs. Most records we reviewed confirmed that these had been completed.
- Where staff had identified particular needs, they had put care plans in place to address these. In inpatient services, these plans addressed patients' physical as well as mental health care needs.
- Care plans were person centred and holistic; there was clear patient involvement in care planning.
- We found that effective multi-agency meetings took place that enabled staff to share information about patients and review their progress. We noted that different professionals worked together effectively to assess and plan patient care and treatment.

However:

- Not all staff received regular supervision and support in line with the organisations policy.
- MHA training was considered essential for some teams and appeared to be regularly delivered and accessed by staff. However, there was no record of this held locally or at provider level to ensure the right staff had received the correct level of training.
- Not all relevant policies and procedures we reviewed had been updated following the implementation of the revised MHA code of practice. For example the policies for both adults and under 18's HBPoS had not been updated since the revised MHA Code of Practice had been introduced in April 2015.

Our findings

Assessment of needs and planning of care

- Staff carried out comprehensive assessments of patients' needs. Most records we reviewed confirmed these had been completed.
- Where particular needs had been identified there were care plans in place to address these. Patients' physical as well as mental health care needs were addressed. Care and treatment records contained up to date information about patients. Most care plans were detailed, person centred and holistic. In the community Learning disabilities and autism team care plans were accessible for patients including the use of capital letters patients own words, large font and symbols.
- Staff stored patient care records electronically. Provider information was held securely. Staff working outside of core office hours, such as the home treatment teams, could access patient records when they needed to in order to treat patients out of hours. However, the substance misuse staff used a system was managed by another substance misuse team outside of the organisation so staff were unable to change the system. Staff felt the system was very slow and ineffective and was not easy to navigate. The manager was aware of this issue but the service commissioners were reluctant to change the system.
- Generally information systems supported effective working in the community health services. However, the community adults team reported there was variable connectivity and access to information via the IT system. This was also reported as an issue in the children's and young people's service.
- Staff held care programme approach meetings to collect and monitor patient outcomes. Patients, their families and relevant professionals were involved in these reviews. Patients were supported to have advocates present at meetings to support them to attend if they required it.

Best practice in treatment and care

- A range of outcome measures were used across all core service. The provider used the health of the nation outcome scales (HoNoS). This is the most widely used routine clinical outcome measure used by English mental health trusts. Staff on Cotehele ward monitored levels of schizophrenia in patients using a commissioning for quality and innovation (CQUIN) framework to improve the quality of care provided to

mental health patients. This was in accordance with NHS professional guidance. The long stay and rehab wards used a modified early warning score which was based on physiological parameters measured on admission and repeated frequently, this benefitted patients by alerting staff to changes in physical health conditions. Syrena House also used a malnutrition universal screening tool to establish and enable monitoring of nutritional risks.

- However, in the end of life care service it was unclear what guidance was being used to support the delivery of end of life care in patients' homes and inpatient units, as there was no evidence-based end of life care plan in use within the service.
- The assessment of nutrition and hydration needs was incorporated into the general nursing assessment in use in the community. For example, the malnutrition universal screening tool (MUST) was completed as part of standard nutritional risk assessments for patients in the community adult teams.
- Physical health checks were carried out were appropriate and in the learning disabilities team physical examinations were undertaken by GPs. The team prompted GPs to complete annual health checks and were monitored on their performance regarding health checks. GPs in turn advised the team if patients did not attend for physical examination. The team had developed an adapted annual health check tool for GPs to use with people with learning disabilities and added a health action plan to it. This tool had been adopted throughout the region.
- All medicine charts that we inspected adhered to British National Formulary guidance. All medicines for detained patients were administered in accordance with consent to treatment forms T2, T3 and section 62 of the Mental Health Act for urgent administration of medication which were up to date.
- There were a number of specialist groups to support young people and carers. One project the neuro development team was piloting was a programme to support parenting of children with autistic spectrum conditions. Current practice for CAMHS teams was to diagnose the condition and then signpost families to educational or social care support. The Plymouth neuro-development team were piloting a project, called Ascend, to develop parent and carer understanding of conditions, and to learn strategies to support the child with autistic spectrum conditions.
- The provider used a range of audit measures to monitor service delivery; these included a seclusion audit, child protection records audit, primary assessment audit within the health visitor service in addition to numerous environmental audits. We saw evidence that learning from these audits was shared with teams and action plans had been developed to improve practice or alter the physical environment as required.
- The provider also engaged in national clinical audits such as National audit of schizophrenia, Sentinel stroke national audit, COPD audit, early intervention in psychosis (EIP) and a Parkinson's disease national audit.

Skilled staff to deliver care

- Staff received induction training which incorporated mandatory training and vision and values training. Specialist training was available, for example, family therapy training and legal frameworks such as the Children Act for all registered staff in the CAMHS inpatient service.
- In the urgent care service it was accepted practice for healthcare assistants to assess and advise people on the seriousness of their injury. They had not received appropriate training to enable them to do this. Although all staff had received recent training in immediate life support for adults, there was no record of how many had received training in life support for children.
- There was evidence of creative recruitment to support staff to fulfil their front line roles; the Glenbourne unit had appointed unit referral co-ordinators and support time recovery workers. The unit referral co-ordinators managed the beds and co-ordinated admissions and discharges. Previously these tasks had been carried out by senior registered nurses. All nurses we spoke to told us that the unit referral co-ordinators had freed them to be able to spend more time on direct patient care.
- Not all staff received supervision in line with the provider's policy; the severe learning disability team children's reported only 25% compliance with the supervision policy. In the community mental health team a band 3 workers had no evidence of supervision for over a year; another band 3 worker who had been in post since 2013 only had a record of joint peer supervision in April 2016.
- Three out of the four locality managers, who each had operational responsibility for the community mental health team for their locality, did not have any mental

health experience and two out of the three team managers had been in post for less than six months. Medical cover relied on locums for three of the community mental health teams.

Multi-disciplinary and inter-agency team work

- We found effective multi-disciplinary meetings took place that enabled staff to share information about patients and review their progress. We noted that different professionals worked together effectively to assess and plan patient care and treatment. At the Glenbourne unit multidisciplinary meetings took place every day. These included doctors, nurses, assistant practitioners, social workers, psychologists, occupational therapists and pharmacists.
- There were good working relationships with other agencies. The HBPoS team held a monthly meeting entitled 'problems in practice' involving the police, emergency department, ambulance and organisational representatives. We reviewed minutes of these meetings which highlighted good inter agency working.
- The substance misuse team form part of a multi-agency approach to treatment of substance misuse in Plymouth. The team were co-located with the other services providing substance misuse treatment, probation and police. This allowed for easy communication and information sharing regarding the client group.
- In the Community mental health teams social workers had been integrated into the provider organisation from social services for one year. However, of the three teams, only one had a social worker and this staff member was new in post. Staff told us that there had been no difference in accessing social work support or joint working since integration took place.
- In urgent care, there were good working relationships with community-based services, such as district nurses and health visitors and with the emergency department and Derriford hospital. In children's and young people's services staff worked with multiple agencies. In end of life care, the specialist palliative care clinical nurse specialists participated in the Gold Standard Framework (GSF) meetings for end of life care that were run by GPs in each locality.

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

- The operations of the Mental Health Act (MHA) were overseen and reviewed by the Mental Health Act Governance Group, which met quarterly. This group was chaired by the provider's mental health professional lead, who was the manager of the Mental Health Act manager. The terms of reference of the governance group included (amongst others) agreeing policies, overseeing the statutory duties in the MHA, receiving any reports or complaints relating to the operation of the MHA, receiving and scrutinising CQC MHA reviewer reports and provider action plans, overseeing the work of associate managers, and recommending training. A review of three sets of minutes confirmed that the governance group discussed these issues.
- We were concerned that not all of the policies and procedures we reviewed had been updated following the implementation of the revised MHA code of practice. For example the policies for both adults and under 18's HBPoS had not been updated since the revised MHA Code of Practice had been introduced in April 2015.
- MHA training was considered essential for some teams and appeared to be regularly delivered and accessed by staff. However, there was no record of this held locally or at provider level to ensure the right staff had received the correct level of training.
- There were four or five training events per year, which included speakers and legal and Code of Practice updates, for staff from throughout the organisation and hospital managers, particularly if they were new to the role. Hospital managers described these as very valuable. Some of these events were linked to hospital managers' meetings.
- We observed copies of the Code of Practice 2015 on some of the wards visited and staff appeared to have a good knowledge of the Code and its guiding principles.
- There was a team of four in the MHA office, headed up by the MHA manager. The team work extended office hours. Although each had responsibility for a particular element of the team's work, all also worked together. A member of the team attended all hospital managers' hearings to provide any necessary advice or information. The team were well known to the clinical and ward-based staff who said they were supportive and accessible for advice and information when needed. In addition they provided MHA advice and training to the large, neighbouring, acute hospital team.
- There was a comprehensive Scheme of Delegation for Functions of the Mental Health Act.

Good

Are services effective?

- The management and scrutiny of MHA paperwork appeared to be thorough and in accordance with the Code of Practice. Information about a person's detention and the paperwork was entered or uploaded onto the organisation's electronic record. The electronic record was also used to record dates (taken from a spreadsheet) for renewals, requests to the CQC for second opinion appointed doctors, and consent to treatment certificates.
- There was evidence that most people had their rights under the MHA explained to them. There was good adherence to consent to treatment and capacity requirements overall. Copies of consent to treatment forms and appropriate certificates were attached to medication charts where applicable. Patients and staff appeared clear on how to access IMHA services appropriately.
- We noted in Glenbourne and Lee Mill that there had been arrangements made by ward staff for a number of patients to be escorted back to their home areas so that they could vote in the referendum.

Good practice in applying the Mental Capacity Act

- The provider had a Mental Capacity Act (MCA) lead who had responsibility for the MCA and Deprivation of Liberty Safeguards (DoLS) policy and training. Training was provided across the organisation, some of it in conjunction with Mental Health Act training. There were four one-day training events per year which tended to be fully booked, and a two hour tailored training session which would be delivered in a ward or unit. A wide variety of staff attended the training events. MCA training was also included in preceptorship and induction days. The programme included the principles of the MCA, capacity assessments, best interests, and the role of the decision maker. In the course of our inspection we heard that one of the minor injuries units and the community child and adolescent team would like MCA training.
- Practice within the organisation was guided by a very clear and comprehensive policy - the Mental Capacity Act including Deprivation of Liberty Safeguards Policy. This policy (available to all on the organisation's website) outlined the MCA, the MCA Code of Practice and the interface between the MHA and the MCA. It also included a number of templates.
- The MCA lead, on occasions, chaired best interests meetings and provided guidance to teams on determining who the decision maker would be in individual cases.
- Records of the use of the MCA were made on the electronic filing system. However some records were stored in different places. An MCA section was under development within the electronic system.
- We were told that there had been a recent audit of the use of the MCA and we saw the report of an audit of capacity assessments for Kingfisher ward and a subsequent action plan which identified the need for further training.
- In some units where assessments of capacity and consent were carried out more regularly many staff appeared to have a good understanding of the principles and deployed the concept of verbal consent and consent forms for children and parents.
- Staff in children's and young people's services described how they would seek consent from a parent or person with parental responsibility for treatment such as immunisations where the child was under 16. If it was appropriate staff would assess a young person's ability to consent using Gillick guidelines.
- Applications for DoLS were used frequently in some parts of the organisation, particularly in the small community hospitals, the neurological unit, and the mental health wards for older people. During 2015 there were 137 applications. Between January and June 2016 there were 70. At the time of our inspection there were 20 applications to the relevant local authorities, none of which had received an assessment. Generally fewer than 20% were authorised. Assessment and authorisation were subject to significant delays, and the majority of patients did not receive an assessment before discharge. Generally priority was given to mental health wards.
- Each unauthorised deprivation of liberty was reported as an incident and a weekly report was made to the executive team and the Integrated Safeguarding Committee. In addition quarterly reports were made to the organisation's commissioners. It appeared that the advice to the organisation was to continue to complete applications.

Good

Are services caring?

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

Summary of findings

We rated caring as good because:

- The majority of patients were positive about the staff, and their experience of care on the wards. Patients and their families or carers had the opportunity to be involved in discussions about their care. Many felt their mental health had improved as a result of the service they received from the provider.
- Staff demonstrated a good understanding of the individual needs of patients. Robust provider wide systems were in place to promote patient confidentiality.
- Most patients and their carers told us that patients were orientated to their ward on admission and were shown around the ward by staff.
- Staff demonstrated a high level of care in their interactions with patients across all services.
- In end of life care services patients and family members fed back that they felt involved and we observed an approach that cared for the whole family when supporting patients at the end of life.

Our findings

Kindness, dignity, respect and support

- We found that patients were treated with kindness, dignity and respect. We saw patients were able to approach staff freely when they wanted help and support or if they were upset. Staff were able to identify when patients needed emotional support and we saw them offering this in an individualised way.
- The 2015 mental health inpatient survey had rated nurses at the Glenbourne unit highest in the country for treating patients with dignity and respect.
- Staff interacted with patients in a caring and compassionate way, showing appropriate levels of humour. They responded to patients in a calm and respectful way. The observed interactions were supportive and enabling. We saw staff listening to and having productive discussions with patients.
- Throughout the organisation staff demonstrated a good understanding of the individual needs of patients. The community learning disabilities and autism team fully demonstrated this approach, by their recognition of the importance of patients to be near to family and friends. The team had won an award for bringing patients who were staying in hospitals out of the area, back home to Plymouth. To achieve this they made visits to hospitals that were a long way away in order to offer opinions and to work on plans to enable patients to come home. This demonstrated a willingness to make efforts beyond what was expected to improve the lives of the patients they worked with.
- We observed a carers group which was well attended and we heard positive comments from the participants. Staff available at this meeting included nursing staff, the mental health crisis manager, therapy leads, the service user experience manager and the lead for the carers group.

The involvement of people in the care they receive

- In the learning disabilities and autism service patients and carers gave feedback about the service through surveys. A meridian survey for the 12 month period from 1 December, 2015 June 30 of June 2016 was completed by 91 people and 92% of them said they would want their friends and family to have the service if they needed it.
- Most patients and their carers told us that patients were orientated to their ward on admission and were shown around the ward by staff. They had received an information leaflet relating to the ward.
- Patients and carers were encouraged to attend to contribute to service delivery in a variety of ways, this included: attendance at business meetings on Cothele ward where feedback could be given on issues affecting patients. Carers had access to carer's forums to provide feedback on the care received and to receive support from other carers. There was a weekly carers groups was available on Edgecumbe ward.
- Throughout the organisation, staff ensured patients could use an independent mental health advocacy (IMHA) service if they needed to. Information about the

Good

Are services caring?

service was displayed on each ward and other patient areas. We saw evidence of a patient with learning disabilities being supported by an advocate during their transition from child to adult services.

- Independent mental capacity advocacy was available to patients this was provided by an external organisation called SEAP (support, empower, advocate, promote), information on this service was available in welcome packs and displayed on notice boards.
- Patients were able to express their views, which staff reflected in the key documents they prepared. Almost all care plans were written in a person centred way and were holistic, which meant they covered all aspects of the patients' care and support needs. Carer's views were also incorporated where it was appropriate to do so.
- Young people at Plym Bridge House could provide feedback and contribute to service development in a number of ways including: community meetings, a suggestion box, staff recruitment amongst others. The ward had recently recruited a participation lead to support young people in getting involved in the development of the service.
- Patients on Greenfields and Syrena wards told us that staff had made contact with them prior to their admission to the ward and they had given them information about what to expect when they were on the ward, they felt comforted by this when they arrived on the ward and saw someone they had already met.
- In the children's and young people's service we saw that staff were working to ensure patients understood their options and we able to make choices in their care.
- In end of life care services patients and family members fed back that they felt involved and we observed an approach that cared for the whole family when supporting patients at the end of life.
- The forensic service wards held weekly community meetings where patients could have a say in the running of the ward. They could give suggestions and make requests for changes to things like menu plans or activities. Patients took responsibility for chairing the meetings. Staff circulated the minutes for future reference.

Good

Are services responsive to people's needs?

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

Summary of findings

We rated responsive as good because:

- Community health services provided by the organisation were planned and delivered to take into account the needs of local people.
- Generally access to the community health services was timely. The average wait time to treatment in the minor injury units was as good as, or slightly better than, urgent care centres nationally and people had access to timely assessment, care and treatment in the community inpatient areas.
- Planning of appointment times and venues was flexible; patients could be seen outside of core working hours and at a choice of venues suitable to them, including their own homes.
- Facilities were generally welcoming and promoted recovery and well-being; we saw refurbishment of outdated wards to make them more suitable for patients needs from a recovery perspective.
- Patients and carers knew how to make a complaint and would be supported to follow the complaints process if needed.
- Generally all facilities used by the provider were accessible to people with disabilities. The inpatient CAMHS unit had full disabled access and had been awarded a five star rating of disabled access and facilities by 'Disabled go' which was an access guide for the locations accessibility using access icons and other information regarding access.
- In urgent care the needs of people with complex needs were well understood and addressed appropriately.
- Bed occupancy was high across the wards. However, patients were always able to returnto their own bed when they returned from leave and leave beds were not allocated to another patient.
- In end of life care services a quarterly meeting of the service user and carer engagement forum enabled people to influence the future direction of the service development and delivery.

However:

- X-ray services were not always available when people needed them in the urgent care setting.
- Waiting times were not transparent in the CAMHS community service; the provider reported that all patients were seen within the 18 week waiting time. However, the provider considered the triage as the start of treatment, rather than the initial assessment. This meant that some young people had long waits to access treatment.

Our findings

Service planning

- Provider board meeting minutes and discussions with commissioners demonstrated that provider services were planned and delivered to meet the needs of people.

Access and discharge

- Access to both community and inpatient services was generally timely for all patients, with the exception of the CMHT for adults where patients were waiting to receive care in excess of the provider's 18 week target. The provider told us that in the community CAMHS service was meeting the target waiting time from referral to treatment of 18 weeks. However, the provider considered the triage as the start of treatment, rather than the initial assessment. Following triage many patients were put on a waiting list for a specialist team, but these waiting times were not reported as part of the key performance indicators. Therefore people were waiting much longer than the target time of 18 weeks to begin the treatment they were assessed as needing, but the provider could not give accurate figures on how long people waited from triage to assessment.
- In urgent care the needs of people with complex needs were well understood and addressed appropriately. However, x-ray services were not always available when people needed them in the urgent care setting.
- In end of life care referrals were prioritised based on assessed patient need. Staff, patients and relatives consistently reported that the community nursing teams

were able to respond quickly to end of life care issues as these were prioritised as part of daily work activities. However, the organisation did not have data specific to end of life care relating to this.

- Support was provided to help ensure children and young people could access services. Staff travelled and set up clinics in all areas of the city and worked flexibly around school and work times where they could. Patients using the sexual services could access the service with a choice of day, evening and Saturday appointments as well as some drop-in sessions at a young people's support centre.
- In the community learning disabilities and autism service urgent referrals were seen quickly and an appointment was arranged as soon as the referral was received. If there was apparent risk in the referral the referral would be allocated for an urgent assessment. Patients who were not known to the service or where their needs were unclear were generally screened earlier
- Generally access to the community health services was timely. The average wait time to treatment in the minor injury units was as good as, or slightly better than, urgent care centres nationally and people had access to timely assessment care and treatment in the community inpatient areas. However, there had been a number of short-term closures of Tavistock and South Hams minor injury units although solutions were being developed.
- The CAMHS community and CMHT both had long waiting times to access treatment, the data submitted by the provider showed discrepancies in the recording of waiting times. The provider considered the triage as the start of treatment, rather than the initial assessment. Following triage many patients were put on a waiting list for a specialist team, but these waiting times were not reported as part of the key performance indicators. Therefore people were waiting much longer than the target time of 18 weeks to begin the treatment they were assessed as needing, but the provider could not give accurate figures on how long people waited from triage to assessment.
- Carers, young people and clinicians expressed concern about the length of time it took to access treatment in the CAMHS community service.
- In the CMHT for adults all teams had higher numbers of admissions into the service than discharges which meant that teams did not have sufficient flow through the service and team caseloads grew beyond capacity. Staff in the home treatment teams told us that they often held cases open longer than they should due to lack of capacity in the CMHT service.
- Bed occupancy rates were high across both community hospital and mental health wards, with the average across all wards at 93% occupancy for the six months from 1 August 2015 to 31 January 2016. However the provider had a commitment to ensuring that patients who were on leave from mental health wards had a bed to return to at all times. There was always access to a bed on return from leave and leave beds were not allocated to another patient.
- Where delayed discharges were identified the provider had robust plans and systems in place to monitor and address these. For example Cotehele ward had four delayed discharges for an average of 19 days and Edgecumbe ward had 12 delayed discharges for an average of 66 days for the period August 2015 to January 2016. Staff told us this was due to a lack of community placements for patients with dementia. All delayed discharges were listed on the risk register including details of why they occurred. The ward managers discussed delayed discharges in weekly meetings with business intelligence staff and locality management.
- Patients with dementia from Edgecumbe ward were not referred to interim placements when waiting for a bed in a nursing home. The team felt it was not in their patients' best interests to disorientate them unnecessarily with an additional care setting while waiting for a longer term placement. This unfortunately caused delays to discharge some patients.
- Between August 2015 and January 2016 there had been two delayed discharges on Greenfields ward and four at Syrena House. The reasons for these delays were in identifying and securing appropriate community accommodation. The ward based rehabilitation services worked closely with the community rehabilitation services and shared some senior clinical staff; this enabled appropriate aftercare post discharge.
- CAMHS teams raised concerns that the adult CMHT services in the Plymouth area, in particular, did not have the capacity to be involved if they needed to plan the transition of young person to the adult community

services. Safe and effective transition from community CAMHS to Adult Mental Health Services (AMHS) was a current commissioning for quality and innovation (CQIN) target.
- Waiting times for triage were monitored and showed that, at Tavistock and South Hams, the average time from arrival to triage was less than seven minutes. (for the year ending May 2016). At the Cumberland Centre for year ending May 2016, patients waited an average of 25 minutes to be triaged. There was a risk their condition could deteriorate during that time.

The facilities promote recovery, comfort, dignity and confidentiality

- The provider's facilities were generally clean and well presented, there were facilities to support people with mobility difficulties, buildings had ramps, access rails adapted toilets.
- The older people's wards had a range of equipment to support patients who were at risk of falls including handling bars and walking frames. Staff on Edgecumbe ward also used hip belts for patients which were fastened around a patient's waist. Staff held onto the belt to support the patient while they walked without causing potential distress by physically holding onto the patient.
- Patients and carers told us that food was varied and of good quality, snacks and drinks were available throughout the day and at night upon request. Ward managers advised us that all dietary needs could be catered for. Patients were able to personalise bedrooms, each room had adequate storage space and lockable cupboards for valuable possessions.
- Patients on Edgecumbe ward also had pictures and photographs which were personal to them displayed outside their bedroom doors. This was done to assist patients with dementia to identify their room.
- Most wards had quiet rooms for patients to use and where they could meet their visitors; there was generally access to outside space and gardens. Where possible staff encouraged patients to take part in gardening clubs.

Meeting the needs of all people who use the service

- The provider's facilities were generally clean and well presented, there were facilities to support people with mobility difficulties, buildings had ramps, access rails adapted toilets, wards had accessible bathrooms and staff were available to support people with bathing if required.
- The older people's wards had a range of equipment to support patients who were at risk of falls including handling bars and walking frames. Staff on Edgecumbe ward also used hip belts for patients which were fastened around a patient's waist. Staff held onto the belt to support the patient while they walked without causing potential distress by physically holding onto the patient.
- In the sexual health service we saw evidence that staff recognised the need for supporting people with complex or additional needs, such as people living with a learning disability.
- Staff in the end of life care service has a good understanding of equality and diversity of patients. We saw outstanding practice in end of life care services in relation to meeting the needs of people living in vulnerable services. There were innovations in both learning disability and alcohol and drug use to improve end of life care for these groups.
- There was access to spiritual support from the chaplaincy and spiritual care team. Where possible patients were encouraged and supported to access spiritual support in their local community.
- At the time of our inspection the east CMHT were using a meeting room to administer a depot injection for a patient. This was because the clinic room was uncomfortably hot and they felt it was too cramped to use with patients who were at risk of becoming agitated or assaultive to staff. This was an unsuitable space and did not protect patients' dignity.

Listening to and learning from concerns and complaints

- In the 12 months to 31 January 2016 the provider received 186 complaints, of these 104 were upheld, no complaints were referred to the Parliamentary and Public Health Ombudsman. Of these complaints, 33, related to staff attitudes and behaviours, 21 related to treatment and the third highest category was appointment cancellations and delays with 19 complaints.
- Between the same time period 45 complaints against community mental health team were upheld. The most common themes of complaints were communication,

Good

Are services responsive to people's needs?

attitude of staff, issues with appointments and provider policy decisions. An action plan had been developed to provide improved customer care training to all staff including clinical staff. This was due to begin July 2016. It was planned that the training would continue indefinitely as it had been accepted that communication was a major influence in patient complaints.

- Formal complaints were fully investigated by senior members of staff (investigating officers). The investigation approach undertaken by the provider was in accordance with the National Patient Safety Agency (NPSA) 'Being Open' Policy published in 2010.
- When the provider sends a response to the complainant it includes an invitation to meet with the investigating officer. The provider informed us that this has been a positive step in the complaint procedure with service users providing feedback with regard to the complaint process as well as an opportunity for the provider to ensure that we have addressed all of the concerns raised by the complainant.
- Staff discussed outcomes of complaints investigations at team meetings and in supervision meetings. There were also formal written communications which detailed complaints information and learning that were produced centrally.
- Complaints and concerns were well managed in the community health services. There was a culture of openness and learning was promoted to ensure organisational learning from complaints. For example, in community adults patients were able to make a complaint or raise a concern. They were treated with openness and transparency. Improvements were made to the quality of the service as a result of complaints and/or incident reports.
- In the community inpatients setting patients told us they felt confident to raise a concern about their care, should they wish to do so, but few people knew how to make a complaint about the service.
- The provider received 1338 compliments during the same 12 month period; the team which received the highest number of compliments was the Early Support Discharge team at Mount Gould hospital with 132 compliments.

Good

Are services well-led?

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

Summary of findings

We rated well-led as good because:

- Staff knew and understood the values of the provider. Most front line staff were aware of and could describe them.
- Staff knew who senior managers in the provider were and said they were visible. Senior managers and board members had visited all locations. Non-executive directors had a good understanding of the trust's strategy.
- Governance structures were robust. There were a range of polices and procedures in place and staff had access to relevant information to undertake their role.
- Staff were positive about the provider as an employer. They described an organisation that looked after their staff, encouraged individual services to improve and had a 'no-blame' culture.
- The provider had participated in a number of applicable Royal College of Psychiatrists' quality improvement programmes or alternative accreditation schemes across a range of core services.
- Action plans and lessons learnt were put in place following investigations in to serious incidents, risk registers were held at local level and staff knew how to contribute to these.

However:

- Regular supervision and appraisals did not always take place and these were not documented in line with policy. The inspection team were not always able to say if supervision was appropriate and effective.
- Some staff side representatives did not all feel they had sufficient allocated time to address staff matters and did not always feel they were consulted in a timely way.

Our findings

Vision, values and strategy

- The provider's strap line is to be 'safe, well and at home' developed through staff consultation. This vision was underpinned by five aims which were linked to the CQC domains.
  - A recognised employee led organisation
  - Based around local people and communities
  - Sustainable, successful and admired
  - Providing seamless system leadership
  - Where experience exceeds expectation
- Executive and board and members interviewed were clear about the vision and strategy. Senior clinicians were clear about their role in the overall direction of the organisation. The vision and values were on display and were available on the intranet. The majority of staff knew and understood the values of the provider and took action to demonstrate them in their work.
- Staff knew who senior managers and executives were and said they were visible. The executive team carried out regular walkabouts which meant that they visited all locations and most services. Some teams described that the current chief executive had participated in a recent flu vaccination programme to support completion of the programme.
- The provider had a range of quality improvement priorities which staff and board members understood.

Good governance

- The provider had a clear report and leadership structure and staff knew who to report to. To support their work there was a range of committees that reported directly to the board:
  - Audit committee
  - Our Voice
  - Safety, quality and performance committee
  - Remuneration committee
  - Sustainability committee

Good

Are services well-led?

- In addition there were a range of sub groups, with clinical and management representation that reported into these committees.
- The provider had robust governance structures in place. This meant that from ward to board there was a good understanding of the challenges they faced. Most areas for improvement were recognised and work was done in a timely manner to make these changes. All board members knew what was on the risk register and what the top risks were. This meant that in almost every case throughout the inspection, where improvements were needed, well developed plans were already in place.
- Clinical team leaders said they had enough time and autonomy to manage their wards and clinical areas effectively. They had access to locally held risk registers and could enter risks as necessary. They said they were able to get support from the senior nursing team and from each other when they needed it.
- There were a range of policies and procedures in place to support staff to deliver care. These were available to staff and easily accessible.
- Extensive data workbooks updated in each locality provided the necessary assurance for the board to consider performance and delivery at local level. In addition, the provider required all clinical areas to submit quality, effectiveness trigger tool (QuEST) which was comprised of 16 generic question and four locally devised questions. Each question was scored and if a variation or high score was submitted this would trigger a range of responses to manage identified issues. This gave teams a focus for their concerns and enabled managers and executives to provide the necessary support.
- We reviewed five files relating to serious incidents requiring investigation (SIRIs), four of these had been conducted within the 60 day target. One had been put on hold whilst the provider supported the patient in the community. There was a clear reporting and monitoring process for SIRIs and we saw evidence of duty of candour in the root cause analysis reports.
- The provider carried out regular audits to assure themselves they were providing safe and quality care. Audits included infection prevention and control, medication management, patient satisfaction, fire safety, the use of seclusion and ligature risks.
- A clinical audit for prescribing for attention deficit hyperactivity disorder (ADHD) found monitoring of medicines was poor. It was identified this was due to a lack of knowledge of NICE guidelines. NICE guidelines are now on the database and all areas have to be completed on the patient record in order for the SystemOne to accept the change.
- Overall, the provider had good working arrangements with commissioners, local authorities and other partners and third party organisations. However, as the organisation is not a NHS trust they have not been included in the improvement and recovery agenda with the CCG for the region although they provide all community and mental health NHS care in Plymouth.
- Staff were trained in safeguarding adults and children, understood procedures and made appropriate safeguarding referrals in most cases with the exception of the Greenfields unit, where a whole service safeguarding enquiry was in place led by the local authority as the staff had not been raising safeguarding concerns with the local authority safeguarding team.
- Ward managers and staff met to discuss summaries of learning from incidents and complaints related to the service, reviewed monthly patient experience reports and considered team performance data.
- Managers had access to information about the training and supervision of staff in their teams. They also received monthly reports of mandatory training, which enabled then to address any deficit. However, there was no central collection of attendance at MHA or MCA training and the level of training required for specific job roles.
- The provider achieved safe staffing in most services and had a clear strategy to address in the long and short term the staffing deficits. Although not required to, the provider displayed safe staffing data in clinical areas to show the public the current staffing situation.
- We reviewed six staff files as part of the inspection; these were complete with references and DBS checks.
- However, in the CAMHS inpatient team, an agency worker had started work with patients under supervision of a permanent member of staff before a disclosure and barring (DBS) check had been completed.
- Some of the personnel files we reviewed had evidence of investigations that had been undertaken, it was clear that the investigation and any associated disciplinary or capability procedure had followed the HR policies appropriately.
- All HR policies were up to date, these were clear and robust and we saw evidence that these had been used

effectively to ensure the provider had the right people working in the services. For example we saw evidence that some staff had not been confirmed in post at the end of their probationary period as they had not demonstrated the appropriate values and behaviours expected by the organisation.

Leadership and culture

- As this is not a NHS trust the board makeup is different to NHS trusts. As such the executive team is smaller and comprised of chair, chief executive four executive directors and three non-executive directors. There was no director of nursing at board level. However there was a senior nursing lead and a range of professionals in place to support nursing practice. Nursing staff we spoke with felt their voice was represented at board level.
- The chief executive and chair were confident that the skills required were present in the current executive team and if required additional skills could be sourced.
- Most staff were positive about the organisation as an employer. They described a provider that looked after their staff, encouraged individual services to improve and had a 'no-blame' culture.
- Managers used performance data to address quality and staff performance issues. All staff had continuous professional development time allocated.
- However, regular supervision and appraisals did not always take place and these were not documented in line with policy. The inspection team were not always able to say if supervision was appropriate and effective.
- Medical revalidation had achieved 100% compliance. We had no formal feedback from GMC.
- The provider has commissioned a staff survey similar to the NHS staff survey via an independent survey company. We did not have access to the findings or outcomes as part of the data request. However we were informed that the key messages concluded that improvements were highlighted in the following areas;
    - Visibility of senior managers and awareness of who occupied the role
    - Communication channels across the organisation.
    - Staffing and activity levels.
    - Role of Our Voice.
    - Understanding of vision and 5 aims.
    - Career progression.
- 'Our Voice' staff engagement council was a subcommittee of the board, chaired by a member of staff and attended by staff representatives. This committee is in addition to staff side meetings which recognise the role of the trade unions and professional bodies. Our Voice committee was developed to represent interests of staff outside of terms and conditions, encourage creative thinking and innovation and facilitate feedback and responses to crucial questions. Staff we interviewed were in the main positive about this committee and hopeful, as it was a new committee, about its future development.
- Staff side representatives did not all feel they had sufficient allocated time to address staff matters and did not always feel they were consulted in a timely way. Some representatives felt they were consulted about change after the decisions or changes were made or already in progress.
- Consultants and junior doctors told us that they felt they could contribute to changes within the organisation; they felt that they had a good working relationship with the senior management team.
- Changes had been made to organisational structures as a result of feedback from staff; this included the introduction of clinical director roles across the services.
- Some staff told us that there were issues with bullying and harassment within the organisation. However, we were unable to find any evidence during our inspection to corroborate this, the majority of staff told us that they felt supported in their roles.
- We were told that staff have three days protected time dedicated to continued professional development (CPD) staff welcomed this.
- Staff were aware how to raise a concern and understood the whistleblowing policy. We heard and saw that regular contact was made in particular with the chief executive who staff described as approachable.
- The NHS Equality and Diversity Council announced on 31 July 2014 that it had agreed action to ensure employees from black and minority ethnic (BME) backgrounds have equal access to career opportunities and receive fair treatment in the workplace. The provider advised us that this was still progressing and that data collection to evidence the work to date was still being collated.

Fit and Proper Person Requirement

Good

Are services well-led?

- In November 2014 CQC introduced a regulation to ensure that all directors were fit and proper persons. During the inspection we checked that all senior staff members met the necessary requirements and that processes and procedures were in place to ensure any director appointments made met this requirement. As a consequence of this the provider had checked that all senior staff met the necessary requirements.
- They had set up policies and procedures to ensure that all future senior staff had the relevant checks.
- During the inspection we were provided with details of all the checks they had undertaken to meet this regulation. We reviewed six individual files at random and these met the required standard. All the records included all the necessary information. This included a photo ID, completed DBS checks, a self-declaration on occupational health, certificates to prove professional qualifications and competencies, insolvency and bankruptcy checks, a full record of employment history and references

Engaging with the public and with people who use services

- The service user and carer group is chaired by a non-Executive Director and has members who represent local service user and carer groups. The purpose of the group is to enable users and carers to influence the future direction of the organisation and debate current issues that affect the business it is engaged in.
- There was a high rate of completion for the friends and family test in the urgent care service.
- The provider engaged with a range of stakeholder and patient and carer groups including, Healthwatch, the bi-polar group, Plymouth Involvement Participation group and the Service user carer strategic forum amongst others.
- We saw that patients were supported on admission to the inpatient wards, young people were allowed to visit the CAMHS ward prior to admission where the circumstances allowed.
- Community and inpatient services had questionnaires and feedback processes to enable patients and carers to comment on the care they had received and to make suggestions about improvements in service delivery. Some wards had patient business meetings where patient could suggest changes and provide feedback on the care that they had received.
- Across the core services we saw patients and carers were consulted on service developments such as service redesign and change. Changes were made as a result of patient feedback and engagement. Systems were in place to engage with the public and seek feedback. For example, in end of life care services a quarterly meeting of the service user and carer engagement forum enabled people to influence the future direction.

Quality improvement, innovation and sustainability

- The sustainability committee, chaired by non-executive director, oversee the sustainable financial position of a recurrent basis. As a community enterprise company the organisation is unable to post a deficit in any financial year. This committee oversees the delivery of board approved saving programme.
- The provider participated in relevant national audits as prescribed by NHS England. For example, of schizophrenia, intermediate care and the chronic obstructive pulmonary disease (COPD) audit programme and Sentinel Stroke National audit (SSNAP)
- The provider had participated in a number of applicable Royal College of Psychiatrists' quality improvement programmes or alternative accreditation schemes. For example, the learning disabilities team were embarking on a new audit of their prescribing for patients with behaviours that challenge. This was a result of The Royal College of Psychiatrists' recent report "Psychotropic drug prescribing for people with intellectual disability, mental health problems and/or behaviour that challenge: practice guidelines."
- The provider had undertaken an audit of patient's records in order to ascertain progress against commissioning for quality and innovation targets (CQUIN) for improving physical health for people with severe mental illness.
- Staff on Cothele ward monitored levels of schizophrenia in patients using a commissioning for quality and innovation (CQUIN) framework to improve the quality of care provided to mental health patients. This was in accordance with NHS professional guidance.
- In end of life care there was evidence of innovative practice including working with the drug and alcohol services focusing on clients at risk of dying.
- The learning disabilities team had developed a 'Crest' group (Camden Street relationship and emotional skills therapy). Long-term treatment was available and a

psychologist gave an example of a patient who had been coming for a year and would be offered a further six months of psychotherapy. The team also considered whether patients could access mainstream psychological therapies services and enabled them to have access to those services if possible.

- There was a staff recognition scheme and awards available for staff demonstrating good or innovative practise in their teams or service.
- The community learning disabilities team had been recognised for repatriation of people from long stay hospitals out of the area.
- The 2015 mental health inpatient survey had rated nurses at the Glenbourne Unit highest in the country for treating patients with dignity and respect.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care The provider had not provided care and treatment that was appropriate and met the needs of patients. All patients on Cothele ward were requested to go to bed and rise at a set time each day. Patients only had access to their rooms during the day from 1pm to 2pm. **This is a breach of regulation 9(1)(c) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.**

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Care and treatment was not provided in a safe way for patients because: The provider did not assess the risks to the health and safety of all patients receiving the care or treatment or do all that is reasonably practicable to mitigate any such risks. The provider did not ensure that persons providing care or treatment to service users have the qualifications, competence, skills and experience to do so safely.

This section is primarily information for the provider

Requirement notices

Healthcare assistants were permitted to assess injuries and advise patients regarding treatment when a registered practitioner was not available.

A risk assessment of resuscitation facilities had not been carried out at Tavistock or South Hams minor injuries units to ensure they were appropriate for geographically isolated locations.

Patients waiting at the minor injuries units at Tavistock and South Hams hospitals could not be observed by staff in order to identify if their clinical condition was deteriorating.

This is a breach of Regulation 12 (1)&(2) (a)(b)(c)(e)&(g), of The Health and Social Care Act 2008 Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment Staff had not been raising adult safeguarding alerts when appropriate to do so and had not ensured that alerts were escalated to the Local Authority and Care Quality Commission. **This is a breach of regulation 13 (1) (2) (3) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.**

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints

This section is primarily information for the provider

Requirement notices

The provider did not operate effectively an accessible system for identifying. receiving, recording, handling and responding to complaints.

This is a breach of regulation 16 (2) of The Health and Social Care Act 2008 (Regulated Activities) Regulations.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Systems or processes were not established and operating effectively to: Assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services) Assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity. The provider failed to update the policies for both adults and young peoples' places of safety had not been updated since the revised MHA Code of practice had been introduced in April 2015. The provider did not maintain accurate records of waiting times for services people required and in so doing failed to assess, monitor and mitigate the risks relating to health safety, and welfare of the services users. The End of life service had failed to maintain securely an accurate, complete and contemporaneous record in

This section is primarily information for the provider

Requirement notices

respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided.

The provider had failed to ensure that patients were protected against the risks of unsafe or inappropriate treatment in relation to the maintenance of accurate records of treatment escalation and resuscitation decisions.

This is a breach of Regulation 17 (1)(2)(a)(b) and (c), of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing Sufficient numbers of suitably qualified, competent, skilled and experienced persons were not deployed. Persons employed by the service provider did not receive such appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform. Healthcare assistants had not been fully trained, or assessed as competent, to undertake clinical assessment of patients. Appropriate resuscitation training had not been provided for all staff. Some wards did not have access to onsite doctors outside of the hours 9am to 5pm from Monday to Friday. Some wards did not have access to the junior doctor rota.

This section is primarily information for the provider

Requirement notices

This is a breach of Regulation 18 (1)(2)(a), of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed The provider allowed a member of staff to work directly with children and young people without obtaining a Disclosure and Barring Service (DBS) check. **This is a breach of Regulation 19 (3) (a) of The Health and Social Care Act 2008 (Regulated Activities) regulations 2014.**