Good

Devon Partnership NHS Trust

Community-based mental health services for adults of working age

Quality Report

Devon Partnership NHS Trust
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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)
RWV62	Wonford House Hospital	Exeter and East Devon Mental Health Assessment Team	EX2 5AF
RWV62	Wonford House Hospital	Mental Health and Recovery Team - Exe	EX2 5AF
RWV62	Wonford House Hospital	Mental Health and Recovery Team - Clyst	EX2 5AF
RWV62	Wonford House Hospital	Exeter Psychosis and Recovery Team	EX2 5AF

Summary of findings

RWV62	Wonford House Hospital	North and Mid Devon Mental Health Assessment Team	EX32 8ND
RWV62	Wonford House Hospital	North Devon Mental Health and Recovery Team	EX32 8ND
RWV62	Wonford House Hospital	North Devon Psychosis and Recovery Team	EX32 8ND
RWV62	Wonford House Hospital	Teignbridge Community Mental Health Team	TQ12 4PH
RWV62	Wonford House Hospital	Newton Abbot Community Mental Health Team	TQ12 4PH
RWV62	Wonford House Hospital	Torbay Psychosis and Recovery Team	TQ2 5NU
RWV62	Wonford House Hospital	Torquay Mental Health and Recovery Team	TQ2 5NU
RWV62	Wonford House Hospital	South Hams and West Devon Community Mental Health Team	PL19 8AB
RWV62	Wonford House Hospital	Mid Devon Mental Health and Recovery Team	EX17 2AN

This report describes our judgement of the quality of care provided within this core service by Devon Partnership NHS Trust. 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 Devon Partnership NHS Trust and these are brought together to inform our overall judgement of Devon Partnership NHS Trust.

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 rated Devon Partnership Trust as **good** because

- Assessments were comprehensive.
- Care plans were up to date, personalised, holistic and recovery oriented. They were outcome- focused and linked to risk assessments.
- Patient's risks were being rated, prioritised and regularly reviewed and crisis plans were being created and used.
- Physical health checks had been carried out on admission.
- Caseloads were manageable.
- 99% of staff had received mandatory safeguarding training and staff demonstrated a good awareness of safeguarding procedures.
- We saw patients being treated with respect and dignity. We observed positive interactions between staff and patients and staff were compassionate and supportive.
- Staff involved patients in the planning of their care. We found the general approach was patient led and focused.
- Teams comprised of a full range of mental health disciplines and met regularly. All teams had weekly team meetings and monthly business meetings. These followed a standard agenda and were thorough and effective.
- Staff felt positive about the chief executive and senior management and felt heard by them.
- Staff were appraised and supervised.
- Managers and clinical leads demonstrated enthusiasm and imaginative problem-solving.

However:

- There were long waiting times for access to psychological therapies.
- Some teams were failing to meet referral to treatment targets. This meant some patients were having to wait to access treatment.
- Care records did not always show whether patients had given informed consent to their treatment. This included administration of depot medication.
- Medication was being stored in a fridge without a record of fridge temperatures being regularly checked.
- Lone working practices varied and systems for raising alarms were not always effective.
- Staffing levels varied and some teams had not been able to recruit experienced nursing staff.
- Morale varied and we were repeatedly told by staff that the pace and rate of change was stressful.

Summary of findings

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

Are services safe?

Good

We rated "safe" as **good** because:

- Patients risks were being rated, prioritised and regularly reviewed and crisis plans were being created and used.
- Patients on the waiting list were risk rated and reviewed regularly
- Patients could be seen urgently when needed and staff could access a psychiatrist without delay.
- 99% of staff had received mandatory safeguarding training and staff demonstrated a good awareness of safeguarding procedures.
- Caseload sizes were manageable.

However

- Lone working practices varied and systems for raising alarm were not always effective.
- The drains at Waverely House got blocked after heavy rain creating a potential hazardous odour.
- Fridge temperatures were not being recorded regularly in fridges that were used to store medication at Waverely House and South Hams.
- Alarms that were used to summon help in an emergency were not being tested regularly at Crediton.

Are services effective?

Good

We rated "effective" as **good** because:

- Assessments were comprehensive and included employment, benefits and housing support.
- Care plans were up to date, personalised, holistic and recovery oriented. They were outcome focussed and linked to risk assessments.
- Doctors were referring to National Institute for Health and Care Excellence (NICE) guidance when making changes to medication and including this in their letters to GPs. The psychosis and recovery reams were using NICE guidance for early interventions in psychosis.
- Physical health checks had been carried out on admission.
- Some clinical staff were trained in psychological therapies and training was available for staff in range of talking therapies.

Summary of findings

- Teams comprised of a full range of mental health disciplines and met regularly. All teams had weekly team meetings and monthly business meetings. These followed a standard agenda and were thorough and effective.
- Staff received regular supervision.
- The trust was enabling patients with a diagnosis of bipolar disorder to participate in dialectical behaviour therapy classes and therapy.

However:

- Care records did not always show whether patients had given informed consent to their treatment. This included administration of depot medication.
- Outcome measures were not routinely used to review the effectiveness of the treatments provided.

Are services caring?

Good

We rated "caring" as **good** because:

- We saw patients being treated with respect and dignity. We observed positive interactions between staff and patients and staff were compassionate and supportive.
- We received very positive feedback from patients.
- Staff had good understanding of their patients' needs and were flexible in accommodating them.
- Mental health assessment teams gave patients a welcome pack which included a range of useful information.
- Staff involved patients in the planning of their care. We found the general approach was patient led and focussed.

However:

- Information on advocacy was not always available to patients.
- Patients said that they were asked what support they wanted but sometimes they were not well enough to answer and were therefore fearful they would be discharged.
- Patients told us that arrangements for support by the community teams immediately after discharge from hospital were not always clear.

Are services responsive to people's needs?

Good

We rated "responsive" as **good** because:

- The psychosis and recovery teams were meeting their targets for waiting times from assessment to treatment.

Summary of findings

- Teams were working creatively to try to prevent patients from waiting for longer than was necessary and were rating and reviewing their waiting lists.
- Patients could choose and book their own appointments.
- Staff were flexible about where appointments took place.
- Teams were actively engaging patients who failed to keep appointments.

However:

- Parts of the service were failing to meet referral and treatment targets so patients had to wait to be assessed and to access treatment.
- Waiting times for psychological therapies were long although this was being addressed through the trust's psychological therapies implementation plan.
- Some rooms used by the Crediton team had previously been hospital wards. Names of wards were still in place above doors and the building would have benefitted from alterations to make it more suitable for a community mental health setting. Waverley House was an old building in a poor state of decoration and some furniture was stained and old.

Are services well-led?

Good

We rated "well-led" as **good** because:

- Staff felt positive about the chief executive and senior management and felt heard by them.
- Governance arrangements were enabling managers to ensure patients were being kept safe and their staff were being regularly trained, appraised and supervised.
- Managers and clinical leads demonstrated enthusiasm and imaginative problem-solving.
- There were good examples of innovation and learning from clinical audits.
- Staff unanimously described their managers as approachable and responsive.

However:

- Morale varied and we were repeatedly told by staff that the pace and rate of change was stressful.
- Staff sickness was above the trust average.

Summary of findings

Information about the service

Devon Partnership NHS Trust had 21 community mental health teams for adults which provided a range of community based mental health services for adults of working age. We inspected 14 teams during this inspection. There were two different service models in operation. In some geographical areas the adult community mental health teams comprised of three distinct teams:

- Mental health assessment teams provided a single point of access to adult community mental health services across Devon. They assessed new referrals to the service and determined where a patient's needs would best be met.
- Mental health and recovery teams supported people whose primary needs related to a non-psychotic mental health difficulty such as depression, anxiety disorders and personality disorders.
- Psychosis and recovery teams supported people whose primary needs related to a psychotic illness such as schizophrenia, episodes of psychosis and some types of bipolar disorder.

In some areas the mental health and assessment, mental health and recovery, and psychosis and recovery teams were combined into one community mental health.

Mental health and recovery and mental health and assessment teams were delivered across the north, east and west clinical commissioning groups and South Devon and Torbay clinical commissioning group for patients from 18-65 years. 17 year old patients could be referred by child and adolescent Mental Health Services (CAMHS). CAMHS were provided by Virgin Healthcare. The Psychosis and Recovery and combined Community Mental Health Teams accepted referrals for patients aged 16 and older.

Services were based in buildings across the county. The community teams also used satellite buildings and saw people in their own homes.

All services were providing a 9am-5pm service.

We inspected the following teams:

- Exeter and East Devon mental health assessment team
- Exeter mental health and recovery team – Exe
- Exeter mental health and recovery team – Clyst
- Exeter psychosis and recovery team
- North and Mid Devon mental health assessment team
- North Devon mental health and recovery team
- North Devon psychosis and recovery team
- Teignbridge community mental health team
- Newton Abbot Community Mental Health Team
- Torbay psychosis and recovery team
- Torquay mental health and recovery team
- South Hams and West Devon community mental health team
- Mid Devon mental health and recovery team

Devon Partnership NHS Trust's community based services for adults of working age were inspected as part of a comprehensive inspection in February 2014. There were no outstanding areas of non-compliance relating to this service.

Our inspection team

The comprehensive inspection was led by:

Summary of findings

Chair: Caroline Donovan, chief executive, North Staffordshire Combined Healthcare NHS Trust. Head of Inspection: Pauline Carpenter, Care Quality Commission. Team Leader: Michelle McLeavy, inspection manager, Care Quality Commission.

The team who inspected this core service comprised of two CQC inspectors, five specialist advisors (four nurses and one social worker) and one expert by experience (a person who has experience of using community mental health services).

Why we carried out this inspection

We inspected this core service as part of our on-going comprehensive mental health inspection programme.

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 visit, we reviewed information that we held about these services, asked a range of organisations for information and sought feedback at focus groups.

During the inspection visit, the inspection team:

- visited three mental health assessment teams, five mental health and recovery teams, three psychosis and recovery teams and three combined community mental health teams.
- spoke with a total of 23 patients and carers of patients who were using the service.
- collected feedback from patients and carers using CQC comment cards.
- attended and observed 16 home visits.
- spoke with three service managers and 15 team managers.
- spoke with 53 other staff members; including doctors, nurses, social workers, support workers and administrative staff.
- attended and observed 12 multi-disciplinary team meetings.
- looked at 53 patient care records.
- looked at staff and supervision records.
- looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the provider's services say

- Patients and carers told us staff were respectful, compassionate and supportive, and they felt they could trust them. Patients and carers said staff had a good understanding of their needs and that they were flexible in accommodating them. Patients said they had choices about their care. Patients and carers told us they felt involved in their care and care planning.
- Feedback from the 'Be Involved Devon' service user group patients said that some patients found the recovery oriented approach challenging as they were under pressure to say what they wanted from the service but felt too unwell to know and that they did not always know what support they would get when discharged from inpatient to community services.

Summary of findings

Good practice

- The mental health and assessment team for Torbay and South West was offering out of hours clinics to enable them to see patients more quickly and this was providing patients with a wide range of appointments to choose from.
- Staff had been issued with tablet computers to enable them to access and update patient records whilst they were out of the office. This meant that staff were able to update notes quickly and enabled patient involvement in care planning.
- The mental health assessment services in Exeter and east Devon had recently been involved in a research project facilitated by the mood disorder clinic at Exeter University. The project was a group for patients with bipolar affective disorder or cyclothymia. The group incorporated dialectical behavioural therapy interventions.
- South Hams community mental health team were working with Partners 2 Research in a project to trial ways of providing intermediate level specialist mental health support within GP surgeries for patients with psychotic illness who were solely being managed in primary care. This was enabling them to develop ways to offer more effective care.
- The manager of the Torquay Mental Health and Recovery team led the Torbay vulnerability forum. This group was set up in 2013 by the public protection unit of Devon and Cornwall Police alongside safeguarding adults and was designed to minimise current or future risk to vulnerable adults within the Torbay community who did not meet the threshold for safeguarding but were likely to in future if they did not receive timely support. The Torbay vulnerability forum enabled agencies to discuss, assess and signpost vulnerable adults to appropriate support and services.
- The wellbeing passport had been developed by north Devon community mental health teams to enable patients to monitor and improve their physical health with the help of secondary mental health services and their GP. The passport was developed in line with the national priority to improve physical wellbeing.

Areas for improvement

Action the provider SHOULD take to improve

- The trust should ensure all premises are clean, comfortable, in a good state of repair and free from malodour.
- The trust should ensure refrigerator temperatures are monitored and recorded to ensure medication stored in them remains useable.
- The trust should test alarms in all buildings regularly and ensure that alarms can be heard in all areas of the building to ensure a timely response.
- The trust should ensure consent to treatment is always recorded.
- The trust should review local lone working procedures to ensure all staff are safe and able to summon help when working alone.
- The trust should continue with their psychological therapies implementation plan to actively reduce the waiting times for access to therapy.

Devon Partnership NHS Trust

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
Exeter and East Devon Mental Health Assessment Team	Exeter Wonford House
Mental Health and Recovery Team - Exe	Exeter Wonford House
Mental Health and Recovery Team - Clyst	Exeter Wonford House
Exeter Psychosis and Recovery Team	Exeter Wonford House
North and Mid Devon Mental Health Assessment Team	Exeter Wonford House
North Devon Mental Health and Recovery Team	Exeter Wonford House
North Devon Psychosis and Recovery Team	Exeter Wonford House
Teignbridge Community Mental Health Team	Exeter Wonford House
Newton Abbot Community Mental Health Team	Exeter Wonford House
Torbay Psychosis and Recovery Team	Exeter Wonford House
Torquay Mental Health and Recovery Team	Exeter Wonford House
South Hams and West Devon Community Mental Health Team	Exeter Wonford House
Mid Devon Mental Health and Recovery Team	Exeter Wonford House

Detailed findings

Mental Health Act responsibilities

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

- 59% of staff have had training in the Mental Health Act (MHA).
- At the time of our inspection 73 patients were on community treatment orders (CTOs). CTOs were a standing item on the multi-disciplinary team agenda and they were discussed every week if there were any concerns.
- We reviewed records of four patients who were subject to the Mental Health Act and found clear record keeping. Patients who were subject to the Mental Health Act had had their rights recorded clearly. When care was transferred to a different team, this was recorded thoroughly in their records. However, we reviewed the record of a patient who had recently been discharged from a CTO and was being treated by the Torquay Mental Health and Recovery team. The fact they had been discharged was not noted in their care plan, the discharge plan was not recorded and the risk assessment was not up-to-date.
- Guidance on implementation of the Mental Health Act and the Mental Health Act code of practice was provided by approved mental health practitioners (AMHPs). AMHPs were employed by Devon county council and were integrated into the Community Mental Health Teams. Administrative support on implementation of the MHA was available from a central team. Torbay had a separate Mental Health Act administrator's office.
- Independent Mental Health Advocate services were available to patients, provided by Rethink. Some staff we spoke to were not aware of how to access advocacy services.

Mental Capacity Act and Deprivation of Liberty Safeguards

- Mental Capacity Act (MCA) training was mandatory. At the time of our inspection 99% of staff had training in the Mental Capacity Act level one and 42% of staff had training in the Mental Capacity Act level two. Level two training was for staff band five and above.
- Staff could access MCA guidance from the "Daisy" intranet system and from social workers and approved mental health practitioners. Mental capacity of patients was discussed at team meetings.
- We saw two examples of good practice in using the MCA in the mid Devon mental health and recovery team where professionals meetings had been held due to capacity issues.
- We asked staff about their knowledge of the MCA and deprivation of liberty safeguards and found that their understanding varied. We were concerned that in some teams the team managers were not aware of this variation in knowledge or that some staff felt they had not had sufficient training.
- Independent mental capacity advocacy (IMCA) was available through a partnership of Age UK Devon and Living Options Devon. Some staff were not aware of how to access IMCA services.

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

Summary of findings

Please see the summary at the beginning of this report

Our findings

Safe and clean environment

- All sites had alarm systems. Most had fixed panic buttons in interview rooms. In Crediton, staff were using hand held alarms. These were not being tested regularly and when activated they could only be heard in reception and not in the team rooms. This could delay the time taken to respond. Additional alarm points were due to be fitted and these would be heard around the building.
- We saw a standard comprehensive cleaning schedule for trust buildings. All buildings we visited were clean and well maintained with the exception of Waverley House where the Torbay team were based. At Waverley House, drains were not clearing satisfactorily after heavy rainfall. This was noted in the team's top five risks as "potentially hazardous odour from drains in basement." However, patients were not seen in this part of the building and the teams at Waverley House were due to move to alternative accommodation.
- Physical health care checks were all being administered by general practitioners and were therefore not provided by this service.

Safe staffing

- The service had an establishment level of 146 whole time equivalent (wte) qualified nursing staff. There were 20 vacancies (14%). Although some teams experienced low levels of sickness other teams experienced sickness rates that were much higher than the trust overall average of 4.7%. For example, as of 31/03/2015 the Torquay mental health and recovery team had a sickness rate of nearly 17% and the Exeter psychosis and recovery team had 10.5% sickness. Over the service as a whole, bank and agency staff were used to cover caseloads on 88 occasions during April 2015 due to vacancies, sickness and other absences. On three occasions cover had not been provided.
- Managers told us they were struggling to recruit experienced staff to some posts. For example they had found it difficult to recruit band 6 nurses to the Newton Abbot community mental health team. This meant patients were experiencing longer waiting times although this was mitigated by offering overtime to staff for out of hours clinics.
- Staffing levels were variable across the service due to vacancies and sickness. This was listed on risk registers for the Newton Abbot community mental health team, east, mid and north Devon teams. Vacancies were being covered by National Health Service Professionals (NHSP). Exeter mental health and recovery team and the Teignbridge mental health team had the highest number of vacancies. There were concerns about loss of experience within teams due to the recruitment difficulties, and a reduction in staff who were able to manage highly complex cases. However, some teams such as the mid Devon psychosis and recovery and mental health and recovery were well-staffed.
- Teams were trying to manage short staffing effectively. For example the psychosis and recovery team in north Devon was covering planned sickness by assigning extra cases to other members of the team. In the south and west team, if staff left or were long term sick, the team held review clinics for all those clinician's patients to enable a robust and thorough handover to another care coordinator.
- Caseloads were manageable and averaged 25–30 patients per full -time and were being managed and assessed regularly.
- Staff in all of the teams said they were able to access a psychiatrist without delay. However, there were staffing shortages in the psychiatry team. A permanent consultant psychiatrist had been recruited to work in the South Hams combined community mental health team but there had been seven locum psychiatrists in the previous 12 months. Vacancies were being covered by locums.

Good

Are services safe?

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- In Exeter, psychiatrists were assigned to geographical areas and GP practices rather than to the mental health and assessment, mental health and recovery and psychosis and recovery teams. This meant the psychiatrist had to work across all three teams and attend all three teams meetings and they spent significant amounts of time in meetings. Managers across all the teams felt it was easier for team working when psychiatrists were embedded in each team.
- The average mandatory training compliance rate for staff across the services was 94%. However, some teams were falling below the 75% compliance rate for completing specific mandatory courses. Five teams were out of date in fire safety training with compliance of less than 70%. Three teams were out of date with manual handling training. The Exeter psychosis and recovery team had less than 70% compliance with clinical risk training and the Torbay psychosis and recovery team were 73% compliant with personal safety training. We heard that in some cases training was due to be booked but there were no courses available.

Assessing and managing risk to patients and staff

- We looked at 53 electronic patient care records.
- We looked at eight sets of records in mid Devon and all had a risk assessment although two were not up-to-date. Eight out of the eight records we looked at in South Hams had an up-to-date risk assessment and all three of the records we looked at Waverley House had up-to-date risk assessments. Weekly reviews of risk enabled teams to respond promptly to sudden deterioration in patients' well-being and to offer more urgent care if needed. Teams were able to respond quickly when necessary, for example, the South Hams combined community mental health team kept two or three urgent appointments slots available each week for crisis reviews with a consultant psychiatrist. However, risk to self was not documented in two out of eight care records we reviewed in Exeter. In one case, we saw planning to manage risk to others but not to self, even though there was an identified risk of overdose.
- All new assessments were discussed team meetings using an SBAR 'situation, background, action, recommendation' tool. We observed cases being discussed in multidisciplinary team meetings. Staff exhibited good awareness of patients' risks, social situation and mental state and made clear action plans.
- There was a risk management tool for patients on waiting lists. Risk was assessed weekly while patients were waiting and a rationale for the risk rating was documented on the patient record. The tool also prompted staff to keep GPs informed by letter. All patients' risks were rated red, amber or green (RAG rated) depending on the urgency of the risk. New referrals and RAG ratings for patients who were waiting were discussed at weekly team meetings.
- Crisis plans were being created and used. We reviewed case records in all of the teams we visited. We saw an example of good crisis contingency planning in mid Devon teams which included relapse indicators, early warning signs and contingency planning. The South Hams community mental health team recognised crisis planning was an area for development for them following feedback from crisis teams. The team manager was meeting with the crisis team every month as part of the improvement plan. In all teams, risk assessments were completed within 24 hours.
- Risk assessments were well linked to care plans which confirmed staff were taking risk into account when considering a patient's care.
- 99% of all the multi-disciplinary staff had completed mandatory safeguarding training. We looked at all of the safeguarding referrals between July 2014 and July 2015 and saw that all teams were making referrals. Safeguarding cases were discussed in multi-disciplinary team meetings. Staff gave us examples of safeguarding alerts they had made and showed good understanding and there was guidance for staff that could be accessed on the DAISY system.
- We saw good team working and development in the partnership between the teams and MARAC (multi-agency risk assessment conference). MARAC is a nationally recognised process for information sharing in cases of high risk domestic violence to enable risk management planning. Being part of the conference had led to increased joint working with the police and other statutory agencies and increased mental health awareness in partner organisations.
- We reviewed the trust's lone worker policy and talked to managers and staff about lone working.All the teams were using white boards or signing in and out sheets and staff visited in pairs when necessary. Teams kept worker information such as mobile numbers but photos of staff were not held. Mobile phone coverage was

Good

Are services safe?

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

unreliable in some areas although 999 calls were possible even when the signal was poor. Lone working devices had been piloted but there had been two incidents when a device alarm was set off by accident with one receiving a quick response and one receiving no response. Each team had a lone working protocol and a particular phrase in place to raise an alarm. We noted that lone working was on the risk registers for Exeter, east and mid Devon teams due to issues regarding rurality and mobile phone reception.

- Medications were checked with the patient at their first assessment and psychiatrists reviewed patients' medications when this was needed. Depot medication was administered by GPs or trust staff depending on local arrangements. Some teams did not hold medication but collected it from the pharmacy as needed. Medication was stored appropriately with the exception of Waverley House where refrigerator temperatures were not recorded and depots were stored in this refrigerator. In South Hams the fridge temperatures were recorded although there were some gaps in recording.

Track record on safety

There were 21 serious untoward incidents recorded from January 2015 to February 2015. These are broken down as follows:

- Twelve unexpected deaths.
- Three suspected suicides.
- One suicide attempt.
- Two assaults by patients.
- One allegation against a healthcare professional.
- Two confidential information leaks.
- A shortage of psychiatrists in some areas meant that patients could be seen by different locums at each of their outpatient reviews. The assessment team for Newton Abbot were concerned about this lack of consistency the quality of notes being recorded by locum psychiatrists. These concerns were raised following two serious incidents. A root cause analysis had been completed and had recognised the risk. This was now being mitigated by providing an improved local induction and placing locum cover on the risk register.

Reporting incidents and learning from when things go wrong

- Most staff were able to give us examples of incidents that should be reported. Learning from incidents was shared at team meetings and we saw this on meeting agendas. However some staff we spoke to were unclear about thresholds for reporting incidents and felt that they needed more guidance on this.
- Service managers described a feedback loop where learning was shared across the county. Adult directorate meetings reviewed trends in incidents and complaints and cascaded information back to teams and there was a newsletter going out about incidents and complaints for people to read. However, we consistently heard from staff that learning from incidents was not occurring outside of the team in which the incident occurred.
- A risk management system was used to document incidents and evaluate future risks. Team managers received feedback from the risk department and root cause analysis sub-team.
- Staff were being de-briefed and supported by team managers following serious incidents and had access to a free counselling service which Devon Partnership NHS Trust provided.
- Knowledge about duty of candour was variable although staff understood the importance of being open about mistakes and apologising to patients when things went wrong.

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.

Summary of findings

Please see the summary at the beginning of this report

Our findings

Assessment of needs and planning of care

- Assessments were completed by the mental health assessment team or community mental health team.
- We reviewed 53 electronic care records. The majority of records that we looked at were of a high quality. Care plans were up to date, personalised, holistic and recovery oriented. We saw assessments and formulations which included patients' historical backgrounds, care and risk management plans, protective factors and potential triggers. Care plans were outcome focussed and linked with risk assessments. Consent to treatment was not always recorded. We saw involvement with GPs and other services around physical health and examples of carers being involved in care planning. The mid Devon psychosis and recovery team were using 'SMART recovery' plans and WRAP (wellness recovery action plans).Through our observations of multi-disciplinary team meetings we confirmed teams were holding detailed discussions about care planning. However, when we reviewed care records for the north Devon teams, we found three out of eight care plans did not comprehensively identify specific action plans for the patients and three out of eight care plans were not well personalised or person centred.
- All information was stored securely on the RIO electronic patient records management system. This was due to be replaced by the Care Note System soon after the inspection. In South Hams there were problems with the RIO system crashing frequently although we were not made aware of impacting on patient well-being. Secondary paper notes were not routinely held.

Best practice in treatment and care

- Doctors were referring to National Institute for Health and Care Excellence (NICE) guidance when making changes to medication and including this in their letters to GPs. We saw an app on staff tablet computers that linked directly to NICE guidelines and on the trust's DAISY website. Patients and staff could also access a "you and your medicines" telephone advice line provided by the trust. The teams were using NICE guidance for early interventions in psychosis, schizophrenia and psychotic disorders. Managers told us that integrated care pathways were being developed by the trust that were based on NICE guidance.
- The trust was enabling patients with a diagnosis of bipolar disorder to participate in dialectical behaviour therapy classes and therapy through collaboration with Exeter University.
- There were long waits for psychological therapies. The trust target was to provide step four psychological therapy within 18 weeks. There were 955 patients waiting for psychological therapy. Of these 316 had been waiting for between 18 weeks and one year, 72 had been waiting for 1 to 2 years and two had been waiting over two years but these were seen during our inspection. There was recognition by service managers of the long waiting times for psychological therapies and there were plans to enable the delivery of dialectical behaviour therapy, cognitive behavioural therapy and family therapy within community mental health teams as part of the new integrated care pathways which were in development. There was a trust psychological therapies implementation plan. Patients were being told how long they would likely have to wait and given access to crisis support contacts. The trust had appointed 2.5 WTE psychologists who were due to start work in November 2015.The trust was also identifying staff working in the community mental health teams who had existing skills in delivering psychological therapies and their training needs by the end of September 2015.
- Some clinical staff were trained to offer psychological therapies such as cognitive behavioural therapy for psychosis and dialectical behavioural therapy. However, staff told us that they were not always able to provide these therapies due to their workloads. Support workers provided some interventions such as graded exposure for anxiety disorders. In the South Hams team support workers ran activity sessions and a discharge planning group.

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.

- Clinical staff considered employment, housing and benefits support in the holistic care they provided and offered support and advice. They had recently been issued with tablet computers and we heard examples of them using these to enable patients to access information with patients. The teams accessed advice on employment, education and vocational training and housing and benefits support from local voluntary sector organisations. The Torbay and south west mental health assessment team had an accommodation officer.
- Physical health checks had been carried out on admission for 17 out of the 19 patients whose electronic care records we reviewed. Patients' physical healthcare needs, including monitoring for people taking some medications, was undertaken by their GP. Some teams were reminding patients when it was time for them to have their annual physical health care check. Support workers could take patients to see their GP if needed.
- Health of the Nation Outcome Scales (HoNOS) were used to assess the severity of symptoms and to determine cluster allocation at assessment. The HoNOS was repeated with patients at their appropriate review points. Some staff were using outcome measures such as the patient health questionnaire 9, brief psychiatric rating scales or the generalized anxiety disorders 7.
- Teams were taking part in clinical audits such as prescribing anti-psychotic medications, z-hypnotics and benzodiazepines for people with personality disorders, dual diagnosis, and the therapeutic management of violence and aggression.
- We reviewed the trust's results from the 2014 national audit of schizophrenia. This showed that availability and uptake of psychological therapies was below average when compared to other mental health trusts and was well below what should ideally be provided; monitoring of physical health risk factors was a little below average and intervention for identified physical health problems was around average but was poor for abnormal glucose control and elevated blood pressure. Most aspects of prescribing practice were around average but an inappropriately high proportion of patients on clozapine had received three or more antipsychotic medications before commencing clozapine.
- Clinical records were being reviewed by managers to ensure quality. Managers were using the clinical record self-monitoring tool to look at samples of random cases every month for each member of their team and offering feedback on record keeping. A 2014 audit of waiting times had revealed that there were inconsistencies in the recording of priority ratings in patients' records. We looked at risk ratings and found they were consistently recorded by all teams at the time of our inspection, which demonstrated that improvements had been made as a result of the audit. The Torbay teams were involved in multi-agency audits with wellbeing and family health commissioners that had demonstrated improved risk assessment and safeguarding arrangements for children of parents with mental illness.

Skilled staff to deliver care

- All team were multi-disciplinary and included psychiatrists, nurses, psychologists, support workers, occupational therapists and social workers. All staff attended weekly team meetings.
- All new staff received a three day corporate induction and local inductions were in place. The South Hams team offered a 2 week induction which included time for staff to familiarise themselves with local services and other staff. The mid Devon team were making changes to their local induction following feedback from new staff.
- Consultant psychiatrists received supervision every three months and all other staff were receiving management and clinical supervision every four to six weeks. Safeguarding, best interest cases, caseload volumes, clinical records, cluster allocations, care programme approach reviews and training were included in supervision agendas. Staff told us the quality of their supervision was very good.
- 87% of non-medical staff had been appraised in the last 12 months However, some were brief or incomplete and some did not include personal development plans.
- The trust was providing training in talking therapies including schema therapy, motivational interviewing, cognitive behavioural therapy, dialectical behavioural therapy, and eye movement desensitisation and reprogramming. Any registered nurse at band 6 or above could undertake training to become nurse prescribers.

Are services effective?

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- There were no examples of poor staff performance. Where there had been informal concerns these were addressed promptly and thoroughly.

Multi-disciplinary and inter-agency team work

- We attended 12 team meetings. All teams had weekly team meetings and monthly business meetings. These followed a standard agenda and were thorough and effective. Staff were actively engaged in the meetings and spoke knowledgably and respectfully about patients.
- Communication between trust services was not always effective. Staff and patients told us that discharge arrangements from inpatient to community services were not always clear. We saw from Exeter team meeting minutes that transfers between mental health and recovery and psychosis and recovery teams were not always being discussed effectively before transfer and relationships with crisis teams were variable. However, the north Devon and mid Devon teams reported positive joint working with the crisis teams undertook joint assessments when appropriate.
- Multi-agency working was of mixed quality. We saw good examples of teams communicating with GPs. Regular meetings with Torbay GPs had been successful in improving working relationship and reducing complaints. The South Hams team met regularly with local police which resulted in positive working relationships. The depression and anxiety service, which was a primary care level improving access to psychological therapies service, were attending team meetings. However, children and adolescent mental health services (CAMHS) were provided by a separate organisation and we were told by staff and carers that transitional arrangements between CAMHS and adult community mental health services were inconsistent.

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

- 59% of staff have had training in the Mental Health Act (MHA)
- At the time of our inspection 73 patients were on community treatment orders (CTOs). CTOs were a standing item on the multi-disciplinary team agenda and they were discussed every week if there were any concerns.
- We reviewed records of four patients who were subject to the Mental Health Act and found clear record keeping. Patients who were subject to the Mental Health Act had had their rights recorded clearly. When care was transferred to a different team, this was recorded thoroughly in their records. However, we reviewed the record of a patient who had recently been discharged from a CTO and was being treated by the Torquay Mental Health and Recovery team. The fact they had been discharged was not noted in their care plan, the discharge plan was not recorded and the risk assessment was not up-to-date.
- Guidance on implementation of the Mental Health Act and the Mental Health Act code of practice was provided by approved mental health practitioners (AMHPs). AMHPs were employed by Devon county council and were integrated into the Community Mental Health Teams. Administrative support on implementation of the MHA was available from a central team. Torbay had a separate Mental Health Act administrator's office.
- Rethink provided independent mental health advocacy services (IMHA). Some staff were not aware of how to access IMHA services.

Good practice in applying the Mental Capacity Act

- Mental Capacity Act (MCA) training was mandatory. At the time of our inspection 99% of staff had training in the Mental Capacity Act level one and 42% of staff had training in the Mental Capacity Act level two. Level two training was for staff band five and above.
- Staff could access MCA guidance from the "Daisy" intranet system and from social workers and approved mental health practitioners.
- Mental capacity of patients was discussed at team meetings.
- We saw two examples of good practice in using the MCA in the mid Devon mental health and recovery team where professionals meetings had been held due to capacity issues.
- We asked staff about their knowledge of the MCA and deprivation of liberty safeguards and found that their understanding varied. We were concerned that in some teams the team managers were not aware of this variation in knowledge or that some staff felt they had not had sufficient training.

Good

Are services caring?

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

Summary of findings

Please see the summary at the beginning of this report

Our findings

Kindness, dignity, respect and support

- During our inspection we attended and observed 16 home visits and spoke with a total of 23 patients and carers of patients who were using the service. We observed that staff were kind, respectful and responsive and they provided both practical and emotional support to their patients.
- During our home visits with the north Devon team we saw patients being treated with respect and dignity. We observed positive interactions between staff and patients. Staff showed good awareness of patients' individual needs and were friendly, calm and compassionate. One patient told us they would not be alive were it not for the north Devon psychosis and recovery team's support and another said the same thing about the Crediton team. During a home visit with the mid Devon team a patient told us they had had many inpatient admissions but none over the last five years and attributed this to the level of care received from the psychosis and recovery team.
- In South Hams we found staff were flexible in meeting patients at a venue of their choice and the patient being offered robust support in addressing social issues and health issues. We observed that staff had very good knowledge of their patient's needs. We saw patients being supported with medication and given advice about local support groups.
- During a home visit with the mid Devon team we saw a patient being fully involved in their care, discussing medication options and side-effects. The patient's preferences were listened to. Interactions between patients and staff members were relaxed and open.
- We received very positive feedback from patients. One patient told us they had been ill for 15 years and the service they were receiving now was the best it had ever been. Another patient who had been using the service for three years said it was improving all the time. We heard staff described as "excellent" and "compassionate." One patient being treated by the South Hams team said "I feel that I can trust her" and "for the first time I feel included in the decision-making process." A patient who had just been assessed by the Torbay mental health and recovery team said "at long last I've found people that understand me. I can only talk in glowing terms of my treatment and the levels of interaction." Patients told us the teams were good at involving their carers in their care and that this was appreciated. Patients spoke of the north Devon team being very supportive and one said they did not have a bad word to say about the facilities and that their experience had been "beyond brilliant." Another patient described the services as "very thorough and very humane and is quite recovery led". Another patient described in detail the on-going decisions they were making about their treatment and how it was empowering them.
- However, we received some feedback from patients via Healthwatch Devon that patients were feeling under pressure because of the recovery oriented approach. There was consistent feedback. Patients said they were asked what support they wanted from mental health teams but sometimes they were not well enough to answer and were therefore fearful they would be discharged. The trust assured us they would not discharge someone unless it was deemed clinically appropriate to do so. Patients also told us that arrangements for support by the community teams immediately after discharge from hospital were not always clear.

The involvement of people in the care that they receive

- Mental health assessment teams gave patients a welcome pack which included a range of useful information.
- Patients were given information sheets to help them choose treatment options. Information was available on the Intranet for staff to print for their patients.
- We witnessed care plans being negotiated with patients. We found the general approach was patient led and focussed. Most patients told us they had care plans and had been involved in making them and this was confirmed in our reviews of patient records. Although

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there was good evidence of service user involvement in care planning, some care plans were not being signed. Some teams were uploading signed care plans to the RIO record system but not others. This meant that some teams could not demonstrate that patients had signed their care plans.

- We saw examples of carer involvement in care records and this was confirmed by patient feedback. Teams were referring to Devon Carers and Care First. Some social workers in the teams were also conducting assessments for carers. In our interviews with carers, they said they have been well supported. A carer in Torquay told us they had received 12 sessions of carer support and was very positive about this. The parent of a patient transferred from CAMHS said that staff had been very helpful and said they had seen the patients care plan and knew what the treatment and discharge plan was.
- The service manager for Newton Abbot community mental health team was meeting regularly with the service user group 'Be Involved Devon'. The group had been looking at smart recovery and members of the group were helping to review patient template letters. The group were also discussing the forthcoming revisions to care pathways.
- Patients were invited to get involved in decisions about their service and had been on interview panels for new staff in some of the teams. One of the team managers was interviewed by a panel which included a service user in attaining their post. However, a mental health and recovery team manager said there were limited processes in place for consultation with patients and carers regarding service provision.
- Information on advocacy was not always available in waiting rooms and some staff we spoke to were unsure about how patients could access advocacy.
- In mid Devon we saw that feedback forms were available in the waiting room and the contact details for patient advice and liaison service were given.
- A friends and family test was being sent to every patient with the assessment letter. The test asks patients whether they would recommend the service for their friends and family. A patient told us they would wholeheartedly recommend the team to their family and friends.

Are services responsive to people's needs?

Good

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

Summary of findings

Please see the summary at the beginning of this report

Our findings

Access and discharge

- The trust had target times for referral to assessment and assessment to treatment. 90% of patients referred urgently to the service were expected to be seen within five working days. 80% of patients referred routinely were expected to be seen within 10 working days. The trust had set a target for patients referred to the mental health and recovery teams and the psychosis and recovery teams to begin treatment within 13 weeks. The trust had set a series of targets to reduce waiting times and expected 90-100% of patients to be allocated a care coordinator if they needed one within 18 weeks by the end of March 2016.
- Where treatment teams were split into mental health and recovery and psychosis and recovery, the mental health and assessment team would first assess the patient.
- In July 2015 there were a total of 195 patients waiting for a first assessment after referral with the mental health assessment teams. 65 patients had been waiting between one and four weeks, 63 had been waiting five to 12 weeks and 67 patients had waited between 13 and 48 weeks.
- In June 2015 the Torbay and south west mental health and assessment team were only assessing 44% of urgent referrals within five days and 28% of non-urgent referrals within 10 days.
- The Torbay and south west mental health and assessment team were failing to meet urgent and routine referrals due to staff shortages. They were offering overtime to staff from other teams to staff out of hours clinics to try to assess patients more quickly.
- Patients referred to the mental health assessment teams could book an appointment using a choose and book system and so received an appointment straight away. The manager was being informed when the booking system had run out of appointments so they could make contact with patients who did not have appointments.
- Before patients were put on the waiting list they were triaged by the team manager and the senior mental health practitioner. The patient was sent a letter which included crisis team numbers and this was copied to their GP. All new referrals were triaged using a red, amber green (RAG) rating and were reviewed weekly. This meant the risk was rated and monitored.
- The longest waiting times for treatment were in the mid Devon mental health and recovery team where there were 35 people on the waiting list. 23 people had been waiting over 13 weeks. The waiting list was being managed using the situation background assessment recommendation tool (SBAR) with weekly reports to the service manager. The team manager was new in post and had made plans to reduce the waiting list to zero within six months by reconfiguring the team to include a referral management and active review function. Approximately 40% of those waiting had involvement from other mental health services.
- All of the psychosis and recovery team waiting times were under 13 weeks and the mid-Devon psychosis and recovery team had no waiting list.
- The trust had set a target for patients to be allocated a care coordinator within 13 weeks. There were waiting times between assessment and allocation to a care co-ordinator in the psychosis and recovery and mental health and recovery teams. Where this was the case, patients had been assessed and their risk RAG rated. In some but not all cases, the GP had been informed the patient was on a waiting list. In all cases there were plans for patients who were waiting and the majority of them were still engaged with other services. Where there were long waiting times these were listed on the risk registers.
- All teams had a duty system between nine and five Monday to Friday. They would also do joint assessments with the crisis team if needed within 24 hours. Psychiatrists were able to offer emergency appointments for all teams during the day. Outside of these hours GPs, crisis services and local authority emergency duty teams provided the response.

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- National guidance required that patients leaving inpatient mental health hospital care were to be followed up in the community within seven days. We reviewed data on patients discharged during the first 6 months of 2015. It showed that all but 3 of the 151 patients who had been discharged from hospital were followed up within 7 days. In the cases of the 3 patients who had not been followed up, it was due to the patients not responding to contact. In these cases, contacts were made via other services to ensure the patients' safety.
- Staff followed up patients who failed to attend their appointments. Teams were making appropriate efforts to engage people who did not attend their appointments. including undertaking unannounced visits to the patient or requesting police welfare checks.
- Appointments were flexible and patients could be seen at team offices or at home. Home visits were often the preference because of the geographical area and the lack of transport. There were satellite buildings that could be used but some patients had to travel up to 20 miles to reach a hub.
- Appointments were only cancelled when absolutely necessary. When this happened patients were informed and another appointment was offered to them. The duty worker could speak to any patient who was left at risk by an appointment not being kept.
- Once discharged, patients could access the service again within six months without having to be re-assessed and would be reallocated to the service they were last seen in within one working day.

The facilities promote recovery, comfort, dignity and confidentiality

- Most team had a range of appropriate rooms available that promoted recovery. The South Hams and west Devon, Exeter and north Devon team buildings had a full range of appropriate rooms to use to see patients in, with appropriate and comfortable surroundings. However, the Crediton team were based in a local community hospital. Some rooms had previously been wards and the building had not been adapted to make it appropriate for a community mental health setting. Names of wards were still in place above doors and one room had hospital beds in it. Managers were aware but alterations were being delayed as the building was managed by a different health service. Waverley House was an old building in a poor state of decoration and some furniture was stained and old. The Torbay and Torquay teams had RAG rated the building as red on their risk register and they were due to move to a different building.
- At Crediton two adjoining interview rooms did not have adequate sound-proofing between them to ensure confidentiality. However, staff were aware of this and were ensuring that where possible they did not use both the adjoining rooms at the same time.
- All teams were displaying information leaflets in their waiting rooms that were useful and relevant to patients such as available treatments, local services, patients' rights and how to complain.

Meeting the needs of all people who use the service

- Waverley House had no disabled access, a lot of stairs and no lift. Although there was disabled access to the building at Wonford House in Exeter, if the lift was out of use because of a fire, then a disabled person could not get out. However staff mitigated against this by arranging to see their patients in GP practices, at home or in other locations if needed.
- Leaflets and information in different languages were not on display in team buildings but they could be printed from the trust's intranet system. Translation services were available via Daisy. Some staff we spoke to were unsure about how to access information in different languages and also about how to access interpreters.

Listening to and learning from concerns and complaints

- There were 149 complaints for adult community services between April 2014 and March 2015. 53 of these were upheld. One complaint that was not upheld was referred to the Ombudsman and was still open.
- 52 compliments received within the same time period. The largest proportion were received for the psychosis and recovery teams which received 30.
- Complaints were handled by the trust's patient advice and liaison service (PALS).We saw some good examples of complaints being handled thoroughly, responsively and sensitively. Managers told us they always tried to

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resolve complaints at a local level first and that they were having training in handling complaints. We saw some good practice, for example the Teignbridge team secretary was sending a PALS leaflet with every first appointment letter and we saw good systems of administration of complaints at Exeter and Newton Abbot. However, the administration of complaints was very slow. One carer told us they had complained 2 years ago and only received a reply 3-4 months ago. The majority of patients told us that they were not given details of how to complain.

- Staff were given direct feedback about any complaints made against them. Teams were informed about complaints and the learning from them completed through team meetings.
- The patient safety group was reviewing complaints once a month. Learning from this group was being disseminated to teams via the business meetings and sometimes good practice would be highlighted. We could not corroborate how well this process was working.
- The Exeter team were able to give an example of a complaint which had led to them developing a card with instructions for accessing crisis support in distress. This was specifically designed following a complaint from a patient who had found their assessment distressing.

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.

Summary of findings

Please see the summary at the beginning of this report

Our findings

Vision and values

- Vision and values posters were seen on display in team buildings and we found that team objectives were consistent with them. However, not all staff were able to tell us the organisation's visions and values. Managers spoke of enabling a positive difference to people's lives, caring and instilling hope and they said these values were embedded in their work.
- Staff could name the senior staff and executives, were positive about them and felt heard by them and we heard very positive feedback about the chief executive. Staff said they had seen improvements in the last 18 months and felt there was good engagement and good support. Several staff told us they had been visited by members of the executive team and senior managers.

Good governance

- Governance at local team levels was good. Managers were using the 'ORBIT' performance management system to ensure staff were up-to-date with mandatory training and this was working well. Staff were having supervision and appraisals regularly and these were documented. However, some appraisals we looked at lacked detail and were incomplete. Staff performance was being given appropriate attention. Managers received weekly reports about key issues such as mandatory training and care plans being out of date and they were taking action to address these with their staff. The move to the new 'Care Notes' system and issuing staff with tablet computers to work on were clear attempts to enable staff to spend more time with patients and less time doing administrative tasks.
- Staff learnt from incidents, complaints and service user feedback but not all staff were aware of the processes and this suggested they were not always getting feedback in team meetings. Teams could give examples of lessons-learned and improvements in practice. There was a county-wide patient safety group which reviewed trends in incidents. However, learning across the county was not evidenced clearly so we could not be confident teams were learning from one another's incidents.
- Staff were able to submit items to the risk register using their incident management system. Team managers were able to access the risk register via their risk management system and they could link their risk to the Devon Partnership Trust risk register.
- Safeguarding, Mental Health Act and Mental Capacity Act procedures were being followed but some staff did not feel confident in these areas and felt they could benefit from more training. We did see good evidence in clinical records of safeguarding procedures being followed.
- There were targets set by the trust, for example, to assess and treat patients within given timeframes. Teams were getting information about breaches via weekly reports and they were acting upon them. Reports informed managers about waiting times, overdue care programme approach reviews and cluster allocations that had not been determined.
- Team managers had autonomy and administrative support. We were impressed with the enthusiasm and imaginative problem-solving managers and clinical leads demonstrated. They were well-supported by service-managers to try new ways of working.
- There was evidence staff were taking part in clinical audits in a meaningful way and that managers were learning from the audits and using them to inform developments to the service.

Leadership, morale and staff engagement

- Sickness rates for the service were 7.6% compared to trust average of 4.7%.
- There were no reported bullying and harassment cases.
- All staff we spoke to knew there was a whistle-blowing process. Staff said they would not fear victimisation if they raised concerns.
- Morale varied. Many staff we spoke to felt the trust was improving. However, staff raised concerns about the change to SMART working. A particular concern was the move to "hot-desking" at hubs and the effect this would have on accessing peer support and increased feelings

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of working in isolation. The move to SMART working featured on the risk register for Exeter, east, and mid Devon team. We heard differing views about the separation into a mental health and assessment, mental health and recovery and psychosis and recovery team structure. Some teams felt it worked well but for others it had led to increased staff stress. As a result of this and other changes there had been some staff losses including people seeking alternative employment. The South Hams team had reverted to the previous mixed caseload structure of a combined community mental health team. We were repeatedly told by staff that the pace and rate of change was stressful.

- Team managers told us that service managers were supportive. Managers covered for each other when they were on leave and so knew about each other's jobs. There were opportunities for leadership development. Managers were given opportunities to attend management training.
- We received positive feedback about managers from all teams and there were reports of supportive team working relationships.
- Staff were open and transparent when things went wrong and understood their obligation to explain errors to managers and patients.
- Staff were being given opportunities to give feedback on services and to input into service development. In October 2014 the Trust held a series of events which were attended by more than 1,200 members of staff. Many people felt the chief executive, operations manager and director of nursing had tried hard to engage staff.
- The trust had circulated posters of the CQC domains in the shape of a daisy. They were encouraging staff to write on them with what they felt they were doing well and what they would like to improve. We saw these on the walls at Exeter, Crediton and South Hams and staff had commented on them.
- Staff could discuss changes at business meetings and some teams had been holding team days where they were given opportunities to discuss future developments to the service.

Commitment to quality improvement and innovation

- South Hams combined community mental health team were working with Partners 2 Research in a project with two other mental health services. The research was to trial ways of providing intermediate level specialist mental health support within GP surgeries for patients with major mental illness (schizophrenia and bi-polar, clusters 10 & 11) who were solely being managed in primary care to support patients and GPs for 6–12 months. Outcome measures would look at service-user motivation and satisfaction with support, hospital admission rates and impact on symptoms.
- The Torbay vulnerability forum, led by the manager of the Torquay mental health and recovery team, was set up in January 2013 by the public protection unit of Devon and Cornwall Police alongside safeguarding adults. The forum was designed to minimise current or future risk to vulnerable adults within the Torbay community. Vulnerable adults included people with mental health issues, learning disabilities, older people, and people with physical disabilities, people who were misusing substances, carers, victims of hate/mate crime, and repeat victims of crime. The Torbay vulnerability forum enabled agencies to discuss, assess and signpost vulnerable adults to appropriate support and services. The forum was reported to have received a high number of referrals from a range of agencies.
- The mental health assessment services in Exeter and east Devon had recently been involved in a research project facilitated by the mood disorder clinic at Exeter University. The project was a group for patients with bipolar affective disorder or cyclothymia. The group incorporated dialectical behavioural therapy interventions.
- The well-being passport was developed in the north Devon teams, and was being rolled out. It was offered to patients who would benefit from discussing, addressing and monitoring their own physical health with the help of secondary mental health services and their GP. The passport was developed in line with the national priority to improve physical well-being. The passport enabled patients to monitor their health needs and progress in areas such as smoking, lifestyle, body mass index and blood pressure. The well-being

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passport identified which routine physical health checks people should expect from their GPs. It also signposted patients to services offered by the health promotion service.