Requires improvement

Devon Partnership NHS Trust

Mental health crisis services and health-based places of safety

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 crisis resolution home treatment team	EX2 5AF
RWV62	Wonford House Hospital	East and mid Devon crisis resolution home treatment team	EX2 5AF
RWV62	Wonford House Hospital	Exeter health-based place of safety	EX2 5AF
RWV55	Torbay Hospital	Torbay crisis resolution home treatment team	TQ2 7AA

Summary of findings

RWV55	Torbay Hospital	Torbay health-based place of safety	TQ2 7AA
RWV62	Wonford House Hospital	Teignbridge crisis resolution home treatment team	EX2 5AF
RWV12	North Devon District Hospital	North Devon crisis resolution home treatment team	EX31 4JB
RWV12	North Devon District Hospital	North Devon health- based place of safety	EX31 4JB
RWV62	Wonford House Hospital	South hams and west Devon crisis resolution home treatment team	PL6 7PL

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	Requires improvement 
Are services safe?	**Requires improvement** 
Are services effective?	**Requires improvement** 
Are services caring?	**Good** 
Are services responsive?	**Requires improvement** 
Are services well-led?	**Requires improvement** 

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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Overall summary

We rated mental health crisis services and health-based places of safety as requires improvement because;

- The Mental Health Crisis Care Concordat states "People in crisis should expect local mental health services to meet their needs appropriately at all times". We found none of the teams we visited could offer any more than two visits a day to a patient and none after 9.30pm. Staff in North Devon told us they could not realistically offer an alternative to hospital admission and if they had significant concerns about a patient they would need to arrange an urgent inpatient stay.
- After 9.30pm teams relied on night nurse practitioners to answer the phone to patients. These staff had a range of other responsibilities to attend to at night such as on-site support and staffing the health based place of safety. Patients trying to contact the crisis teams for support could not be guaranteed their call would be answered in a timely fashion.
- The care plans we reviewed were standardised but not all were personalised or recovery orientated. Not all care plans we saw listed the interventions on offer, nor did they address how interventions would alleviate the patients' crisis.
- None of the teams we visited were participating in any clinical audits.
- Physical health checks were not a standard part of the assessment process, but we saw how staff addressed patients' immediate physical healthcare needs.
- The Police told us there were times when people were refused admission to the hospital based place of safety due to smelling of alcohol or a previous history of aggression. We were unable to substantiate this during our inspection due to a lack of records being made available. Information provided by the trust as part of the accuracy process identified that of the times the place of safety was closed 65% of closures was due to lack of staff, 15% was due to the place of safety being used as an extra bed, 12% of closures were due to staff being required for observations elsewhere and 8% was a result of the patient being assessed as being too violent for admission to the place of safety.

However:

- The layout of all three health based places of safety enabled staff to observe patients safely whilst in the suites. We saw that there were ligature risk assessments undertaken by senior staff and risks were mitigated by the presence of staff at all times, who were able to constantly observe the patient.
- Each crisis team had a mid-day handover along with at least two bed management meetings per day. For the teams attached to the acute inpatient units the bed management meetings included ward managers and senior staff.
- The waiting times for all teams from referral to triage assessment were 4 hours for very urgent and 24 hours for routine cases. All the team managers showed us the systems they used for monitoring and reporting to ensure these timescales were met.

Summary of findings

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

Are services safe?

Requires improvement

We rated safe as requires improvement because:

- We did not see any of the teams routinely use crisis plans or advance decisions for their patients. We were told by team managers the trust was developing crisis contingency plans for all patients, but they were not aware of the implementation date.
- At night, if a patient was in crisis, they were only offered support by telephone helpline which was manned by the night nurse practitioners. These staff had a range of other duties to attend to which meant that they could not guarantee to answer the phone for the patients and offer advice.

However:

- The layout of all three health based places of safety (HBPOS) enabled HBPOS staff to observe patients safely whilst in the suites. Staff had completed ligature risk assessments and mitigated risks by constant observation of the patient.
- We saw evidence in all the records we reviewed of the risk assessment process which staff completed for all new patients at the initial assessment.

Are services effective?

Requires improvement

We rated effective as requires improvement because:

- The care plans we reviewed were standardised but not all were personalised or recovery orientated. Not all care plans we saw listed the interventions on offer, nor did they address how interventions would alleviate the patients' crisis.
- The physical healthcare needs of patients within the crisis teams was not routinely addressed. Whilst we saw some individual cases in each of the teams where staff had identified particular physical healthcare issues, it did not form part of the overall care plan.
- The trust, with its partner agencies, was not always adhering to its local policy or the MHA Code of Practice in its use of police custody. The police told us admission to health based place of safety was sometimes refused because of the person smelling of alcohol, a history of aggression or insufficient staff to cover a unit. Staff working on these units confirmed this did happen but not on regular occasions. As part of the accuracy check following the inspection the trust provided data that showed that the health based place of safety had been closed 17 times

Summary of findings

due to lack of staff; four times due to it being required as an additional bed; three times because staff were required for observations and twice because the patient was too violent to be admitted to the health based place of safety.
- None of the teams we visited participated in any clinical audits.

However:

- Each crisis team had a mid-day handover along with at least two bed management meetings per day. For the teams attached to the acute inpatient units the bed management meetings included ward managers and senior staff.
- Data provided by the trust within the accuracy challenge demonstrated a reduction in the use of police custody under section 136 of the MHA, from 23 occasions in October 2014 to 4 in July 2015.The use of the health based place of safety had increased during the same period from 2 to 24 occasions.

Are services caring?

Good

We rated caring as good because:

- We observed staff interactions with patients in all the crisis teams. These were respectful, caring and supportive. Staff conducted themselves in a professional manner and showed empathic behaviours towards the patients.
- We spoke with eight patients either during our inspection or subsequently over the phone. They told us they found the staff supportive and had been very helpful in overcoming the immediate issues they faced.

Are services responsive to people's needs?

Requires improvement

We rated responsive as requires improvement because;

- The Mental Health Crisis Care Concordat states “People in crisis should expect local mental health services to meet their needs appropriately at all times”. The information leaflets produced for the crisis teams indicated they operate 24 hours a day, with telephone support available at night. None of the teams we visited operated after 9.30pm and all relied on night nurse practitioners to answer the phone to patients. These staff had a range of other responsibilities to attend to at night such as on-site support and staffing the health based place of safety. This meant patients trying to contact the crisis teams for support could not be guaranteed their call would be answered in a

Summary of findings

timely fashion. We had received feedback from patient groups prior to our inspection confirming this was a concern. The trust subsequently made us aware of the work its undertaking with its commissioners to improve this situation.

- The main target group for the crisis teams were; patients aged 18 and over whose mental illness is of such severity they were at risk of requiring acute inpatient care. Whilst the stated aim of these teams is to provide treatment within the patient's home environment we found very little evidence of this being available. No team was able to offer any more than two visits per day per patient, with a limited range of interventions based on the skills of the individual staff.
- Staff told us they tried to respond as quickly as possible to any deterioration in a patients' mental health. However they acknowledged this may only be a phone call to the patient or the carer. Staff in North Devon told us they could not realistically offer an alternative to hospital admission and if they had significant concerns about a patient they would need to arrange an urgent inpatient stay.

However:

- The waiting times for all teams from referral to triage assessment were four hours for very urgent and 24 hours for routine cases. All the team managers showed us the systems they used for monitoring and reporting to ensure these timescales were met.
- The Torbay and Teignbridge teams had access to a crisis house which provided 24 hour support based on a coaching model. Crisis house beds are used as part of a home treatment package.
- All of the crisis teams had access to a social care budget to support a three night stay for people who require alternative accommodation to facilitate home treatment. This could be in a supported provider accommodation or if appropriate a bed and breakfast or hotel.

Are services well-led?

Requires improvement

We rated well led as requires improvement because:

- Some team managers reported difficulty in getting consistent and timely feedback to outcomes from complaints and serious incident reporting.
- Managers were not able to tell us how many people were refused admission to the health based place of safety.

Summary of findings

- Managers were not ensuring that important functions of a crisis and home treatment team such as monitoring people's physical health and implementing crisis intervention plans were in place across the service.

However:

- Staff knew who their local managers were and were aware of the chief executive and nursing director. In Torbay, staff were very positive about the recent trust board walkabout visit to their unit.
- Crisis team managers had access to electronic trust wide governance systems which enabled them to monitor and report on team performance such as; assessment times, supervision, appraisals, training, sickness absence etc. These systems reported information direct to the directorates' senior management team and the central trust governance teams.
- The team managers and staff were working hard with the resources available to provide interventions for people in crisis within a challenging geographical area which included both urban and rural locations.

Summary of findings

Information about the service

Devon Partnership NHS Trust has three health-based places of safety, or section 136 suites, located on three hospital sites across Devon. The place of safety is for people who were detained under section 136 of the Mental Health Act. This is the power police officers have to detain people, who they believe have a mental disorder in a public place, and to take them to a place of safety for assessment.

There were six crisis and home treatment teams within Devon. These teams help support people at home when in mental health crisis and support with earlier discharge from hospital. The teams aim to facilitate the early discharge of patients from hospital or prevent patients being admitted to hospital by providing home based support.

There is a street triage service in Exeter to provide police officers with support when they believe people need immediate mental health support. The aim of this team is to ensure that people get mental health professional input and divert people from inappropriate police custody or section 136 of the Mental Health Act assessments.

We previously inspected mental health crisis services and health-based places of safety in February 2014, but they were not rated.

Our inspection team

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 which undertook the core service inspection was:

- one inspection manager
- two inspectors
- one Mental Health Act reviewer
- three nurses
- one commissioner of 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?

Summary of findings

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

During the inspection visit, the inspection team:

- visited six crisis teams and the three health-based place of safety. We looked at the quality of the environments and observed how staff were caring for patients
- spoke with eight patients who used the crisis service
- spoke with five carers of patients who used the service
- spoke with 38 staff members; including doctors, nurses, support workers and student nurses
- attended and observed four clinical meetings, three assessments, three handovers and two bed management meetings
- looked at 40 treatment records of people using services
- 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

We received positive feedback from people who were either currently using the crisis services or those with recent experience. We did however receive some negative feedback from the local Healthwatch group about the experiences of some patients trying to access the out of hours telephone support service.

Good practice

In the south Hams and west Devon team we saw a good example of embedded learning practice. As soon as any event or incident was identified to the team the manager, they delegated a member of staff to undertake a timeline of events. This was to identify if there was a time or action that could have resulted in a different outcome for the patient. Any outcomes or learning was then shared with the team.

Areas for improvement

Action the provider MUST take to improve

- The trust must provide a dedicated telephone support line throughout the night for patients of crisis teams.
- The trust must ensure care plans are personalised, recovery oriented and contain crisis plans.

Action the provider SHOULD take to improve

- The trust should ensure that outcome measures and clinical audits are routinely used.
- The trust should ensure that the information leaflets for the crisis teams correctly reflect the hours of operation and services available.
- The trust should ensure a range of interventions is available within each team to provide a consistent approach.
- The trust should ensure that physical health assessments are completed for all patients if clinically indicated.
- The trust should, with its partner agencies, ensure that it is adhering to its local policy or the Mental Health Act Code of Practice in its use of police custody.

Devon Partnership NHS Trust

Mental health crisis services and health-based places of safety

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Exeter crisis resolution home treatment team	Wonford House Hospital
East and mid Devon crisis resolution home treatment team	Wonford House Hospital
Exeter health-based place of safety	Wonford House Hospital
Torbay crisis resolution home treatment team	Torbay Hospital
Torbay health-based place of safety	Torbay Hospital
Teignbridge crisis resolution home treatment team	Wonford House Hospital
North Devon crisis resolution home treatment team	North Devon District Hospital
North Devon health-based place of safety	North Devon District Hospital
South hams and west Devon crisis resolution home treatment team	Wonford House Hospital

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.

Detailed findings

- Staff in the crisis teams and the staff managing the health based place of safety could refer people for Mental Health Act (MHA) assessments as required. The approved mental health practitioners were employed by the local authorities.
- At our previous inspection we highlighted that the trust had an ad-hoc approach to accessing Section 12 approved doctors when considering detaining a patient under the Mental Health Act. The trust had addressed this and ensured that Section 12 doctors were available 24 hours a day for the crisis teams.
- We saw how data was collected about how long people spent in the health based place of safety suite, and what the outcome of their assessment was.
- The trust, with its partner agencies, was not always adhering to its local policy or the MHA Code of Practice in its use of police custody. The police told us admission was sometimes refused because of smelling of alcohol, a history of aggression or insufficient staff to cover a unit. Staff working on these units confirmed this did happen but not on regular occasions. As part of the accuracy check following the inspection the trust provided data that showed that the health based place of safety had been closed 17 times due to lack of staff; four times due to it being required as an additional bed; three times because staff were required for observations and twice because the patient was too violent to be admitted to the health based place of safety.

Mental Capacity Act and Deprivation of Liberty Safeguards

- Mental Capacity Act training was completed by at least 94% of staff in crisis teams with the exception of the east Devon team which was 67%.The team manager told us staff could not book in on the electronic system for future courses at the moment.
- Care records we examined in all the crisis teams did not consistently record patients' mental capacity status or their consent to treatment.
- There was considerable variance across the teams in how the Mental Capacity Act was applied. With the exception of the Teignbridge team we noted a marked lack of capacity assessments of patients who were on the team's caseload.
- Patients were being offered limited treatment in the community by the way of medicines, and without a legal framework to support the actions of the staff. Where assessments of capacity were undertaken they were "tick box" style without any depth or evidence to justify why they had arrived at the conclusion that the person lacked/did not lack capacity.
- Managers told us their teams knowledge about mental capacity assessments and the legal framework was depleted when approved mental health practitioners had left the teams.
- Training for nursing staff on their duties to operate within the legal framework was delivered by e-learning and was updated every three years.

Requires improvement

Are services safe?

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

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

Summary of findings

Please see the summary at the beginning of this report.

Our findings

Safe and clean environment

- Staff working within the three health-based places of safety were issued with personal alarms which were linked to the associated ward and part of the overall emergency response process.At Torbay there was a panic alarm linked to the local police station, and staff we met told us their expectation was for a response by the police within four minutes.
- The layout of all three health based places of safety enabled staff to observe patients safely whilst in the suites.
- We saw there were ligature risk assessments undertaken and risks were mitigated by the presence of staff at all times, who were able to constantly observe the patient.
- All three health-based places of safety had reasonable furniture and equipment. At the Torbay health based places of safety we noted there was only a mattress on the floor rather than a bed for patients to sleep on. Staff told us the base was broken and they were awaiting a replacement.
- Each one had clean bathroom and toilet facilities which were cleaned on a daily basis by the ward based cleaning staff. There were also facilities for making tea and coffee along with the availability of snacks or meals for the patients.
- All of the teams within the health-based places of safety had access to a clinic area where resuscitation and emergency equipment was located.

Safe staffing

- Staffing levels for the crisis teams were: East Devon 9.4 qualified staff and 3.0 support workers, Exeter 8.6 qualified staff and 2.0 support workers, Torbay 12.0 qualified staff, North Devon 11.3 qualified staff and 5.0 support workers, South Hams and West Devon 8.0 qualified staff, Teignbridge 9.3 qualified staff and 1.0 support worker with 1 band 5 vacancy.
- Each of the three health-based places of safety were currently managed by a night nurse practitioner.These were the only staff dedicated to work within these environments across the 24 hour period. At least two extra staff were required each time a patient is admitted to the suites and these had to come from the associated inpatient wards. We were told by managers that a dedicated team for the places of safety were being actively recruited and should be in place by January 2016.
- Each manager of the crisis and home treatment teams we visited reported there was very little staff turnover in each of the teams.In each team, staff on duty matched the numbers indicated within the current rota. Sickness levels were under 4% except in North Devon (9.4%) and South and West Devon (9.6%).
- The trust had previously made changes which affected the staffing mix within each team following the departure of social workers to the local authorities. Whilst the crisis teams could still have access to social workers to fulfill their approved mental health practitioner role they were not part of crisis team.
- We were told by team managers and staff that each team accommodated the varying caseload demands placed on it. Each team assessed its caseload size and any new patient referrals at least once a day. We were told by one manager that they had recently been made aware of a clinical standard operating process which indicated a maximum caseload of 20 patients per team.They and none of the other staff we spoke with were aware this was being introduced by the trust. The caseloads for each team at the time of the inspection were : East and mid Devon 33, Exeter 44, north Devon 26, south and west Devon 20, Teignbridge 26, Torbay 24.
- Each of the crisis teams had established systems to gain rapid access to a psychiatrist either via their own consultant or an on call system.

Requires improvement

Are services safe?

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

- The health based place of safety were covered by on call psychiatrists and section 12 doctors via two separate rotas.
- The trust provided us with the latest data on compliance with mandatory training for staff in the crisis teams.This indicated 85%of staff were up to date. However, managers we spoke with told us they have difficulty in booking staff on to future mandatory training dates as the system would not allow it.

Assessing and managing risk to patients and staff

- We saw evidence in all the records we reviewed of the risk assessment process which staff completed for all new patients at the initial assessment. However these risks were not routinely updated within the risk management plan, but staff used the progress notes section to indicate a change in risk.
- We did not see any of the teams routinely use crisis plans or advance decisions for their patients. We were told by team managers the trust was developing crisis contingency plans for all patients, but they were not aware of the implementation date.
- Staff told us they tried to respond as quickly as possible to any deterioration in a patient's mental health. However they acknowledged this may only be a phone call to the patient or the carer. None of the teams we visited were able to offer any more than two visits a day to a patient and none after 9.30pm. Staff in North Devon told us they could not realistically offer an alternative to hospital admission and if they had significant concerns about a patient they would need to arrange an urgent inpatient stay. At night if a patient was in crisis they were mainly offered support by telephone helpline which was manned by the night nurse practitioners. These staff had a range of other duties to attend to which may include; bed management, site support, assessment within the emergency department, staffing the health based place of safety. This meant that they could not guarantee to answer the phone for the patients and offer advice. Patients were supported to travel to the health-based place of safety to be assessed in person if necessary. Transport was provided to facilitate this if required.
- Staff were trained in safeguarding arrangements and all those we spoke with knew how to recognise the signs of abuse and how to raise safeguarding alerts. We observed in two handovers staff highlighting safeguarding concerns about patients and making plans to ensure patient safety.
- Each of the crisis teams had established personal safety and lone working protocols. Staff had access to diary or a white board which highlighted their whereabouts. In all teams staff used personal tracking devices and alarms. We were told by managers that the trust had stopped issuing these to new staff as the contract had now expired. Teams had created their own practices in ensuring staff safety on visits. For example in south Hams and west Devon where staff visited many rural areas without any mobile or electronic coverage, staff text their visit plan and when they had access to a mobile network text the manager that they had completed their visit.
- The medicines management arrangements differed across the teams as not all administered medicines. In the Exeter and east Devon teams a wide variety of medicines were used and stored on site. We noted that the fridge temperature had not been routinely monitored throughout the month of July. We bought this to the attention of the team manager who advised us they would immediately arrange for the shift coordinator to undertake this role each morning.

Track record on safety

- There were ten serious incidents recorded within the health-based places of safety and eight serious incidents recorded for the crisis and home treatment teams.
- Team managers told us they wouldn't get routine information about serious incidents occurring in other teams as it was only focused on their areas. They did, however, receive information about improvements or learning once root cause analysis had been undertaken across the core service. They told us they would pass this information on to staff via the team meetings and we saw evidence to corroborate this. An example of an improvement which had been made was a named team lead for patients who were receiving services across multiple teams

Requires improvement

Are services safe?

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Reporting incidents and learning from when things go wrong

- All staff we spoke with knew how to report incidents using the trust wide electronic system.There was concern in the team about the outcomes around individual incidents, as staff told us this system do not provide any direct feedback to them.The team managers expressed frustration over this but said they were now receiving monthly summaries of lessons learnt from the governance team.We also saw evidence of a patient safety group which met monthly for the directorate and analysed trends from incident reporting.
- Staff also told us they did receive feedback from incident investigation and were able to be debriefed and supported as required. We received mixed feedback from staff about the process for explaining to patients when things had gone wrong. Some told us they thought it was appropriate, whilst others thought more could be done to improve communication for patients.
- In the south Hams and west Devon teams we saw a good example of embedded learning practice. As soon as any event or incident was identified to the team manager, they delegated a member of staff to undertake a timeline of events. This was to identify if there was a time or action that could have resulted in a different outcome for the patient. Any outcomes or learning was then shared with the team.

Are services effective?

Requires improvement

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

During the inspection of this core service we looked at 40 care records.

Assessment of needs and planning of care

- We looked at a sample of new patient assessments in each team and saw these were comprehensive and completed on the first meeting. However, the teams reported that when they were at their busiest and reaching full capacity there were occasions when assessments were completed over the phone.
- The care records we looked at were of a standardised nature using the trust's electronic (RiO) system. The care plans were not personalised or recovery orientated. The patients' progress notes were of good quality and indicated risk updates and treatment progress. Not all care plans we saw listed the interventions on offer and nor did they address how interventions would alleviate the patients' crisis. An example of this we saw included taking a patient for a coffee. Another listed the patient to ring the crisis team on a daily basis but did not indicate to staff what support to give.
- All the teams used the electronic RiO system and had access to the records at all times. This information was also available to the acute inpatient units and health-based places of safety. We were told by the trust and staff we spoke with that this system would be replaced later in the year.

Best practice in treatment and care

- Patients referred to the crisis teams were not always assessed by a psychiatrist but predominately by nursing staff. The patients' GP mainly undertook prescribing although in Exeter and east Devon there was involvement from a psychiatrist. We saw they had access to detailed prescribing guidance and regular support from the trust pharmacist.
- There were no psychologists attached to any of the teams. We were told by staff this was due to the short term nature of the work. Psychological interventions such as mindfulness were not routinely available within the teams. We were told by the manager of the Torbay service that a couple of their staff had undertaken training in these interventions and were able to offer that to the patients.
- Patients who required support for issues such as employment, housing or benefits would be referred on to either the social services or an appropriate agency.
- The physical healthcare needs of patients within the crisis teams was not routinely addressed. Whilst we saw some individual cases in each of the teams where staff had identified particular physical healthcare issues, it did not form part of the overall care plan.
- None of the teams we visited were routinely participating in any clinical audits. They did use health of the nation outcome scales to assess the level of severity of the patients health needs.

Skilled staff to deliver care

- The crisis teams consisted of psychiatric nurses, support workers and psychiatrists. There were no occupational therapists or psychologists employed in any of the teams. In the east Devon team they were managed by a social worker but this discipline was not available elsewhere. Devon and Torbay local authorities operated separately approved mental health professional (AMHP) service. These were available to the crisis and health-based place of safety teams on request. We were told by staff that at night there were often delays in getting timely access from the Devon AMHP service, as they had to cover a large geographical area.
- All of the staff we met had substantial experience of working within the crisis teams. There was very little turnover of staff in any of the teams, with most averaging only one leaver over the last 12 months.
- We did meet a member of staff who had been recently transferred into one of the teams from an inpatient service. They described to us their induction and support they had received since taking up their post, which they described as very helpful. The team managers showed us their plans for local as well as trust wide induction.
- Staff we spoke with and evidence we saw confirmed there was supervision undertaken every six weeks in line

Are services effective?

Requires improvement

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.

with the trust policy. Staff also confirmed they could seek additional supervision from peers and managers as required. All staff were appraised in line with the trust policy.

- There were two teams where the appraisal rate was not 100%.These were both at 93%.
- There was no role specific training available for nursing or support staff, either within crisis teams or the health based places of safety.
- There were no staff performance issues identified at the time of the inspection. Team managers were able to competently describe how they would deal with any performance issues which may occur.

Multi-disciplinary and inter-agency team work

- Staff told us that they held regular team meetings. We saw the minutes of monthly team meetings. These included a range of issues, both clinical and organisational, which the teams needed to be informed of.
- Each crisis team under took a mid-day handover along with at least two bed management meetings each day. For the teams attached to the acute inpatient units the bed management meetings included ward managers and senior staff. We observed handovers in each of the teams we visited and these were conducted in a professional manner.
- Working links with primary care services, the police, social services and housing were well established within each of the teams. We found team locations impacted on the level of interagency working. For example, Teignbridge team was co-located with social services and community mental health teams. We saw how this enabled good communication with staff able to consult with other colleagues. However, the south Hams and west Devon team were quite isolated and had limited face to face interactions with other agencies.
- We found good working relationships with the police and regular liaison meetings took place with key agencies including the ambulance service, approved mental health professionals and the trust's street triage team. The street triage team was based in the police control centre and not in police vehicles. The team was able to pass on information to police on the beat which should contribute to reducing the use of section 136; examples were linking a person with their mental health care coordinator and educative role for officers. Data collation was not yet integrated between agencies. The funding for street triage was not yet permanent and was shared with other agencies including the police commissioner.

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

- At the time of our inspection no patients were subject to the Mental Health Act on any of the crisis teams caseloads.
- Staff in the crisis teams and the staff managing the health-based place of safety could refer people for Mental Health Act assessments as required.
- At our previous inspection we highlighted that the trust had an ad-hoc approach to accessing Section 12 approved doctors when considering detaining a patient under the Mental Health Act. The trust has addressed this and ensured that Section 12 approved doctors were available 24 hours a day for the crisis teams.

Good practice in applying the Mental Capacity Act

- Mental Capacity Act training was completed by 94% of staff in crisis teams with the exception of the east Devon team which was 67 %. The team manager told us staff could not book in on the electronic system for future courses at the time of the inspection, due to technical difficulties but these were subsequently resolved.
- Care records we examined in all the crisis teams did not consistently record patients' mental capacity status or their consent to treatment.
- We saw there was considerable variance across the teams in how the Mental Capacity Act was applied. With the exception of the Teignbridge team we noted a marked lack of capacity assessments of patients who were on the teams caseload. By virtue of being a crisis resolution patient (i.e. in crisis, mentally unwell, consideration of hospital treatment) it would indicate that a person's capacity may be lacking or variable.
- Patients were being offered treatment in the community by the way of medicines, and without a legal framework to support the actions of the staff. Where assessments of

Are services effective?

Requires improvement

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.

capacity were undertaken they were "tick box" style without any depth or real justification as to why they had arrived at the conclusion that the person lacked/did not lack capacity.

- Managers told us their teams' knowledge about mental capacity assessments and the legal framework was depleted when approved mental health practitioners had left the teams. Training for nursing staff on their duties to operate within the legal framework was delivered by e-learning and was updated every three years.
- We saw that only doctors were provided with face to face training delivered by the trust's solicitors. Given that crisis resolution team nurses had to make immediate assessments of people's mental capacity to accept care and treatment they should be afforded the same level of training. This would help ensure that all staff were provided with the knowledge and understanding of the legal framework they should operate within.

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

- We observed staff interactions with patients in all the crisis teams. These were respectful, caring and supportive. Staff conducted themselves in a professional manner and showed empathic behaviours towards the patients.
- We managed to speak to eight patients either during our inspection or subsequently over the phone. They told us they found the staff supportive and that the staff had been very helpful in overcoming the immediate issues they faced.
- The knowledge of staff about patients' needs on the team's caseload was understandably varied. As the average length of stay on the case load was about three weeks this did not give staff the opportunity to establish detailed understanding of patients' longer term needs. However, they could describe the immediate issues patients faced, and drew this from both their knowledge and that on the care record system.
- The teams used large wall mounted whiteboards as a case load management tool, these boards contained personal and confidential information about patients. Not all boards had been fitted with blinds to protect confidential information. We did not observe any blinds in use during our visits and in the Exeter and mid Devon team office we observed people passing through the office where whiteboards displayed this information. We raised this with the team manager who told us they would address the issue with the estates department to get blinds fitted.

The involvement of people in the care that they receive

- In the 40 care records we reviewed there was quite limited patient involvement within the care plans, as these were standardised and generic in nature. The staff and patients we spoke with told us copies of the care plans were routinely shared with patients. However, staff told us they would not necessarily share any risk management information.
- Although we saw information leaflets written for carers we did not routinely find information about either their involvement or support needs. We did see frequent mention of patients' carers throughout the progress notes we reviewed.
- In the health-based places of safety staff were caring and aware of what was required of them. For example there was an awareness of protecting dignity, particularly where the environment had its limitations, such as not having a separate entrance, and awareness about informing the person about their rights including how to access this in different languages.

Are services responsive to people's needs?

Requires improvement

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

- Access to the crisis teams was by referral from the patients GP or by the community mental health team. Patients already known to the service could self- refer.
- People who did not meet the criteria for the crisis teams are referred to other support agencies such as the Samaritans or Mindline south Devon and Torbay.
- The waiting times for all teams from referral to triage assessment were 4 hours for very urgent and 24 hours for routine cases. All the team managers showed us the systems they used for monitoring and reporting to ensure these timescales were met. All of the teams used telephone contact to initially triage all referrals using standard assessment templates.
- All of the teams managed the referral process within the existing staff complement, and each day would identify key staff to administer the referral and assessment system. Team managers told us it was not always possible to physically assess new patients when team capacity was at full stretch. They and staff we spoke with confirmed assessments may be completed over the phone. At night any patient requiring an urgent assessment could only be seen within a hospital environment. This assessment was undertaken by either a night nurse practitioner, on call junior doctor or the liaison psychiatry team. Patients were provided with support to travel to and from the hospital if required.
- Each crisis team were the gatekeepers for acute bed management within their catchment area. They liaised every day with inpatient services and the bed management team to identify and manage available beds. The average occupancy for acute beds within the trust was approximately 96 per cent. Staff we spoke with told us it was an ongoing issue for them and their patients, and had consistently resulted in patients requiring beds outside of the trust area.
- Crisis teams within south Devon had access to 19 crisis beds located within two separate independent providers. Patients' we spoke with who used this service told us they found it useful and supportive.
- The Torbay and Teignbridge teams had access to a crisis house which provided 24 hour support based on a coaching model. Crisis house beds were used as part of a home treatment package.
- Patients who lived within the south Hams and west Devon's catchment area could be admitted to a health-placed place of safety (HBPOS) provided by a different trust. This meant that whilst the patient may be known to the crisis team they were receiving care and treatment from the HBOS provider might not be familiar with the patient's history. Staff told us that the other provider rang the night nurse practitioner or the south Hams and west Devon crisis team to get information on the patient's history.
- The information leaflets produced for the crisis teams indicated they operated 24 hours a day, with telephone support available at night. None of the teams we visited operated after 9.30pm and a limited response of a night nurse practitioner to answer calls from patients was provided. These staff had a range of other responsibilities to attend to at night such as on-site support and staffing the health-based place of safety. This meant patients trying to contact the crisis teams for support could not be guaranteed their call would be answered in a timely fashion. This did not comply fully with the Joint Commissioning Panel for Mental Health guidance which states that there should be a 24 hour telephone line for those receiving home treatment. We had received feedback from patient groups prior to our inspection confirming this was a concern.
- The main target group for the crisis teams were; patients aged 18 and over whose mental illness was of such severity they were at risk of requiring acute inpatient care. Whilst the stated aim of these teams was to provide treatment within the patient's home environment we found very little evidence of this being available. No team was able to offer any more than two visits per day per patient, (this is the minimum number of visits recommended by the Joint Commissioning Panel for Mental Health) and with a limited range of interventions based on the skills of the individual staff.

Are services responsive to people's needs?

Requires improvement

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

- Staff explained to us that where they had concerns or were unable to contact the patient they could escalate this and arrange a home visit. However, this could not always be done immediately due to variations in staff capacity and the large geographical catchment areas. Each team told us they could rely on the police service to undertake a home-based welfare visit in very urgent cases.
- Information provided by the trust as part of the accuracy process demonstrated a significant reduction in the use of police custody and a corresponding increase in the use of the health based place of safety.
- There was limited flexibility for appointment times due to the availability of staff, but the patients to be seen were prioritised by senior staff based on clinical need.
- We saw how information on the electronic RiO system was recorded about how long people spent in the health-based place of safety suite, and what the outcome of their assessment was, such as being admitted to a bed.
- The trust, with its partner agencies, was not fully adhering to its local policy or the Mental Health Act Code of Practice in its use of police custody. The police told us admission was sometimes refused because of smelling of alcohol, a history of aggression or insufficient staff to cover a unit. Staff working on these units confirmed this did happen but not on regular occasions. As part of the accuracy check following the inspection the trust provided data that showed that the health based place of safety had been closed 17 times due to lack of staff; four times due to it being required as an additional bed; three times because staff were required for observations and twice because the patient was too violent to be admitted to the health based place of safety.

The facilities promote recovery, comfort, dignity and confidentiality

- Torbay and Exeter health-based place of safety had direct access from the car park. The one at Combehaven required staff and patients to access the suites via corridors some distance from the main entrance.
- The environments for all the staff based in the crisis teams were clean and tidy, but appeared rather cramped for the number of staff based in those rooms. Staff we spoke with told us handover times were particularly difficult given the number of staff needing to be in the room at once.

Meeting the needs of all people who use the service

- A wide range of information leaflets were available within each team base which gave patients and carers details of services available, medicines, complaints process, and service feedback. The only information readily available was in English, which would cater for the pre-dominant ethnic group in the county. However, managers told us they had access to translation services via the trust website which we were shown. The information leaflet for the crisis teams gave the impression that teams were made up of social workers and other professional staff. It also suggested patients had access to the team 24 hours a day. Neither of these statements were factually accurate, although patients did have access to the night nurse practitioner via the telephone.

Listening to and learning from concerns and complaints

- There were 26 complaints for community crisis services during the last year. 12 were upheld. None were referred to the parliamentary health ombudsman.
- We had a mixed response from patients we spoke with about whether they knew how to complain. Some told us they had seen the information on how to contact PALS (patient advice and liaison service), whilst others were unsure but said they would speak to the nurse or team leader. Staff told us that they were now using an electronic acute care survey with all patients seen by the service. However, they were not aware of the results of the surveys.
- Staff we spoke with told us they would refer complaints to the team manager or pass the information to the PALS department. Team leaders described how they would investigate complaints on the direction of the service manager. They would not investigate complaints within their own teams.

Are services responsive to people's needs?

Requires improvement

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

- Not all staff we spoke with were aware of the outcomes or actions arising from complaints within their teams. Whilst team managers told us they would endeavour to pass on information in team meetings there were no formal established routes.

Are services well-led?

Requires improvement

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

- Copies of the trust's visions and values were on display across team bases we inspected. However, staff we spoke with had varying degrees of knowledge about these values. They all told us they were committed to providing good quality patient care.
- None of the crisis teams had any specific team objectives in line with the values and vision of the trust.
- Staff knew who their local managers were and were aware of the chief executive and nursing director. In Torbay, staff were very positive about the recent trust board walkabout visit to their unit.

Good governance

- Crisis team managers had access to electronic trust wide governance systems which enabled them to monitor and report on team's performance such as; assessment times, supervision, appraisals, training, sickness absence etc. These systems reported information to the directorate's senior management team and the central trust governance teams. However, all team managers reported difficulty in getting consistent and timely feedback to outcomes from complaint and serious incident reporting.
- Teams had effective safeguarding processes but did not consistently ascertain patients' mental capacity or consent to treatment.
- None of the teams we visited could produce any evidence of clinical audits taking place.
- Team managers told us they felt they had sufficient managerial authority to undertake the role. The amount of administrative support did vary with each team, and in the south Hams and west Devon service was absent.
- We were shown copies of both local and directorate team risk registers which in turn could submit items to the trust risk register.

Leadership, morale and staff engagement

- There were no bullying and harassment cases we were made aware of during inspection week.
- Staff we spoke with told us they knew how to use the trust whistle-blowing process.
- Staff morale across the teams varied but overall staff were positive and remained professional in their discussions with us.
- Staff did not demonstrate knowledge of the crisis care concordat action plan which details many proposed changes to the operation of the service, it was not clear at the time of the inspection how involved staff had been in the development of the action plan.

Commitment to quality improvement and innovation

- The trust was participating in the mental health crisis care concordat with their partners and had developed an acute care pathway to improve services. This had included the development of an action plan. The crisis care concordat action plan recognised that the service was not operating as an efficient alternative to inpatient treatment and had agreed with key partner agencies and commissioners the priority actions required to improve the service. These included developing a single point of contact with access to clinicians 24 hours a day, developing clear crisis care pathways to make accessing crisis care easier for patients and professionals referring them, and the introduction of outcomes and progress measures to enable appropriate monitoring of service delivery and allow improvements to be made where areas of under performance were identified.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care We found the provider had not ensured care plans contained crisis plans, they were not personalised or recovery oriented. This was a breach if Regulation 9(1)(a)(b)(c)(3)(a)

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment We found that the 24 hour telephone line could not be guaranteed to always be answered in a timely manner, as the night nurse practitioner may be attending to other duties. This could place patients at risk. This was a breach of Regulation 12(1)