

# Livewell Southwest CIC

## Inspection report

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

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

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

## Ratings

### Overall rating for this organisation

Good 

Are services safe?

Good 

Are services effective?

Good 

Are services caring?

Good 

Are services responsive?

Good 

Are services well-led?

Good 

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

# Summary of findings

## Background to the CIC

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

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

The organisation officially formed on 1 October 2011 as an independent health services provider, working as part of the NHS family in a similar way to GP's, Dentists and Pharmacies.

On 1st April 2015, Livewell Southwest took over the adult social care assessment service from Plymouth City Council.

Following our inspection in 2018 we rated the organisation as good overall. We rated safe, effective, responsive as good and caring as outstanding.

The organisation provides the following services:


### Community Health Services:

- community health services for adults
- community health services for children and young people
- community health inpatient services
- community end of life care
- sexual health services

### Mental Health Services:

- acute wards for adults of working age and psychiatric intensive care units
- long stay rehabilitation mental health wards for adults of working age
- forensic inpatient or secure wards
- child and adolescent mental health wards
- wards for older people with mental health problems
- community based mental health services for adults of working age
- mental health crisis services and health-based places of safety
- specialist community mental health services for children and young people
- community based mental health services for older people
- community mental health services for people with a learning disability or autism

## Overall summary

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

# Summary of findings

## Key questions and ratings

We inspect and regulate healthcare service providers in England.

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

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

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

## What we inspected and why

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

At this inspection we inspected three mental health services and two community health services:

- community health inpatient services
- community end of life care
- child and adolescent mental health wards
- wards for older people with mental health problems
- community based mental health services for adults of working age

Other services provided by the organisation that were previously rated as good or outstanding were not inspected as we had no information to suggest the quality of those services had changed.

## What we found

### Overall

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

- We rated all five of the key questions 'are services safe, effective, caring, responsive and well-led' as good. Our rating for the organisation took into account the previous ratings of services not inspected this time.
- Staff in the organisation had worked hard to address concerns we had raised in the last inspection. Two services that were previously rated as requires improvement at the last inspection were now rated as good. Community end of life care and child and adolescent mental health wards had both improved.
- Livewell Southwest had strong leadership who had the appropriate range of skills, knowledge and experience to deliver community health and mental health services. Staff felt they were visible and approachable. There was a rolling programme of visits scheduled to services by the executives. Executives used these visits to engage with staff and also listen to their views on the services.
- There was a positive, open and honest culture throughout the organisation. Staff at all levels of the organisation were proud to work at the organisation and morale among staff was very good. Both leaders and staff across the organisation put patients at the centre of everything they did.

# Summary of findings

- The organisation had recently refreshed and published its new strategy which had been coproduced with staff and stakeholders. The organisation had worked hard to ensure it forged strong strategic alliances with partner organisation. Its contribution to the wider health economy was highly valued by partner organisation and it was now seen as equal partner.
- Livewell Southwest had effective systems and processes in place to support delivery of the services it delivered. There was an appropriate sub board committee structure and escalation to board through the structure. Non-executive directors (NEDs) chaired committees and were confident to raise any concerns or challenge to the executive team. The organisation was financially stable and there was relevant financial expertise among the executives and NEDs.
- There was a strong emphasis, from both leaders and staff across the organisation for putting patients at the centre of everything they did.
- There was also a strong emphasis on listening to staff and providing opportunities for staff at all levels to develop and a strong emphasis on Quality Improvement. The organisation had appointed two Freedom to Speak Up Guardians (although there is no requirement for a CIC to do so). The organisation were using innovative ways to develop its existing staff and to attract new staff.
- Staff treated all patients with compassion, respect and kindness. The privacy and dignity of patients was maintained at all times. Patients were supported by staff to understand and manage their care and treatment. Staff actively involved families and carers of patients in their care appropriately.
- Across the organisation clinical areas and premises where patients received care were clean, well equipped and maintained.
- Services had enough medical and nursing staff. Teams in the organisation had access to a full range of specialists required to meet the needs of patients in their care. Care was planned and provided in a way that met the needs of local people and the communities it served. Staff met the needs of patients with a protected characteristic. Staff supported patients with communication, advocacy and cultural and spiritual support.
- Generally, staff across the organisation knew their roles and responsibilities under the Mental Health Act 1983, Mental Health Act Code of Practice and the Mental Capacity Act 2005. Staff assessed and recorded capacity clearly for those who might have impaired mental capacity.
- The organisation managed incidents well and staff understood how to report them appropriately. Incidents were investigated, and lessons learned were shared with staff.
- The organisation treated concerns and complaints seriously. The organisation investigated concerns and complaints and shared lessons learned with staff. Patients were included in the investigation of their complaint.

However:

- Patients on Cotehele ward, part of the wards for older people with mental health problems service, did not have access to their bedrooms during the day without a staff member escorting them. This limited their ability to be as independent as possible, which is important for older people in hospital. There were also blanket restrictions in relation to the time patients went to bed in the evening which meant that patients had to go to bed at set times.
- Staff did not undertake a risk assessment of patients at the time of referral to the community mental health teams and did not monitor patients on the waiting lists prior to their initial assessment. This meant that they did not know whether a patient's mental health deteriorated whilst waiting for an assessment. Staff assumed the GPs would monitor them but there was no agreement in place as to who should monitor patients on the waiting list.

# Summary of findings

- In the community health services for inpatients staff on South Hams ward were not assessing pressure ulcers and wounds adequately and in line with the organisation's policy. Some staff were also unaware of the organisation's policy on safeguarding in relation to the development of pressure ulcers and when notifications should be made to the Care Quality Commission.
- There was further work needed by the organisation on equality and diversity.

## Are services safe?

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

- In the majority of services that we inspected the organisation provided safe care. The ward environments, clinical areas and premises where patients received care were safe, clean well equipped and maintained. The organisation controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection.
- The services in the organisation had enough medical and nursing staff. Staff knew the patients and received training to keep patients safe from avoidable harm. Staff understood how to protect patients from abuse and the service worked well with other agencies to do so.
- Staff had access to clinical information and maintained high quality electronic records.
- Medicines were well managed across the organisation. There were systems and processes in place to safely prescribe, administer, record and store medicines. The effects of medications on patient's physical health was monitored regularly by staff.
- All the services inspected had a good track record on safety. They managed patient safety incidents well. Staff knew how to recognise incidents and reported them appropriately. Managers within services investigated incidents and shared lessons learned with staff and the wider service. Staff were open and transparent when things went wrong and apologised and gave patients information and support.

However:

- Staff did not undertake a risk assessment of patients at the time of referral to the community mental health teams and did not monitor patients on the waiting lists prior to their initial assessment. Staff told us that it remained the responsibility of the patient's GP to monitor and contact the service if the patient deteriorated further during this wait. There was no policy in place to ensure GPs monitored patients whilst they were waiting. At the time of the inspection the wait was approximately six weeks, but people could wait up to 18 weeks for an initial routine assessment.
- On the child and adolescent ward young people were not allowed to go outside unaccompanied. This blanket restriction had been put in place while the ward was waiting for building work to take place to install anti climb walls.
- In the community health service for inpatients staff on South Hams ward were not assessing pressure ulcers and wounds adequately and in line with the organisation's policy.
- In the community health service for inpatients staff were unaware of the organisation's policy on safeguarding in relation to the development of pressure ulcers.

## Are services effective?

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

- Staff assessed the physical and mental health needs of all patients. Staff worked with patients, their families and carers to develop individualised care plans. These were updated when required. Care plans we reviewed reflected the assessed needs of patients, were personalised, holistic and recovery-orientated.

# Summary of findings

- Staff provided suitable care and treatment interventions for patients which were based on and consistent with national guidance on best practice. Staff ensured patients were supported to live healthier lives.
- Teams in the organisation had access to a full range of specialists required to meet the needs of patients in their care. Managers of services ensured staff had the correct range of skills needed to provide high quality care. Staff were supported with appraisals, supervision and opportunities to develop and update their skills.
- Staff of all disciplines worked well together as a team to the benefit of patients. Staff supported each other to ensure patients had no gaps in their care. There were effective working relationships among teams and with other relevant teams within the organisation and relevant services outside the organisation.
- Staff knew their roles and responsibilities under the Mental Health Act 1983 and Mental Health Act Code of Practice.
- Staff supported patients to make decisions about their care for themselves. Staff understood the organisation's policy on the Mental Capacity Act 2005. Staff assessed and recorded capacity clearly for those who might have impaired mental capacity.

However:

- Feedback from some GPs about the community mental teams for adults of working age stated communication was poor and it was difficult to get advice from the services.
- In some teams staff had not received training in the Mental Capacity Act and/or the Mental Health Act.

## Are services caring?

Our rating of caring went down. We rated it as good because:

- Staff treated patients with compassion and kindness. The privacy and dignity of patients was respected and embedded in the work of staff. Staff understood the individual needs of patients. Patients were supported by staff to understand and manage their care, treatment or condition.
- Staff involved patients in decisions about their care and treatment. Patients were involved in care planning and risk assessment. Managers and staff sought patient feedback on the quality of care received. Patients had access to advocates.
- Staff kept families and carers appropriately updated and involved in the care their family members received.
- Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.

However:

- Some patients on the wards for older people with mental health problems told us their sleep was disturbed by staff talking in the corridor and using torches when undertaking welfare checks overnight.

## Are services responsive?

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

- The organisation planned and provided care in a way that met the needs of local people and the communities serves. The organisation also worked well with others in the wider system and local organisations to plan care.
- The organisation met the needs of patients including those with a protected characteristic. Staff supported patients with communication, advocacy and cultural and spiritual support.

# Summary of findings

- The organisation treated concerns and complaints seriously. It was easy for people to provide feedback on the services and raise concerns about care received. The organisation investigated concerns and complaints and shared lessons learned with staff. Patients were included in the investigation of their complaint.
- The organisation managed beds well. Beds were available when required and patients were not moved between wards unless this was for their benefit. Discharge was rarely delayed for other than clinical reasons.

However:

- Patients on Cotehele ward did not have access to their bedrooms during the day without a staff escort. This limited their ability to be autonomous and in some cases led to discomfort as patients could not retrieve things such as glasses and hearing aids which had been left in their rooms. There were also blanket restrictions in relation to the time patients went to bed in the evening.

## Are services well-led?

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

- Leaders in the organisation had the skills, knowledge, integrity and experience to perform their roles. They had a good understanding of the services they managed. They were visible in the service and approachable to patients and staff. Leaders ensured there were structures, systems of accountability for the performance of services. Staff were clear about their roles and accountabilities.
- Staff throughout the organisation knew and understood the organisation's vision and values and applied them to their work. Services within the organisation had a vision for what they wanted to achieve and a strategy to turn it into action. The vision and strategies had been developed with all relevant stakeholders.
- Staff felt respected, supported and valued by the organisation. Staff reported morale was good and were proud to work for the organisation. The organisation promoted equality and diversity throughout. There were opportunities for career progression.
- Staff were familiar with the organisation's whistleblowing policy and felt able to raise concerns without fear of retribution.
- The services in the organisation had governance processes that operated effectively at local level and performance and risk issues were managed well.
- The services we inspected had access to information they needed to provide safe and effective care and treatment.
- Staff throughout the organisation were actively engaged in local and national quality improvement activities. Staff collected and analysed data about outcomes and performance and undertook regular audits.

## Ratings tables

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

## Outstanding practice

We found examples of outstanding practice organisation wide and also on the wards for older people with mental health problems. For more information, see the Outstanding practice session of this report.

# Summary of findings

## Areas for improvement

We found areas for improvement including four breaches of legal regulations that the organisation must put right. These included concerns about blanket restrictions, risk assessment, safeguarding and notifications. We found 22 things that the organisation should improve to comply with minor breaches that did not justify regulatory action, to prevent breaching a legal requirement, or to improve service quality. For more information, see the Areas for Improvement section of this report.

## Action we have taken

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

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

## What happens next

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

## Outstanding practice

We found examples of outstanding practice in the following services:

### Wards for older people with mental health problems

- On Cotehele ward, there was a designated staff member that spent the first three days after admission with every patient. This was to get to know the patient very well and fully understand their needs and preferences. This information was used to provide person centred care in much detail.
- On Edgcumbe ward, all assessments and care plans were exceptionally detailed and well written. Managers ensured patients were taken to visit care homes with their families so that they had a choice of homes before being discharged to them. Once they had made their choice they visited with a staff member from the ward and their families to become familiar with the home.

## Areas for improvement

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

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

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

- the organisation must take action to ensure patients can access their bedrooms during the day and the communal ward areas at night time, if they wish, unless there is a clinical reason to prevent this from happening (Regulation 9).

#### Community-based mental health services for adults of working age:

- the organisation must ensure that patients are adequately assessed once their referral has been received by the services and ensure that patients waiting for assessments are monitored to detect and respond to any deterioration in their mental health (Regulation 12).



# Summary of findings

## **Community health service inpatients**

- the organisation must ensure staff complete robust pressure ulcer risk assessments (Regulation 12).
- the organisation must ensure that safeguarding referrals are made appropriately to the local authority safeguarding team (Regulation 13).

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

### **Child and Adolescent Mental Health wards**

- the organisation should consider assessing young people individually for risk of absconson rather than place a blanket restriction on all patients who want to access the outdoor space unaccompanied.
- the organisation should have a blanket restrictions policy.
- the organisation should record individual search protocols in young people's risk assessments following admission and following any change in risk.
- the organisation should either remove or complete the ward's record of which staff had administered medication.
- The organisation should improve the regularity and recording of managerial supervision
- The organisation should arrange for all staff to have specific Mental Capacity Act training.

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

- the organisation should address the blind spots and ligature points in the open access garden on Cotehele ward.
- the organisation should address the broken fence, nails, unlocked shed, blind spots, ligature points and bench against the fence in the large garden therefore making it safe to use.
- the organisation should address the sinks on Edgcumbe ward which have been identified as problematic for patients with dementia.

### **Community-based mental health services for adults of working age:**

- the organisation should ensure that referrers receive a detailed rationale when a referral is rejected.
- the organisation should complete regular reviews of rejected referrals to ensure that those referred would not have benefited from the support of the community mental health services.

### **Community health service inpatients:**

- the organisation should ensure do not attempt cardiopulmonary resuscitation forms are completed and reviewed in line with the organisation's policy.
- the organisation should ensure that all capacity assessments are fully documented prior to making best interests decisions on South Hams ward.
- the organisation should ensure all staff are aware of procedures to store equipment on Plym Neuro ward that ensure the ability for staff to evacuate patients safely if necessary.
- the organisation should monitor the action plan to reduce delayed discharges for patients awaiting therapy assessments on Kingfisher ward.
- the organisation should ensure that staff are trained to use new information systems and assessment tools in a timely manner.

# Summary of findings

- the organisation should ensure the action plan to improve mandatory training levels on kingfisher ward is implemented and effective.
- the organisation should ensure that managers provide opportunities for team meetings that allow for discussion and feedback on ward issues and performance.

## **Community End of Life Care:**

- the organisation should ensure that staff consistently complete the palliative care bundle on the electronic system to reflect patient wishes and feelings and ensure care plans reflect these wishes.
- the organisation should ensure that staff are trained in advance care planning and are supporting patients with this where appropriate.
- the organisation should ensure that all treatment escalation plans (TEPS) and do not attempt cardiopulmonary resuscitation (DNACPR) orders are legally compliant. Where these are inherited from previous care providers, the provider should ensure these are updated without delay.
- the organisation should ensure that all staff are familiar with the end of life strategy and how this impacts on them in their work.

## Is this organisation well-led?

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

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

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

- The leadership team of the organisation had the appropriate range of skills, knowledge and experience to deliver community health and mental health services. The organisation had a strong and experienced group of Non-Executive Directors (NEDs) from a range of professional backgrounds. NEDs chaired committees and were confident to raise any concerns or challenge to the executive team.
- The leadership team were considered visible and approachable by staff of the organisation. There was a rolling programme of visits scheduled to services by the executives. Executives used these visits to engage with staff and also listen to their views on the services.
- Staff at all levels of the organisation were proud to work there and morale among staff was good. Staff were patient centred.
- The leadership team and staff at all levels of the organisation were open and transparent. The vision and values of the organisation were clear and understandable and were integrated into services across the organisation.
- The organisation had recently refreshed and published their new strategy. The strategy was developed inline with the NHS long term plan, STP plans and local authority plans. The strategy was co-produced with staff and stakeholder engagement.

# Summary of findings

- The organisation was financially stable and there was relevant financial expertise among the executives and NEDs.
- The organisation had implemented and were beginning to embed the People first programme.
- There were leadership and development opportunities available to staff. There was a strong emphasis in the organisation on recruiting and developing staff at all levels. The organisation were utilising innovative ways of developing existing staff members.
- The organisation had a Freedom to Speak Up Guardians. There was no requirement on the organisation to have a Freedom to Speak Up Guardian as they are not an NHS organisation. However, the organisation had lobbied to get access to training for the roles. We were provided with examples of support and guidance that had been offered to staff by the Freedom to Speak Up Guardians.
- The organisation were engaged in local strategy and had strong working and strategic alliances with partners. The executive team had worked hard to ensure Livewell was an equal partner within the local health economy and supported partner organisations. The organisation was valued in the STP as a non-NHS partner.
- The organisation had effective systems and processes in place to support delivery of care. There was an appropriate sub board committee structure and escalation to board through the structure. The organisation had recently had a governance review and had convened a working group to take forward the actions identified to further strengthen and develop their governance arrangements.
- The organisation treated complaints seriously and investigated them appropriately. The organisation learned from complaints and also engaged with complainants.
- There were a range of mechanisms that provided assurance from service level to board level. Directorate governance meetings were held monthly and considered service line performance by operational activity, quality governance metrics (including incidents, complaints and compliments), workforce and financial KPIs and risks faced by each individual directorate.
- There was a strong emphasis on Quality Improvement throughout the organisation.

However

- There was further work needed by the organisation on equality and diversity.

## Ratings tables

Key to tables					
Ratings	Not rated	Inadequate	Requires improvement	Good	Outstanding
Rating change since last inspection	Same	Up one rating	Up two ratings	Down one rating	Down two ratings
Symbol *	→←	↑	↑↑	↓	↓↓
Month Year = Date last rating published					

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

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

### Ratings for the whole trust

Safe	Effective	Caring	Responsive	Well-led	Overall
Good →← Jan 2020	Good →← Jan 2020	Good ↓ Jan 2020	Good →← Jan 2020	Good →← Jan 2020	Good →← Jan 2020

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

## Ratings for community health services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community health services for adults	Good Oct 2016	Good Oct 2016	Good Oct 2016	Good Oct 2016	Good Oct 2016	Good Oct 2016
Community health services for children and young people	Good Oct 2016	Good Oct 2016	Good Oct 2016	Good →← Oct 2016	Good →← Oct 2016	Good →← Oct 2016
Community health inpatient services	Requires improvement ↓ Jan 2020	Good →← Jan 2020	Good →← Jan 2020	Good →← Jan 2020	Good →← Jan 2020	Good →← Jan 2020
Community end of life care	Good ↑ Jan 2020	Good ↑ Jan 2020	Good Jan 2020	Good →← Jan 2020	Good ↑ Jan 2020	Good ↑ Jan 2020
Sexual Health Services	Good Oct 2016	Good Oct 2016	Good Oct 2016	Good Oct 2016	Good Oct 2016	Good Oct 2016
<b>Overall*</b>	Good →← Jan 2020	Good →← Jan 2020	Good →← Jan 2020	Good →← Jan 2020	Good →← Jan 2020	Good →← Jan 2020

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

## Ratings for mental health services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Acute wards for adults of working age and psychiatric intensive care units	Good Oct 2016	Good Oct 2016	Outstanding Oct 2016	Good Oct 2016	Outstanding Oct 2016	Outstanding Oct 2016
Long-stay or rehabilitation mental health wards for working age adults	Good Apr 2018	Good Apr 2018	Good Apr 2018	Good Apr 2018	Good Apr 2018	Good Apr 2018
Forensic inpatient or secure wards	Good Oct 2016	Good Oct 2016	Good Oct 2016	Good Oct 2016	Good Oct 2016	Good Oct 2016
Child and adolescent mental health wards	Good ↑ Jan 2020	Good →← Jan 2020	Good →← Jan 2020	Good →← Jan 2020	Good ↑ Jan 2020	Good ↑ Jan 2020
Wards for older people with mental health problems	Good →← Jan 2020	Good →← Jan 2020	Good ↓ Jan 2020	Requires improvement ↓ Jan 2020	Good →← Jan 2020	Good →← Jan 2020
Community-based mental health services for adults of working age	Requires improvement ↓ Jan 2020	Good →← Jan 2020	Good →← Jan 2020	Good →← Jan 2020	Good →← Jan 2020	Good →← Jan 2020
Mental health crisis services and health-based places of safety	Good Apr 2018	Good Apr 2018	Good Apr 2018	Good Apr 2018	Good Apr 2018	Good Apr 2018
Specialist community mental health services for children and young people	Good Apr 2018	Good Apr 2018	Good Apr 2018	Good Apr 2018	Good Apr 2018	Good Apr 2018
Community-based mental health services for older people	Good Oct 2016	Good Oct 2016	Good Oct 2016	Good Oct 2016	Good Oct 2016	Good Oct 2016
Community mental health services for people with a learning disability or autism	Good Oct 2016	Good Oct 2016	Outstanding Oct 2016	Outstanding Oct 2016	Good Oct 2016	Outstanding Oct 2016
<b>Overall</b>	Good →← Jan 2020	Good →← Jan 2020	Good ↓ Jan 2020	Good →← Jan 2020	Good →← Jan 2020	Good →← Jan 2020

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

# Community health services

## Background to community health services

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

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

The organisation provides the following community health services:

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

We inspected the following core services: community health inpatient services and community end of life care. Our last inspection had been in 2018 where we inspected community health inpatient services and community end of life care.

The organisation provided care for adults in three community hospitals; South Hams, Tavistock and Mount Gould care centre. End of life care was provided by community nursing teams and on inpatient wards in three community hospitals (Mount Gould hospital, South Hams hospital in Kingsbridge and Tavistock hospital).

## Summary of community health services

**Good**   

Our rating of these services stayed same. We rated them as good because:

- Community health inpatient services remained rated as good overall. Effective, caring responsive and well led were rated good. Safe was rated as requires improvement.
- Community end of life care improved and was rated good overall. We rated safe, effective, caring, responsive and well led as good.

# Community health inpatient services

Good   

## Key facts and figures

Livewell Southwest Community Interest Company (CIC) provide community health inpatient services across three community hospitals; Tavistock, South Hams and Local Care Centre/Mount Gould Hospital Plymouth. There are six wards across the three sites, Skylark general rehabilitation, Skylark Stroke, Kingfisher, Plym Neuro, Tavistock and South Hams. The wards provide 72 general rehabilitation, 15 stroke rehabilitation and 15 neurological rehabilitation beds for adults. Patients are admitted from the wards from the acute hospital or community who require assessment, treatment or rehabilitation but who do not need to be in an acute hospital. We visited all six wards as part of an unannounced inspection of Livewell Southwest CIC.

This inspection was undertaken as part of our comprehensive programme of inspections. Our inspection was unannounced (staff did not know we were coming) to enable us to observe routine activity.

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

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

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

During the inspection, the inspection team:

- visited all five wards at the three community hospital sites, looked at the quality of the ward environment and observed how staff were caring for patients
- spoke with 12 patients who were using the service
- spoke with six carers or family members of patients using the service
- spoke with the managers for each ward
- interviewed 36 staff including, consultants, staff nurses, healthcare assistants, occupational therapists, physiotherapists, pharmacists, hotel services staff and social workers
- reviewed 23 care records of patients
- attended two multidisciplinary team meetings and a ward handover
- carried out a specific check of medication management and administration records on all wards
- looked at policies, procedures and other documents relating to the running of the service



# Community health inpatient services

## Summary of this service

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

- The service managed safety incidents well and learned lessons from them. Staff collected safety information and used it to improve the service. The service controlled infection risk well. Staff managed medicines well.
- Staff provided good care and treatment, gave patients enough to eat and drink and gave them pain relief when they needed it. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information. Key services were available seven days a week.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.
- The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback. People could access the service when they needed it and did not have to wait too long for treatment.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.

However:

- Managers did not ensure that management and reporting for incidents of pressure ulcers was completed in line with policy. Staff at South Hams ward did not fully assess and document care plans for patients with pressure ulcers. Staff did not raise pressure ulcers as a safeguarding concern and did not document discussion and decision making in relation to this. Managers did not submit notifications of serious injury to the Care Quality Commission for pressure ulcers grade 3 and above.

## Is the service safe?

**Requires improvement** ● ↓

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

- Staff on South Hams ward were not assessing pressure ulcers and wounds adequately and in line with policy. Staff had not documented the depth, size and location of pressure ulcers or created care plans to review and manage associated risks.
- Staff on South Hams were unaware of the organisations policy on safeguarding regarding development of pressure ulcers. Managers did not ensure safeguarding concerns were raised in response to incidents of pressure ulcers and there was no documentation of decision-making discussions for not submitting safeguarding referrals.
- Managers had not submitted notifications to the Care Quality Commission for four incidents of grade 3 or above pressure ulcers, which patients had developed while receiving inpatient care.

# Community health inpatient services

- A consultant had not taken overall responsibility for two patients' do not attempt cardiopulmonary resuscitation (DNACPR) decisions, which had been completed by a locum junior doctor. The environment on Plym Neuro ward was not always kept safe due to equipment being stored in communal areas and corridors causing obstacles for staff and patients.
- Managers on Kingfisher ward had not ensured that mandatory training had been completed by all staff. Only 62% of staff were up to date with their basic life support training.

However:

- The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean. Staff managed clinical waste well.
- The service had enough nursing, support and medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix and gave locum staff a full induction.
- The service used systems and processes to safely prescribe, record and store medicines.
- The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

## Is the service effective?

**Good**   

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

- The service provided care and treatment based on national guidance and evidence-based practice. Staff protected the rights of patients in their care.
- Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients' religious, cultural and other needs.
- Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.
- Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients
- Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent.
- The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.
- All those responsible for delivering care worked together as a team to benefit patients. They supported each other to provide good care and communicated effectively with other agencies.
- Staff gave patients practical support and advice to lead healthier lives.

However:

# Community health inpatient services

- Staff on South Hams ward did not always clearly document discussions around capacity prior to documenting best interests decisions.
- Managers on all wards did not provide regular opportunities for team meetings to take place where staff could provide and receive feedback on the ward processes and performance.

## Is the service caring?

Good  → ←

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

- Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.
- Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.
- Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.
- We observed strong multidisciplinary team working which supported patients and empowered them to manage their own health and maximise their independence.
- Managers liaised with community services to organise volunteers to attend the ward to provide support. This included befriending services, help with completion of forms and support to attend outpatient appointments.

## Is the service responsive?

Good  → ←

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

- The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.
- The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.
- People could access the service when they needed it and received the right care in a timely way
- It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

However:

- There was insufficient therapy staff on Kingfisher ward due to vacancies and staff on maternity leave. Although managers had made improvements with recruitment and therapy provisions, there had been 52 delayed discharges over the previous 12 months due to patients waiting for occupational and physiotherapy assessments.

# Community health inpatient services

## Is the service well-led?

Good   

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

- Leaders had the integrity, skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They supported staff to develop their skills and take on more senior roles.
- The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.
- Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development.
- Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and leaders had regular opportunities to meet, discuss and learn from the performance of the service.
- Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.
- Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.
- All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

However:

- The organisation did not ensure that staff were adequately trained in the use of information systems following updates.
- Managers did not ensure regular team meetings were held with staff on the wards.

## Areas for improvement

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

# Community end of life care

Good  

## Key facts and figures

Livewell is an independent social enterprise that provides two types of services contributing to end of life care for the people of Plymouth, South Hams and West Devon.

These services are:

- a community nursing service, where nurses visit and treat patients in their own homes; and
- an inpatient ward service providing care to patients who are at the end of life in three community hospitals (Mount Gould Hospital, South Hams Hospital and Tavistock Hospital).

There are seven community nursing care teams providing end of life care, covering geographical localities across the organisation. Plymouth has four teams covering north, south east and west Plymouth. The three other teams cover outlying geographical areas.

The end of life team has a Director of Transformation, the director of people and professionalism and Palliative and End of Life lead. Each locality has a manager, operational lead and a matron. Each nursing team has a district nurse manager. However, there is not a specific end of life care staff team. End of life care is provided within the community inpatients wards and by community nursing staff.

The organisation has a single point of access hub based in Plymouth. They take all referrals for end of life care from GPs, hospitals, residential homes, specialists nurses, domiciliary carers and patients could also self-refer. All referrals were triaged by a senior band six nurse and prioritised. Out of hours referrals were managed by the local on call medical service.

Specialist palliative care is not provided by Livewell, but they do work in partnership with a local hospice and other services to ensure collaborative care delivery. The local hospice provides specialist palliative care nurses and carries out joint visits with a cancer charity, who also provide night sitting services. All organisations work collaboratively and with the GPs in the area. This inspection only covered those services provided by Livewell, although it is important to note that the end of life service was provided in an integrated way.

Until November 2018, Livewell also provided a multi-visit team service, predominantly made up of health care assistants, visiting end of life patients in the community with approximately 12 weeks left to live, to provide basic care needs. However, this service is now provided by a local hospice.

Livewell do not provide end of life care for children. The service also has no dedicated end of life care beds.

At the last inspection of this service in April 2018, we rated the service as requires improvement. We rated caring and responsive as good, with safe, effective and well led rated as requires improvement. We issued requirement notices under regulations 12 (safe care and treatment), 17 (good governance) and 18 (staffing). We told the provider they should improve their management of medicines, ensure that the service is audited for quality and effectiveness, and that they should ensure all staff had access to appropriate end of life training.

Our inspection was unannounced (staff did not know we were coming) to enable us to observe routine activity.

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

Is it safe?

# Community end of life care

Is it effective?

Is it caring?

Is it responsive to people's needs?

Is it well-led?

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

During the inspection visit, the inspection team:

- visited Mount Gould, Tavistock and South Ham hospitals and looked at the ward environment including the clinic rooms
- visited the community nursing teams based at Mount Gould, Tavistock and South Ham
- spoke with four ward managers, the Palliative and End of Life lead and the quality compliance officer
- spoke with 42 other staff members, including community and inpatient nurses and health care support workers, doctors, and occupational therapists
- spoke with visiting GPs, a pharmacist and a specialist palliative care nurse from a partner agency
- spoke with five patients receiving end of life care and three carers
- reviewed six staff personnel files
- reviewed eight sets of patient medical notes, 17 patient care records and 35 treatment escalation plans and DNACPR (do not attempt cardiopulmonary resuscitation) records
- attended a multidisciplinary team meeting and a staff handover meeting
- joined community nurses on three home visits to a patient and observed the care provided
- looked at a range of policies, procedures and other documents related to the running of the service
- observed the care and support provided and interactions between people, visitors and staff throughout the inspection.

## Summary of this service

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

- The service had enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. The service controlled infection risk well. Staff assessed risks to patients, acted on them and kept good care records. They managed medicines well. The service managed safety incidents well and learned lessons from them.
- Staff provided good care and treatment, gave patients enough to eat and drink, and gave them pain relief when they needed it. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, supported them to make decisions about their care and had access to good information. Key services were available seven days a week.

# Community end of life care

- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs and helped them understand their conditions. They provided emotional support to patients, families and carers.
- The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback. People could access the service when they needed it and did not have to wait too long for treatment.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.

However:

- There was room for improvement with the recording of patient wishes, including the use of treatment escalation plans (TEPS) and do not attempt cardiopulmonary resuscitation (DNACPR) orders, and supporting patients with advance care planning.
- Not all staff were familiar with the end of life care strategy and how this applied to them in their work.

## Is the service safe?

**Good**  

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

- The service provided mandatory training in key skills to all staff and made sure they completed this.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.
- The service controlled infection risk well. They used control measures to prevent the spread of infection before and after the patient died. Staff used infection control measures when visiting patients on wards or in the community, and transporting patients after death.
- The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well. When providing care in patients' homes staff took precautions and actions to protect themselves and patients.
- Staff completed and updated risk assessments for each patient and removed or minimised risks. Risk assessments considered patients who were deteriorating and in the last days or hours of their life.
- The service had enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.
- The service used systems and processes to safely prescribe, administer, record and store medicines.
- The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

# Community end of life care

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

However:

- Not all staff on the community health service inpatient wards were completing the palliative care bundle, which are documents around key issues of a patient's life, on the electronic records. This was something the Palliative and End of Life lead was aware of and they were working with the teams to address the issue.

## Is the service effective?

Good  

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

- The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patients in their care.
- Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.
- The service monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.
- All those responsible for delivering care worked together as a team to benefit patients. They supported each other to provide good care and communicated effectively with other agencies.
- Staff gave patients practical support to help them live well until they died.
- Staff supported patients to make informed decisions about their care and treatment. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.
- Staff always had access to up-to-date, accurate and comprehensive information on patients' care and treatment. All staff had access to an electronic records system that they could all update.
- The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development. There were a number of end of life specific training courses in place, although staff had not all accessed these.

However:

- Staff did not have access to advance care planning training and were not routinely supporting this when speaking with patients. This was included as part of the service development plan for the next year.
- While there was a clear improvement in the completion of treatment escalation plans (TEPs) and do not attempt cardiopulmonary resuscitation (DNACPR) orders from the previous inspection, we found a number of records that did not demonstrate legal compliance. These were not all however completed by Livewell staff, and some had been inherited by the previous care providers.

## Is the service caring?

Good   



# Community end of life care

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

- Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs. Staff in South Ham hospital provided end of life patients with comfort packs, with dry shampoo, lip balm for mouthcare, hand cream and deodorant. Staff could also arrange access to a hairdresser on the ward if patients wished.
- Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs. In acknowledgement of the emotional challenges working in end of life care, staff were on occasions given time off to attend patient funerals.
- Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

## Is the service responsive?

Good   

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

- The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.
- The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.
- Patients could access the specialist palliative care service when they needed it.
- It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

## Is the service well-led?

Good  

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

- Leaders had the integrity, skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills.
- The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders knew how to apply them and monitor progress.
- Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work, and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

# Community end of life care

- Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.
- Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.
- The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.
- Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

However:

- Not all staff were familiar with the end of life care strategy and how this applied to them in their work.

# Mental health services

## Background to mental health services

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

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

The organisation provides the following mental health services:

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

We inspected the following core services: child and adolescent mental health services, wards for older people with mental health problems and community-based services for adults of working age. Our last inspection had been in 2018 where we inspected long stay rehabilitation wards for adults of working age, child and adolescent mental health wards, wards for older people with mental health problems, mental health crisis services and health-based places of safety and specialist community mental health services for children and young people

## Summary of mental health services

**Good**   

Our rating of these services stayed same. We rated them as good because:

- Wards for older people with mental health problems remained rated as good overall. Safe, effective, caring and well led were rated good. Responsive was rated as requires improvement.
- Child and adolescent mental health wards improved and was rated good overall. We rated safe, effective, caring, responsive and well led as good.

## Summary of findings

- Community based mental health services for adults of working age remained rated as good overall. Effective, caring, responsive and well led were rated good. Safe was rated as requires improvement.

# Wards for older people with mental health problems

Good   

## Key facts and figures

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

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

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

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

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

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

Following our previous inspection in 2018 we told the service that:

- The provider should ensure that staff write the 'opened date' on all liquid medication after opening, in line with the provider's policy. During this inspection we found that medicines were being managed in line with best practice.
- The provider should record staff supervision in line with the organisation's policy. During this inspection we found that all supervision was being recorded in line with the organisations policy
- The provider should ensure that learning from incidents is recorded and disseminated to all staff. During this inspection we saw evidence that the service was learning from incidents. During this inspection we found evidence that learning was being disseminated and learnt from.

We inspected all five key questions.

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

During the inspection visit, the inspection team:

- visited two wards
- interviewed two ward manager
- interviewed one modern matron
- spoke with 12 staff members, including consultant psychiatrists, qualified nurses, healthcare assistants, occupational therapists and hotel services
- checked two clinic rooms
- undertook two ward tours
- observed two medicine rounds

# Wards for older people with mental health problems

- observed two patient meal times
- reviewed all the medication charts on Cotehele unit and Edgcumbe unit.
- reviewed 12 care records
- spoke with seven patients
- spoke with six carers
- observed daily activities and staff interactions with patients
- observed two multi-disciplinary team meetings
- we reviewed policies and procedures, meeting minutes, training and supervision records and audits.

## Summary of this service

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

- The service provided safe care. The ward environments were safe and clean. The wards had enough nurses and doctors. Staff assessed and managed risk well. They minimised the use of restrictive practices, managed medicines safely and followed good practice with respect to safeguarding.
- Staff developed holistic, recovery-oriented care plans informed by a comprehensive assessment. They provided a range of treatments suitable to the needs of the patients and in line with national guidance about best practice. Staff engaged in clinical audit to evaluate the quality of care they provided.
- The ward teams included or had access to the full range of specialists required to meet the needs of patients on the wards. Managers ensured that these staff received training, supervision and appraisal. The ward staff worked well together as a multidisciplinary team and with those outside the ward who would have a role in providing aftercare.
- Staff understood and discharged their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, and understood the individual needs of patients. They actively involved patients and families and carers in care decisions.
- Edgcumbe ward had cared for a patient on the end of life pathway so that the person did not have to be moved to a different ward potentially causing confusion and distress. The ward demonstrated an ability to be flexible and responsive to the needs of the patient and family allowing the experience to be as peaceful and dignified as possible.
- The service managed beds well so that a bed was always available locally to a person who would benefit from admission and patients were discharged promptly once their condition warranted this.
- The service was well led and the governance processes ensured that ward procedures ran smoothly.

However:

- Patients on Cotehele did not have access to their bedrooms during the day or the main ward area overnight and were all taken to their rooms at a set time of the day.
- Patients complained that they were disturbed by staff shining torches on them during the checks overnight and staff could be overheard talking, disturbing patients.

# Wards for older people with mental health problems

- The garden areas on Cotehele ward were not fit for purpose.
- Some patient files were not being securely stored on Edgcumbe ward.

## Is the service safe?

Good   

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

- The service had enough nursing and medical staff, who knew the patients and received basic training to keep patients safe from avoidable harm
- Staff assessed and managed risks to patients and themselves well and followed best practice in anticipating, de-escalating and managing challenging behaviour. Staff used restraint only after attempts at de-escalation had failed. The ward staff participated in the provider's restrictive interventions reduction programme, which had been modified to meet the needs of the older patient group.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.
- Staff had easy access to clinical information and it was easy for them to maintain high quality electronic clinical records.
- The service used systems and processes to safely prescribe, administer, record and store medicines. Staff regularly reviewed the effects of medications on each patient's physical health.
- The wards had a good track record on safety. The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.
- Staff on Edgcumbe ward undertook analysis of data regarding falls and aggression and used this to reduce the number of incidents in the future.

However:

- The gardens on Cotehele were potentially unsafe. The small garden had blind spots and a tree which obscured view and was a ligature risk. The large garden had an unstable fence with nails sticking out of it, the tool shed was unlocked and a bench was against a fence allowing for the potential to be climbed over.
- The bedroom corridor was not observable from the main ward area and conversely overnight when staff were based in the bedroom corridor. This was mitigated by limiting patient access to these areas.

## Is the service effective?

Good   

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

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

# Wards for older people with mental health problems

- Staff provided a range of care and treatment interventions suitable for the patient group and consistent with national guidance on best practice. They ensured that patients had good access to physical healthcare and supported patients to live healthier lives.
- Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives.
- The ward teams included or had access to the full range of specialists required to meet the needs of patients on the wards. Managers made sure they had staff with a range of skills needed to provide high quality care. They supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.
- Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. The ward teams had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.
- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and discharged these well. Managers made sure that staff could explain patients' rights to them.
- Staff supported patients to make decisions on their care for themselves. They understood the provider's policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly for patients who might have impaired mental capacity.

## Is the service caring?

**Good**  

Our rating of caring went down. We rated it as good because:

- Staff treated patients with compassion and kindness. They respected patients' privacy and dignity. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.
- Staff involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided. They ensured that patients had easy access to independent advocates.
- Staff informed and involved families and carers appropriately.

However

- Some patients told us that they were disturbed overnight by staff talking in the corridor and pointing torches at them when carrying out the welfare checks overnight.

## Is the service responsive?

**Requires improvement**  

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



# Wards for older people with mental health problems

- Patients on Cotehele ward did not have access to their bedrooms during the day without a staff escort. This limited their ability to be autonomous and in some cases led to discomfort as patients could not retrieve things such as glasses and hearing aids which had been left in their rooms. Patients told us that staff were not always responsive to requests to access their rooms.
- Overnight from 21:00hr patients on Cotehele did not have access to the main ward area to watch TV or make a drink. We were told that patients who could not sleep were encouraged to sit with the nurses and read magazines. A drinks trolley was taken into the bedroom corridor to reduce the need to go in to the main ward areas. Patients were taken to their rooms at 13:00hr and brought back into communal areas at 14:00hr. Although we were told patients could choose not to go, the manner in which this was approached did not make this choice clear. Patients had raised this in the community meeting, however these had not been acted upon.

However

- Staff managed beds well. This meant that a bed was available when needed and that patients were not moved between wards unless this was for their benefit. Discharge was rarely delayed for other than clinical reasons.
- Edgumbe ward had cared for a patient on the end of life pathway so that the person did not have to be moved to a different ward potentially causing confusion and distress. The ward demonstrated an ability to be flexible and responsive to the needs of the patient and family allowing the experience to be as peaceful and dignified as possible.

## Is the service well-led?

Good   

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

- Leaders had the skills, knowledge and experience to perform their roles, had a good understanding of the services they managed, and were visible in the service and approachable for patients and staff.
- Staff knew and understood the provider's vision and values and how they were applied in the work of their team.
- Staff felt respected, supported and valued. They reported that the provider promoted equality and diversity in its day-to-day work and in providing opportunities for career progression. They felt able to raise concerns without fear of retribution.
- Our findings from the other key questions demonstrated that governance processes operated effectively at ward level and that performance and risk were managed well.
- Ward teams had access to the information they needed to provide safe and effective care and used that information to good effect.
- Staff engaged actively in local and national quality improvement activities.

However

- Leaders had not addressed the practice relating to blanket restrictions on Cotehele ward.

## Areas for improvement

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

# Community-based mental health services of adults of working age

Good   

## Key facts and figures

Livewell Southwest Community Interest Company (CIC) provides adult community mental health services across Plymouth.

The community mental health service of adults of working age provides mental health support to individuals aged 18 - 65. Support is continued past the age of 65 unless it is felt a person's needs are better met by older peoples mental health services. The teams predominately support individuals in the community, but also support individuals who are inpatients and those in residential care homes. Referrals to this service are predominately from local GPs.

Prior to April 2019, there were four community mental health teams in Livewell Southwest CIC. These teams subsequently merged and there are now two community mental health teams that cover Plymouth. One team covers south and east Plymouth and the other covers north and west Plymouth. The adult community mental health services also contain an assertive outreach team, a duty team, a primary care mental health team, a perinatal mental health team, a community recovery team and a complex needs team that supports individuals who have chaotic drug/alcohol use.

During this unannounced comprehensive inspection, we visited both community mental health teams, the duty team, the assertive outreach and the primary care mental health team. The community mental health teams are based at Avon House and the Cumberland Centre.

The duty team manage the referrals into the community mental health teams, triage and pass to the appropriate community mental health team, dependant on which part of the county the individual lives. The duty team are based in the local care centre at Mount Gould.

The assertive outreach team supports individuals in the community who have a long-term, enduring mental health condition, typically schizophrenia. The assertive outreach team are based at Riverview.

The primary care mental health team supports individuals with low to moderate mental health conditions. The service is for individuals that do not meet the threshold for secondary mental health services, such as the community mental health teams, but require mental health support beyond the remit of a general practitioner. This service has been in place since April 2019 and is currently being run as a pilot service. The primary care mental health team are based at Ridgeview clinic in Plympton.

The service was previously inspected in May 2017 and was rated good in all key questions and overall.

Before and after the inspection, we reviewed information we held about these services, information requested from the organisation and requested feedback from relevant stakeholders.

During the inspection visit, the inspection team:

- visited the premises where teams were based or were seeing patients and looked at the quality of the service environment
- spoke with the manager of the south & east community mental health team, the manager of the assertive outreach team, the manager of the duty team and the manager of the primary care mental health team.
- spoke with eight patients and three carers
- received comment cards from two patients

# Community-based mental health services of adults of working age

- spoke to 33 staff including 14 nurses, two student nurses, one occupational therapist, two clinical psychologists, three assistant psychologists, three consultant psychiatrists, one senior trainee consultant psychiatrist, six support workers, and one administrative staff.
- reviewed 15 care records of patients under the community mental health teams, 14 care records of individuals referred into the duty team, and six care records of patients under the primary care mental health team
- completed a check of the clinic rooms, reviewed seven medication records of patients under the community mental health teams and 12 medication records of patients under the assertive outreach team
- attended one visit to a patient's home and observed two patient appointments
- observed one multi-disciplinary meeting and
- looked at policies, procedures and other documents relating to the running of the service.

## Summary of this service

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

- The service provided safe care. Clinical premises where patients were seen were safe and clean. The number of patients on the caseload of the teams, and of individual members of staff, was not too high to prevent staff from giving each patient the time they needed. Staff assessed and treated patients who required urgent care promptly and those who did not require urgent care did not wait too long to start treatment. Staff managed risk well and followed good practice with respect to safeguarding.
- Staff developed holistic, recovery-oriented care plans informed by a comprehensive assessment and in collaboration with families and carers. They provided a range of treatments that were informed by best-practice guidance and suitable to the needs of the patients. Staff engaged in clinical audit to evaluate the quality of care they provided.
- The teams included or had access to the full range of specialists required to meet the needs of the patients. Managers ensured that these staff received training, supervision and appraisal. Staff worked well together as a multidisciplinary team and with relevant services outside the organisation.
- The organisation was piloting a primary care mental health team to fill a gap in mental health provision who don't meet threshold to receive support from secondary mental health services but require more support than GPs can offer. Stakeholders provided unanimously positive feedback about this service and praised the team's ability to work with patients promptly and effectively as well as providing support to local GPs.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, and understood the individual needs of patients. They actively involved patients and families and carers in care decisions.
- The service was well-led and the governance processes ensured that that procedures relating to the work of the service ran smoothly.

However:

- Staff were not assessing risk prior to patients accessing the service. Patients were not risk assessed at the point of referral, therefore staff could not prioritise patients waiting for an initial assessment based on level of risk. A basic risk

# Community-based mental health services of adults of working age

assessment was completed during initial assessment and only when accepted to the service did patients receive a comprehensive assessment. Staff did not monitor patients who were waiting for their initial assessment. Staff told us that it remained the responsibility of the patient's GP to monitor and contact the service if the patient deteriorated further during this wait.

- The duty team reviewed the suitability of referrals for the community mental health team but were concerned that they were rejecting a high number of referrals due to pressures in the service to keep waiting lists down. Feedback from local GPs who weren't able to access the primary mental health team stated that a high number of their referrals were being rejected. There was no auditing process to ensure referrals were not being rejected incorrectly.
- GPs who had referred into the service were not always receiving a rationale for why their patient had been rejected from the community mental health teams. Some received advice to signpost patients to other services however GPs commented that often their patients had already accessed those services and required further support.
- Not all staff had completed training in Mental Capacity Act and Mental Health Act.

## Is the service safe?

**Requires improvement**  

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

- Staff were not risk assessing individuals at the point of referral, therefore staff could not prioritise patients waiting for an initial assessment based on level of risk. A basic risk assessment was completed during initial assessment and only when accepted to the service did patients receive a comprehensive assessment.
- Staff did not monitor patients who were waiting for their initial assessment. Staff told us that it remained the responsibility of the patient's GP to monitor and contact the service if the patient deteriorated further during this wait. There was no policy in place to ensure GPs monitored patients whilst they were waiting. At the time of the inspection the wait was approximately six weeks, but people could wait up to 18 weeks for an initial routine assessment.

However:

- The service had enough staff, who knew the patients and received basic training to keep patients safe from avoidable harm. The number of patients on the caseload of the teams, and of individual members of staff, was not too high to prevent staff from giving each patient the time they needed.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.
- Staff assessed and managed risks to patients and themselves. They responded promptly to sudden deterioration in a patient's health. When necessary, staff worked with patients and their families and carers to develop crisis plans. Staff followed good personal safety protocols.

## Is the service effective?

**Good**   

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

# Community-based mental health services of adults of working age

- Staff assessed the mental health needs of all patients. They worked with patients and families and carers to develop individual care plans and updated them when needed. Care plans reflected the assessed needs, were personalised, holistic and recovery-oriented.
- Staff provided a range of treatment and care for the patients based on national guidance and best practice.
- The teams included or had access to the full range of specialists required to meet the needs of patients under their care. Managers made sure that staff had a range of skills needed to provide high quality care. They supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.
- Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. The teams had effective working relationships with other relevant teams within the organisation and some relevant services outside the organisation.
- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice.
- Staff supported patients to make decisions on their care for themselves. They understood the organisation's policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly for patients who might have impaired mental capacity.

However:

- Feedback from some GP practices stated that communication was poor and that it was difficult to get advice from the service.
- Despite the organisation deeming Mental Capacity Act and Mental Health Act training as essential training for all community mental health team staff, only 61% of the South & East team had completed Mental Health Act training and 67% of the North & West team had completed Mental Capacity Act training.
- At the time of the inspection the organisation had not fully implemented physical health clinics.

## Is the service caring?

Good   

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

- Staff treated patients with compassion and kindness. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.
- Staff involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided. They ensured that patients had easy access to advocates when needed.
- Staff informed and involved families and carers appropriately.

## Is the service responsive?

Good   

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

# Community-based mental health services of adults of working age

- Staff assessed and treated patients who required urgent care promptly and patients who did not require urgent care did not wait too long to start treatment. Staff followed up with patients who missed appointments.
- The service met the needs of all patients including those with a protected characteristic. Staff helped patients with communication, advocacy and cultural and spiritual support.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff.

However:

- Some individuals found the service difficult to access. Feedback from local GPs stated that a high number of their referrals were being rejected. For example, one GP practice group reported that over a one-month period 16 out of 20 referrals had been rejected. GPs often re-referred their patients to the service once they had been rejected as they felt their patient may have benefitted from the support of the community mental health teams.
- When a referral was rejected a clear rationale was not always provided back to the referrer. Some received advice to signpost patients to other services but GPs commented that often their patients had already accessed those services and required further support. There was no auditing process to ensure referrals were not being rejected incorrectly.
- The waiting room at Riverview, where the assertive outreach team were based, did not have posters up informed patients, visitors and staff that there was CCTV recording in operation.

## Is the service well-led?

Good   

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

- Leaders had the skills, knowledge and experience to perform their roles. They had a good understanding of the services they managed and were visible in the service and approachable for patients and staff.
- Staff knew and understood the organisation's vision and values and how they were applied in the work of their team.
- Staff felt respected, supported and valued. They reported that the organisation promoted equality and diversity in its day-to-day work and in providing opportunities for career progression.
- Our findings from the other key questions demonstrated that governance processes operated effectively at team level and that performance and risk were managed well.
- Teams had access to the information they needed to provide safe and effective care and used that information to good effect.
- Staff collected analysed data about outcomes and performance and engaged actively in local and national quality improvement activities.

However:

- A review of comments made by staff who had left the service showed a number of negative themes towards the managers of the community mental health teams. Staff had described a culture where if you weren't in the "in crowd" you were treated poorly by management.
- Certain staff expressed concerns about management competency in one team and were unclear how to raise these concerns to senior management.

# Community-based mental health services of adults of working age

- Some staff felt unable to raise concerns for fear of retribution.

## Areas for improvement

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

# Child and adolescent mental health wards



## Key facts and figures

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

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

The unit has an on-site place of safety facility and education facilities. The education facilities are inspected by the Office for Standards in Education, children's services and skills (Ofsted) and during their last inspection, received an 'outstanding' rating.

The service was last inspected in May 2018 and was rated as requires improvement in the safe and well-led domains. It was rated good in effective, caring and responsive. During our inspection we found that the provider had met all but one of their requirement notices.

During our inspection in 2018, we told the provider that they must:

- review its risk assessments and blanket restriction policy. This includes the blanket restrictions imposed on the young people and the non-individualised assessment of the restrictions. (Regulation 12).
- ensure that regular team meetings take place and are recorded. (Regulation 17).
- ensure there are robust procedures for sharing of information and learning following incidents. (Regulation 17).
- ensure supervision and appraisal of staff members happen regularly. (Regulation 17).
- update the risk register appropriately and more accurately reflect key risks (Regulation 17).
- must ensure that fridge temperatures and checks are recorded daily. (Regulation 15).

We inspected this core service as part of our ongoing comprehensive mental health inspection programme. Our inspection was unannounced (staff did not know we were coming) to enable us to observe routine activity.

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

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

During the inspection visit, the inspection team:

- visited one ward and looked at the quality of the ward and clinic room environment and observed how staff were caring for young people



# Child and adolescent mental health wards

- spoke with seven young people who were using the service
- spoke with one carer
- spoke with the manager of the ward
- spoke with nine other staff members; including doctors and nurses
- observed an art therapy session
- observed one handover

We also:

- looked at five care records
- looked at five prescription charts
- carried out a specific check of the medication management on the ward
- looked at a range of policies, procedures and other documents relating to the running of the service.

## Summary of this service

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

- The service provided safe care. The ward environments were safe and clean. The wards had enough nurses and doctors. Staff assessed and managed risk well. They minimised the use of restrictive practices, managed medicines safely and followed good practice with respect to safeguarding.
- Staff developed holistic, recovery-oriented care plans informed by a comprehensive assessment. They provided a range of treatments suitable to the needs of the young people and in line with national guidance about best practice. Staff engaged in clinical audit to evaluate the quality of care they provided.
- The ward teams included or had access to the full range of specialists required to meet the needs of young people on the wards. Managers ensured that these staff received training, clinical supervision and appraisal. The ward staff worked well together as a multidisciplinary team and with those outside the ward who would have a role in providing aftercare.
- Staff understood and discharged their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. They followed good practice with respect to young people's competency and capacity to consent to or refuse treatment.
- Staff treated young people with compassion and kindness, respected their privacy and dignity, and understood the individual needs of young people. They actively involved young people and families and carers in care decisions.
- Staff planned and managed discharge well and liaised well with services that could provide aftercare. As a result, discharge was rarely delayed for other than a clinical reason.
- The service was well led and the governance processes ensured that ward procedures ran smoothly.

However:

- The provider did not have a blanket restrictions policy and although had lifted the blanket restrictions found during our last inspection, were not allowing young people outside unsupervised due to a perceived risk of absconsion.

# Child and adolescent mental health wards

## Is the service safe?

Good  

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

- All wards were safe, clean, well equipped, well furnished, well maintained and fit for purpose.
- The service had enough nursing and medical staff, who knew the young people and received basic training to keep them safe from avoidable harm.
- Staff assessed and managed risks to young people and themselves well and followed best practice in anticipating, de-escalating and managing challenging behaviour. Staff used restraint and seclusion only after attempts at de-escalation had failed. Staff understood how to protect young people from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it. The provider had a named nurse and doctor for child safeguarding and the teams had a safeguarding lead.
- Staff had easy access to electronic clinical information and it was easy for them to maintain high quality clinical records.
- The service used systems and processes to safely prescribe, administer, record and store medicines. Staff regularly reviewed the effects of medications on each young person's physical health.
- The wards had a good track record on safety. The service managed safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave young people honest information and suitable support.

However:

- Young people were not allowed to go outside unaccompanied. This was a blanket restriction whilst the ward waited for building work to take place to install an anti climb fence. Although the provider had lifted the blanket restrictions we asked them to remove in 2018, they had not considered this temporary condition as a restriction.
- Staff did not document individual search protocols in young people's risk assessments. There had been incidents when young people had bought contraband onto the ward due to not being adequately searched.
- Staff had created their own record to show which staff had administered medication. This had not been approved by the organisation and had not been completed.

## Is the service effective?

Good   

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

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

# Child and adolescent mental health wards

- Staff provided a range of care and treatment interventions suitable for the patient group and consistent with national guidance on best practice. They ensured that young people had good access to physical healthcare and supported them to live healthier lives.
- Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives.
- The ward team included or had access to the full range of specialists required to meet the needs of young people on the ward. Managers made sure they had staff with a range of skills needed to provide high quality care. They supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.
- Staff from different disciplines worked together as a team to benefit young people. They supported each other to make sure young people had no gaps in their care. The ward team had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.
- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and discharged these well. Managers made sure that staff could explain young peoples' rights to them.
- Staff supported young people to make decisions on their care for themselves proportionate to their competence. They understood how the Mental Capacity Act 2005 applied to young people aged 16 and 17 and the principles of Gillick competence as they applied to young people under 16. Staff assessed and recorded consent and capacity or competence clearly for young persons who might have impaired mental capacity or competence.

However:

- Although staff were receiving regular clinical supervision, there were large gaps in the recording of managerial supervision.
- Only 40% of the team had received Mental Capacity Act training.

## Is the service caring?

Good  → ←

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

- Staff treated young people with compassion and kindness. They respected young peoples' privacy and dignity. They understood the individual needs of young people and supported them to understand and manage their care, treatment or condition.
- Staff involved young people in care planning and risk assessment and actively sought their feedback on the quality of care provided. They ensured that young people had easy access to independent advocates.
- Staff informed and involved families and carers appropriately.

## Is the service responsive?

Good  → ←

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

# Child and adolescent mental health wards

- Staff planned and managed discharge well. They liaised well with services that would provide aftercare and were assertive in managing the discharge care pathway. As a result, young people did not have excessive lengths of stay and discharge was rarely delayed for other than a clinical reason.
- The design, layout, and furnishings of the ward/service supported young peoples' treatment, privacy and dignity. Each young people had their own bedroom with an en-suite bathroom and could keep their personal belongings safe. There were quiet areas for privacy.
- Staff facilitated young people's access to high quality education throughout their time on the ward.
- The food was of a good quality and young people could make hot drinks and snacks at any time.
- The ward met the needs of all young people who used the service – including those with a protected characteristic. Staff helped young people with communication, advocacy and cultural and spiritual support.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and the wider service.

## Is the service well-led?

Good  

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

- Leaders had the skills, knowledge and experience to perform their roles, had a good understanding of the services they managed, and were visible in the service and approachable for young people and staff.
- Staff knew and understood the provider's vision and values and how they were applied in the work of their team.
- Staff felt respected, supported and valued. They reported that the provider promoted equality and diversity in its day-to-day work and in providing opportunities for career progression. They felt able to raise concerns without fear of retribution.
- Our findings from the other key questions demonstrated that governance processes operated effectively at ward level and that performance and risk were managed well.
- Ward teams had access to the information they needed to provide safe and effective care and used that information to good effect.
- Staff engaged actively in local and national quality improvement activities.

## Areas for improvement

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

Action the provider SHOULD take to improve:

- The provider should consider assessing young people individually for risk of absconson rather than place a blanket restriction on all patients who want to access the outdoor space unaccompanied.
- The provider should have a blanket restrictions policy.
- The provider should record individual search protocols in young people's risk assessments following admission and following any change in risk.

# Child and adolescent mental health wards

- The provider should either remove or complete the ward's record of which staff had administered medication.
- The provider should improve the regularity and recording of managerial supervision.
- The provider should arrange for all staff to have specific Mental Capacity Act training.

This section is primarily information for the provider

## Requirement notices

### Action we have told the provider to take

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

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

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

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care
Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment
Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment

# Our inspection team

Karen Bennett-Wilson, Head of Hospital Inspection for Mental Health South chaired this inspection and Evan Humphries, Inspection Manager, led it. Executive reviewers supported our inspection of well-led for the organisation overall.

The team included inspectors, executive reviewers, specialist advisers and experts by experience.

Executive reviewers are senior healthcare managers who support our inspections of the leadership of organisations.

Specialist advisers are experts in their field who we do not directly employ. Experts by experience are people who have personal experience of using or caring for people who use health and social care services.