Plymouth Community Healthcare CIC

1-271962340

Community health inpatient services

Quality Report

Local Care Centre
Mount Gould Hospital
Plymouth
Devon
PL4 7PY
Tel: 08451 558100
Website: www.livewellsouthwest.co.uk

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Summary of findings

Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
1-297622270	Local Care Centre Mount Gould Hospital	Kingfisher Ward, Skylark Ward, Plym Neurological Rehabilitation Unit	PL4 7PY
1-2078154330	Tavistock Hospital	Tavistock Medical Ward	PL19 8LD
1-2078169826	South Hams Hospital	South Hams Ward	TQ7 1AT

This report describes our judgement of the quality of care provided within this core service by Plymouth Community Healthcare CIC, also known as Livewell Southwest. Where relevant we provide detail of each location or area of service visited.

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

Where applicable, we have reported on each core service provided by Plymouth Community Healthcare CIC and these are brought together to inform our overall judgement of Plymouth Community Healthcare CIC

Summary of findings

Ratings

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

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Overall summary

We rated community health services for inpatients as good overall because:

- The organisation had a strong track record of safety performance. Openness and transparency about safety was encouraged and incidents and near misses were reported, monitored and learned from.
- The service had enough staff to care for the number of patients and their level of need. Treatment was planned and delivered using guidelines and best practise. Staff were well-trained, received regular appraisal and had access to further training and development. Teams worked well together to deliver a high standard of outcomes for patients, which audits showed were above the national average.
- Staff consistently demonstrated a person-centred culture where patients and those close to them were involved in their care and treatment. Feedback from people using the service and those close to them was very positive. It demonstrated staff treated them with kindness, dignity and respect.
- The service was planned and delivered in a way that took account of different people's needs, and offered flexibility and choice. Complaints and concerns were monitored and well-managed.
- Staff were engaged in delivering the vision and strategy for the service which was driven by quality, safety and the experience of people receiving and delivering services. Quality and safety were well monitored and there were effective processes in place to identify, monitor and address, current and future risks. The organisation worked well with its stakeholders. Leaders were respected, visible and approachable and staff felt well supported by them. Staff told us they felt respected, valued and were proud to work for the organisation, and there was a strong culture of supporting others. Staff were encouraged to develop and improve services and worked well with local communities, voluntary organisations and stakeholders, to develop the service.

However:

- We identified some variation in the supply, storage and management of medicines across the organisation.
- 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.
- We identified some concerns about the environment on Skylark Ward, Plym Neurological Rehabilitation Unit and at Tavistock hospital.

Summary of findings

Background to the service

Information about the service

Plymouth Community Healthcare CIC provides community health and social care services for the people of Plymouth, South Hams, West Devon and North and East Cornwall which includes a catchment population of approximately 374,000 (excluding N&E Cornwall).

Care and general rehabilitation for adults was provided on Kingfisher ward, a 30 bedded ward, and Skylark ward, a 30 bedded ward, based at the Local Care Centre at Mount Gould. Skylark ward also housed the Stroke Rehab Unit and 15 of these beds were dedicated to the rehabilitation of stroke patients. Plym Neurological Rehabilitation Unit provided in-patient rehabilitation services to people with neurological injury or disease, who are aged 18 or above. This unit may also accept referrals of people aged between 16-18 years on an individual basis, depending on their needs and circumstances. The unit was a purposefully adapted, 15 bedded ward based at Mount Gould. South Hams hospital was a 12 bedded ward and Tavistock hospital a 15 bedded ward. These hospitals became part of Plymouth Community Healthcare in June 2015.

Care and support were provided by nurses, health care assistants and allied health professionals such as occupational therapists and physiotherapists. Medical and specialist medical support was provided by staff based on the wards and from the local acute trusts, and GPs who were employed from local surgeries in Tavistock and South Hams.

Our inspection team

Our inspection team was led by:

Chair: Andy Brogan, Executive Director of Nursing, South Essex Partnership Trust

Head of Hospital Inspections: Pauline Carpenter, Care Quality Commission

Inspection Manager: Nigel Timmins, Care Quality Commission

The community inpatients team included three Care Quality Commission inspectors, a Clinical Nurse Specialist and a Consultant Cardiologist.

Why we carried out this inspection

We inspected community inpatients as part of our comprehensive community health services 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 visiting, we reviewed a range of information we hold about the organisations community inpatient care and asked other organisations to share what they knew. During the visit, we held focus groups with a range of staff who worked within the service, such as nurses, doctors, therapists and administrative staff. We talked with people

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who use services. We observed how people were being cared for, and talked with carers and those close to them. We reviewed care or treatment records of people who use services.

During the inspection, we visited all three community hospitals. We inspected inpatient wards at South Hams, Tavistock and the Local Care Centre Mount Gould, which included the Plym Neurological Rehabilitation Unit. The theatre at Tavistock hospital was temporarily closed in November 2015 and therefore was not included in our inspection.

We spoke with 65 staff, 18 patients and 8 relatives. We received feedback through comment cards provided by the CQC, from 31 patients and those close to them. We organised drop in sessions and focus groups open to all community staff across Plymouth, South Hams and West Devon where staff told us about their roles and services provided by Plymouth Community Healthcare CIC.

What people who use the provider say

People who used the service and those close to them were overwhelmingly positive about the care they received on inpatient wards at Plymouth Community Healthcare. The comment cards filled in by patients, carers and relatives reflected the same message. It demonstrated staff's commitment to delivering high quality care. They ensured they listened to patients and often went the extra mile to meet their needs.

Patients felt their privacy and dignity were well respected at all times. There were numerous, positive comments about the cleanliness of the environment and the food served to patients. People said staff helped them to achieve their goals and to become independent.

Specific comments worth noting represented the themes from feedback gathered as follows:

"The staff are a credit to the health service"

"Nothing was too much trouble"

"Each and every one of them are amazing, professional, caring and a pleasure to work with" (therapy team)

"I cannot speak too highly of the care and attention I have received at this hospital. Everyone without exception has been kind, caring and highly professional"

"This service is fantastic…they (staff) are always there to help you and listen to any worries or concerns"

"Some individuals have gone out of their way to help me and my daughter cope with a traumatic event"

"I have been treated with absolute care and dignity and I have never wanted for anything"

"Wonderful staff and excellent care in safe, hygienic surroundings"

Good practice

- We heard a wide number of staff speaking passionately about treating patients on the ward as if they were their own relatives. There were many examples of where staff had gone the extra mile to ensure patients are well cared for and had a positive experience at hospital. Patients often described how nursing and care staff had gone 'above and beyond' to ensure their stay was comfortable and homely. This included going to the shops on behalf of the patient, taking the patient in their wheelchair to the cash point and some staff brought clothes in for a patient who had very few belongings. At Tavistock hospital, staff made it possible for a patient to have a marriage ceremony. The hospital prepared the food, made the day room suitable for more visitors and allowed the couple to stay in a side room overnight.
- The Stroke Rehabilitation Unit on Skylark ward and the Plym Neurological Rehabilitation Unit achieved outcomes for patients that were higher than the national average, according to nationally recognised outcome measures and audits.
- The organisation aimed to provide services which reflected people's needs and where possible, ensured they had choice, flexibility and continuity of care. For

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example, at the time of the inspection, a pilot was taking place where two therapy staff from South Hams hospital, jointly reviewed patients at the local acute trust in Plymouth. The therapists reviewed patients who were destined for South Hams and Tavistock hospitals and discharged two thirds of these patients to alternative settings, such as returning home with appropriate therapy and care support in place. . This ensured patients were returned home earlier or to a more suitable care environment. In turn, more community hospital beds were then available for other patients, due to avoiding unnecessary admissions. At the time of the inspection, a business case was under development to make this a permanent process.

- Staff felt actively engaged so that their views were reflected in planning and delivering services and in the culture.
- We heard from a variety of senior staff and locality managers that there was a real drive for sustainability within the organisation. The wards shared a variety of ideas that were under development which aimed to improve the service or ensure sustainability. Leaders both encouraged and recognised staff for this.

Areas for improvement

Action the provider MUST or SHOULD take to improve

Action the provider SHOULD take to improve

- 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.

Plymouth Community Healthcare CIC

Community health inpatient services

Detailed findings from this inspection

Good

Are services safe?

By safe, we mean that people are protected from abuse

Summary

We rated safe as good because:

- Staff had a good understanding of the types of incidents and near misses that should be reported, knew how to report them and were encouraged to do so. Openness and transparency about safety was encouraged.
- The organisation had a strong track record of safety performance over time. Incidents were well reported and monitored. Learning from them was shared widely and improvements to safety were made as a result.
- There were well-defined and embedded systems, processes and procedures that kept people safe and safeguarded from abuse. Staff across the hospital were well trained in how to recognise and report safeguarding concerns.
- Patients' medical records and care plans were accurate and completed to a high standard.
- We observed, and patients told us, care was delivered in a clean and hygienic environment where infection prevention and control procedures were well embedded.
- Staff had good access to a wide range of equipment that was well maintained.
- Staffing levels and skill mix was planned, implemented and reviewed regularly to keep people safe.
- Staff monitored patients' condition to check for deterioration, and recognised and responded appropriately to changes in patient risk.

However:

- We identified some variation in the supply, storage and management of medicines across the organisation.
- We identified some concerns about the environment on Skylark ward, Plym Neurological Rehabilitation Unit and at Tavistock hospital.

Detailed findings

Safety performance

- The NHS safety thermometer is a local improvement tool for measuring, monitoring and analysing patient harm and 'harm free' care. Staff collected safety thermometer data on all wards, which was displayed on

the walls of three out of the five inpatient wards. Plymouth Community Healthcare was no longer an NHS organisation and as such, not all inpatient wards chose to display this data. Tavistock and South Hams hospitals had continued to display this information, since joining the organisation in June 2015. Plym Neurological Rehabilitation Unit also chose to display data. The data provided a snapshot of avoidable patient harm occurring on one specific day each month and could be measured against other hospitals and wards in the NHS. Data collected looked at the prevalence of incidents, such as falls, catheter-related urinary tract infections and pressure ulcers. However, data on all incidents was collected and monitored on an ongoing basis, across all inpatient wards.

- Data for the period June 2015 to June 2016 showed incidents such as; catheter related urinary tract infections, falls with harm and new venous thromboembolisms (potentially life-threatening blood clots) and new pressure ulcers were all low, and below the NHS average.
- Data relating to the 12 month period between January 2015 and February 2016 showed no serious incidents occurred on inpatient wards.

Incident reporting

- There were a total of 1036 incidents reported by community inpatient services during the period between 30 June 2015 and 30 June 2016. These were incidents of varying degrees of severity. They included, patient falls, missed doses of medication, pressure ulcers, and delayed discharges.
- Staff reported incidents in line with the organisation's policy. Staff had a good understanding of the types of incidents that should be reported, knew how to report them and were encouraged to do so. Staff recorded all incidents, accidents and near misses on the electronic incident reporting system. Staff reported serious incidents requiring investigation, which resulted in death or serious injury, to the risk management department, director of operations or on-call director, via their departmental manager. Senior managers told us all serious incidents were investigated and a route cause analysis carried out to support investigations, where appropriate. This followed the organisation's incident reporting and investigation policy. Although serious incidents occurred infrequently, staff were able to tell us about the process they would follow should they need to report one, as per the organisation's serious incident policy.
- Senior managers on all wards said there was a good reporting culture on the ward and that staff were actively encouraged to report concerns. All senior nurses received additional training in the management of incidents and shared this training with staff. Student nurses also received training in the management of incidents and how to report them.
- Staff across all wards felt it was important to be open, to report incidents and near misses and were supported by managers to do so. For example, they told us about instances where they had reported incidents of falls, even when the patient was unharmed. As with all incidents and near misses, staff told us it was important to get an accurate reflection of how many falls occurred on the wards, in order to learn from this and prevent it happening again.
- Staff told us, we observed in meeting minutes, and by looking at the electronic incident recording system, all incidents were monitored by clinical leads, ward managers and matrons, and were overseen by safety and quality management. The reporting system linked an incident reported to the relevant line manager or department for review.
- The level or seriousness of the incident determined the breadth of staff with whom the lesson was shared. This ranged from a discussion with line management or at team meetings, through to hospital-wide feedback. Quality and safety processes relating to incidents were reviewed at regular team meetings. For example, we were told of an incident where a nurse observed a new member of staff managing a prescription pad incorrectly. The nurse raised this with their colleague. The matron arranged a refresher training session for all staff in order to, avoid any future incidents. As a minimum, staff received feedback from incidents they had reported directly from line management. The electronic incident reporting system did not allow the line manager to close the incident without having sent written feedback to the reporter.

Duty of Candour

- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or

other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person. Plymouth Community Healthcare's Incident Reporting and Investigation Policy, stated the duty of candour must be applied to any incident where there is a level of harm or distress to the individual, or people acting lawfully on their behalf.

- Leaders instilled a policy of being open and honest in line with Regulation 20: Duty of candour. Staff told us they were encouraged to be open and honest throughout their employment and received training on this subject. Staff confirmed they spoke openly with patients when they had made a mistake, at the time an error occurred and understood the need to be honest with patients. In the case of more serious incidents, managers would write to the patient and highlight their duty under the duty of candour, to keep them informed. They offered the patient the opportunity to come in and speak with them and to share the investigation report with them. These processes ensured inpatient wards were meeting the requirements related to the duty of candour.
- A section of the incident reporting form prompted staff to answer whether the duty of candour applied to the incident.

Safeguarding

- Staff across the hospitals were able to competently describe how to recognise and report safeguarding concerns.
- At a handover meeting that we observed, staff discussed safeguarding concerns to ensure that all staff were informed about the patients in their care.
- The Plym Neurological Rehabilitation Unit admitted patients from the age of 16 and had considered the segregation of children and adults fully. There had only been one service user under the age of 18 in the last ten years but staff we spoke to were fully aware of the processes involved to manage this safely. All patients, regardless of their age, had a risk assessment conducted by the unit's staff to assess their appropriateness for the unit, prior to admission. If there were conditions to their admission (for example, being a safeguarding risk to children) no children would be admitted to the unit until this patient was discharged. .
- Staff we spoke with in the Plym Neurological Rehabilitation Unit had good knowledge of safeguarding and an understanding of the process. There was a safeguarding referral board in the therapists' office with flow charts illustrating the processes to follow. Staff told us about previous safeguarding notifications and informed us of learning from these.
- According to annual data reported on 29 February 2016, 100% of inpatient staff had received safeguarding children level one, 92% had received safeguarding children level two and 100% had received safeguarding level three training. 92.3% of staff had received adult safeguarding training. This was above the organisation's target of 90%.

Medicines

- We identified some variability in practice across different wards in relation to the storage of medicines. For example, on all wards, medicines and intravenous fluids were kept within locked cupboards or rooms with restricted access. However, on Kingfisher ward, we found some non-medicinal items were kept in locked medicines cupboards, such as a camera, cable and keys. Staff did not consistently record fridge temperatures on Kingfisher ward. At South Hams, fridge temperatures were recorded as out of range on 26 occasions in six weeks, and all eye drops were refrigerated. This included eye drops where storage recommendations indicated they should be kept at room temperature. This could have impaired their effectiveness, and therefore may not have been appropriate to administer to patients. These issues were raised with staff at South Hams during the inspection, who agreed to take action.
- There were no regular, medicines storage audits completed on the inpatient community wards to monitor compliance with the organisation's policy and procedures on Safe and Secure Handling of Medicines.
- Controlled drugs are medicines that require additional security. We saw that controlled drugs were well managed. All places for storing these were locked and keys were held by a suitable member of staff, and records were maintained appropriately.
- Processes for obtaining medicines were not well monitored. A variety of supply mechanisms were in place to provide patients with medicines and maintain appropriate levels of stock medicines on the wards. Some medicines were provided by the dispensary at Mount Gould hospital, some medicines were provided from the local NHS acute hospital and some medicines were supplied from community pharmacies, including

medicines for patients to take home. Deliveries of medicines from the local acute hospital to Tavistock and South Hams hospitals were twice weekly. Staff sometimes reported access to medicines was delayed, and monitoring of supply services was only through ad hoc performance feedback. During our inspection, we saw one patient at South Hams hospital had missed five days of a prophylactic (preventative) antibiotic medicine because it was unavailable. This did not cause any harm to the patient.

- Omitted doses were a commonly reported type of medicine incident at these sites, and we saw that missed dose audits had been introduced on some wards to monitor this. However, it was not clear what the findings from these audits were, or the actions taken to address them.
- Some medicines management processes did not follow Royal Pharmaceutical Society guidance. For example, on occasions, patients' own medicines were used as stock items when no longer needed, instead of being returned back to the pharmacy.
- A clinical pharmacy service provided was provided to the wards. However, the frequency of visits varied. The pharmacy team visited wards at Mount Gould hospital each weekday, but visited wards at South Hams and Tavistock hospital once weekly. An emergency, on-call service was available out of hours from the acute trust. Pharmacy staff reviewed and confirmed the prescriptions for people on first admission to hospital (reconciled) to reduce the risk from discrepancies in medicines prescribed, and figures showed over 90% of patients had their medicines reconciled within 72 hours. However, this was not achieved on wards where the pharmacist only visited once a week.
- We observed good practice on wards during medicines preparation and patients told us that staff looked after their medicines well. Staff on some wards reported that patients were supported to continue to administer their medicines themselves during their stay in hospital. We saw this was well-established, embedded practice on Plym Neurological Rehabilitation Unit rehab ward. Staff offered comprehensive, consistent support to patients to manage their own medicines before being discharged. However, we did not see this approach replicated consistently on all wards.
- We looked at the prescription and medicine administration records for 16 patients on the five inpatient wards. Prescription charts were fully and legibly completed, and all allergies were documented where necessary. Administration records showed that people mostly received their medicines as prescribed, and people taking medicines requiring regular monitoring or blood tests, such as anticoagulants, had these recorded as necessary.
- Patient records and audit data received from the organisation showed venous thromboembolism (VTE) assessments and reassessments were well completed. Data supplied by the organisation relating to the 12 month period July 2015 to June 2016 showed VTE assessments were completed for 96% of community inpatients. This meant it protected a high proportion of its patients from dangerous and potentially life threatening blood clots.

Environment and equipment

- The maintenance and use of equipment was regularly checked and audited by staff. We reviewed audit data relating to a range of equipment during the period January to June 2016, which showed staff checked equipment regularly and ensured appropriate action was taken if an issue was identified.
- We were informed by a senior risk manager, the risk of fire was reviewed regularly in community hospitals and remedial actions taken where necessary. When Tavistock and South Hams hospitals became part of Plymouth Community Healthcare in June 2015, the organisation sought additional assurance from the local Fire and Rescue Service in July 2015, who we were told, provided extra training for staff at these locations. However, the corridors at Tavistock were not wide enough to get a bed through. This meant that evacuation would be slowed during an emergency situation. Arrangements were made to ensure this risk was mitigated. This included arrangements for the fire service to arrive at the hospital within eight minutes, the fire doors had regular checks to ensure their integrity, and the ward would not admit immobile, bariatric patients.
- We identified outstanding estates work relating to a fire risk at Tavistock hospital. A Fire Risk Assessment of Tavistock hospital in 2012 identified a high level of risk relating to a fire escape at one end of the ward, which was very steep. This could have made it difficult to evacuate patients from the ward during an emergency. Staff raised the risk relating to the fire exit, during the inspection and we were provided with assurances

interim actions were already in place to mitigate the risk. Following the inspection, a decision was taken to reconstruct the fire exit would, which would commence imminently. On Skylark ward the air temperature was uncomfortably high which could have impacted on the health of both staff and patients. This was less apparent on the ward but in offices situated in side rooms where staff worked at desks, the temperature was around 30 degrees. This was on the ward risk register. As a result, some air cooling equipment was installed. However, this was not effective during the time we visited the ward. Staff commented it was unbearably hot.

- Despite the age of some of the other hospitals, the buildings were cleaned and maintained to a high standard.
- Staff reported they had adequate access to equipment. There was a wide range of therapy and mobility equipment available across the different sites. There was a gym facility at the Mount Gould site near to Kingfisher and Skylark wards which contained a range of equipment for rehabilitation purposes. There were occupational therapy assessment kitchens on wards and a self-contained flat on skylark ward to support patients with their re-ablement.
- The storage of cleaning chemicals and substances that are hazardous to health were stored securely in locked rooms which were inaccessible to patients and visitors. This was compliant with the Control of Substances Hazardous to Health Guidelines.
- The Plym Neurological Rehabilitation Unit was cluttered with equipment. The corridors were cluttered throughout the day and the bathroom was used as a storage cupboard when not in use. When it was in use, the equipment needed to be moved into the corridor. Staff used the accessible toilet as the storage place for a commode. The environment on this ward did not lend itself well to the function of the unit. During the inspection, it was noted that the corridor was often cluttered and that it was difficult for staff to manoeuvre beds, chairs and other large items through the ward. The concerns about the storage space and environment were risk assessed. The risk register for the unit showed fire risk assessments and actions were in place to ensure the risk of fire was mitigated. There were mitigating actions in place to address the lack of space in order to reduce the risk of this causing an accident. The ward manager said that there were plans to move to a better designed building, although it was not clear when this would be.
- Drinks stations were placed in dining rooms to encourage patients to become more mobile and to socialise. At Mount Gould, there were games and activities in the dining rooms which included games and a computer games consoles used for light, physical activities.
- There was a patio area for patients to use at South Hams hospital. We were told patients could access this area once they had been risk assessed and patients could go out there weather permitting. There were two small areas of outside space at Mount Gould where patients could sit.
- Staff had easy access to equipment which often arrived on the same day that it was ordered, particularly if it was needed for patient safety.
- Equipment to prevent pressure ulcers and reduce falls was available for patients who needed it. On some wards, accommodation and equipment was in place to accommodate the needs of bariatric patients. For example, at Mount Gould, there was a bariatric hoist, the floor was strengthened and there was a purpose-built toilet. Staff said any other bariatric equipment needed on the ward was accessible within 24 hours.
- All equipment-related safety alerts went directly to the risk team who shared this information with a named contact in each team or ward. Responses and actions were sent to the risk team and reminders sent for outstanding actions.

Quality of records

- We reviewed a number of patients' medical records and care plans across the five wards we visited. We found staff completed them to a high standard. They were accurate, up to date and demonstrated good evidence of multidisciplinary team input.
- Patients arriving from the local acute trusts came with their patient records. Staff told us these were reviewed to ensure the information was correct and up-to-date. Records were stored in locked rooms until they were sent promptly back to the acute trust.
- We reviewed a selection of patient records and saw staff completed patients' individual electronic care records in a manner that kept people safe and maintained patient confidentiality.

Good

Are services safe?

- Laptops which contained the electronic record database were password protected and kept in locked rooms when not in use.

Cleanliness, infection control and hygiene

- Patient comment cards we collected during the inspection, and feedback from patients showed patients felt the wards were cleaned and maintained to a high standard.
- Staff carried out monthly audits of infection prevention and control, such as hand hygiene, mattress checks and cleaning audits. These were monitored on a monthly basis and given a red, amber green rating for each ward area so that issues could be identified and addressed. Audit data we looked at during the inspection or provided by the organisation, demonstrated a high level of compliance with infection prevention control and actions identified were addressed.
- We observed that staff adhered to infection prevention and control procedures for patients with an infection or suspected infection. Staff placed these patients in side rooms. Signs to identify the risks were visible on doors and protective equipment and clothing used as appropriate.
- Staff were compliant with infection, prevention and control procedures. We observed, and patients confirmed, staff washed their hands and wore personal protective clothing such as aprons and gloves, before providing care and treatment. Sinks for handwashing and antibacterial hand cleaner were available throughout clinical areas.

Mandatory training

- A high proportion of staff received mandatory training. Annual data to the end of February 2016 showed 90% staff received mandatory training. During the inspection, managers felt this had since increased with some wards reportedly achieving 100% compliance.
- Mandatory training consisted of a variety of subjects including: safeguarding for adults and children, dementia, manual handling, fire, diversity, information governance and infection prevention and control. There was a mixture of face-to-face an e-learning. Staff said on the whole, they were given time to complete this during working hours.

Assessing and responding to patient risk

- Staff carried out comprehensive risk assessments for people who used inpatient services in line with national guidance. All patients were risk assessed on admission and at regular, planned intervals throughout their stay. These assessments included the risk of falls, pressure ulcers, urinary tract infections and malnutrition. Staff used recognised tools to assess the risk, such as the pressure ulcer risk Waterlow score and the Malnutrition Universal Screening Tool. Speech and language therapists carried out swallow assessments of stroke patients to assess their ability to swallow and risk of choking. They made recommendations to adjust food texture and gave advice and support to staff about patients' needs with eating and swallowing. We reviewed a number of patient records, all of which had well completed risk assessments.
- The admission criteria for Plym Neurological Rehabilitation Unit included patients aged 16 and 17. However, although no patients under the age of 18 were admitted in the last ten years, a children's registered nurse was employed to manage child-specific care needs if required.
- Staff risk assessed which patients were suitable for single occupancy rooms. For those who staff considered inappropriate for single rooms, staff placed these patients in beds opposite the nursing station. Ward managers confirmed staff were continually risk assessed in this way throughout their stay, as the risk sometimes increased. For example, a patient who was initially placed in a bay began wandering due to confusion. Nursing staff found the patient was much more settled and accepting of care and treatment when placed in a side room, where they had access to a television and radio.
- At safety briefings and handover meetings, staff were made aware of any patients who required more close monitoring and supervision, such as those at risk of wandering or falling.
- Staff monitored patients' condition to check for deterioration, through the use of an National Early Warning System. This tracked changes in a patient's condition and identified those at risk of deterioration. We saw these were carried out and documented effectively. Nursing staff could speak with medical staff from the GP practices who worked on the wards or with ward medical staff. Alternatively, they could, access medical support using the out of hours service, or dial 999 in an emergency.

Good

Are services safe?

- There was a catheter care hotline in the continence department to support staff with advice about patient care. Therapy staff said that healthcare assistants were very competent at changing and documenting catheters as appropriate. This helped to avoid the risk of a catheter-related urinary tract infection.

Staffing levels and caseload

- Staffing levels, skill mix and caseloads were planned and reviewed regularly in order to ensure people received safe care and treatment at all times. The organisation used the principles of National Institute for Health and Care Excellence (NICE), the Royal College of Nursing Safe Staffing guidance and their annual NHS benchmarking audit, to ensure staffing and skill mix met the needs of the patients within the service.
- At Tavistock and South Hams hospitals staffing levels and skill mix were assessed when the hospitals joined Plymouth Community Healthcare in June 2015. We saw that staffing levels were increased at this time as a result. For example, registered nursing staff at South Hams hospital had increased from one registered nurse on duty in the day and at night, to two on duty during the day and at night. Staff said the ward felt safe with two registered nurses being in place at all times and they were able to deliver safe care to patients.
- The Plym Neurological Rehabilitation Unit used the United Kingdom Rehabilitation Outcomes Collaborative (UKROC) guidance to plan staffing levels effectively. Patients were categorised based on their needs with level A patients being those who had the most complex needs. The Plym Neurological Rehabilitation Unit was a level 2a unit with NHS England expecting the unit to have a 30% proportion of patients with level A needs. However, the unit was averaging a level A patient caseload of between 70-80%. The establishment for the unit was for a level 2a ward and was not staffed to provide a higher level of care. When we asked about this staff said that it was sometimes difficult but they managed and that staffing levels were safe. A staffing acuity tool was used to ensure a safe staffing mix. The organisation was in the process of addressing this with commissioners.
- Compared to the average level 2a neuro rehabilitation unit the Plym Neurological Rehabilitation Unit provided services to 14% more category A patients than the UK average. Due to the increased caseloads there were not always enough physiotherapists or occupational therapists to provide the optimum treatments. For example, some patients required multiple therapists to ensure optimum treatment but these were not always available. However, staff told us, and patient outcome data showed, this did not impact upon patient outcomes. The ward manager reviewed every patient prior to admission to assess patients' care needs. This ensured they planned care and staffing based on the dependency and acuity of patients' needs. For example, the unit would only accept up to three patients with a tracheostomy (a surgically-created hole in the windpipe to relieve any obstruction to breathing) at any time.
- Staffing levels on the stroke rehab unit on Skylark ward were planned and delivered in accordance with the Sentinel Stroke National Audit Programme. This is a national audit programme to look at the management of patients following a stroke. It included recommendations and assessments of the stroke unit's staffing. This ensures it provided the right level of appropriately skilled healthcare professionals, to manage patients' needs.
- There were safe levels of nursing staffing on all general rehabilitation wards we visited. We reviewed staffing rotas which confirmed staffing was in line with planned levels, based on patient numbers and acuity. Staff said they felt staffing was adequate.
- Measures were in place to ensure temporary staff were made familiar with the wards and safety procedures. These included a short induction and ward orientation and information about safety procedures.
- Staff told us they were able to request additional nursing staff when it had been identified that a patient required enhanced support. Extra staff could be requested easily when needed and we were told that this was more of a courtesy call than a request to senior management.
- One ward manager said that staffing levels were reviewed each time they had a vacancy and this meant they could be flexible in offering revised shift patterns or increase hours as a result. For example, a recent vacancy to fill three, six-hour shifts was increased to three, seven and a half hour shifts to reflect the revised staffing needs.
- On Kingfisher and Skylark wards, there were concerns from a number of therapy staff about staffing levels. This could sometimes reduce the amount of time spent with

patients and was mainly due to maternity leave and sickness. Managers had plans in place to address this, such as the use of temporary staffing, or, were actively recruiting for vacancies. .

- At South Hams hospital, staff told us management responded appropriately to staffing levels and caseload to ensure patient safety. For example the deputy locality manager prevented further admissions to the hospital on occasion, due to a temporary staffing issues.

Managing anticipated risks

- All wards worked closely with their acute care colleagues and local commissioners to alleviate winter pressures where possible. Managers from the wards attended the Tactical Control Centre at the local acute trust on a daily basis. This ensured discharge and admissions information was accurate and helped patient flow, especially during times of increased activity, such as in winter.
- We were informed by ward managers, they anticipated risks to patients and staff and responded appropriately. For example, the theatre at Tavistock hospital was closed in November 2015 due to concerns relating to the performance of the air conditioning unit. Work was ongoing to ensure this was rectified safely, to avoid any risk to staff or patients. Staff at the theatre were redeployed during this time so they could maintain their skills. There was a mix of both old and new buildings that served the patients using the community hospitals. For example, Kingfisher and Skylark were of modern construction but were not purpose built. Staff felt the curved shape of the ward and the high number of single rooms was not ideal as it meant patients were less visible to staff. However, on all wards, we saw staff effectively mitigated any risks to patient safety this might have caused by risk assessing patients to ensure they were in the most appropriate setting. For example, those who required closer observation were in rooms near the nursing station, and the hospital asked the acute trust if the patient was suitable to be in a single room, as part of the pre-admission checklist.

Major incident awareness and training

- The hospitals and wards had a major incident plan in place and staff we spoke with knew how to access this. There were winter plans in place, in particular in the rural community hospitals. Records were kept of which staff had access to an all-terrain vehicle, which staff could walk to the hospital and which staff could be deployed in areas more local to where they live. Agreements were in place to move patients to places of short-term respite.

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

We rated effective as good because:

- Care and treatment was planned and delivered using best practice and current evidence-based guidance. A range of outcome measures were used to monitor the effectiveness of patient care and treatment, and consistency of practice. The organisation participated in national audits and demonstrated outcomes that were above the national average.
- Staff had the skills they needed to carry out their role effectively and in line with best practice. They were supported by the organisation to maintain their skills and to develop professionally. They received regular supervision and appraisal.
- The multidisciplinary team worked cohesively to assess, plan and deliver people's care and treatment. Staff worked together to keep patients informed about their discharge plans. They worked with other health care providers to ensure they took account of people's needs and circumstances and expected outcomes, following discharge.
- Staff could access the information they needed to assess, plan and deliver care effectively.
- Consent to care and treatment was obtained in line with legislation and guidance, and staff worked closely with families to ensure the best decision for the patient was made.

However:

- On Kingfisher and Skylark ward, some staff reported occasional delays in patients being discharged due to the length of the ward round procedure. They said this impacted upon some patients being discharged and on new admissions as a result.

Detailed findings

Evidence based care and treatment

- Nurses, therapy staff, care assistants and medical staff used best practice guidelines to assess people's needs and give care and treatment in line with evidence-based best practice. For example, when caring for patients on the stroke ward who required rehabilitation, staff demonstrated how they implemented stroke guidelines.
- A consultant confirmed that staff regularly discussed the National Institute for Health and Care Excellence (NICE) guidelines to make evidence-based choices about patients' care and treatment. For example, during ward rounds, staff discussed medication and guidelines with the pharmacist.
- Physiotherapists and occupational therapists attended regular team meetings to discuss new evidence-based practice to develop the quality and effectiveness of care. NICE guidelines were discussed and best practice shared to support learning and development within the therapy team. Specific time was dedicated for therapists to review new evidence and journals every six weeks. Time was set aside every six weeks with their line management to review patient caseloads. This provided them with further opportunities to discuss and ensure patients care was planned in line with good practice, with clear outcome goals.
- Staff discussed guidelines and good practice during in-service training sessions, team meetings and on the ward. During a multidisciplinary team meeting, we observed staff discussing guidelines and evidence-based practice in order to assess and implement the most effective care and treatment for the patient.
- The organisation developed policies, care pathways and procedures in line with national guidance. Staff accessed these from the intranet and showed us how easy it was to find them. We reviewed a number of these and found them to be current and in line with guidance.
- Some medical staff said they had access to journals which they used to remain up to date with current good practice.
- The Plym Neurological Rehabilitation Unit used recognised tools to assess, monitor and plan rehabilitation goals and outcomes, for example, the Rehabilitation Complexity Scale and the Wessex Head Injury Measure. Staff also used these tools to help identify the equipment, nursing, medical and therapy needs of patients.

Good

Are services effective?

- Therapists used a wide range of recognised rehabilitation outcome measures (a test that is used to objectively determine the function of a patient at the beginning and the end of treatment), such as the Elderly Mobility scale and the Berg Balance Scale, with patients requiring rehabilitation. There were none set as a standard and therapists selected the most appropriate one for each patient.
- Staff said they were mindful of not discriminating when making care and treatment choices. The felt they treated all patients as individuals, regardless of age, ethnicity, religion or disability etc.
- Staff had regard to the Mental Health Act Code of Practice. If staff were concerned about a patient's mental capacity, they could speak to someone more senior if they were not trained to assess mental capacity.

Pain relief

- Patients regularly had their pain assessed by staff and were given medicines promptly, relative to their needs. We looked at patient care records and saw staff regularly assessed pain and comfort needs. We observed doctors, nursing and other staff during ward rounds discussing pain management with patients and prescribe medication accordingly.
- Pain relief was administered to patients by nursing staff, on request from the therapy staff, to optimise function and participation during therapy sessions. Pain was continually assessed using a numerical rating scale with scores of one to ten, one meaning no pain and 10 meaning significant pain. Staff also monitored and assessed for pain by looking at their face and body for non-verbal cues.

Nutrition and hydration

- Staff followed NICE guidelines relating to screening for malnutrition. Staff completed a malnutrition screening and assessment tool within 24 hours of admission to the ward. This identified the nutritional risk for each patient and how this should be managed. For example, staff could prescribe supplemental drinks to patients who needed them to support their nutrition and hydration needs.
- Ward staff had regular input from speech and language therapists and could access dietitians if required. Patients sometimes experienced difficulties in swallowing following a stroke or during advanced stages of dementia. Speech and language therapists provided advice and guidance for patients who had difficulties with eating and swallowing, due to their medical condition.
- Patients were complimentary about the hospital food and told us they were offered plenty of hot and cold drinks. We observed water jugs were frequently refreshed.
- Visiting times were changed so that families and carers could become more involved in supporting patients to eat and drink.
- Staff were able to provide light snacks or drinks in between meals when requested.Drinks stations were situated in some wards at Mount Gould and in the dining room areas so that patients could make their own refreshments.

Patient outcomes

- The Plymouth Neurological Rehabilitation Unit submitted monthly data to the United Kingdom Rehabilitation Outcomes Collaborative (UK ROC) for all patients in the last three years. This measured a patient's functional gain (their improvement from admission to discharge). Patients on the unit achieved a 96% increase in functional gain, which exceeded the national average of 73%. The UK ROC also measured the reduction in cost of ongoing care, which reflected a patient's level of independence following discharge. Over the last three years, the unit demonstrated an 87% reduction in cost, which is better than the national average of 59%.
- The Stroke Rehabilitation Unit on Skylark ward participated in the Sentinel Stroke National Audit Programme (SSNAP). During the period January 2014 to March 2015, the unit consistently achieved the highest rating (level A). This exceeded the England average (level D) and demonstrated the rehabilitation unit achieved a high standard of outcomes for their patients admitted following a stroke. The unit ranked within the top 12% nationally.
- There were two Commissioning for Quality and Innovation (CQUIN) payment frameworks in place on Kingfisher ward and for Skylark general patients during 2015 and 2016. The Enhanced Recovery for Medicine CQUIN involved patients, their families and carers in decisions about their care to ensure that patients left the hospital safely and at the right time.

Good

Are services effective?

- Another scheme known as the SAFER CQUIN was implemented on Kingfisher and for Skylark general rehabilitation patients in 2015 to 2016. This was an abbreviation of; S-senior review, A-all patients will have an expected discharge date, F- flow of patients, E- early discharge, R- review all patients with delayed discharge. It focused on improving the patient experience, patient flow through the wards and to prevent unnecessary waiting for people.
- Locality managers reported CQUINs were having a positive impact for both patients and the organisation and we found evidence to support these findings. For the patient, this meant a better experience, greater involvement and improved outcomes. Locality managers reported this had led to improved patient and family involvement and decision making about their care. For staff and patients, there was an increased level of awareness and focus on early reablement to ensure the patient could return to normal, daily activities as soon as possible. Discussions about discharge and ongoing support were happening earlier than before and where possible, family and carers took patients home when they were ready to be discharged. This avoided delays with patient transport and cost to the hospital .There were plans in place to roll these out to all wards and agreement to continue this into 2016 to 2017.
- The average length of stay between 1 February 2015 and 31 January 2016 in the community hospitals' general rehabilitation wards was 23 days. For the Plym Neurological Rehabilitation Unit it was 54 day and for the Skylark Stroke Unit it was 44 days. The lowest, average length of stay was 12 days, on the South Hams ward. Senior staff told us social care provision in this locality was far better than in areas surrounding other wards and so there were less delays to discharge as a result.
- Avoiding emergency hospital admissions is a major concern for the NHS and healthcare providers due to the high cost of emergency admissions and the disruption it causes to access to health care. Between 01 August 2015 and 31 January 2016, there were no patients readmitted to inpatient wards.
- Staff used person-centred goals and care plans as their focus for rehabilitation. The aim was to ensure patients were discharged to a suitable destination, in a timely manner. For appropriate patients, therapists used the Elderly Mobility Scale, a tool used to assess the mobility of frail, elderly patients. Therapists scored patients on admission and again on discharge. The aim was to score higher than 15 out of 20 on discharge. Therapists always reassessed patients' goals prior to leaving and relayed this information to colleagues in the community, to provide continuity of care.
- Goal setting and discharge meetings took place for stroke patients to ensure that the patient was on track to achieve their individual goals and outcomes. A range of staff were involved in progress meetings with patients. These included family members and carers, therapists, nurses, social worker and sometimes a doctor if there were medical issues to be discussed.
- All deaths were subject to a review. Senior staff followed a serious incident reporting and investigation process for all unexpected deaths. The risk team had an overview of mortality and were able to identify trends if any. Locality managers reported there were no current themes or trends identified. The risk team carried out a quarterly report on serious incidents, incidents and root cause analysis. They shared learning with relevant teams where appropriate.
- Tavistock and South Hams hospitals established a peer review process, where teams would audit each other's services, to benchmark the service and to identify where improvements could be made. We did not see evidence of sharing of benchmarking between these sites and Mount Gould. However, senior management informed us this would happen increasingly in the future and through matrons meetings in particular.

Competent staff

- Data supplied to us by the organisation prior to the inspection in January 2016, showed 82.7% of inpatient ward staff received an appraisal. This was below the target of 90%. However, during the inspection, we spoke with ward managers and reviewed records which showed a higher percentage of staff received an annual appraisal. For example, the January data showed, only 28.5% of staff on Tavistock inpatient ward received an annual appraisal. We queried this with the hospital who confirmed there were issues with the information being transferred when Tavistock hospital joined the organisation in June 2015. The matron confirmed appraisal data was currently at 95.7%.
- Data supplied by the organisation showed all medical staff were up to date with revalidation in line with medical profession guidance.

Good

Are services effective?

- Staff across all wards had the right knowledge, skills and experience to carry out their role effectively. Skills and competencies were assessed during the appraisal process and on the wards. Staff of various roles spoke highly of access to additional training within all of the community hospitals. This included access to training courses and conferences. People's learning needs were identified and actioned through appraisal and continual supervision and staff could discuss their needs outside of these opportunities if required. Staff across all wards said the organisation provided a positive environment to develop and grow professionally.
- In the Plym Neurological Rehabilitation Unit, training sessions were held every Tuesday afternoon with outside speakers regularly attending.
- Students said they were well supported within their role and were always considered as supernumerary staff rather than included in the rota. There was no pressure on the students who were able to learn at an appropriate pace.
- Staff said that they felt empowered to ask for, and access training. There was recognition of where staff had specific interests, and this was encouraged. Staff accessed more bespoke, additional training where needed and were familiar with how to ask for this.
- There were opportunities to gain qualifications both internally and externally. For example, one therapist had part completed a masters level course prior to joining Plymouth Community Healthcare. The organisation agreed to fund the remaining part of the course. A nurse from the Plym Neurological Rehab Unit attended external, nationally-recognised training for tracheostomies (a surgically created hole through the front of the neck into the windpipe to relieve any obstruction to breathing). The nurse shared training on how to care for patients with a tracheostomy with internal staff and external private providers. We were told this improved the patient experience on discharge and ensured their safety.
- There were examples across the wards of where the organisation supported staff to complete further training and achieve nationally recognised qualifications. For example, the healthcare apprentice placement supported staff to gain their healthcare certificate. These staff went on to work in qualified positions on the wards.
- National apprentices and students worked on the wards. Designated nurses were given responsibility to ensure that appropriate learning was taking place during their placements. A nurse on the Plym Neurological Rehabilitation Unit said that it could sometimes be difficult to spend enough time with students on top of all the other tasks of a working day. Student nurses said they felt very well supported and spoke highly about the support they received.
- Staff we spoke with on the Plym Neurological Rehabilitation Unit felt they had had good access to training, but on occasion, fitting training into working hours could be difficult. Band 7 physiotherapists and occupational therapists had a clinical caseload as well as the management responsibility for their teams. It was felt that this sometimes affected the amount of time given to staff development. However, therapists ensured patient outcomes were met.
- Locality managers informed us the Plym Neurological Rehabilitation Unit offered opportunities to nursing staff from outside of the area to complete placements.
- A consultant from the Stroke Rehabilitation Unit spoke highly of the skills and competencies within the team. They spoke about the confidence they had in their team's skills and knowledge to manage patients in their care and felt this was demonstrated by the high standard of patient outcomes achieved on the unit.
- Staff said they had access to regular, high quality, face-to-face training and learning was not all computer based which they felt was positive.
- Staff reported that the introduction of a shorter shift provided the opportunity for lots of small teaching sessions, such as training in catheter care.
- There were examples across the organisation where staff were able to train colleagues for the benefit of improved patient care. For example, therapy staff on Kingfisher ward held a workshop for health care assistants and nurses in upper limb care. There was a rolling programme of drop-in sessions during the afternoon, so all staff could access the education.
- There was an experienced tissue viability nurse who worked on wards and within the community. Staff spoke very highly of the support and education they received in the training and management of pressure ulcer care.
- All staff were appraised at three, six and nine months, and then again at just under 12 months. Managers provided extra support where needed and could extend

the probationary period if necessary. Managers said poor performance was identified through this process and supported staff to improve. This was in line with policy.
- Clinical supervision happened on a regular basis, and often monthly but was not always documented. This practice was in line with hospital policy.

Multi-disciplinary working and coordinated care pathways

- A range of staff, including those in different teams and services, were involved in assessing, planning and delivering people's care and treatment. We observed a number of different multidisciplinary team (MDT) meetings across the community inpatient wards. A variety of different staff attended including a locality manager, medical staff, ward sisters, therapists and social care. The meetings were effective, well organised, well led and each member of the team was listened to. All staff were clear about who was responsible for each patient and their ongoing care and treatment plans.
- A consultant informed us their ward's MDT meetings had recently been improved by encouraging staff to prepare thoroughly prior to the meeting and to focus on the patients' progress, their care and discharge plan. To avoid inappropriate admissions, patients awaiting a referral to the community hospital (from the stroke ward at the local NHS acute hospital) were discussed at the end of MDT meetings. This helped the team to decide if they needed more information about the patient from staff at the acute hospital.
- The involvement of relevant professionals, such as social workers, enabled Plymouth Community Healthcare to make timely referrals for services the patient would need following discharge.
- The entire multidisciplinary team worked collaboratively at the Plym Neurological Rehabilitation Unit under the same line manager. We observed the planning of therapy sessions, which happened in a joined up way. Staff considered the patients' wellbeing and the effects of the number of therapy sessions on any given patient.
- Ward based therapists also worked collaboratively with nursing staff to ensure they could work around patients' nursing or care needs. On some wards, staff used a whiteboard to capture when personal and nursing care would take place so they could plan therapy input around these times. All therapists were involved in the daily handover process to ensure collaborative working and care planning for the patient needs.

Referral, transfer, discharge and transition

- The Plym Neurological Rehabilitation Unit performed better than the national average for three consecutive years for its referral to admission targets. The United Kingdom Rehabilitation Outcomes Collaborative (UK ROC) measured the average referral to assessment, assessment to admission and referral to admission times based on national targets. The Plym Neurological Rehabilitation Unit met the target 100% of the time during the last three years. This exceeded the national average of 80%. The outreach community team visited the unit at the point of, or following discharge, in order to ensure a seamless patient handover and effective discharge process.
- Both Kingfisher and Skylark wards liaised closely to ensure they worked collaboratively with the local acute hospital. This allowed them to decide which patients could be admitted as soon as either ward had a suitable bed vacant.Occupational therapists had access to therapy assessment kitchens in some of the community hospitals to help patients practice, build confidence and prepare to manage independently on discharge. The objective of these interventions was to reduce the risk of readmission following discharge from the hospital, by assessing how well patient might be able to cope at home carrying out daily tasks.
- During MDT meetings and board rounds, we observed staff discussed each patient, their diagnosis, estimated discharge date and the multidisciplinary team input needed to facilitate discharge.
- Patients told us they felt they were kept informed about their discharge date and any changes to this.
- On Kingfisher and Skylark wards, a 'grand round' review of patients was initiated in January 2016 as a standard operating procedure. The grand round was focused on a virtual review of patients who were coming up to their estimated discharge date or patients whose transfer of care was delayed. It was led by the Tactical Control Centre team from the local acute trust in Plymouth and the multidisciplinary team on the Plymouth Community Healthcare wards. The team reviewed each patient's notes and discussed the patient with the ward sister or doctor where available. Any delays to discharge were

logged and actions taken to escalate this. The team initiated any necessary onward referrals for example, to social care. The team assessed the ward's board rounds in order to monitor improvements and escalate issues.

- Staff commenced early discharge planning for patients admitted to the hospital and aimed to discharge patients by 11am. Staff reported most patients had left the ward by 2pm.
- Delays in discharge were reported as being mainly due to the lack of complex care packages in the community. We were told the complexity of patient assessment forms and funding arrangements for social care, also caused delays for patients returning to Devon and Cornwall areas, but not for Plymouth-based patients. On occasions, there were delays due to patient transport services.
- Staff told us relatives and carers were involved in goal setting meetings, progress meetings, and discharge planning meetings as standard. Staff took time to understand the patients' home situation and the level of support they would require following discharge.
- Staff reported the patient only left the hospital when appropriate ongoing care was in place. We reviewed care plans and observed in MDT meetings, staff liaised effectively with patients' GPs and other services in a timely way in order to coordinate their ongoing care.
- On Kingfisher and Skylark, some staff reported delays in patients being discharged from the ward. Some felt the ward round procedure was long. This meant patients reviewed later, who were deemed ready for discharge, caused patients coming from the local acute trust to be admitted later than necessary.
- As part of the Commissioning for Quality and Innovation payment frameworks (CQUIN) in place on Kingfisher ward, locality managers said families and carers were now involved much earlier in the discussions with patients, who arranged to take them home. This made the process quicker and avoided any potential delays from patient transport services.
- Patient discharges were monitored on a spreadsheet to identify delays. This was monitored daily through the Tactical Control Centre. It identified recent issues with occupational therapy staff shortages causing delays. In order to mitigate this, advertisements for locum staff had gone out and occupational therapists from other teams within the organisation were being used. There were further plans in place to address this in the longer term.
- We were told the Early Supported Discharge team (a community team) were based on-site and often came to the multidisciplinary team meeting to ensure they were aware of patient progress and could support patients' early discharge where possible.

Access to information

- Information needed to deliver effective care and treatment was available to all staff in a timely and accessible way. We saw ward staff, medical staff and allied health professionals wrote in the patients' electronic records or medical notes, which included information about test results and care plans, care needs and risk assessments.
- The electronic patient record system was accessible to all healthcare professionals within and to some outside of the organisation. This supported staff in having the information needed to deliver care and treatment in a timely and accessible way. For example, staff were able to see what the GP did with the patient the day before, as in some surgeries the GP used the same electronic record system.
- Patient records arrived from the local acute hospital in Plymouth in paper based form and generally arrived with the patient. If records did not arrive, staff reported this as an incident.
- Staff reported that on occasion, patients arriving from the local acute trust in Plymouth were more unwell than described. In this situation, they ensured the patient was readmitted to the acute hospital. However, this was rare and a ward manager explained staff always acted to ensure the patient was in the safest place to receive the most appropriate care and treatment. Staff confirmed they recorded this as an incident. A system was in place to ensure the local acute trust were made aware of this. This issue was monitored by Plymouth Community Healthcare and reported to the local acute trust through the Tactical Control Centre based at the local acute hospital. To mitigate inappropriate referrals, the admissions forms and information discussed on the phone with the acute trust had been developed to ensure they had access to information about the patient that could help them quickly rule out the admission of patients not appropriate for the community inpatient wards. For example, they asked if the patient would be safe in a single room, due to the large number of single rooms on wards at Mount Gould.

Good

Are services effective?

- A recent change to procedure was that prior to admission, staff speaking with the acute trust ensured they asked for handover information about patients' rehabilitation goals. This provided focus for staff managing the patient who used this information when planning rehabilitation goals.

Consent, Mental Capacity act and Deprivation of Liberty Safeguards

- Staff we spoke with had a clear understanding of the relevant consent and decision-making requirements of the Mental Capacity Act 2005. Healthcare professionals supported people to make decisions in a variety of ways. For example, staff told us that they would give information to patients in a variety of different formats. They would revisit that information on different days and at different times to check patients fully understood what staff explained to them. For example, this took place at an appropriate time of day so that patients' decisions were not affected by medication.
- Not all staff received Mental Capacity Act training, as it was not mandatory. However, there were processes in place to ensure those not trained, such as healthcare assistants, would recognise signs of confusion or impaired mental capacity. For example, if staff recognised changes in the patient's behaviour or speech, they would alert nursing staff.
- We were told trained staff assessed patients' mental capacity within 24 hours of admission and made a Deprivation of Liberty Safeguard (DoLs) application where appropriate, in line with policy. This was an application to deprive a patient of their liberty which is put in place to protect patients and staff when patients lacked capacity to make decisions for themselves. A clear algorithm was available for staff to follow. All patients under a DoLS were flagged on the whiteboard for staff to be aware of. When an application was made to deprive a patient of their liberty the whiteboard outlined when the application was made, if it was authorised, and if not, whether a risk assessment was carried out. Healthcare professionals raised an incident form if they had not heard about the application within seven days. We saw staff followed the application process and management, in line with policy.
- At the time of our inspection there had been a recent audit on Kingfisher ward to look at documentation supporting seven deprivation of liberty safeguards applications made since September 2015. It showed where the British psychiatric standards were being met. It identified some positive findings, however it identified that further training was necessary. We saw training dates were booked for staff or were being arranged. We were not aware if this happened on all wards.
- We were told staff work closely with families to ensure that the best decisions for the patient were made. They afforded patients and carers the time and space, in a quiet room if needed, to think about decisions over a period of days if required. Interpreters and advocates were used where needed.
- Consent was a mandatory part of the patient's electronic record system. It was compulsory for staff to mark where consent was given by the patient or declined. There was also a section to mark where the decision was made on behalf of the patient through the use of a best interests assessor. Staff described consent as an embedded and part of the culture. We heard staff and patients told us they continually checked the patient was consenting before carrying out procedures or delivering care.
- There was a safeguarding lead in the organisation with whom staff told us they discussed any questions or concerns.
- Staff had access to the advice from a psychiatric liaison nurse and there were dementia champions on the wards. A DoLS lead from within the organisation visited wards at Mount Gould if there were any concerns or issues.
- Patients under a deputy deprivation of liberty safeguarding supervision could be placed on a bed that lowered to the floor, in order to maintain their safety. We saw in patients' records decisions to use equipment such as this, that protected the patient from harm, were documented in patient's notes.

Good

Are services caring?

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

Summary

We rated caring as good because:

- People were respected, valued as individuals and were empowered as partners in their care.
- Feedback from people who use the service and those close to them was overwhelmingly positive about the way staff treated them with kindness, dignity and respect. Staff took time to interact with people, to listen to their needs and often went the extra mile.
- Staff consistently demonstrated a person-centred culture and took peoples' personal needs into account.
- Staff involved patients and those close to them in planning their care and treatment. They ensured people and those around them were consulted about decisions they made about their care and treatment.
- Staff recognised the emotional and social impact the person's care, treatment and condition had on them, and those close to them.

Detailed findings

Compassionate care

- Staff took the time to interact with people who used the service and those close to them in a respectful and considerate manner. We observed, and patients told us, their personal, social and cultural or religious needs were taken into account. Patients commented that staff listened to them and always tried to meet there personal needs where possible.
- Patients felt staff treated them in a caring compassionate way and often commented that nothing was too much trouble for them. Patients said staff talked to them in a way that they could understand. They felt able to ask questions if they needed to clarify anything.
- We received 31 comment cards from people who had used inpatient services. All spoke very highly about the compassionate care they received on inpatient wards. A card filled in by a patient at Mount Gould mentioned the staff's good humour and attentiveness, saying the entire staff were, "a credit to the health service". There were many other similar comments made by patients and carers.
- We heard a wide number of staff speaking passionately about treating patients on the ward as if they were their own relatives.
- We saw staff ensuring patients were treated respectfully and that privacy and dignity was maintained. Feedback on a number comment cards stated staff ensured their dignity was paramount. Staff spoke to patients discretely where necessary and drew curtains around the patient during examinations and procedures to protect their privacy and dignity.
- A patient on Skylark ward told us the nurses were lovely and the therapists gave them the confidence to go home again.
- There were many examples of where staff had 'gone the extra mile' to ensure patients were well cared for and had a positive experience at hospital. Patients often described how nursing and care staff had gone 'above and beyond' to ensure their stay was comfortable and homely. This included going to the shops on behalf of the patient, taking the patient in their wheelchair to the cash point and some staff brought clothes in for a patient who had very few belongings.
- At Tavistock hospital, staff made it possible for a patient have a marriage ceremony. The hospital prepared the food, made the day room suitable for more visitors and allowed the couple to stay in a side room overnight.
- Staff were described as empathetic towards patients' needs. It was clear that staff took the time to build relationships with the patients, their carers and families. One patient said all staff, including the cleaning staff were on first name terms with them.
- We observed a patient being taken through a series of exercises. Therapists communicated clearly, and at a pace understood by the patient. They checked the patient understood what was being asked of them, and took account of the patient's communication needs. Staff demonstrated a clear and comprehensive knowledge of the patient by discussing their hobbies and interests. They checked the patient's level of pain regularly, and adjusted their treatment accordingly. All of the staff supporting the patient introduced themselves and checked the patient was happy for them to be there. The session took place in a closed room and privacy was maintained.

Good

Are services caring?

- Patients told us, and comment cards showed, people felt included in their care and were aware of the plans for their on-going care needs. Patients, and those who cared for them, felt fully involved in the planning of their care and discharge plans. Staff showed an encouraging, sensitive and supportive attitude towards patients, families and their circles of support. Patients said they were able to ask questions and were included in the treatment of their loved ones.
- Staff took account of patients' needs and interests and met these where possible. For example, on Skylark ward during an international football tournament, a big screen was set up in the day room for patients who had expressed they were keen to watch the game.
- We saw healthcare professionals delivering care were sympathetic to patients' pain and responded accordingly. During our visit, when patients rang their call bells, the longest time we observed that a bell rang without a staff member responding, was less than 30 seconds.

Understanding and involvement of patients and those close to them

- We observed, and families and carers of relatives across all wards said staff involved them in patients' care throughout their stay on the ward. They were also involved with discharge planning and ongoing care and re-ablement plans post discharge. We saw teams planned joint meetings with people and those close to them, and this took place regularly across the wards. This ensured staff had a greater understanding about the patients' home situation and the level of support they would need when leaving the hospital.
- We observed in care plans, and during staff discussions and multidisciplinary team meetings, evidence that staff worked closely with families and carers to ensure patients understood the decisions they made about their care and treatment. This evidence showed they consulted the patient and those close to them frequently.
- Patients said they and their families were involved in the planning of ongoing care in the community to support independent living, and were aware of their goals towards discharge. Families and carers were then more able to understand the patients' goals for on-going rehabilitation at home, and how they could support them with this. We observed meetings where patients and those close to them were called in to discuss how they could work together to ensure the patients' future care arrangements were well managed. Carers and families said they knew what to expect and felt staff worked closely with them.
- Locality managers and senior ward staff said they now regularly consulted with relatives about arrangements to leave the hospital, so they could help transport the patient home where possible. Staff said this helped to ensure patients did not go home alone and were discharged in a timely way.

Emotional support

- Staff recognised the emotional and social impact of a person's care, treatment and condition, and on those close to them. For example, at Tavistock hospital, a 'pat dog' attended the ward on a weekly basis to interact with patients. These were dogs with specific training that were safe to work with patients. This type of service was recognised as providing patients with a great deal of comfort and emotional benefit. It was reported patients often felt calmer and happier as a result, and was particularly helpful to those who had difficulty in communicating (sometimes as a result of a stroke). A matron at Mount Gould was having their own dog assessed so it could become a pat dog for the wards.
- Clinical Psychologists worked with patients on Plym Neurological Rehabilitation Unit and the Stroke Rehabilitation Unit on Skylark Ward. They provided emotional and psychological support to patients through neuropsychological assessments, cognitive rehabilitation, counselling and psychological therapies. Staff said families and carers were encouraged to be involved in the meetings with the psychologist. They provided advice and support to families and carers as well as other professionals involved with the person's care.
- The parent of a patient on the Plym Neurological Rehabilitation Unit expressed in a comment card we reviewed, how staff had gone out of their way to help them and their daughter to cope with a traumatic experience. Another patient commented how staff were inspiring, and encouraging at all times, and staff had done everything they could to help them cope emotionally with their condition.
- Staff said they encouraged patients to socialise as much as possible and to use the social spaces within the wards, such as the dining rooms and day room. To

support this, the organisation provided equipment such as drinks stations, games and games consoles in these areas to improve the use of the spaces, and arranged communal activities and meals.

- At the Plym Neurological Rehabilitation Unit, staff escorted patients on goal-led shopping trips to boost mood, and to assess the patients' use of money, selection of goods, use of public transport and integration into the community. Visits to the local aquarium and museum were arranged to help enhance patients' mood and behaviour. Staff worked to support and involve patients with younger children.
- We saw staff were sympathetic to the concerns and anxieties patients had about returning home. Where appropriate, therapists involved the early supported discharge teams in discussions with the patient, about their on-going treatment and care. Staff said this provided an opportunity for patients to work with both teams collectively, which helped to reduce the patient's anxiety.
- During our visit, we were told of an example of how a psychiatric liaison nurse had supported a patient who was suffering from emotional distress, who was lying on the floor in the middle of the corridor. The nurse lay down next to the patient and calmed them until they were able to return to their bed.
- People were given appropriate and timely support and information to cope emotionally with their care, treatment and condition. We saw and staff staff told us, people were given information and advice about their condition and treatment, and were signposted to support services whilst on the wards or following discharge.
- Staff provided links within the patients' own communities and social networks. There were a number of voluntary groups linked closely with the wards to enable ongoing emotional support within the patients' local community. For example, representatives from the Spinal Injuries Association came to Plym Neurological Rehabilitation Unit. Representatives from the Stroke Association visited the Stroke Rehabilitation Unit on Skylark ward. Other organisations came in to help with arranging benefits or provided legal advice.
- We saw many examples where people who used the service were empowered and supported to manage their own health and care to maximise their independence. There were a number of initiatives across the wards, which encouraged patients to get themselves dressed and use communal areas. For example, therapy staff organised a breakfast meeting for patients to help support them in carrying out day-to-day tasks, using the kitchen on Kingfisher ward. We observed staff laughing and joking with patients and interacting in a positive manner. When we entered the room, patients were laughing and were happy to tell us about how positive this experience was. Patients and staff said it provided people with an opportunity to interact with staff and other patients, to have fun and to feel good about themselves.
- During multidisciplinary team meetings, staff were mindful of patients' emotional wellbeing when reviewing patients' goals, progress, therapy and care plans. We observed staff made clear links between people's rehabilitation goals and the impact this had on their emotional state. For example, therapy staff spoke about a patient's desire to return to driving and about why this was important to the patient, for their emotional wellbeing and their independence.

Good

Are services responsive to people's needs?

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

Summary

We rated responsive as good because:

- The needs of different people were taken into account when planning and delivering services.
- Other providers and stakeholders were engaged in planning and delivering services to support people in hospital and with their ongoing care needs.
- The services provided were reflective of people's needs and offered them choice flexibility and continuity of care.
- People had timely access to assessment, care and treatment.
- Staff were responsive to patients' needs, which included those living in vulnerable circumstances.
- People's complaints and concerns were monitored and well managed, in line with the organisation's policy.

However:

- Staff showed a willingness and understanding of how to care for patients with dementia. However, we did not see a great deal of activities that were planned for patients living with dementia.
- Although most patients we spoke with felt able to speak to someone if they had a concern, very few people knew how to make a complaint about the service and few knew where to find this information.

Detailed findings

Planning and delivering services which meet people's needs

- Locality managers and senior staff explained how the organisation worked with commissioners, other providers and relevant stakeholders in planning services. This included supporting people in hospital and at home with ongoing, complex health needs and long term conditions.
- Locality managers felt Plymouth Community Healthcare had developed an increasingly strong relationship, over the last 18 months in particular, with the local acute trust in Plymouth. The organisation informed us and local commissioners confirmed they worked cohesively to ensure it provided services that met the needs of the local population.
- The organisation set clear admission criteria for the different services provided by inpatient wards. Managers from the organisation attended the Tactical Control Centre at the local acute trust in Plymouth on a daily basis. This helped both organisations to plan the ongoing care and treatment of patients and to manage patient flow. The aim was to ensure the right patients were admitted at the right time of day, where possible.
- Staff on Skylark ward said they sometimes found it difficult to manage meeting the needs of all people on the ward in the evenings due to late transfers form the local acute hospital. Some staff said patients were sometimes admitted late into the evening, which meant that additional staff were required to manage an admission. One member of staff told us that late admissions could have a detrimental impact on a patient's wellbeing. We were given an example of a patient living with dementia, who was admitted in the evening, and became restless due to the change of environment. Staff told us that if they stayed in the acute hospital until the next day, they would have had better opportunity to settle them into the ward. We were told this would be recorded as an incident and the acute trust informed.
- The organisation reported it had positive relationships with local clinical commissioning groups (CCG) and social care colleagues. Locality managers described this as a positive and transparent relationship. Feedback provided by commissioners prior to the inspection reflect this. For example, Plymouth Healthcare used a recognised tool kit to add structure to the discussions with health and social care teams outside the organisation, which focused on set data and criteria. Locality managers said this approach led to an improved level of understanding between the organisation and its stakeholders, and added clarity around the roles and responsibilities of the organisation and with those it worked with. The relationship was described as significantly improved from 18 months ago.

Good

Are services responsive to people's needs?

- A daily call took place with partner organisations which included the local acute trusts, the CCG, the local authority and the regional ambulance trust. Any issues or concerns affecting patient care in the locality were raised and escalated, as appropriate.
- The organisation aimed to provide services that reflected people's needs and where possible, ensured they had choice, flexibility and continuity of care. For example, at the time of the inspection, a pilot was taking place where two therapy staff from South Hams hospital, jointly reviewed patients at the local acute trust in Plymouth. The therapists reviewed patients who were destined for South Hams and Tavistock hospitals and discharged two thirds of these patients to alternative settings, such as returning home with appropriate therapy and care support in place. This ensured patients were returned home earlier or to a more suitable care environment. In turn, more community hospital beds were then available for other patients, due to avoiding unnecessary admissions. At the time of the inspection, a business case was under development to make this a permanent process.
- The organisation developed services that reflected the needs of the local population. For example, South Hams hospital worked in partnership with the local library to promote the hospital as part of the community. Local GPs, the hospital and voluntary groups met twice a year at the library to work on a community plan. They consulted with carers and patients to identify how they could work together to keep the hospital as part of the community and how they could deliver services to meet the needs of the local population.
- Plymouth Healthcare developed initiatives to provide care closer to the patients' home and avoid admissions to the acute trusts. For example, two beds on Kingfisher ward were ring fenced for patients admitted via the Robin Assessment Centre. The Robin Assessment Centre was a community-based service that was designated to enable treatment and tests to be completed without the need for a hospital stay. Patients were admitted on to the ward for a maximum of 72 hours and were monitored by the ward's nursing staff only. Medical and therapy staff came from the assessment centre every day to manage these patients. This meant people did not have to be admitted to the acute trust.
- We saw in care plans and observed in meetings, staff worked closely with other healthcare colleagues within and outside the organisation. For example, social workers, the local authority, GP practices and community-based nursing and therapy staff liaised and worked together to support the ongoing care of patients with long-term conditions and complex needs. Therapists said they encouraged patients to continue with community-based rehabilitation through attendance at groups and classes established within the community such as falls and exercise groups. Therapists worked collaboratively with community-based therapy staff to ensure that patients' goals were then transferred to the community teams.

Equality and diversity

- Staff received training in equality and diversity as part of their corporate mandatory training.
- Staff said they were able to access telephone translation services if they needed to but they had not had many occasions where this was needed.
- Information leaflets were available in all of the hospitals, community wards and communal areas. All of the leaflets could be printed in large print or other languages as required.
- The hospitals all had level access at the front entrances, with lifts available to facilities on other floors and disabled parking places near to the main entrances. This provided ease of access to all service users .
- It was clear from staff we spoke with they were keen to meet the needs of the patient and to be sensitive to their religious, cultural personal needs or sexual preferences. Patients we spoke with felt the needs were listened to, respected and met where possible. The hospital could arrange chaplaincy services if required by patients.

Meeting the needs of people in vulnerable circumstances

- Staff across all inpatient wards were responsive to individual patients' needs. Patients told us staff provided personalised care and treatment. We spoke with patients, families and carers who told us staff checked with patients how they preferred to receive their care.
- 'This Is Me' documentation was completed for all patients who had been diagnosed with a dementia or were suspected of living with dementia. This is a document which compiled information about the patient, their preferences and how to best communicate with them. However, we were told this was not used for

all patients admitted onto the wards. Where a patient was identified as to be living with dementia, a blue flower was put on a board over their bed to raise staff's awareness of this patient's condition. We observed staff flagged patients identified as living with dementia to other staff during handovers and safety briefings.

- The hospital had facilities to support patients living with dementia. A ward manager at Mount Gould told us wards were audited annually and managers responded to feedback to ensure they provided a dementia-friendly environment. Flooring was non-reflective which ensured a more suitable surface for patients to walk upon, as reflective surfaces could sometimes be confusing for people living with dementia. To manage the eating habits of patients living with dementia, we saw Skylark ward had a board that the patients and staff could fill in to ensure they had their meals at a time that suited them. On Kingfisher, Skylark, Tavistock and South Hams wards, toilets and showers were labelled with pictures as well as writing to represent their function, and clocks were visible to help with orientation.
- On wards at Tavistock and South Hams hospitals, each patient bay was painted in a different colour with a flower painted on the wall to help patients to orientate themselves.
- Staff showed a willingness and understanding of how to care for patients with dementia. For example, they explained ways in which they adjusted their communication style. We saw staff speaking clearly, calmly and slowly, and seek assurance about the patients' understanding. However, we did not see a great deal of activities that were planned for patients living with dementia.
- Tavistock and South hams hospitals achieved dementia-friendly status several years ago, prior to joining the organisation. This charter recognises hospitals as providing a dementia-friendly environment where staff have received dementia training. The matron at South Hams was looking into purchasing software to help patients remember, by using images, films and family videos to support patients living with dementia. They hoped this might be funded through the league of friends.
- Staff told us 'dementia champions' met regularly to discuss ways in which they could meet the needs of patients living with dementia and support other staff to do so. Dementia champions were staff who had received extra training and support in this subject. We told there was no dementia training specifically for healthcare assistants. However, there was an arrangement with the dementia champions to support healthcare assistants with their learning.
- A psychiatric liaison nurse was able to support staff at Mount Gould with any psychological issues or concerns they had in relation to patients, or to help with referral to mental health services.

Access to the right care at the right time

- Locality managers and senior staff said patients had timely access to initial assessment, diagnosis and treatment. We reviewed a number of medical records and care plans which showed a multidisciplinary team of doctors, nurses, physiotherapists and occupational therapists, carried out assessments on admission to the wards with the patient. The team planned their care, rehabilitation and set patient centred achievable goals.
- The organisation provided data for Tavistock ward, Skylark ward and the Plym Neurological Rehabilitation Unit. It used the NHS 18 week referral to treatment time as a benchmark. This showed patients accessed the wards in 20, eight and four days respectively. Feedback provided by the local acute trust in Plymouth stated the organisation had raised capacity issues with local commissioners, in order to address any concerns about delays to accessing the service.
- Patients on the Plym Neurological Rehabilitation ward accessed care and treatment in a timely way. The United Kingdom Rehabilitation Outcomes Collaborative (UKROC) measures the mean referral to assessment, assessment to admission and referral to admission times based on national targets. The Plym Neurological Rehabilitation Unit met the target 100% of the time in the last three years. This is better than the national average of 80%.
- Patients at Tavistock, South Hams, Kingfisher and Skylark ward had access to medical care from doctors during Monday to Friday between 8am and 5pm. On Kingfisher ward, there was a named care of the elderly consultant based at the local acute trust in Plymouth who was on the ward most days. GPs from the neighbouring practice in South Hams visited the ward on a Monday, Wednesday and Friday or on other days if there were new patients. Staff confirmed they could phone the surgery at any time and a GP would come.
- There was a stroke consultant based on the stroke rehab unit on Skylark ward. There was an out of hours

senior nursing rota and a doctor on call seven days a week after 5pm. At weekends there was an on-call doctor dedicated to Mount Gould. All wards could access an emergency doctor promptly. An ambulance would be called in an emergency situation to transfer patients to the nearest acute hospital. There were no doctors on-site at the weekends after 5pm, but there was always a director and consultant on-call.

- Therapists told us they reviewed patients within 48 hours of admission. However, some therapy staff on Kingfisher ward said they sometimes struggled to meet this timescale due to staffing, but always managed to complete them within the timeframe.
- A system was in place to monitor if patients arriving on the wards did not meet the admission criteria. On Skylark and Kingfisher wards, we were informed by a ward manager this occurred a couple of times every six months. Managers reported to this to the acute trust in Plymouth through the Tactical Control Centre. Staff said they recorded this as an incident if it occurred..
- Patients on the Plym Neurological Rehabilitation Unit and the Stroke Unit on Skylark ward were able to access a neuropsychology service. This provided assessments, cognitive rehabilitation, counselling and psychological therapies to patients and their families and carers.

Learning from complaints and concerns

- Very few people we spoke with knew how to make a complaint about the service. Patients said staff had not explained the process to them and few knew where to find this information. We saw there were some complaints leaflets available on wards, but these were not always visible to patients. However, most patients felt confident to raise concerns if they were unhappy, but had little cause to do so.
- The organisation kept a formal record of all complaints at each community hospital. Systems were in place for patients to register complaints and concerns through the customer services department. Complaints were screened by a service manager and risk assessed.
- Information on how to make a complaint was also available on the organisation's website. Patients could access details of how to access the complaints department under the 'contact us' section on the website, but not by typing 'complaints' into the search engine, which meant making a complaint was not as easy as it could be. The complaints policy was in date and accessible under the policies section of the website. It contained clear guidance, and anticipated time scales for responses, which the public and staff could access.
- We reviewed five complaints from a variety of departments. People's complaints and concerns were handled effectively and confidentially, and in line with the organisation's policy.
- Staff provided us with numerous examples of how the organisation and its staff learnt from complaints, which showed a systematic approach, in line with policy. For example, therapists described an example of how a discharge meeting process was changed in response to learning from a complaint. Staff conveyed the feedback they received from a patient to the matron and locality manager. In the case, the locality manager visited the complainant at home. The chief executive wrote personally, to explain how changes were made and processes improved. We were told this had a hugely positive impact upon the complainant and their emotional wellbeing.

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

We rated well led as good because:

- There was a clear strategy for community inpatients which was aligned to the organisational vision. The vision and values were driven by quality, safety and the experience of people receiving and delivering services. Staff understood the vision and strategy and their role in delivering this. The strategy and objectives were supported by quantifiable and measurable outcomes focused on safety and quality.
- There was a comprehensive governance system in place to monitor quality and safety. There are effective and comprehensive processes to identify, understand, monitor and address current and future risks.
- Leaders understood the challenges to good quality care within and outside the organisation. There were collaborative and open relationships with stakeholders. Leaders were respected, visible and approachable and staff felt well supported by them. Staff felt respected, valued and were incredibly proud to work for the organisation. There was a strong culture of supporting others.
- People who used services and local communities were involved in developing the service.
- Staff felt engaged and encouraged to develop and improve services and innovation was encouraged, recognised and rewarded.

However:

- We identified some issues to the governance of the supply and management of medicines, and a variation in pharmacy services across the organisation. Whilst wards were monitoring omitted doses of medications, it was not clear as to what actions were being taken as result.

Detailed findings

Service vision and strategy

- There was a vision and strategy for community inpatient services, which was based on the organisational vision and strategy . The vision was to work together and with others, to support people to be safe, well and at home. The organisation's aim was to have a strong focus on getting the basics right and improving quality, safety and the experience of people receiving and delivering services. This incorporated both local and national healthcare strategies, to provide more care in the community and to avoid people having to be admitted to the local, acute hospitals, unless necessary. If people were admitted, the aim was to ensure patients were discharged home promptly and cared for in a safe environment.
- Staff we spoke with demonstrated their understanding of the organisation's vision and strategy and of the vision and strategy for community inpatients. Staff clearly understood their role in delivering this strategy. Staff told us, and demonstrated, they aimed to provide high quality, person-centred, safe care and aspired to re-enable patients in order for them to return home safe and well, as soon as possible.
- Progress against delivering the strategy was monitored and reviewed in a variety of ways. For example, through ongoing, regular local and national audits, as well as monthly performance reviews for each ward. Wards monitored key performance indicators regularly. This included a variety of safety and quality markers such as length of stay, incidents, infection prevention and control and a range of safety performance data.
- The Commissioning for Quality and Innovation (CQUIN) payment frameworks in place on Kingfisher ward and for Skylark ward general rehabilitation patients for 2015 to 2016, underpinned this strategy. The CQUIN payments framework encouraged care providers to continually monitor, share and improve how they delivered care. The CQUINs supported the strategy of early reablement, improved patient experience, carer involvement and the patient returning home sooner. Ongoing evaluation of the CQUINs took place at monthly steering group meetings where learning and actions were shared as a result. Based on initial, positive findings, a decision was taken to continue the CQUIN for a further year for 2016 to 2017 and to implement this on other wards.

Good

Are services well-led?

- Tavistock and South Hams hospitals were previously part of a local NHS hospital until June 2015. The organisation was still in the process of merging policies and procedures at the time of the inspection. Although it was clear staff and leaders working across the different wards and hospitals understood the vision and strategy for community inpatients, locality managers and senior staff agreed further integration was required. Locality managers said work had commenced to better integrate the new hospitals. We were told, and meeting minutes confirmed, matrons had begun to look at this through the matron's forum.

Governance, risk management and quality measurement

- There was an effective governance framework within the organisation and across inpatient wards, which supported the delivery of the strategy and high quality patient care.
- There was a good flow of information regarding quality, safety and risk within inpatient services. Regular team meetings took place in which staff discussed incidents and quality indicators. Ward managers met monthly and shared learning from incidents and trends across the wards. They reported to the matrons, who met at monthly meetings and were line managed by locality leads. The locality leads met every month to discuss the risk registers and reported to the board and the corporate risk management team to discuss relevant areas of concern.
- The community urgent care sector group met monthly and ward managers and therapy leads rotated attendance at these meetings. Minutes were sent out to staff with feedback and learning related to quality and safety matters.
- Wards held weekly staff meetings to share information from more senior meetings and to discuss any concerns raised by staff. We observed one of these meetings in the Plym Neurological Rehabilitation Unit where students, health care assistants and nurses attended. This was a structured meeting which effectively shared information. Meeting minutes were distributed to all staff after the meeting so that people who could not attend had access to the same information. The minutes were printed and placed in the staff room and on notice boards. However, we were told by staff on one ward, a band 6 nurse's meeting was arranged but was routinely cancelled.
- There was a comprehensive assurance system which measured quality, effectiveness, safety and risk. The trust used a computer-based system to manage and mitigate current risks and to identify potential risks, in a structured and systematic way. This provided assurance that arrangements to identify and manage risks were in place.
- Staff completed a form of 16 questions in a risk 'workbook' on a monthly basis. Band 6 nurses and above were trained in using the risk workbooks. These examined elements of the hospital across a broad spectrum of measures and pulled information from current audit data. These included staffing levels, vacancies and sickness, learning and appraisals, complaints and incidents, equipment audits and infection prevention and control. The process gave a predictive score that used a coloured and numeric scoring system, which escalated any risk area that had increased, to the appropriate team for review. For example, a rating of 'Red level 2' would mean senior management would meet with the team to review the risk within a week of escalation. A risk rating of 'Purple level 3' was the highest risk score and triggered a meeting with directors within two days.
- Across wards, staff consistently demonstrated how at this computer system worked as a trigger to identify risks which may not have been otherwise considered. Measures scored as red or purple risks were reviewed monthly, along with safety and quality data. This formed part of the director-level, safety, performance and quality meeting.
- The matrons of the community hospitals held a risk register for each hospital and reported to the locality leads. One ward manager we spoke with was aware of their biggest risks, but could not demonstrate how the risk software was used to manage risk. However in general, ward managers, senior staff and locality managers were clear about what was on their risk register and what their top risks were.
- The theatre at Tavistock hospital remained on the local and corporate risk register. Surgical procedures at the theatre at Tavistock hospital ceased in November 2015 due to issues related to the air-handling unit. To manage the risks of losing staff competence and of increasing waiting lists, the organisation redeployed staff to other areas of the hospital or to the acute hospital in Plymouth. Work to revise the theatre would take approximately 30 weeks to complete. A further risk

identified at Tavistock hospital related to outstanding estates work and the fire risk associated with this. We sought clarity on this following the inspection and were subsequently informed about current mitigating actions that were in place, as well as further actions that would be taken to address this.

- Any new risks added to the risk register were kept as pending before being reviewed monthly by a risk moderation panel. A director within the organisation was assigned to the highest risks, which scored greater than 15 in order to provide senior influence and oversight, and to monitor and mitigate the risk.
- Risk registers reflected what managers said were their concerns. For example, risks for South Hams related to x-ray equipment and the contract with the neighbouring practice that provided the ward's medical care. Staffing and recruitment was also on the register and actions were in place to attract new staff and improve staff retention.
- However, during our inspection, we identified some issues in monitoring the supply and management of medicines, and a variation in pharmacy services across the organisation. A clinical pharmacy service was provided to the wards but the service was not equitable and we found monitoring of the supply of medicines was ad hoc. Ommitted dose audits were introduced on some wards, but it was not clear as to the learning this provided or what actions were taken as a result.
- There was a process in place to systematically seek and provide assurance up, down and across the organisation. All staff had access to the risk monitoring system and the risk register which matrons reviewed monthly. Each risk was described as being 'owned' by the member of staff that identified it. This meant all staff had access to risks they identified and reviewed actions and timelines associated with them. The team manager or matron reviewed any actions that needed to be addressed and discussed these with individual staff or the relevant team. Risks were marked as open or closed and alerts were generated by email to ward managers and matrons if unresolved.

Leadership of this service

- The Chief Executive was respected by staff in all areas of the community inpatients teams. Staff said the Chief Executive was visible, contactable and listened to staff's suggestions and concerns. We were told about occasions where he had helped on the wards. This included helping during a busy shift on Boxing Day and assisting in staff immunisations. He visited the South Hams and Tavistock hospitals to welcome new staff when they became part of Plymouth Community Healthcare in 2015 and stayed to work a nursing shift on the ward.
- Senior staff told us and demonstrated they understood the challenges to good quality care and identified actions needed to address them, both within an outside the organisation. Senior staff told us there was a mature and transparent relationship with outside bodies such as the local acute trust and commissioners and they felt their senior team had influence within these groups in order to improve patient care. For example, the organisation was part of a resilience group organised by the Clinical Commissioning Group where Plymouth Community Healthcare shared its ideas and contributed to the wider health economy.
- Leaders within the organisation were visible and approachable. Staff felt they were well supported by their manager and clinical leadership. Staff reported a culture where there was always an opportunity to seek this support if needed.
- Staff of all seniority were familiar with their line management and locality management team. One locality manager said they felt much closer to the board than with their previous organisation. The hierarchy was described as flat, which meant managers and the executive team were more accessible.
- Staff on one ward described their manager as not only going 'the extra mile' for patients, but they also did this for their staff.

Culture within this service

- Staff across all wards said they felt respected and valued. Health care assistants, nursing, medical and therapy staff across community inpatient services spoke about the positive, patient-centred culture on the wards. It was clear they were treating people how they would want to be treated themselves. Staff said we treat patients as if they were relatives. Others "wanted to provide good quality care at hotel Mount Gould".
- Staff told us they were overwhelmingly proud to work for the organisation and felt part of the community. There was a supportive culture of openness, candour and honesty which permeated the organisation.
- Staff at Tavistock and South Hams hospitals told us they felt anxious prior to the merger. However, they found the

transition incredibly positive, felt welcomed and part of it. Senior nursing staff described the move to a social enterprise as very smooth and they felt included. New staff said that the 'safe and well at home' strapline really lived, which meant the organisation was focused on delivering patient-centred care in line with its vision.

- One therapist who had worked in the organisation for over ten years felt more supported than ever and listened to about the challenges around staffing. They were clear about the actions both department and locality managers were taking in order to address these issues and to reduce the impact on staff and patient care.

Public engagement

- The various inpatient hospital locations we visited were looking at a variety ways in which they could link better with services and organisations within the patient's own locality, with the local authority, commissioners, with GP federations, and the voluntary sector. This focused on putting the patient at the heart of what they do, in order to achieve the vision. For example, in June 2016 the organisation held an event in conjunction with the voluntary sector and the Red Cross to improve engagement with these organisations as stakeholders. The aim of which was to ensure a more rapid and supported discharge of the patient back into their own community.
- All of the locations where inpatient services were delivered forged strong links with, and worked closely with the voluntary sector, including for example, the League of Friends, the Stroke Association and the Red Cross. There were numerous examples given where staff, ex-patients and volunteers had been involved in working together to raise funds to improve patient services.
- People who used the services and local communities were involved in the development of the service. For example, there was a community plan in place for Kingsbridge, Yelm and Ivybridge, in collaboration with the community voluntary partnership. At other locations, local people and voluntary groups were involved in supporting patients to address social isolation.
- Staff said they sought feedback from patients and carers, and encouraged them to complete the national friends and family test feedback questionnaire. There was an engagement forum held quarterly for service users and carers to share their experiences.
- The stroke unit on Skylark ward held activities to involve staff, patients and the public, such as a 'step out for stroke' event where patients were invited to attend a charity walk. The unit held a cake sale, which the patients and their relatives were involved in.
- Patients could provide feedback to staff on the wards or via a number of different forums on the organisation's website, such as 'Patient Opinion' or 'NHS Choices'. There were suggestion boxes around the hospitals for the public to place comments which were reviewed by ward management, who shared this feedback with staff. Staff said they were always willing to listen to patients and families and acted on feedback where possible. We saw evidence this occurred across the wards. For example, at South Hams hospital, some patients felt they needed more information about their medicines from the GPs who visited the wards. The matron acted upon this feedback by raising this with the GPs.
- The Plym Neurological Rehabilitation Unit held both internal and external fund raising activities, fairs and fun days. These included cake-baking competitions that were judged by the executive team and a bungee jump by an ex-patient. Staff at the unit ran the Plymouth 10k race with an ex-patient. The unit was the designated charity for Plymouth businesses this year and a charity ball is being held in September 2016 to raise funds for the unit.

Staff engagement

- Staff felt actively engaged so that their views were reflected in planning and delivering services and in the culture. 'Our Voice' was published on a regular basis to circulate news to all staff in the organisation. It contained information from high-level meetings, including governance meetings, and updates from the senior team. This also acted as marketing to encourage staff to be forthcoming with ideas and suggestions and provided an opportunity to communicate with the senior team.
- An 'Our Voice' representative who worked in the therapy team explained how ideas, concerns and suggestions were taken forward through the 'Our Voice' group. For example, the staff awards scheme and rebranding of the

uniform were ideas brought about by staff's suggestions. Fitness, wellbeing and exercise class at a discounted rate were also established through this forum and other staff engagement initiatives. A board member attended a part of every meeting and staff felt they were listened to 'at the top'.

- Staff had regular access to the executive team at Tavistock and South Hams hospitals. Executive team members were based at Mount Gould, but provided a drop-in session every quarter where staff could discuss concerns, ideas and improvements across all wards.
- The matron at South Hams hospital compiled a monthly bulletin for all staff at the hospital to provide an update about performance, new resources and feedback about new initiatives and activities staff had carried out on the wards. There was agreement to roll this out across other wards.
- The organisation took part in a staff survey that was comparable to the NHS Staff Survey. Senior managers said the results were better than local acute trusts and there was a higher response rate, which suggested staff were engaged in the process.
- An annual award ceremony for staff took place every autumn, in which staff were rewarded and recognised. Staff received £20 on an annual basis her head to spend within their team for the benefit of patient care.
- There were opportunities in place for those who expressed an interest in attending board meeting to do so.who Senior manager and staff we spoke with felt this provided staff with an opportunity to have insight into discussions and processes at a board level.

Innovation, improvement and sustainability

- We heard from a variety of senior staff and locality managers that there was a real drive for sustainability within the organisation. The wards shared a variety of ideas that were under development to improve the service or ensure sustainability.
- There were sustainability plans in place for Tavistock and South Hams hospitals to open up more services on site. Senior staff described projects they had set up with the local community to raise money for improvements to the hospitals. This included volunteer days where they discussed how the service was moving forwards.
- Innovation was encouraged within the organisation and staff felt empowered in the development and changes to the service. One locality manager said that they were always able to offer improvements and suggestions. They felt change happen quickly within the organisation and that the organisation prided itself on being innovative.
- Innovation was both recognised and rewarded at the highest level. The chief executive spoke at every staff induction and communicated a clear message to staff they should be forthcoming with ideas relating to quality, safety and innovation could improve the service.
- Staff continuously told us that they were able to talk to managers about ideas, innovation and service improvements. For example, one member of staff spoke about a conversation they had with a member of the executive team in passing, only to find that their idea had been trialled, and adopted. They received recognition from the executive team for this.
- There was an academic partnership with the local university and some staff attended a 'leadership in social enterprise' programme. The staff engaged on this course were asked to propose an idea to develop the service and to pitch it to a cross section of the board. The proposal was then taken back to the board and executive team. Feedback was given about the idea, even if it was not taken forward.
- Staff reported financial pressures did not compromise care being delivered. For example, work had been ongoing for a number of years to ensure the commissioning arrangements reflected the higher level of dependency of patients they had at the neurological unit. The nearest alternative service in the South West for these patients was Salisbury. In the meantime, the organisation funded the extra staff needed for the unit.
- The organisation was engaged in discussions with NHS England to look at developing a community neuro-rehabilitation service. The aim was to decrease length of stay at the neurological unit or to avoid admission altogether. This would further ensure patients could receive care and treatment at home.
- Staff reported they were continually focused on improving the quality of care. A 'mid shift' was introduced on general rehabilitation wards at Mount Gould in order to ensure cover was appropriate during times of increased demand, such as during lunch and evening meals. This also gave staff increased flexibility in shift patterns.
- Managers at the Plym Neurological Rehabilitation Unit aspired to use the latest technology to treat patients. They were in the process of purchasing new equipment,

such as nerve stimulation equipment for patients with muscle spasticity. They were submitting a business case for a fibre-optic endoscope to assess patients' swallow function. The unit recently hosted a course with external speakers on facial therapy, to develop their multidisciplinary team approach to treating patients with facial weakness. This would mean staff on the Plym Neurological Rehabilitation Unit could work jointly to assess and treat patients, rather than having to wait for the specialist physiotherapy service to come over from the therapy unit.

- Priorities for the stroke rehabilitation service aimed at improving links with the local acute hospital stroke service. A review of the stroke pathway for the locality was due to commence in July 2016. Medical and management staff expressed their desire to improve joint working and to ensure they were clear what they could do to help improve stroke patient care, following the review.
- We heard a range of ideas that were in the development phase which were aligned to delivering the strategy. For example, a new rapid response service was being developed. The aim was to provide intensive nursing and therapy care in order to support early discharge and avoid admissions to hospital.
- As rural hospitals, there was a clear focus on sustainability at Tavistock and South Hams hospitals. Their ideas were aimed at ways in which they could support and work cohesively with the acute trust. Plans were linked to the vision of delivering care closer to the patient's home. Ideas to create an acute-care facility at South Hams hospital were under development. This would mean patients would not have to travel to the NHS acute trusts in the area for some aspects of care and treatment which would provide a more local service. Other ideas were linked to an acute care at home service, and ensuring the long-term sustainability of staffing at the community hospital through new roles and ways of working.