Good

Livewell Southwest CIC

Community-based mental health services for adults of working age

Quality Report

Community Mental Health Teams
Avon House
Mount Gould Hospital Local Care Centre
Mount Gould Hospital
PL7 4QD
Tel: 08451 558100
Website: www.livewellsouthwest.co.uk

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Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
1-2719622340		Community-based mental health services for adults of working age	PL4 7PY

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

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

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

Summary of findings

Ratings

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

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

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

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

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

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

Summary of findings

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Summary of findings

Overall summary

We re-rated community-based mental health services for adults of working age as **good** overall because:

During our re- inspection in October 2016, we saw that the services had made substantial improvements against the breaches to:

Regulation 12 (1)(2)(a)(b)(c)(g) safe care and treatment.

Regulation 17 (1)(2)(a)(b) good governance.

Regulation 18 (1)(2)(a) staffing.

Since that inspection we have received no information that would cause us to re-inspect these areas of the warning notice. During our most recent inspection in May 2017, we found that the services had addressed the issues that were outstanding from the re-inspection in October 2016. The community based mental health services for adults of working age were now meeting all of the requirements under Regulations 12, 17 and 18 of the Health and Social Care Act (Regulated Activities) Regulations 2014: The South and West teams had reduced their nurse vacancy rate from 33% and 15% down to 0%. The management teams had introduced systematic changes to their recruitment and retention processes which resulted in decreased staff turnover, a single point of

reference from start to finish of the recruitment process, increased staff morale and regular reviews of team capacity. The provider had reviewed and made systematic changes to reduce caseload sizes. As a result, the teams had reduced their wait times significantly, and had reduced their allocation list from 50 patients last October 2016 down to two. These two patients had been referred on the same day as the inspection. The provider was auditing their allocation lists regularly

and assessing any breaches with the MDT in weekly meetings to ensure they met their target waiting time.

Summary of findings

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

Are services safe?

Good

We re-rated Safe as Good because:

The service had addressed the issues that had caused us to rate safe as Inadequate following the June inspection. During this inspection, we specifically looked at the breach under Regulation 18 (1)(2)(a) staffing: "The provider must ensure that sufficient numbers of suitably qualified, competent, skilled and experienced persons are deployed."

• The provider had made systematic changes to the way in which they recruited and retained staff. At the time of the inspection there were no nurse staff vacancies, only one long term agency worker was employed. Caseload sizes had been reviewed and

reduced.

Additionally,

• Most staff had completed their mandatory training and had received training in suicide prevention.

• Risk assessments were in place for all patients and we saw that staff were monitoring patients on the allocation list daily.

• Staff were prioritising incident reporting and staff shared any lessons learnt from incidents at the weekly multidisciplinary meeting.

However:

• There were three locum doctors in the West team.

Are services effective?

Good

We re-rated Effective as Good because:

The service had addressed the issues that had caused us to rate Effective as Requires Improvement following the inspection in

October.

Additionally:

• All care records we reviewed had comprehensive assessments. Patients on a care programme approach had detailed risk assessments and crisis plans.

• Staff were well trained and there were increased opportunities for career development.

• Staff received regular appropriate supervision and annual appraisals.

Summary of findings

• Multi-disciplinary meetings were comprehensive; risk based and occurred daily and weekly.

However:

• Patients not under a care programme approach (CPA) had less detailed risk assessments or full crisis plans. (The care programme approach is a way that services are assessed, planned, co-ordinated and reviewed for someone with mental health problems or a range of related complex needs.)

• Some staff were unable to locate patient information on their electronic record system.

• Despite seeing full physical healthcare and medication information in the referral section of the patients' electronic records, there was limited evidence of the provider carrying out routine physical healthcare checks on patients. Where it was not appropriate for the provider to carry out the physical healthcare check, we could not find regular documentation of routine GP physical healthcare checks documented in the care

records.

• Five out of 12 care plans reviewed were not person centred, containing the patients' views or evidence that the plan had been written with the patient.

Are services caring?

Good

At the last inspection in June 2016 we rated caring as **good.**

Since that inspection we have received no information that would cause us to re-inspect this key question or change the rating.

Are services responsive to people's needs?

Good

We re-rated Responsive as Good because:

The service had addressed the issues that had caused us to rate Responsive as Inadequate following the October 2016 re-inspection.

During this inspection, we specifically looked at the breaches under Regulation 12 (1)(2)(a)(b)(c)(g) safe care and treatment: "The provider must ensure that care and treatment is provided in a safe way for patients. The provider must ensure that they assess the risks to the health and safety of patients receiving care or treatment. The provider must ensure that they do all that is reasonably practicable to mitigate any such risks."

Summary of findings

• The provider had made systematic changes to ensure their referral to treatment time had reduced significantly. At the time of the inspection, there were only two external people on the waiting list in the West team who had come in that day.

• The provider was using their allocation list to ensure that internal patients were being tracked whilst moving from one service to another.

• The provider were auditing their allocation lists regularly and assessing any breaches with the MDT in weekly meetings to ensure they had met their target waiting time.

Additionally,

• Rates of cancelled appointments had reduced significantly since our last inspection.

Are services well-led?

Good

We re-rated Well–led as Good because:

The service had addressed the issues that had caused us to rate Well led as Inadequate following the October 2016 inspection. During this inspection, we specifically looked at the breaches under Regulation 17 (1)(2)(a)(b) good governance: "The provider must ensure that systems or processes are established and operated effectively to assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of patients in receiving those services). The provider must ensure that systems or processes are established and operated effectively to assess, monitor and mitigate the risks relating to the health, safety and welfare of patients and others who may be at risk which arise from the carrying on of the regulated activity."

• One person had taken over the responsibility for recruitment for each team and staff were now recruited for the community teams as a group rather than for a specific locality.

• The provider had increased staff involvement, staff responsibility, supervision and appraisal, training opportunities and feedback meetings.

• Staff told us that they felt more involved, empowered, morale had increased and they felt more cohesive as a team.

• We saw that turnover rates had decreased in the West and had only increased in the South due to internal promotions.

Summary of findings

- Staff told us that the senior management teams were now more visible, they felt listened to and we saw evidence that processes had been changed as a result of staff feedback.
- The provider had published a comprehensive operational plan for all community mental health teams which detailed all the processes and systems staff needed to implement the agreed changes.

Summary of findings

Information about the service

Livewell Southwest CIC (Community Interest Company) provided community mental health teams for adults of working age. A community interest company is a business with primarily social objectives whose surpluses are principally reinvested for that purpose in the business or in the community, rather than being driven by the need to maximise profit for shareholders and owners. They provided four teams under a locality model. The four localities were north, south, east and west, and each locality had agreed GP practices from which they accepted referrals. The provider was commissioned to use the Devon Referral Support Service (DRSS). The DRSS was a referral contact centre. DRSS supported the GP referral process from referrer to the first outpatient appointment, using the electronic referral system 'e-Referral Service'. This meant the DRSS could directly book a referral appointment directly into the provider's calendar. This was the provider's single point of access. The teams offered assessment and treatment for a range of mental health conditions. During our re-inspection in May 2017, we inspected the West community team, based in the west locality at Avon House, and the South team, based in the south locality which also worked from a base at Avon House.

Our inspection team

Our inspection team was led by:

Team Leader: Kate Segrave, Inspector.

The team that inspected these services comprised a CQC inspection manager, a CQC inspector and a specialist advisor who was a nurse with experience of working in community mental health services.

Why we carried out this inspection

We carried out a full comprehensive inspection of Livewell Southwest CIC in June 2016. We rated community based mental health services for adults of working age as inadequate overall. We found that the provider was in breach of the following regulation of the Health and Social Care Act 2008

(Regulated Activities) Regulations 2014 :

• Regulation 12 (1)(2)(a)(b)(c)(g) safe care and treatment.

• Regulation 17 (1)(2)(a)(b) good governance.

• Regulation 18 (1)(2)(a) staffing.

We rated the core service as Inadequate for Safe, Responsive and Well-led, Good for Caring and Requires Improvement for Effective.

We issued a Section 29 warning notice on 15 July 2016 to ensure the provider took action to address the concerns identified:

• The provider must ensure that care and treatment is provided in a safe way for patients. The provider must ensure that they assess the risks to the health and safety of patients receiving care or treatment.

• The provider must ensure that they do all that is reasonably practicable to mitigate any such risks.

• The provider must ensure that persons providing care or treatment to patients have the qualifications, competence, skills and experience to do so safely.

• The provider must ensure the proper and safe management of medicines.

• The provider must ensure that systems or processes are established and operated effectively to assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of patients in receiving those services).

Summary of findings

• The provider must ensure that systems or processes are established and operated effectively to assess, monitor and mitigate the risks relating to the health, safety and welfare of patients and others who may be at risk which arise from the carrying on of the regulated activity.

• The provider must ensure that sufficient numbers of suitably qualified, competent, skilled and experienced persons are deployed.

• The provider must ensure that persons employed by the service provider receive such appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform.

We carried out an unannounced, focussed inspection on 17 October 2016 to assess if the provider had addressed the concerns and to check the progress that had been made. Overall, in October 2016, we found evidence of progress and improvements being made across all the concerns raised in the warning notice although this was not enough to remove the warning notice. The provider had put in place several positive changes that were improving the safety of the service delivered. However, the provider had not addressed all concerns relating to waiting lists and vacancies.

On 03 May 2017 we undertook a focussed inspection to find out whether Livewell Southwest CIC had made improvements to the two outstanding areas of concern following the inspection in October 2016. Specifically, these issues were :

• The South and West teams had over 50 patients on their waiting lists. At the time of inspection the longest a patient had been waiting was 26 weeks.

• The provider had recruited more band six nurses; the South and West teams were less reliant on agency staff. However, at the time of inspection the teams were still carrying eight vacancies.

How we carried out this inspection

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, we reviewed information that we held about community-based mental health services for adults of working age and requested information from the trust. This information suggested that findings from the re-inspection in October were still valid. Therefore,

during this inspection, we focused on those issues that were outstanding from the October inspection.

During the inspection visit, the inspection team:

• visited two community mental health teams (South and West)

• spoke with the manager and deputy locality managers for each of the teams

• spoke with six other staff members; including doctors, nurses and recovery workers

• spoke with six people using the service

• attended two morning 'mini multi-disciplinary team (MDT)' meetings and one full MDT meeting for the West team

• reviewed four management supervision files and 12 clinical supervision folders

• reviewed 12 care records

• accompanied one care co-ordinator on a home visit

• looked at a range of policies, procedures and other documents relating to the running of the service

Summary of findings

What people who use the provider's services say

During our inspection, we spoke with six people using the service. When we asked if people had waited a long time to see a care co-ordinator, only one person described a long wait. Patients told us that it was rare for staff to cancel appointments. When it happened, another appointment was offered. Everyone we spoke to saw the same care co-ordinator each time and spoke positively of their working relationships. People said they had not been seen by agency staff. All patients informed us that they saw their GPs for physical healthcare checks. There was no mention of the

provider routinely carrying out physical healthcare checks. Patients said that the provider informs them if something goes wrong, and that generally they were very happy with the service provided by the community mental health teams (CMHTs). We accompanied a staff member on a home visit and found the staff member caring and compassionate throughout. They allowed the patient to express their needs and they worked jointly to find solutions. The environment was relaxed and of the patient's choice. The staff member established how long the meeting would be from the outset. The patient was very positive about their care co-ordinator. They discussed a referral that had not

resulted in any action. The care co-ordinator arranged to follow this up. They discussed a need to update the patient's care plan. The patient was encouraged to look at it again and change it as required. A next appointment was made. The staff member worked around any barriers to conversation. The staff member appeared to be very supportive. The provider completed annual 'friends and family' tests to ask if patients are happy with changes they have made, such as opening up the depot clinic at the Cumberland Centre. We saw evidence that patients could feedback via the provider's website and during their appointments and that patients' feedback was displayed on the staff comments board in Avon House.

Areas for improvement

Action the provider SHOULD take to improve

• The provider should address permanent consultant vacancies and the use of locums in the West team

• The provider should carry out physical healthcare checks where appropriate, or document more clearly when GPs have done this so it is easy to identify in peoples' care records.

• The provider should ensure all staff know how to access patient information on their electronic patient system.

• The provider should ensure all care plans are person centred, written with the patient and signed that the patient has received a copy.

Livewell Southwest CIC

Community-based mental health services for adults of working age

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location

Mental Health Act responsibilities

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

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Good

Are services safe?

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

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

Our findings

Safe staffing

The South team consisted of nurses and mental health (MH) practitioners:

- one band seven team manager
- four band six nurses/MH practitioners
- four band five nurses/MH practitioners
- three band three community support workers
- two band three medical secretaries
- one band two administrator
- one band two team secretary
- two consultants
- two speciality doctors
- one psychologist

The West team consisted of:

- one band seven team manager
- four band six nurses/MH practitioners
- five band five nurses/MH practitioners
- one band four nurse/MH practitioner
- five band three community support workers
- two band three medical secretaries
- one band two team administrator
- one band two administrator
- one band two receptionist
- two locum consultants
- one lead consultant
- one speciality doctor
- one locum speciality doctor
- one lead clinical psychologist
- one psychologist assistant

- Although no nurse vacancies within the teams, there were three locum doctors in the West team.

- Vacancy, sickness and staff turnover rates in the West team had improved since the last inspection. Nurse vacancy rates in the West team had improved from 33% to 0%, sickness from 10% to 8% and turnover from 48% to 19% during the 12 months between March 2016 and February 2017. Although the South team had increased their turnover rate from 20% to 37%, we saw that this was due to several promotions within the team. In the South, vacancy rates had reduced from 15% to 0% and sickness rates had increased from 6% to 15%.

- The senior managers, with support from their business intelligence team utilised a 'demand and capacity' model of staffing levels based around caseload sizes for each team. The safety and quality panel reviewed the staffing ratio versus team caseloads every month. Managers met with band six and seven staff monthly and asked if their current staffing structure was adequate for each team. Staff told us that they were no longer short-staffed and confirmed the provider had addressed the staffing issues. They reflected on the inspection in June 16 when there was a period with a lot of agency staff. Staff told us that the teams have since been re-modelled, using band four nurses and support workers to reduce caseloads for care co-ordinators. Staff informed us there were some internal promotions taking place in July; for example, band six nurses moving to band seven, and we saw that there was an advert already out to fill this.

- Non medical staff had low caseloads; the highest being 24 people for a healthcare assistant in the West team. Staff in the West teams had an average caseload of 18 whilst staff in the South had an average of 12. The hospital had opened up a depot injection clinic based at the Cumberland Centre (where staff conduct physical healthcare checks at the same time as administering the depot) and we saw that out of 56 patients receiving depot injections in the West CMHT, 52 of these people

attended the depot injection clinic, freeing up the staff's appointment times.

- Staff confirmed that caseloads had been reviewed, using supervision to monitor patient activity and ensure patients

that could be signposted to more suitable services were removed from caseloads. Staff told us that previously, patients had been on their caseloads for long periods of time, when other agencies could have been more appropriate. We saw that supervisions were

occurring in line with the provider's policy and there was a constant review of caseloads.

• At the time of our inspection, the team received two new referrals, who staff allocated a care co-ordinator in the morning multi-disciplinary team (MDT) meeting.

• Staff were supported to allocate cases based on their capacity and skill set to work with an individual patient. They told us that managers monitored allocations closely, there was a risk assessment for allocations and this kept the team on track.

• We saw evidence of caseload audits for each location, which described the number of patients on a caseload, the number of patients on a care programme approach (CPA), the staff role and the number of patients on a CPA for more than six months.

• There was only one long term agency worker in the South team and none in the West team. Rather than using bank or agency staff, the CMHTs had a 'clinical support team', who were known to each locality.

• In the West team, there was one substantive consultant psychiatrist, two locum consultant psychiatrists and two speciality doctors. In the South there was one consultant, two locum consultants, one speciality doctor and one locum speciality doctor. Patients could be seen by a psychiatrist within a week or sooner if necessary.

• Mandatory training was at 98% in the South and at 92% in the West. Any training highlighted on the matrix as out of date had a date for the next booked training. We saw that all staff bar three were now trained in suicide prevention and self-harm mitigation (STORM) training. The three exceptions had dates booked in May and June 2017 for this training. Essential training for clinical staff, bands three to eight was identified in the CMHT's operational plan. We saw that mandatory training included infection control, diversity, manual handling, safeguarding adults and children, STORM and CPA training.

Assessing and managing risk to patients and staff

• Band six or seven mental health practitioners triaged new referrals every morning in the South and West teams' morning 'mini MDT' meetings. We observed both of these meetings during the inspection and saw that staff discussed the new referrals at the beginning of the meeting and staff made a plan to see them. We observed detailed discussions of risk and detailed planning of interventions, tailored to individual need. We observed good leadership around planning actions

with support for less senior staff. Staff discussed patients on the allocation lists as well as the

occupational therapy and psychology lists. All patients discussed had a plan around when they would be seen.

• We reviewed 12 care records during the inspection. Eight out of 12 care records had a threshold assessment grid (TAG) risk assessment, which had held critical information and a risk score, but did not give much detail to the reader. (A TAG risk assessment is a short, quickly completed assessment of the severity of an individual's mental health problems. It was developed to help identify people who should be referred to community mental health services for adults and older people.) TAG risk assessments were provided for patients on standard care (patients not on the CPA framework) who were open to a member of the medical team. Patients who were on a care programme approach (CPA) had detailed risk assessments, which we saw in the four care plans for patients on a CPA. Staff

told us that TAG risk assessments were completed for all patients during their initial assessment and updated every 6 months unless admitted to a ward or seen by the home treatment team (HTT), in which case CMHT staff updated the risk assessment.

• Staff described how systems had changed since the inspection in June because the allocation list was managed better. Previously the team were managing crises, not planning case work and caseloads. Staff said the process was now much more effective, with more opportunity to share risk in MDTs and discuss different approaches as a team. Staff told us that risk assessment and risk management was now embedded in the team and discussed at morning MDTs. Any risk areas were

considered by the team, patients who had dropped out of contact were discussed and welfare visits by police considered and agreed if concerns were sufficient. Support

workers called patients on the waiting list to provide support and assess their level of risk on an ongoing basis. This contact was discussed in MDT's so risk could be considered by the team.

• The team kept one appointment slot available each day for any urgent referrals that needed to be seen immediately. Staff told us that discharging patients felt safer, because it was discussed as a team. We saw that the team considered recovery and planning towards positive discharge during their MDT meetings. The team told us that by reviewing the throughput of people in the service, they were able to reduce caseloads, enabling staff to work more effectively with people, understanding individual needs and providing holistic support.

• Staff in the CMHTs saw very urgent patients at risk of from suicidal ideation on the same day. They saw urgent patients, who were at no immediate risk to themselves, but could deteriorate within seven days. The provider's protocol for routine patients allowed for 18 weeks, but in practice this was no more than four weeks, with contact from the support workers by telephone.

• Crisis plans were present in nine out of 12 care records reviewed. Where present, crisis plans were detailed and included identifying triggers for each patient. Only one patient with a TAG risk assessment had a crisis plan, and this did not detail triggers. Information was present with a TAG risk assessment, but not detailed.

• We saw in the morning MDTs that the team discussed areas of risk within the caseload. The duty worker reviewed tasks completed from the previous day and tasks carried over for follow up. There was clear evidence of using patient's family members to identify risk or changes in behaviour.

• Staff told us that they monitored risks of patients on the waiting list. Staff called patients on the list two weeks and then completed additional risk forms. Patients were prioritised for allocation if their risk score increased or if during a visit they were reassessed. There was a flowchart in the CMHT's operational plan which detailed the steps needing to be taken when monitoring people

using the service awaiting care co-ordination.

Track record on safety

• We reviewed all serious incidents relating to the South and West CMHTs prior to our inspection. We reviewed operational meeting minutes and saw that the serious incidents requiring investigation (SIRI) panel held quarterly meetings, sharing learning from incidents across the four localities. Managers disseminated learning points in team meetings, the annual team away day or, if appropriate, via one to one supervision. Staff told us that they reported any incidents to their line

manager to see if anything needed to be done immediately. Staff informed medical staff about incidents to gain advice regarding any necessary action. Staff recorded incidents on the MDT notes and on an incident form. Actions were followed up in the next MDT. When reviewing the MDT meeting minutes for the last six months, we found this to be the case. Following an incident, the lead psychologist offered 1:1 personal debriefing. Managers also offered debriefing support. Staff told us that the team offered good peer support.

• Staff told us that there had been an increase in incident reporting. Staff previously weren't reporting incidents, now they understood what they needed to report and when. Staff told us that incident investigation was quicker.

Are services effective?

Good

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

Our findings

Assessment of needs and planning of care

During the inspection, we reviewed 12 care records of people using the service.

• In comparison with patients who had entered into the service last year, all patients coming into the service this year had been assessed within a month of being referred. Patients who were on a care programme approach (CPA) had detailed risk assessments and crisis plans. Other patients who were on standard care and were open to a medic rather than a care co-ordinator, had the necessary information available to assess immediate risk. However, five records lacked personalised information that might support staff to work more holistically with someone for the first time.

• Staff told us that there were always two clinicians present at an assessment, led by a band six or five nurse plus a band three, who wrote up the notes which the senior nurse then checked and agreed.

• Staff told us that crisis plans were developed over time as the care co-ordinator got to know the patient and they could become very detailed. They were recorded on the electronic records system but were printed off for the client. We saw that nine out of 12 care plans reviewed had crisis plans present.

• Details of what should be included in an assessment were laid out for all staff in the CMHT's operational plan.

• Seven out of the 12 care plans reviewed appeared to be person centred and recovery orientated. These care plans were written in the first person, copies were given to the patients and listed self management skills to use in a crisis. Five care plans reviewed lacked this person centred aspect, did not look as though they had been written with the patient and did not record that the patient had received a copy of their care plan.

• The CMHTs used electronic records to store information on their patients. Where GPs also used the system, we saw updated, easily accessible records. In the West team, some information, such as physical healthcare checks were hard to find, and in the South this was also the case. Some staff knew how to retrieve this information but some did not. Staff told us that they found the system hard to use.

Best practice in treatment and care

• Patients' needs for therapy were co-ordinated by the psychology lead. The team made referrals to improving access to psychological therapies (IAPT) services via tier four psychotherapy. The provider used other agencies to offer psychological therapy or counselling, such as Rethink, Mind, STEPS, OPTIONS, bereavement counselling, PDAS, Twelve's Company (for male victims of childhood sexual abuse) and the Eating Disorder Service. These services shared information with Livewell.

• Staff told us that physical health monitoring was an item in the care plan. On admission, staff checked medication concordance. Patients were encouraged to see their GP for physical health monitoring. Livewell had started to monitor client's physical health, such as weight, height, and blood pressure but this was not easily found in care records.

• We reviewed 12 care records and found that eight (from the South) had detailed physical health care information in the referral section of their electronic patient records. In the West, staff were unable to find this information so we saw less detailed physical health care information and very little evidence of regular checks. Some GPs were also using the same electronic records system; with these care records we saw information was more easily viewed as they had stored notes on physical healthcare checks directly onto the system. Although physical health care information was

available for most, care records lacked evidence of any on going physical health care checks by the provider or GP.

• Staff told us that they had experienced much more auditing recently. There was a quantitative audit process in regards to risk assessment where the database identified if risk assessments and care plans were complete. Staff prioritised (RAG rated) the report. The report could be broken down into individual caseloads. This was then used for qualitative review in supervision.

Skilled staff to deliver care

• Both teams comprised a range of bands seven to three mental health staff.

• Staff could apply for funding for specialist training such as cognitive behavioural therapy via the training and education panel and there were also assistant practitioner opportunities within the teams. We saw evidence of a two year funded course started last September which included weekly attendance at university.

Are services effective?

Good

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

• Staff received case load supervision every four weeks. These supervision meetings were audited by the deputy location manager during band six or seven supervision. Staff told us that supervision was previously sporadic but had improved since the June inspection report was published. Staff told us they received both clinical and line management supervision. Clinical managers supervised band six's. Band sixes supervised band fives and community support workers.

• We reviewed 12 clinical supervision folders. Clinical supervision was happening monthly and there was a reason recorded, such as patient crisis or staff sickness, where it did not happen. Our review of supervision files demonstrated that both management and clinical supervision was taking place as it should. There was evidence of patient needs being discussed and discussion of moving patients within the service as required. We also reviewed four management supervision files. These included six weekly records of supervision. All records demonstrated annual appraisals had taken place.

• The percentage of non-medical staff that have had an appraisal in the last 12 months was 100%.

Multi-disciplinary and inter-agency team work

• In both the South and West teams, multi-disciplinary meetings (MDT) took place every morning. The purpose and frequency of MDTs was laid out in the CMHT's operational plan.

• In the South team, they discussed the daily activity of the whole team, new referrals and areas of risk within the caseload. Duty workers reviewed tasks completed from the previous day and tasks were carried over for follow up. We observed both these morning meetings and we observed a clear and considered approach. The team demonstrated knowledge of their patients and an

understanding of what approaches to take with the individuals discussed. The administrator took minutes and logged discussions and agreed actions in the patient record. Safeguarding concerns were discussed as required on an individual basis. The meeting in the South was attended by an occupational therapist (OT), a psychiatrist, the clinical team lead, the community psychiatric nurse and a community support worker.

• In the West MDT, we observed both the morning mini MDT and the weekly MDT. We saw that the meeting was attended by the OT's, mental health nurses, specialist doctors, consultant psychiatrists, support workers, the team leader and administrative minute taker. Patients on the current caseload were discussed. We witnessed a comprehensive discussion about each patient,

including feedback from assessments, diagnoses, historical risk issues, personal and family history, risks around medication, symptoms of mental illness, social needs and suicide risks. For each patient, staff made a plan which included allocation of a keyworker and referral decisions. In the West the team also discussed each patient who were on the caseload and were flagged as 'did not attend' (DNA). The team discussed all DNA's even for routine appointments. They reviewed

risks before discharging back to the GP or escalated the issue, for example, by cold calling. In the West, the allocation list and waiting list for occupational therapy was discussed. All patients discussed had a plan around when they would be seen.

• The lead psychologist joined for part of the West meeting. The psychologist gave feedback on

assessments with consideration of readiness for therapy emphasised. The team discussed ward feedback, also discussed clients under home treatment, two out of area clients and clinical incidents were very briefly discussed. The team discussed children's safeguarding issues; one nurse took the lead. The team also reviewed family protection issues. The team also discussed adult safeguarding and actions were reviewed for each individual. The team discussed transfers where cases were moving form CPA to standard care as part of a discharge pathway. All discharges were discussed and risks reviewed. We reviewed the minutes from all MDT meetings over the past six months and found them to be consistent with what we observed.

• During the South morning team meeting, we observed a discussion of referrals into the team and suitability for the team to accept from the home treatment team (HTT). The team were able to refuse admission into the team for a patient not considered stable enough for the community mental health team (CMHT). We saw evidence of joint meetings with HTT to transfer patients

safely in a co-ordinated manner. There was clear sign posting to other teams considered to be more suitable to meet the needs of the patient. In the West, we observed

Are services effective?

Good

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

positive team engagement in case discussions with all members participating and sharing in decision making. There was a detailed discussion of risk. There was detailed planning of interventions, tailored to individual need. We observed good leadership around planning actions with support for less senior staff.

• We observed that as part of the MDT, staff from other departments, such as the inpatients units, would attend the weekly MDT meetings. This meant that staff who were responsible for patients coming over to the CMHTs were able to deliver a face to face handover about their patients' discharge plans.

Good

Are services caring?

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

Our findings

At the last inspection in June 2016 we rated caring as **good.** Since that inspection we have received no information that would us to re-inspect this key question or change the rating.

Are services responsive to people's needs?

Good

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

Our findings

Access and discharge

• We saw that the provider's referral to treatment summary report was updated every day. On the day of our inspection, the average wait to see a consultant was, seven weeks in the South and eight weeks in the West.

• The provider had a referral to treatment target time of 18 weeks for routine patients. There was a seven day target for urgent patients and emergency patients were seen on the same day. The provider was commissioned to use the Devon Referral Support Service (DRSS) where the NHS provider could directly book an appointment in their calendar. This was the provider's single point of access.

• The provider had an 'allocation list' which comprised external and internal patients. External patients, or patients new to the service, were referred into the community mental health teams by their GP. These patients were identified either in the daily morning meeting or if not, in the weekly MDT. Staff told us that they had to look at a new patient within 48 hours. The provider was commissioned to meet this target by the DRSS. At the time of our inspection, there were no

external patients on the CMHTs' allocation list; they had all been allocated a care co-ordinator and had an appointment booked in the system. We saw that the patients on the current allocation lists in the South and West teams were patients known to the team, who were either receiving treatment with another team or who had come back into the system after being discharged. For example, we saw in the South team, there were five internal patients on the allocation list all receiving care from another department in the mental health team. In the West, two people had come in that morning and were on the allocation list, allocated during the morning MDT meeting. In the South, one person was currently an inpatient whose discharge plan included receiving care from the South CMHT, so they were placed on their allocation list. Another low risk person was currently

open to the psychology team and had been allocated a care co-ordinator within the South CMHT with a date for assessment and had received a phone call 10 days after the referral.

• The internal people on the allocation lists were referred to as being 'tracked', to safeguard against them being lost on the CMHT system whilst they were 'waiting' to transfer in to services from the CMHT. With each person checked, they were already receiving treatment from another service whilst they waited, risk assessments were present and were either TAG risk assessments if

the patient was on standard care, or CPA risk assessed if more complex. The CPA risk assessments we saw were full and detailed with crisis contingency plans. All care notes checked had up to date medication information and full physical healthcare information.

• We saw evidence of referral to treatment (RTT) audits which were RAG rated and listed any breaches along with the average length of wait for each locality. There was a flowchart which laid out the referral process for all staff in the CMHT's operational plan.

• Patients triaged as emergency referrals were seen by the duty worker on the same day, who had slots built into their calendar for this possibility. Urgent referral slots were also built into the duty worker's calendar. Urgent referrals were seen on the day or at the latest, within the provider's target of seven days. Patients were allocated a care co-ordinator within ten days; such as an

occupation therapist, a psychologist, a social worker or a support worker. If there was no capacity to immediately assign a care co-ordinator, that patient would then go on the 'allocation list'. During the South morning team meeting, we observed the team were able to offer an urgent psychiatric appointment to a young woman who was considered to be at high risk of suicide.

• The CMHTs did not have a crisis team in place at the time of inspection. However, they referred to the home treatment teams (HTTs) who had a 24 hour response system in place. Staff described the HTTs as the 'gate-keepers' for the provider's inpatient service. People in crisis were also referred to an out of hours helpline; 'Mental Health Matters', who were an independent crisis contingency planning service.

• Essential referral criteria was laid out in the CMHTs' operational policy, including exclusion criteria.

• The process for responding to 'did not attend' (DNA) appointments was set out for all staff in the operational policy. The process included a call on the day (escalating

Are services responsive to people's needs?

Good

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

all the way up to a call to the police if concerned), two letters sent out and a discharge to the person's GP if no response. In the South team meeting, we observed a discussion where patients had not been in contact and there were concerns, discussion included requesting police welfare visits as required. We saw a flowchart that was in place and followed by staff to make sure that all staff followed the same process for

when a patient did not attend appointments. People we spoke to told us that if an appointment was cancelled, they were offered another one quickly.

• The deputy location manager explained the reasons behind cancelled appointments in the CMHTs. The 'cancelled by service' figures may have initially looked high because they included dummy appointments booked into by the Devon Referral Service (DRSS). This notified the CMHT that they needed to place the patient into an appointment with one of their consultants. Once

an appointment was booked with one of the consultants, the dummy appointment was cancelled.

This did not affect the patient and was purely a system error. The CMHTs have since identified this and now started to record these as "rescheduled" appointments going forward. Between April 2016 and March 2017, in the South, 86% of all patients were seen and in the West, 82%. Only 9% of all cancelled appointments in the West were cancelled by the service and in the South the figure was even lower at 4%.

• The average wait time for the South team had decreased to seven weeks and the West team had

decreased to eight weeks, where the response target set for the trust was 18 weeks. Allocation lists were reviewed daily in the morning MDT meetings, wait times were reviewed weekly in the location MDT meetings. Both were audited on weekly by location managers, who were then audited by the deputy location manager.

Listening to and learning from concerns and complaints

• During the inspection we observed a complaints board displayed in the communal area at Avon House. The complaints board had a brief description of recent complaints, an action plan and a summary of recent themes. There was also a compliments board, a patient experience dashboard and a friends and family contacts board.

• Feedback from complaints was discussed in quarterly CMHT consultation meetings where 'You said, we did' was referenced. Staff told us that meetings felt more meaningful and this has impacted on morale which has improved.

Are services well-led?

Good

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

Our findings

Good governance

The senior leadership team had made several changes to their recruitment and retention processes since the inspection in June 2016. These included:

• The community mental health teams (CMHTs) had a new strategy of recruiting staff into a CMHT group rather than recruiting staff to each individual locality. This enabled them to prioritise the recruitment of staff into the team most in need of a post. At the time of the inspection the senior management team were working towards a model of pooling staff.

• The deputy locality manager had taken over the responsibility of recruiting staff from CMHT locality managers. This meant that all vacancies were being managed by one person who was more able to keep on top of vacancy releases, adverts, interview dates, disclosure and barring checking and appointments. This enabled locality managers to concentrate on the day to day running of their services and ensured vacancy releases did not lapse nor adverts expire and that vacancies were filled as quickly as they could be.

• The senior management team alongside their human resources department had extended the notice period required for band six and seven staff. Band seven staff were required to give three months' notice and band six staff were required to give two months' notice. This meant there was less of a potential time gap between staff leavers and new starters.

• The senior management team had developed work that we saw in June 2016, identifying gaps in levels of band four staff via a skill review. This piece of work assessed whether the band four role could have been more extensively used following the success of one band four in the West team. At the time of inspection, there was one preceptor nurse in the South, one in the north and one in the West. Each team now had a full time clinical band 7 member of staff who specifically worked towards accreditation and mentored other bands to work towards promotion.

• The senior management team had worked on the levels of involvement the staff had in their teams, which staff told us had improved staff retention. For example, there was a clear development pathway for band three to four staff and continuous professional development was

reflected in staff files. Appraisal rates were 100%, a training and education panel where staff could apply for funding for specialist training such as cognitive behavioural training was ongoing and there were assistant practitioner opportunities within the teams. There were quarterly CMHT feedback and staff consultation meetings called 'You said, we did', which involved all members of the CMHT teams, whether clinical or non-clinical. The aim was for staff to be involved in the way forward of shaping the future of the CMHTs in Livewell. This meeting was chaired by the lead for the CMHT and also had representation from senior management within Livewell. We saw evidence of these minutes which showed the senior management team had acted upon staff feedback.

• Staff we spoke to reflected that morale had improved since the last inspection. All staff were invited to team away days which were team led. Topics included care quality Staff we spoke to reflected that morale had improved since the last inspection. All staff were invited to team away days which were team led. Topics included care quality Staff we spoke to reflected that morale had improved since the last inspection. All staff were invited to team away days which were team led.

Topics included care quality Staff we spoke to reflected that morale had improved since the last inspection. All staff were invited to team away days which were team led. Topics included care quality commission (CQC) improvement plans, any staff issues and senior management team thank yous. This annual event provided opportunities for staff to suggest how they would like to see improvements to their teams made. Band six to seven staff asked band five to six staff to review their job descriptions. Staff used toolkits for development such as band six supervisory

responsibilities like leading MDT meetings. We saw that the last team away day in the South team had taken place on 8 November 2016 and in the West team on 16 November 2016.

• CMHT posts had been continuously advertised and we saw this was the case from viewing a supporting email

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which outlined the number of times posts had been advertised. Since October, CMHTs had recruited five band five RMNs which left one band five vacancy overall, which had been allocated to a preceptor who was commencing in the north CMHT in July 2017.

• Staff told us that supervision previously had been sporadic, but was much better now, occasionally cancelled if there was a crisis which needed to be prioritised, but generally took place as scheduled. Staff told us that the management team were supportive, leadership was visible, the team managers took ownership for decision making and there was accountability within the management structure. Staff said that this was an improvement and had really helped staff morale.

• Staff told us that historically, incidents were not reported nor seen as a priority within the team.

However, this had changed and now staff had been actively encouraged to report incidents and share the learning from them. Staff discussed incidents in team meetings so that staff could apply any lessons learnt.

• During the inspection, we saw evidence that audits were regularly carried out on referral to treatment wait times. Copies of high level audits were completed by the deputy locality manager in conjunction with team managers. The team managers performed caseload audits of their teams which were recorded on the patient electronic record system. We saw copies of these monthly audits, which demonstrated the locality manager had audited each team's caseloads. They also

checked that risk assessments and CPA reviews were in date, and that the number of people on allocation lists were checked. There were also caseload discussions and reviews. We saw documentation that demonstrated the deputy locality manager audited each locality manager's audits on allocation lists and care plan audits, including risk monitoring. We also saw audits were kept in a 'case discussion folder'. All audits were reviewed in monthly safety and quality meetings. Each month, a different theme was reviewed, such as environmental checks and visual checks. Minutes were being recorded and identified actions were completed.

• We saw that the CMHTs now had a comprehensive operational policy which had been published in November 2016. The operational policy set out a clear framework for the operational processes of the CMHTs, based on the key service criteria identified within the service specification.

• We reviewed minutes from the teams' operational meetings and saw that caseload reviews, referrals, care co-ordination and recruitment issues were again all discussed at these meetings.

• We saw copies of each team's risk register which showed that different members of each team could input onto the register. The risk register showed the level of risk, who was responsible for each identified risk and when the next review date was.

Leadership, morale and staff engagement

• Staff reflected that the team was now more stable and there were fewer vacancies as a result. Staff told us that they were not aware of any bullying or harassment cases in the team but that they knew how to whistle blow and stated that people in the team were confident to be open. Staff told us that they had no fear at all in talking to their manager about any issues and that they felt good about their job. Staff told us that the team was very supportive but they were able to challenge each other.

• The staff we spoke to told us that they were able to feedback on services and input into service

development. They confirmed that there were regular meetings with all the CMHTs where they split into their bands and discussed issues. They told us that the chief executive attended from time to time and had a genuinely 'open door' policy.

• Staff told us that the management structure was established and was positive. Staff felt that if the team started slipping back to the previous management style they felt confident that they could raise it and that they would be heard. Staff told us that the management team appeared to be listening more than they used to.

• Staff told us team was more settled with less throughput of staff, this has meant that caseloads could be better managed and that previously due to shortages, patients would be on and off caseloads as staff covered vacancies. Staff told us that by permanent staff being recruited, the

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team felt more stable and settled and that the team was building a rapport. Staff described a happier team, better morale, the team felt listened to and supported. Staff said the team felt that they were functioning better together. The team felt more connected to Livewell.